COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Reference: Long-term strategies to address the ageing of the Australian population over the next 40 years

WEDNESDAY, 17 SEPTEMBER 2003

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Wednesday, 17 September 2003

Members: Dr Southcott *(Chair)*, Ms Hall (*Deputy Chair*), Ms Corcoran, Ms Ellis, Ms Gambaro, Mr Hartsuyker, Mr Hunt, Mrs May, Mr Mossfield and Mr Tony Smith

Members in attendance: Ms Ellis, Ms Gambaro, Ms Hall, Mr Mossfield, Mr Tony Smith and Dr Southcott

Terms of reference for the inquiry:

Long-term strategies to address ageing of the Australian population over the next 40 years.

WITNESSES

GRAY, Mr Richard Nelson Worsley, Director, Aged Care Services, Catholic Health Australia 691

SULLIVAN, Mr Francis John, Chief Executive Officer, Catholic Health Australia 691

Committee met at 9.28 a.m.

GRAY, Mr Richard Nelson Worsley, Director, Aged Care Services, Catholic Health Australia

SULLIVAN, Mr Francis John, Chief Executive Officer, Catholic Health Australia

CHAIR—I declare open this public hearing of the House of Representatives Standing Committee on Ageing in its inquiry into long-term strategies for ageing. Today we will hear from Catholic Health Australia. The committee has heard from a number of witnesses that effective community, residential and health care strategies will be essential for addressing the needs of an ageing population. Catholic Health Australia, as a provider of services throughout the country, has national systemic experience which will provide useful insights for the committee.

I welcome representatives of Catholic Health Australia to today's public hearing. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. Catholic Health Australia has made a submission, submission No. 94, to the inquiry and copies are available from the committee secretariat. Would you like to make an opening statement before I invite members to proceed with questions?

Mr Sullivan—Thank you for the opportunity of presenting here this morning. We need to make a few comments in addition to everything that is in our submission. Australians need a national aged care system. At present, aged care services are best described as a mixture of hit-and-miss programs. Elderly Australians do not enjoy equal access to essential aged care. Too often, access to residential care is restricted by geography or simply by the availability of beds. Increasingly, aged care home providers are being encouraged to pursue user-pays solutions to the declining subsidy base from governments. In the long run, this will unfairly discriminate against people on meagre incomes and with modest assets.

CHA has tracked the erosion of the Commonwealth's aged care subsidy in relation to the costs of care. Our research covers the period from the start of the government's aged care reforms in 1998. It demonstrates the degree to which user charges bridge the gap between the community's contribution and the real costs of providing the level of care the community expects. Even by conservative estimates, last year the Commonwealth subsidy was short by $248 million. I will table that research—a graph—for you. We will also provide the secretariat with electronic mechanisms for that.

It is important to be reminded of who actually is being cared for in aged care homes. The Australian Institute of Health and Welfare figures show that these days the average age of admission to a home is 86 years. Over 63 per cent of people are admitted to the high care end of the service. Well over 80 per cent of these people are pensioners. They are the frailest and the sickest in the aged care program. They also have not had a long history of superannuation and accumulated wealth. Close to 83 per cent of residents die in the homes. Of those, 31 per cent die within the first nine months since admission. Clearly, residential aged care is increasingly a health care service, in particular for terminal care. In the past, people sought hostel

accommodation to live in supported dependency. Today, much of that service is conducted in people's own homes.

It is essential that the high care service becomes integrated with the health system. Commonwealth, state and territory governments have not come to terms with an ageing Australia. There is a dysfunctional relationship between the hospital and community care sectors. Responsibilities are blurred and hospitals have become the places of last resort for the frail and dependent. CHA has suggested previously that the Commonwealth take full responsibility for the over-70s, including their hospital and aged care needs. This would be similar to what the Commonwealth presently does for veterans. There is plenty of scope to creatively balance extending Medicare cover for the over-70s and continuing to provide a mixture of public and private insurance cover for the remainder of the population. This will not undermine universal health insurance—rather, it will streamline access for vulnerable elderly people whilst making private cover more affordable and thus more effective in shifting demand in the health system.

