Chapter 6
Disability support and special categories of care

6.1 This chapter discusses issues relating to ageing with a disability, the dementia and veterans' supplements, and special segments of society with special needs such as the homeless and lesbian, gay, bisexual, transgender and intersex (LGBTI) people.

Dementia and veterans' supplement

6.2 The Aged Care (Living Longer Living Better) Bill 2013 (Bill) proposes to create two new categories of supplements for individuals in addition to the existing supplements – respite, oxygen, and enteral feeding:

- The dementia supplement; and
- The veterans' supplement.[1]

6.3 This section provides some background information on the proposed operation of these two subsidies, and the following section discusses some of the issues raised by stakeholders in relation to them.

6.4 The Minister for Mental Health and Ageing the Hon. Mark Butler explained that these supplements are in recognition of the greater needs of some veterans and people with mental illnesses:

> These supplements will be available across all care levels for consumers whose care needs might be greater due to dementia, and for veterans with mental health conditions who may also need greater support.[2]

6.5 One of the key reasons that the supplements have been proposed is the growing number of people who are expected to suffer from dementia and other mental illnesses in Australia, and the high costs and challenges of supporting those individuals. The Department of Health and Ageing (the department) reported to the committee that it was anticipated that by 2050 there will be 980 000 people living with dementia in Australia.[3]

6.6 The department's submission explains that the new supplements will apply to both home and residential care from 1 July 2013:

> Approved providers who deliver home care at any level (ie. 1, 2, 3 or 4) will be able to receive a new dementia supplement or veterans' supplement if the care recipient meets certain eligibility requirements. This additional funding will allow home care providers to provide additional and more appropriate care to care recipients with dementia and eligible veterans.

---

1 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 52.

2 The Hon. Mr Butler, Minister for Mental Health and Ageing, *House of Representatives Hansard*, 13 March 2013, p. 1835.

3 Ms Huxtable, Deputy Secretary, DoHA, *Committee Hansard*, 2 April 2013, p. 61.

> These supplements will also be available in residential care from 1 July 2013.[4]

Supplements in Home Care

6.7 From 1 July 2013 all existing packaged care places will transition to home care. Extended Aged Care at Home Dementia (EACHD) packages will transition to Level Four home care packages with a dementia supplement.[5] Both the Dementia and Veterans' supplements provide a ten per cent increase on the home care package basic subsidy; level one would attract an additional $750, while a level four recipient would receive an additional $4550 per annum.[6]

6.8 It was explained to the committee that the dementia supplement in home care is to help with the extra costs of dealing with cognitive impairments in the home:

> The dementia supplement in home care has been designed to capture the additional costs of caring for an individual with cognitive impairment. In the current community care system, this extra cost is only acknowledged at the highest level of package in the [EACHD] packages. The proposed supplement will provide important additional funds for individuals at all four levels of packages.[7]

6.9 The committee learnt that:

> Veterans, who have a mental health condition accepted by the Department of Veterans' Affairs (DVA) as associated with their service, will automatically attract the Veterans' Supplement worth 10 per cent of the basic subsidy amount of their Home Care Package...While veterans may be eligible for both the dementia and veterans' supplement, the Approved Provider may claim only one supplement per care recipient.[8]

6.10 In contrast to the Veterans' Supplement for which eligibility will be assessed by DVA, the eligibility assessment for the Dementia Supplement for other care recipients will be the responsibility of an Approved Provider. The assessment must be undertaken by a registered nurse, clinical nurse consultant, or nurse or medical practitioner.[9]

---

4 DoHA, *Submission 92*, p. 17.

5 DoHA, *Submission 92*, p. 16.

6 DoHA, *The Dementia and Veterans' Supplements in Aged Care – Consultation Paper*, April 2013, p. 2.

7 Alzheimer's Australia, answer to question on notice, 2 May 2013 (received 8 May 2013), p. 2.

8 DoHA, *The Dementia and Veterans' Supplements in Aged Care – Consultation Paper*, April 2013, pp 3, 4.

9 DoHA, *The Dementia and Veterans' Supplements in Aged Care – Consultation Paper*, April 2013, p. 2.

Supplements in Residential Care

6.11 Currently the costs associated with sufferers of dementia in residential care are funded through the Aged Care Funding Instrument (ACFI). The committee heard however, that:

