INQUIRY INTO THE COST OF LIVING PRESSURES ON OLDER AUSTRALIANS

SUBMISSION TO THE COMMUNITY AFFAIRS COMMITTEE OF THE AUSTRALIAN SENATE

FROM

AGED AND COMMUNITY SERVICES AUSTRALIA

Aged and Community Services Australia represents over 1,200 church, charitable and community-based organisations providing housing, supported accommodation and community care services to over 700,000 older Australians, people with a disability and their carers.

Introduction

The focus of this submission from Aged and Community Services Australia is on the relationship between the cost of living pressures on older Australians and the costs of aged and community care services, such as those provided by our members. Our submission therefore refers to only some of the Inquiry's Terms of Reference ((a) iii; (b) and (e)) and is structured in terms of how the issues arise in that care relationship.

Our submission focuses on three issues: older people's purchasing capacity; the consequences of inadequate investment and the significant inequities that characterise the current system.

1) Older people have limited capacity to purchase more care.

The majority of older people are principally dependent on the aged pension for their income. Fully 90% of the sub set of older people receiving Australian Government funded residential and community care services are either whole or part pensioners. If they require assistance to remain living independently at home and participating in their communities, they are therefore limited to the care that can be provided by their families or other carers and the quite limited services available from Government-funded community care services.

While these services are generally of high quality and are highly valued by their participants, they are stretched very thinly. As an illustration, the average quantity of personal care services available per person under the Home and Community Care program is under 10 minutes a day. Similar shortages apply in other types of services including those specifically designed to address the social isolation from which many older people suffer[1]. Affluent older people can purchase more services from a variety of sources but the majority lack the means to do this.

This thin spread of services is therefore a constraint on the ability of older people to participate in their wider communities and makes it more likely that their health and well-being will deteriorate and they will need to access more restrictive and more costly (to Government) residential or other health care.

This can be addressed by either giving older people more purchasing power, or funding more services, or by a combination of these measures.

2) Failure to invest has adverse consequences

A very good specific illustration of this point is the one signalled in the committee's Terms of Reference. A lack of good dental care is likely to lead to a range of other health issues, both for people living in the community and for those admitted to residential care. Conditions such as diabetes, heart disease, immune deficiency diseases, cancer can be significantly influenced by the standard of oral health. To the

[1] The range of community care services includes day centres, friendly visiting services and other social supports as well as some community transport. Transport issues are one of the principal challenges facing older people most of whom cannot afford much use of taxis.

extent that the affordability of dental care services, and a low level of public investment in supporting dentistry has resulted in poor dental health,[2] both the individuals concerned and the nation bear the cost of this failure.

ACSA's residential care members are held responsible for the 'oral and dental health' of residents by the Accreditation Standards (2.15) but they cannot do much to make up for long periods of prior neglect (and are not funded to provide dentistry).

Again the solution could be more (public or subsidised) service, greater purchasing power in the hands of older people[3] or a combination of these.

3) People should be treated equitably - and aren't

User charges, or co-contributions for services are now a very familiar part of health and other care provision in Australia and have been a feature of aged and community care services for a considerable time. In total consumers contribute around 27% of the costs of Australian Government funded aged care (around $2 billion in 2004). The 2004 Hogan Review of residential aged care predicted that, on current policy settings, the proportion which would have to be contributed by consumers will rise to 36% as Government subsidies fail to keep pace with rising costs.

User charges raise two issues with regard to the Terms of Reference for this Inquiry:

1. Do they leave older people with sufficient means to purchase other things?
2. Are they applied equitably to all service users?

Community care

In the case of Australian Government funded community care services fees are set in such a way that no more than 15% of the aged pension can be charge in fees, with a sliding scale applying to income above this level. This does not allow more than a modest lifestyle to be maintained for those on a pension but the charges are applied equitably across all classes of care recipients. The greatest degree of income stress is noted by ACSA's members in the cases of: socially disadvantaged or marginalised older people; people with costs arising form a disability; and those in private rental accommodation.

User charges in the (much larger) Home and Community Care program are regulated by the State and Territory authorities responsible for managing this well-regarded program. Introducing greater uniformity into HACC fees is the subject of one part of the current community care reform project being carried out by the Department of Health and Ageing (The Way Forward). Achieving uniform user charges would mean their introduction in some jurisdictions that don't currently levy fees but his would be

[2] Public investment in dentistry should encompass both treatment and public health components. An expansion in the supply of dentists is also required.

[3] Putting greater purchasing power in the hands of older people can either be general and across-th-board – giving them more money through higher retirement incomes – or specifc and tied to the provision of specific ranges of service – ie. consumer-directed care (sometimes referred to as 'voucher systems'.)

expected to be accompanied by strict rules about the extent of fees – as currently apply in the Commonwealth programs and in those States that do levy fees currently. Care must be taken to cap the **total** fee paid for the range of services that may be received.