Our submission suggests particular initiatives to provide certainty for the elderly, including the extension of the Medicare entitlement to cover access to private hospitals and the development of an aged care benefit schedule to better fund home and community care. Sadly, a decent level of home care support relies more on the goodwill and sacrifice of families and carers than it does on an adequate and predictable level of government intervention. This is the growth end of aged care services, but remains poorly organised, resourced and evaluated.

Governments of all persuasions have sought market type solutions to both residential and home care services. Obviously, this is an attempt to encourage private capital investment in lieu of diminishing public investment. However, there has not been an explicit debate over what is a reasonable return on investment from a public policy perspective. CHA believes the best human services system should be based on a not-for-profit motivation. This still encourages private investment, but with a greater degree of tolerance by investors for sustained low returns. It also accords more appropriately with the ethos of providing care to sick and vulnerable people.

We would encourage the committee to consider the role of private investment and the consequent incentives for profit-making a system must inherently provide. Is this the most suitable public policy structure for the future? Does this shift responsibility too far from public duty and create inevitable poverty traps for the hard-up and disadvantaged? We appreciate that the committee has a broad ranging set of terms of reference. You will note our submission has addressed many of the financing as well as service delivery aspects of those references. However, our sector is committed to delivering care. We are particularly concerned for the poor and marginalised. We would encourage you to see these issues through their eyes and from their life experience. In so doing, you can be confident that the common good will be served and the dignity of everyone will be preserved. Thank you.

CHAIR—Thank you very much for your submission and your opening statement. You mentioned the role of private investment. Were you talking about aged care?

Mr Sullivan—More broadly—health and aged care.

CHAIR—So that I have Catholic Health's position clear, do you have any preconceived idea of how private investment can be facilitated into aged care?

Mr Sullivan—Our assumptions are the following. We have a mixed system now and our experience has come from our hospital experience. We have 60 hospitals, 22 of which are public hospitals—they are privately owned, but there is full public access. The remainder are classic private hospitals. So we have a long history of private investment in public services. The model I am suggesting here is a model of partnership with private investment, rather than establishing an environment where private investors can expect a best return on investment. You can see it at the moment if you take the private hospital sector. We have a major private hospital chain, which seemingly wants to get out of either direct management or direct ownership of its hospitals. You can only go on the published reports of their managing director, who would argue that there is not the sustained return on investment to keep private shareholders interested. Why? Basically the structure of health services and the structure of aged care services are such that they require massive capital investment on an ongoing basis, but the break-even margins of those industries are so high that you cannot guarantee the sorts of levels of return that shareholders will persist with. Thus, if you are going to look for other than public investment from predominantly, I would suggest, not-for-profit organisations, you need to provide those organisations with a sense of long-term certainty of participation in the industry. You can see it across many programs.

I do not believe this is party political. I think this move by particularly the Commonwealth has been much more towards price competition markets than sustained partnerships between government and other than government organisations. You need to give people certainty that, if they put capital investment in, they will be able to meet the capital repayment requirements over the period. I think aged care is a classic example. We all know there is an issue about capital investment in aged care for construction and the like, and the acquisition of capital. So it strikes me that it is about a paradigm firstly. What are the parameters of the paradigm? What are the assumptions? Are the assumptions that private investment should get what is considered to be a reasonable return or should they be able to maximise their return? Are we talking about reasonable cost recovery or are we talking about maximising market niches? There are a whole set of parameters that need to be examined.

Mr Gray—In residential aged care, once you move outside the metropolitan areas and major regional centres, private for-profit investment in residential aged care is nonexistent, and in the foreseeable future there is not likely to be any mechanism for those investors to really want to move into those geographic areas.

CHAIR—I think your idea of a health savings account is very interesting. Singapore does something similar. I do not know if you were thinking specifically of what Singapore does. How would that be different from someone, say, making a voluntary contribution to their superannuation fund? I presume you are thinking of a fund that would offer similar returns to superannuation, with similar sort of management, but people would presumably be able to withdraw it if it were to pay for some sort of health expense.