> ACFI does not fully capture people with severe and complex behaviours and psychological symptoms associated with dementia and mental illness. Residents with these conditions are a small and difficult to define group and because of their challenging behaviours are less likely to be accepted into residential care facilities. Because of their high care needs, there are demands on resources and difficulties in co-locating these residents with others. They are also more likely to move around the health system in acute and subacute care and mental health facilities because of the complexity of their care needs and the difficulties in placing them in appropriate care.[10]

6.12 The eligibility requirements for the dementia supplement in residential aged care will focus on identifying those residents with severe behavioural and psychological symptoms associated with dementia or mental illness. To attract the dementia supplement, a resident must have a medical diagnosis. The diagnosis must be one of the listed Aged Care Assessment Program (ACAP) mental and behavioural conditions, and may include conditions other than dementia such as schizophrenia and obsessive compulsive disorder.[11]

6.13 Approved Providers are required to review a resident's eligibility for the dementia supplement every 12 months to ensure it is not paid for residents who no longer have severe symptoms because of the progression of their disease.[12]

6.14 Any veteran in residential care with a mental health condition accepted by DVA as associated with their service will attract a veterans' supplement.[13]

Issues raised throughout the inquiry in relation to the supplements

6.15 The inclusion of the dementia supplement in LLLB was widely regarded as a positive reform to recognise the additional requirements of caring for a person with dementia and the special needs of veterans.[14] Alzheimer's Australia (AA) noted for instance: 'I think that Living Longer Living Better is positive, because it recognises

---

10 DoHA, *The Dementia and Veterans' Supplements in Aged Care – Consultation Paper*, April 2013, p. 6.

11 DoHA, *The Dementia and Veterans' Supplements in Aged Care – Consultation Paper*, April 2013, pp 7, 12.

12 DoHA, *The Dementia and Veterans' Supplements in Aged Care – Consultation Paper*, April 2013, p. 9.

13 DoHA, *The Dementia and Veterans' Supplements in Aged Care – Consultation Paper*, April 2013, p. 10.

14 Consumers Health Forum of Australia, *Submission 29*, p. 4; COTA, *Submission 87*, p. 9; Mr Shepherd, Professional Officer, Queensland Nurses Union, *Committee Hansard*, 30 April 2013, p. 57.

for the first time the need to recognise the extra costs of dementia care.'[15] AA went on to say:

> The dementia supplement which has been proposed for residential aged care will address long standing concerns that the [ACFI] does not capture the cost of providing care for individuals with the most severe behavioural symptoms.[16]

6.16 The Attendant Care Industry Association noted that: 'The veteran loses out beyond every other person in the community, so I am glad to see them included in this legislation.'[17] National Seniors Australia similarly noted that 'support to veterans through a behavioural and mental health supplement is long overdue'.[18]

6.17 Several stakeholders put it to the committee that additional clarity needed to be provided to stakeholders regarding what the dementia home care and residential supplements covered.[19] AA suggested that this process may be assisted by the use of more appropriate nomenclature:

> There is a need for greater clarity in the sector on the two supplements that are available. It would be prudent for the [department] to rename the supplements according to their purpose instead of referring to both as "dementia supplements". The dementia supplement proposed in community care could be referred to as a "cognitive impairment" supplement. The dementia supplement proposed in residential aged care has the purpose of providing the additional funding required to support individuals with the most severe behavioural symptoms and could be referred to as "severe behaviour" supplement.[20]

6.18 It was pointed out to the committee that not all facilities were appropriately equipped to deal with the requirements of dementia patients:

> We are already seeing a lot of complaints coming through the complaints commission with regards to dementia residents mixing with non-dementia residents in older facilities. Putting a fence around something, and a lock on the gate, does not make that a dementia-specific facility. It is not designed

15 Mr Rees, Chief Executive Officer, Alzheimer's Australia, *Committee Hansard*, 2 April 2013, p. 23.

16 Alzheimer's Australia, answer to question on notice, 2 May 2013 (received 8 May 2013), p. 1.

17 Ms Merran, Board Director, Attendant Care Industry Association, *Committee Hansard*, 30 April, p. 7.

18 Mr Carvosso, Chairman, National Seniors Australia, *Committee Hansard*, 2 May 2013, p. 29.

19 Dr Morris, Chief Executive Officer, Baptistcare, *Committee Hansard*, 29 April 2013, p. 36; Alzheimer's Australia, answer to question on notice, 2 May 2013 (received 8 May 2013), p. 3; Mr Shepherd, Professional Officer, Queensland Nurses Union, *Committee Hansard*, 30 April 2013, p. 58.

20 Alzheimer's Australia, answer to question on notice, 2 May 2013 (received 8 May 2013), p. 3.

> for their special needs. It is not staffed for their special needs. It is a huge area of unmet need.[21]

6.19 Some stakeholders argued that the dementia supplement should only be available to aged care facilities that are certified as capable of providing the services required for people with dementia and other challenging problem behaviours:

> It is [AA's] view that this supplement should be linked to specific requirements to ensure that facilities have the capacity to provide appropriate care for these individuals for example in respect to regular review of care plans, medication use and environmental design.[22]

6.20 The Queensland Nurses Union argued that the dementia supplement 'should be dependent upon a provider's employment of competent, registered nurses to coordinate and provide the care that is being given by the enrolled nurses and carers.'[23]

6.21 The committee heard the importance of ensuring adequate collaboration between intergovernmental and intersectoral services to ensure a high level of care for people with mental health conditions:

> Part of the difficulties stem from the gap between the aged-care system and the mental health system. Some states do that better than other states. I would agree with you that, in terms of implementing Living Longer Living Better, one of the things that has to be worked on is looking at how the 3,000 or so people who have really severe psychiatric conditions and dementia get assistance from both the aged-care system and the mental health system.[24]

6.22 The committee received a number of submissions that were prepared without the benefit of having access to the *Dementia and Veterans Supplements* consultation paper which was tabled by the department on 2 May 2013. Consequently, a number of key concerns such as the inclusion of other mental illnesses in the Dementia supplement, and assessments of eligibility under the supplements, appear to have been addressed by the department.

Committee view

6.23 The committee notes the general support for the additional supplements to help ensure that older veterans and people with mental illness receive the care that they need and that the community would expect for these people. The committee agrees with the stakeholders who raised concerns regarding the naming of the dementia supplement, noting that it is not sufficiently clear.

---

21 Mrs Christensen, Chief Executive Officer, Narrogin Cottage Homes, *Committee Hansard*, 29 April 2013, p. 49.

22 Alzheimer's Australia, answer to question on notice, 2 May 2013 (received 8 May 2013), p. 1.

23 Mr Shepherd, Professional Officer, Queensland Nurses Union, *Committee Hansard*, 30 April 2013, p. 57.

24 Mr Rees, Chief Executive Officer, Alzheimer's Australia, *Committee Hansard*, 2 April 2013, p. 23.

Recommendation 6

6.24 The committee recommends that the dementia supplement be renamed as the *Dementia and Behavioural Supplement,* in both residential and home care.