Community care is overwhelmingly the preferred mode of care for most older people who want to maintain their independence for as long as possible. It is much cheaper (per care recipient) for governments though the proportion of Australian Government spending on aged care going to community care has not risen significantly.

Consumers however are paying more. The consumers' preference for care at home comes at a price in the form of the input required from carers (family members and others). They are paying for something that they want but there is a strong case for transferring some of the savings accruing to Government back to consumers and carers - for example in the form of more community care services.

Residential care

While the proportion of older people using residential care is considered small if the frame of reference in persons aged over 65, it is much greater, nearly one in four, of the population over 85[4].

In Australian Government funded residential care, user charges apply in two areas – care fees and charges for accommodation. As is the case with community care, the residual amounts left with residents are modest, starting from around 15 % of the pension (with respect to care fees). This leaves residents with around $95 per fortnight to pay for all other expenses. This does give rise to some affordability issues[5] and ACSA members report that many families supplement the income of their relatives in care – for example when it comes to buying gifts for grandchildren or significant expenditures such as motorised wheelchairs.

User charging policies for residential care however give rise to significant inequities between consumers because they are applied unevenly between different classes of resident and with insufficient regard to the differential means of residents. Leaving aside those residents whose means are such that they are not required to contribute to their accommodation[6], two different user charging regimes apply.

For those people in low care and who have assets above a prescribed amount[7] a lump sum, largely refundable deposit can be paid to fund their accommodation costs. These deposits, somewhat confusingly called 'Bonds' by the Aged Care Act averaged $141,690 in 2005/06 for new residents[8]. They are often financed by the consumer by

[4] AIHW 2007 puts the number at 237 per 1,000 people aged 85+.
[5] Dental care, pharmaceutical costs some mobility aids, clothing and other costs must all be met from this residuum.
[6] Such 'concessional, residents currently make up around 40% of the total. The Aged Care Program pays fees on their behalf.
[7] The Aged Care Act requires that residents be left with a minimum amount equivalent to two and a half times the annual single Age Pesion (currently $33,000)
[8] This represented a significant increase on the previous year following legislation which made changes to the treatment of Accommodation Bonds as assets for pension purposes. This made them a more

the sale of their, now vacated, former home. This arrangement, together with higher daily fees also applies in what are termed 'Extra Service' high care facilities – effectively luxury nursing homes. These make up quite a small proportion of the total number of beds available due to a range of factors in ACSA's view including the over regulation of this area by the Aged Care Act.

This system has some desirable features. Firstly it recognises the real variations in older people's means and in property values. Both the home that is sold and the aged care bed that is 'purchased' are generally in the same property market meaning that higher bonds can be charged in high cost areas and be supported by high sale prices and vice versa. Given the variability in land and building costs around Australia this is much fairer than setting an artificial price in Canberra and more realistic than pretending that building and land costs are uniform. Secondly, this system can raise sufficient capital in most urban parts of Australia (but not elsewhere or in areas of low home ownership) to ensure the replacement of capital stock when required. Thirdly, because it represents a capital to capital transaction, it does not impact on cost of living and affordability concerns. Fourthly, this system is treated favourably, since 2005, by the social security system with Bonds being treated as exempt assets for the purposes of the assets test.

Aged care providers are allowed to use the interest on these lump sum deposits and to draw down a relatively small amount each year (currently $273.50 per month) from the 'principal' for the first five years. The residual amount is returned to the resident, or their estate, on departure.

In high care a scale of user charges applies that is income and asset related and uniform across Australia. In round figures this raises about one half of the amount that is derived from the low care system and is not nearly as responsive to differential property prices in different markets. Not only does this system not raise sufficient capital to ensure the replacement of the capital stock (or the construction of additional capacity to meet the needs of our ageing population) but it is also fundamentally inequitable.

People in low care are on average paying twice as much for their accommodation as those in high care.

There are several possible solutions to this dual problem of the inadequacy and inequity of the high care accommodation user charging system. ACSA would argue that the desirable features of a better user charging regime must include:

- ***Equity between consumers on the basis of their means***
- ***Responsiveness to differential levels of means***
- ***Adequacy to meet the cost of replacing the capital over time***

Whether this is achieved by extending the low care (refundable deposit) system into high care or by setting a market-linked rental charge on the same basis for both levels of care or by other means is a second order issue.

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aattractive financial management option fo many older people entering low care (or extra service homes).

A continued refusal to address this issue means the continuation of significant inequities between different groups of older people using residential care and will inhibit the ability of older people needing high care to join the communities they need to be in.

Conclusion

While the issues raised in this submission are a specialised sub-set of the total range of issues relating to the impact of cost of living pressures on older people, they are significant in that they are very strongly conditioned by Government policy, particularly in the portfolio of Health and Ageing.

Their solution is therefore amenable to changes in that policy.