Mr Sullivan—More broadly, over the last few years we have used the term 'long-term savings vehicle' because we did not want to lock too specifically into how that would be structured. Our only thought around this would be that the moneys in it would be used for health or aged care services only. We feel that one of the problems is that the encouragement to save is

fine, but by the time people actually hit the aged care system they have probably drawn down a fair bit of their savings. As I said earlier, in some cases people have meagre assets; they do not have huge assets. So the assumption that people are going to have huge amounts of money by the time they hit residential aged care I think is false. We are saying that, if the system in the future is going to be a mixture of public funding and user charges, we need to put in place real incentives now for people to save, if they are going to be asked to pay later. We understand that we are looking at a very pragmatic future. The health savings accounts could be similar to the Singapore experience. We have read research. Particularly, I know the experiment with health savings accounts in the United States has not been bright, but I think the concept can be persisted with. We would see it as a supplement to universal health care contributions. In some countries it is seen as an opt-out of paying for universal health care. We would not support that. I think we have made that clear.

Yes, the contributions could be deemed as obligatory, just like super. The issue is that the contributions may die with you rather than being transferred to your family. I think that is a difficult issue, but it might be important because it would require less money being specifically earmarked for services only, rather than giving people broader choice about how they spend the money. I know that is controversial for some people, but we are just trying to think through a more pragmatic way of doing it such that moneys are earmarked at the service end. Clearly, we are open to the fact that there will be public policy issues around how much money, who gets to use it, where it can be spent, and the like, but it strikes us that some sort of savings vehicle mechanism is needed. We have put this in the last couple of federal budget submissions to encourage that sort of signal and, hopefully, it will start to come forward soon. It seems to us that there are some signals in the community that probably are misleading, with regard to how much money will be needed. It is better, if we are not going down the hypothecated tax route, to at least have a hypothecated savings mechanism.

Ms HALL—You have looked at the German model and what they are doing in Germany with the levy. How different to that is what you are proposing?

Mr Sullivan—To be honest, I do not know how different it would be. I think we are really trying to encourage some innovation at the moment.

Ms HALL—It seems to be going quite well there so far, but it is only early days.

Mr Gray—We have suggested that the cost could be shared between the employer and the employee. As a compulsory savings vehicle that is clearly earmarked for care costs only, the costs would be lower. From a public policy point of view, it would be more acceptable to the community if, firstly, the cost is low and it is shared between the employer and the employee.

Ms HALL—I notice also, in the summary of your recommendations, that you mention:

Increase public spending on aged care to compensate for its falling share of welfare payments in recent years.

Maybe you also touched a little bit earlier on the actual capitalisation within aged care. You might like to expand on that a little.

Mr Sullivan—Yes, that comment again comes from published Australian Institute of Health and Welfare reports which demonstrate, as an overall share of social spending—particularly health and welfare spending—that the increase in that spending is being driven more by pensions than it is by direct aged care program funding. What we wanted to make clear there is that the drain on the system is not at the service delivery end; the drain on the system is at the pension end. I think that is very important because, although the pension contributes to the funding of the system when people go to residential aged care, it is not the driver in our system that is leading to the blow-out in costs. This is a really important issue. We appreciate that over $4 billion is spent on the aged care program by the Commonwealth, but the growth in the blow-out of Commonwealth finances is in the area of pensions rather than the area of aged care services. I suppose we are trying to make this point in the first instance: let us not prejudice those receiving aged care and let us not wrongly target the aged care program as the area that needs restraint. The area that needs proper reform is the pension area. That is what we were trying to say there.

Ms HALL—Good point. Would you like to speak a little bit about the actual funding of aged care and the ability of not-for-profit organisations, like yours? What initiatives do you think need to be taken in the future?

Mr Sullivan—We did the research, which again I will make available to you. I know the committee has probably heard ad nauseam about the issue of the aged care program and whether it is meeting the real costs of care and the like. We have taken the Commonwealth subsidy, which is determined through an established COPO arrangement, and we tracked it since 1998, simply because that is when the reforms started, but you could take it back further—I appreciate that fact. We tracked it against what we think is a conservative estimate of the costs of care. You can see that the gap just continues to widen. That is simply because the real costs of the industry are not the basis on which subsidies are evaluated.

We need some type of industry based index. The Productivity Commission has used the words ‘a benchmark of care’. We have used similar language. I do not think it matters what you call it. I do not think it matters whether you want to change the index arrangements of COPO. What is probably more suitable, as we did with the schools system, is to have an aged care funding agreement per se. If you are going to ask nongovernment providers to actually be the providers of the program, which they are, then why are we not having an agreement similar to what happens with—and I know people will smile about this—the health care agreements, where you have a negotiated payment based on the costs of care, growth projections, capital requirements and, more importantly, an established benchmark of what you want the care levels to be?

That takes us to what we think is one of the ways to go forward: establish an aged care benefits schedule. I know the committee is interested in services beyond bricks and mortar. At the moment we have aged care in the home and in residential aged care, and we have the Home and Community Care program, but it is a mixture of programs. There is no system of aged care services. I am sure you have heard from plenty of consumer groups who will tell you how confusing and perplexing it is to access levels of care. I am not talking about just the Commonwealth program here. Firstly, you need the system. Secondly, you need a schedule such that, where people get the care, they are getting the appropriate levels of care. If there is a Commonwealth subsidy attached to it, people know exactly what that will be and, if the remainder has to be user charges or a contribution of insurance, it is clearly understood.

At the moment you have home care and you are either given a subsidy based on level 6 of low care or level 3 of high care—that is, four and five levels of frailty you are not funded for, even if your degree of dependency and frailty deteriorates to that level, and you are certainly not funded for it when you have no access to an aged care home. In a sense that is what we said earlier: there is a cross-subsidisation of unpaid care back to carers and families occurring. That may be suitable for a good percentage of families who have the capacity, both financially and emotionally, to do it, but, generally speaking, particularly under the rubric of an ageing Australia, I think that is going to become problematic and social isolation is going to be one of the outcomes.

Ms HALL—Definitely.

Mr MOSSFIELD—Just looking at your aged care savings scheme that we have been talking about, do I have it right: that would be, say, a combination of the superannuation scheme as we know it now and maybe a private health fund, where people would make a contribution on a personal basis and then they would claim back at the appropriate time when the needs are there?

Mr Sullivan—Maybe it is typical us, but we have kept our powder dry on the structure of it simply because we felt that there would be a number of options you could put forward as a vehicle. All we are simply saying is that, yes, you could attach it to superannuation as a contribution, paid individually or by employers, or both. We do not see it as a structure similar to private health insurance. The reason is that our experience with private health insurance—although it is a major funder of half of our hospitals—is that it has not been very successful in restraining costs. It has a huge moral hazard element built into it; it is an unfunded model; and, to a degree, it does not seem to be able to capture enough of the population to keep it affordable without a significant subsidy from government. So we have tended not to go the health insurance model route but rather have looked more at the obligatory superannuation model. If you wanted to go more broadly and be a little bit more radical, you could shift from the savings vehicle per se and move back to the taxation model, like the GST. You could argue the case that a percentage increase on the GST can be attributed to long-term aged care. Other countries have argued this before. I think it was something that was justified in Japan. A three per cent to five per cent increase in the GST was justified on the grounds of paying for long-term care. Is that right? I think that was said a few years ago.

CHAIR—Yes, I think they went from three per cent to 10 per cent actually.

Mr Sullivan—Yes, there was something like that. It does go up. The point is that mechanisms are available, as long as it is clear.

Mr ANTHONY SMITH—Apart from the fact that is not going to happen, on another point, don't you think that has other dangers?

Mr Sullivan—Do you mean the GST model?

Mr ANTHONY SMITH—Ideas of that hypothecation nature, apart from the fact that it is not going to happen: you need an agreement with the states, the federal government is not going to do it, and all the rest of it. Look at the Medicare levy. Most of the population think the Medicare levy pays for health entirely.

Mr Sullivan—I said earlier that some wrong signals are sent around savings, and I think that is probably right. If there is going to be a hypothecated tax, we need to educate people more clearly about what it is about and what it is going to pay for. If we did hypothecate tax for health care, it would be a lot higher than what people pay on the Medicare levy. My point, though, is that we need to identify some vehicle not only that brings money into the system but also that people clearly know is part of their savings, their investment, for their aged care.

Ms GAMBARO—Gentlemen, seeing that you do operate quite a number of private hospitals, I was quite interested in your Medicare grey card suggestion that those over 70 without private health insurance would be eligible for elective surgery. Seeing that there has been an increase in private hospital admissions, how would you see that impacting on the people who do have private health insurance, most of whom are electing to go to private hospitals? From the figures I have seen recently, most of the people who carry private health insurance are pensioners and they maintain it at all costs. You mentioned also getting rid of some of the ancillary items. Again, older people are the largest users of those ancillary items. You might be imposing some difficulties by doing that. I see your suggestion about where you are going to try and get the $400 million from. I wouldn't mind your thoughts on that.

Mr Sullivan—Our thinking about the over-70s proposal and the Medicare grey card is similar but not the same. The Medicare grey card was a suggestion that we have put forward to try and give people who are on public hospital waiting lists accelerated access to elective surgery if they are elderly and if they have no other option but to wait. I take your point: there are a significant number of people on pensions who have private health insurance, and we are not trying to put in place a disincentive. If we are going to target an age group like 70 and above, our preference would be that all people over 70 would become the sole responsibility of the Commonwealth, as veterans are. Veterans are treated by the Commonwealth as if they were private patients. The Commonwealth purchases hospital care for them, oftentimes in private hospitals but not exclusively. Our suggestion is to start looking at a model where, once you reach 70, if you want to buy private health insurance, it will be your choice but you will not need to. You will be insured by the Commonwealth and it will be purchasing beds for you in the public and private sectors.

If you look at the gold card arrangement for veterans, you will see that very few veterans need private health insurance because they still get the access that they would have had if they had insurance. That sounds cute until you start thinking through the ramifications. One, it means that private health insurance should theoretically become a lot cheaper for everybody else, because big users are no longer in the pool. The Commonwealth is actually taking that risk. That means that, if private health insurance is much more affordable, it is going to be a vehicle that others may also purchase alongside their public insurance.

We are operating on the assumption that the system is always going to be about public and private insurance. We are not operating on the assumption that it should be just about public insurance. We are also trying to work on a practical problem, which is access to services for the elderly. The private sector is best set up for elective surgery the way it is presently being funded through insurance companies. We would much prefer it to be a more comprehensive service than elective surgical services. In many cases, the elderly need more than surgical services, they need acute medical services, and people with complicated conditions need long stays.

It is our thinking that a model like that should be explored. In the context of insurance cover for ancillaries and the like, our difficulty is not that some ancillaries give people immediate benefits: optometry, dentistry, physiotherapy and the like. It is just that the prime reason that the rebate system was established was to shift demand from public hospitals to private hospitals. Our view is that, as it is presently structured, the Commonwealth subsidy buys the promise that people may use insurance when they need hospitalisation. In our view, it would be better to use the money to reward the behaviour change and, when people take the service in the private hospital rather than the public hospital, to discount something on the bill for them. That way the Commonwealth would actually purchase a service rather than a promise which people may or may not keep.

Given the fact that under the present arrangements the government is keen to support insurance, we are then saying, 'Let's support insurance that actually delivers the demand shift.' The only insurance that delivers the demand shift is hospital table insurance, not ancillary insurance. We are not denying the fact that people like getting and sometimes need to get ancillaries; we are simply saying that, if we have scarce resources, let us target them to the highest level of need, which would be acute services.

Ms GAMBARO—That is an interesting proposition. I want to ask you one other question on the aged care funding agreement that you were speaking about earlier. You likened it to the health care agreements that have just been undertaken, and you mentioned some factors that would be taken into consideration. I come from Queensland, where we love welcoming southerners, but it is putting an enormous amount of pressure on aged care facilities. How would you envisage that model working, where you would have states like Queensland, for example, saying, 'We should get more of this funding based on demographic population changes to coastal towns et cetera'? You will have that perennial problem. Other states will say, 'No, we don't want to lose that funding to you.' I can see that as a bit of a problem. Also, the average age of most people going into an aged care facility is 85 years. The minister is at the moment looking at changing the way the department assesses funding models—I think everything is done from the age of 70 at the moment. What is your view on that and its implications for the greater funding agreement that you were talking about?

Mr Sullivan—I will leave the second part to Richard but, in response to the first part about the funding agreement, again the assumption is that aged care is best done when there is one level of government responsible. That is partly why we are talking about the over-70s. There is a dysfunctional relationship between the Commonwealth, states and territories over aged care. We saw that in the recent health agreement debate—even though those agreements have been signed, there has not really being a comprehensive plan of improvement around that. There have been a couple of pilot offerings and we have supported the Commonwealth in what they put on the table, such as the pathways home program and the like.

There is not a sustained—and this is my view—system of aged care services that is coordinated, with one level of government responsible to ensure that access happens. If you were going to go down the path of a set of agreements, the basic assumptions need to be thrashed out like that, in our view. But with whom are the agreements? In this case the agreements are with providers. The states do not provide aged care services generally anymore. There is still a bit of lag where some states may run some state aged care homes, but the argument was that they were

meant to be transferring those through to the Commonwealth. I know that is slow in some places.

The states are involved in the Home and Community Care program but again there is no reason why that needs to be the case. We could have one level of government dealing with it all. Therefore, to some degree you could bypass one of the issues you raised, which is the bickering about demographic risk, because you are now talking about funders—that is, government—and providers—non-government. There should be a general agreement around that, about not only the nature of the services to be covered but, as I said earlier, the degree of participation of private investment: what is a reasonable level of that investment and what is a reasonable period of certainty about staying in the field and the like. Those things are never discussed.

When health and aged care ministers meet, there are no provider group organisations at the table. When the health care agreements were discussed in relation to the pathways home program, there was no major provider group at the table to say, 'Hold on. There are no beds in the system but we're meant to provide them or manage the risk.' I suppose I am saying that there needs to be a much more participatory mechanism because it is a program that is run and delivered by non-government owners but it is quibbled about by levels of government.

Mr Gray—The 70-plus figures in the planning ratios in terms of how the Commonwealth determines the allocation of residential aged care places and community care places originally was a planning ratio for the distribution of nursing home beds and hostel beds, for two reasons. One was to ensure that places were established in areas of need where the 70-plus population demanded that places be made available. The major overriding reason for the planning ratios was the constraint on outlays by the Commonwealth. Given the average age of entry into residential aged care, the 70-plus planning ratio is really irrelevant. Given that there are still 40 high care places per thousand people aged 70-plus, when in reality 63 per cent of all residents in residential aged care are high care, it is no longer a relevant planning ratio for what the system needs to provide.

As a mechanism for controlling outlays, it still operates because it rations the availability of places so that people who are assessed by an ACAT as needing residential aged care do not necessarily get into an aged care place. They have to wait for one to become available. That can be problematic for many people. Many of course may die before they get a place. There is still a control on outlays but there are other mechanisms for controlling outlays. Therefore, it could be argued that the planning ratios are becoming irrelevant in terms of what the actual need is in the community and how that need should be met.

Ms GAMBARO—Thanks for that. I agree with what you are saying, particularly as 20 per cent of people in my electorate are in the over-65 demographic already. I am not sure what the national average is at the moment; is it about 13 per cent?

CHAIR—Yes.

Ms GAMBARO—More places would be available for those people in an electorate like mine.

Ms ELLIS—Thank you for your oral submission this morning; it has been very useful and very informative. I want to talk about affordability but, before I do, I want to make a comment in

relation to the subject we were just talking about and ask for your response, if you wish to make one. I am very pleased that the minister is in fact now reviewing that; we have been calling for that for some time. It is a flat earth policy approach in the sense that not only is the 70 years well and truly no longer applicable but, as Teresa was saying, the formula does not give any ability to recognise differences in geographic areas—not just from state to state but from region to region, particularly regional centres to which people gravitate. What is your view in relation to any consideration of that formula? When we look at the formula currently encompassing both residential care and at home care, not only does it have the 70-year thing and the 40 high, 50 low but it also contains 10 per that 100 at-home packages, which are now being talked about more and more as the really good alternative to residential care. What is your view in any consideration of the formula in relation to those aspects? We know your view on the age limit, but what about putting into that same mix the at home care, which is quite a different scenario?

Mr Gray—As I mentioned before, I think there are other ways of controlling outlays. Already there is an ACAT assessment as to who is eligible to enter age care. There could be an assessment as to who is entitled to a subsidy and on what basis that subsidy is available to an individual. If you had portability of care subsidy so that the consumer could determine where they want the care to be provided—either in their own home or in a residential aged care facility—as long as there is a control on the numbers of people who have access to the care subsidy to those who need the care and have an entitlement to the care subsidy, then in my view there is no need for any planning ratios. What you need to be sure of is that the care services are being delivered by approved care providers and that they are delivering the quality of care, which is monitored through some other mechanism. We would therefore suggest that the planning ratios do not need to be constructed, because they serve to ration services and people miss out. Often the most needy miss out under the current planning ratio process.

Ms ELLIS—That is very true, given that in many regions—in fact, I would estimate the majority—the system could actually boast that the formula has been surpassed and therefore they are doing well, with no regard to the waiting lists in the region at the same time. Can we talk a bit about the affordability that Francis was talking about earlier? Richard, you made mention that in some areas the for profit providers do not enter at all. Let us pick on Tasmania as a great example. There are home owners in very low real estate value areas where bonds are almost not worth considering even though they own a home, because it is an achievement if they can get $30,000 to $50,000 for a house, if they can sell it, so bond levels are desperately low. What is your response to this vexed question—which I think you have already talked about; Francis has talked about it at length—of this profit possibility versus the not for profits? Without being critical of the for profits, which I am not, it is a conundrum that you can have one system in which the not for profits and the for profits can enter equally, receive the same money from government and supposedly provide the same level of care, yet one makes a profit and one does not. Then you look at how you encourage those for profits to go to areas of need. There really is a conundrum in how you manage that. Can you elaborate a bit further on that dilemma, particularly in terms of the affordability of bonds and so on in those areas and the injection of money from the resident?

Mr Gray—The bond system has certainly got some issues of concern about it because, as you are aware, certainly in many parts of metropolitan Australia bond values have become quite high, and in some cases bonds are being charged where a pensioner totally loses their pension, which is an unfortunate outcome. You have also got the system whereby some consumers

entering residential aged care do not want to pay a bond lump sum—they want to pay a periodic payment—but, even though they supposedly have the choice under the Aged Care Act, the reality is that, if the provider will not accept them unless they pay a bond lump sum, they just do not get entry into residential aged care.

A classic example is the relative of a friend of ours who needs a low-care, secure dementia unit in Melbourne and does not want to pay a lump sum because she wants to retain ownership of the unit. She is going to have difficulty finding a low-care, secure dementia unit on a periodic payment basis. It may be very difficult to find access for that sort of individual. So the capital income side of it is very variable and, as you have identified, there are parts of Australia where a house value means the bond value just does not equal the cost of the capital for that residential aged care facility. This means that government really has to look at the whole way the capital income side of it is structured.

We need to have a lot more flexibility about the types of capital payment. At the moment we have an accommodation charge for high care and it cannot be converted to a lump sum, and we have a bond lump sum, which can be a periodic payment or a combination of both, but again it really is the provider who determines whether they will accept the resident on that basis. There is not a current rent type payment available as an option in low care, other than the periodic payment. You also have the situation where you cannot purchase a place in advance. If you say, 'I know I'm going to need residential aged care and I want to purchase a place in advance,' you cannot do it. There are too many restrictions around the flexibility about how the capital side of it can be financed and whose responsibility that is.

Mr Sullivan—This goes to the first point. The differentiation on bonds in the present arrangement is based upon the demarcation of high and low care. Why? I think it is quite simple. The government realised that high care is attached to the health system. A lot of groups do not want to say that for a whole lot of reasons, but the figures bear it out. We have suggested this to the minister and others: it would be far more sensible to start naming the service for what it is. There are aspects of what you call 'residential care' that are purely a health service. They are a post acute service, but they are about health care. As we said earlier, they are about terminal care and palliative care, and just because someone does not die one month after getting there does not mean they are not in that phase.

This is a very difficult discussion for the public to have because you either get criticised that you are talking down the industry or you get criticised because you are making people feel bad about the fact that they are going there, but people going to that sort of aged care know why they are going. This is the end phase of life. I think we are caught in the paradigm about moving from one house to the next. There is certainly nothing wrong with the argument that, if you move from one house to the next, you move and you may divest from one to the next. That was the hostel system, but we are not in that system when we are dealing with high care. I think we have to reclassify and rename the services. When you do that, you have to be fair about the way you are financing that aspect of the service compared to the hospital system.

If people can receive a similar service in the hospital health system, then why are we asking for a different payment model in the other system? That is the first point. It is a policy issue which is still not clarified. Secondly, we now have an arrangement where, in order to meet their capital costs, high care providers are encouraged to seek extra service places, which is a

backdoor way of getting bonds, or load up on low care places to cross-subsidise into high care. It strikes me that this is somewhat lacking in transparency about the issue. We think there is still a huge community obligation around the capital costs of the high care end. It is not just an individual's responsibility to meet the capital costs.

Richard earlier made a point which is really important and is one of the reasons why we structure it into our aged care benefits schedule—that consumers want choice and flexibility, and that the care subsidy should move to where the consumer seeks the care; that is the whole idea of our schedule. At the same time, when a person is so frail that they can only receive care in an institutional setting like an aged care home, the community's responsibility does not vanish. You get the sense that, if you live in a certain part of Australia—and this is what I said in my introduction—your access to care is not based on equal opportunity. It comes down to principles as a first issue. It is like any sort of long-term planning: we have to be clear about those principles.

Ms ELLIS—I would like to ask a question that goes in a slightly different direction and which is two-pronged. Through your organisation, you are obviously also involved in the care at home packages. There is a debate going on, and I think it is a good one, about to what degree we are carefully checking and registering the level of care and the qualifications of caregivers and so on in those circumstances, given that they are basically supposed to be equivalent to residential care standards.

Putting that aside, you also talk about future affordable, appropriate housing. I want to ask you to take a longer view for me if you can. If, as a community, and as parliaments and governments, we are going to be genuine about providing really appropriate options, then one of those options is care at home. I also have a view that we should talk up adaptable housing and all those other things that make that become an even more rich option in the future, not just tomorrow but in 10 years time, that we need to marry all those ideas together—not only affordable housing, but housing which is adaptable and which is appropriate when families downsize. How are we really educating our communities to look at this in a more positive way? I would like your views as an organisation about bringing those things together so that care at home becomes an option that is even more rich and even more real than I think is currently being delivered. It is a good idea but I think we are short-changing it a bit in terms of what it can possibly do. I will finish by saying that I am also extremely conscious that no government of any colour, in the future or now, should in my view ever be allowed to see community at home care as a cheap option to residential care and, therefore, undervalue what it actually is. I think it has to be done honourably and honestly. I wonder what your views are on that broad scope.

Mr Gray—It is interesting how the adaptable standards originated. They actually started when I was National Executive Director for Aged Care Australia and there was a concern about the application of AS1428 to standards of residential aged care. That standard of course is access for people with disabilities, who primarily need independence. The standards were not really working specifically for residential aged care. In conjunction with ACROD, we jointly agitated to Standards Australia and suggested that we needed an access standard specifically for residential aged care that encompassed the building stock as well as the external environment. As a result of that, they set up a subcommittee of AS1428 which was to look at this very thing. I was a member of that subcommittee. We started to develop the adaptable standards, and then I no longer had any role on that committee.

The outcome was the adaptable standards that we have today. The problem is that they are not mandated standards. Consequently, new developments do not necessarily have to meet the adaptable standards at all in terms of housing stock. If all housing stock was built according to the adaptable standards, then at least in the long term we would be ensuring we are going to have some infrastructure that is going to be better able to meet the needs of the ageing population. I think we also should be able to look at how we meet the needs of the older population in terms of making existing housing stock more adaptable. It is done for veterans and, to some extent, a little of the services provided by HACC focus on some aspects of that. But, from a policy point of view, I think we do not do enough to try to ensure that conversions of, say, office buildings into apartments build in adaptability for access. In terms of the fundamental plank of meeting the care needs of individuals into the future—care needs as much as possible at home—we need to be able to ensure that that home is going to be able to be suitable for that. To some extent that also encompasses being able to ensure that appropriate lifting equipment can be utilised in the residential facilities as well to assist caregivers who come in and provide the care without themselves being physically damaged as a result of that process. I think there are some policy goals that could be achieved as part of a long-term strategy.

CHAIR—We have to close the meeting because Hansard officers can only be here until 10.30 a.m. I want to thank the witnesses who have appeared before the committee today.

Resolved (on motion by **Ms Gambaro**, seconded by **Ms Ellis**):

That the committee accept exhibit No. 46, Aged care funding scales.

Resolved (on motion by **Ms Hall**, seconded by **Mr Mossfield**):

That this committee authorises publication, including publication on the parliamentary database, of the proof transcript of the evidence given before it at public hearing this day.

Committee adjourned at 10.28 a.m.