Special categories

6.25 Special categories are defined in the Allocation Principles. The Allocation Principles help ensure that the people who comprise the special categories have access to aged care services by distributing the available care places according to certain needs. If the Government is of the opinion that particular types of care places need to be allocated in a geographical location, it has the power to redress imbalances by directing the allocation of care type places. That is, the Government, by having the power to allocate funded places and types of funded places, will have direct control of the care places approved providers can provide.[25]

6.26 The Bill amends section 11-3 of the *Aged Care Act 1997* (Act) with the effect that all of the following categories of people will be deemed to be 'people with special needs':

- People from Aboriginal and Torres Strait Islander communities;
- People from culturally and linguistically diverse backgrounds;
- People who live in rural or remote areas;
- People who are financially or socially disadvantaged;
- Veterans;
- People who are homeless or at risk of becoming homeless;
- Care-leavers;
- Lesbian, gay, bisexual, transgender and intersex people; and
- People of a kind (if any) specified in the Allocation Principles.[26]

6.27 The committee has worked with a range of these special needs groups in the course of some of its previous inquiries, most notably care-leavers. It supports the identification of people who may require assistance from time to time in ensuring they are receiving appropriate care in the aged care system. The committee's inquiry into the Commonwealth contribution to former forced adoption practices recognised the traumatic experiences, health issues and socio-economic disadvantage that parents affected by those adoption practices were disproportionately likely to face. Accordingly, the committee would add to the above list parents separated from their children by former adoption practices.

25 Aged Care (Living Longer Living Better) Bill 2013 – Bills Digest, May 2013, p. 26

26 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 10.

Recommendation 7

6.28 The committee recommends that the bill be amended to include parents separated from their children by former adoption practices.

Homelessness

6.29 The committee heard that providing aged-care services for homeless people presented unique challenges around funding, services, access and restrictions.

6.30 The last census by the Australian Bureau of Statistics (ABS) estimated that there were about 14 000 elderly homeless people across Australia. There are currently around 700 beds in residential services specifically for homeless people spread across 16 facilities (10 in Melbourne, three in Sydney, two in Western Australia and one in Adelaide).[27]

6.31 The physical and emotional demands of homelessness mean that people who are homeless need to access care sooner than people who have not experienced homelessness. The head of Wintringham – a large provider of homeless aged-care services – reported to the committee that: 'I have very rarely found any of our homeless clients of 50, or certainly 60 plus, who have not needed some aged care intensively or at least minimally.[28]

6.32 It was reported that 'many of [the elderly homeless] are in situations that would be very surprising and very unacceptable to most of the community',[29] one example of which was provided by Wintringham:

> Our guys, when our outreach workers find them, are often in appalling condition. For example, we recently picked up someone who was sleeping in a urinal because he needed electricity to run his oxygen. It was the only place he could get any, so he slept in a urinal in Carlton for something like two years before he was found…This is a 65-year-old, fairly frail man. Obviously, needing oxygen, he is not in great shape.[30]

6.33 Mr Lipmann, Chief Executive Officer of Wintringham, explained to the committee that homeless people tend to be more expensive to care for due to their lack of access to informal supports, complex medical requirements, and classification under the existing funding structure. As summarised by Wintringham:

> In the situation where a person is homeless and has no ability to make any contribution and has no family members to help them through any of the types of things that we all do for our parents when they are in care—visiting them, taking them out, helping them with purchases and whatever—it becomes very difficult to financially manage that. The other issue is that

27 Ms Horton, Member, Prime Minister's Council on Homelessness, *Committee Hansard*, 1 May 2013, p. 26.

28 Mr Lipmann, Chief Executive Officer, Wintringham, *Committee Hansard*, 1 May 2013, p. 31.

29 Ms Horton, Member, Prime Minister's Council on Homelessness, *Committee Hansard*, 1 May 2013, p. 26.

30 Mr Lipmann, Chief Executive Officer, Wintringham, *Committee Hansard*, 1 May 2013, p. 29.

> our guys invariably suffer from different types of aetiologies and symptoms than mainstream.[31]

6.34 The committee heard from the Prime Minister's Council on Homelessness that due to the practical operation of the ACFI, aged-residents who were homeless attract a lower subsidy than residents of some other services:

> The average daily subsidy across the industry as a whole—whether you are large, small, rural, remote or whatever—was $135.84 per resident per day. If you were a homeless service provider in receipt of the viability supplement your average subsidy is $100.18 a day. As Brian has already articulated, that is a $35 difference. The average payment of the homeless viability supplement is $14.55 per day. That brings you up to about the $115 mark.[32]

6.35 The reason for this was explained to the committee as result of the way the effects of homelessness can manifest in residents:

> With regards to the dementia supplement, my mum would be touching you all the time and showing nervous responses like that. They were all claimable because there is constant effort required in looking after a person like that. Our guy would sit for three or four months perfectly calmly and then have a flare-up where he will charge through and knock people over. The police would be called and capsicum spray would be used and he would be locked up. Eventually, he would return. He would be perfectly calm for months afterwards but everyone was on tenterhooks not knowing when the flare-up was going to happen again…All of that tenterhooks time is not claimable under ACFI.[33]

6.36 Although the committee heard that the department has consistently and constructively engaged with providers of services to the homeless, there remains a funding gap between what mainstream and homeless providers receive. The committee heard that this may jeopardise the ongoing viability of services to the homeless:

> I hope, when you read the submission, you do not think I am being a bit dramatic, but we are actually on a slow death. We will not survive with $20 a day less than the industry, given that we have got harder clients to deal with and no bonds to support us. I would suggest that virtually everyone you are going to be speaking to during your inquiry is going to be earning, on average, $20 a day more than us, with far less complex clients. It is a simple fact.[34]

---

31 Mr Lipmann, Chief Executive Officer, Wintringham, *Committee Hansard*, 1 May 2013, p. 25.

32 Ms Horton, Member, Prime Minister's Council on Homelessness, *Committee Hansard*, 1 May 2013, p. 26.

33 Mr Lipmann, Chief Executive Officer, Wintringham, *Committee Hansard*, 1 May 2013, p. 28.

34 Mr Lipmann, Chief Executive Officer, Wintringham, *Committee Hansard*, 1 May 2013, p. 25.

6.37 The current funding situation of aged-care for homeless people also seriously limits their ability to access mainstream services, as the following hypothetical that was presented to the committee highlights:

> Could you imagine being the CEO of XYZ aged-care service and you go to the board and say, 'I want to have some homeless people in our organisation.' You end up having a huge discussion with the board about whether homeless people would fit in et cetera, and then they finally say, 'By the way, I'm going to lose $20 or $30 for each one I have.' It is not going to happen. There is no financial incentive. It would have to be a stupid financial decision to do it.[35]

6.38 The committee heard the suggestion that a special category should be created for homeless people due to the specialised arrangements that can be required in order to give them effective care. The committee notes that homeless people and people who are at risk of becoming homeless are included on the list of people with special needs.

Committee view

6.39 The dementia supplement is designed to cover behavioural difficulties in residential care across a number of ailments. While recognising that the behavioural challenges associated with dementia and other mental illnesses are often similar to those exhibited by homeless residents,[36] there are differences as well. There is also a significant shortage of aged care for people experiencing homelessness. Based on the evidence the committee received from Wintringham, it appears that there is a case to ensure that a supplement be provided for residential beds for homeless people. This should help ensure the viability of facilities providing this specialised and challenging form of care.

Recommendation 8

6.40 The committee recommends that the government create a Homeless Supplement.

Sexual diversity

6.41 The committee heard from a number of groups that highlighted the special needs of people who identify as LGBTI.

6.42 Overall, the LLLB reforms were well received, in particular the inclusion of LGBTI elders as 'people with special needs' in the bill:

> First, the fact that lesbian, gay, bisexual, trans and intersex people are now to be included within paragraph 11-3 as people of special needs is to be applauded and indicates that this bill recognises the specific and unique needs of this group, who too often are marginalised and ignored. This is an

35 Mr Lipmann, Chief Executive Officer, Wintringham, *Committee Hansard*, 1 May 2013, p. 32.

36 Mr Rees, Chief Executive Officer, Alzheimer's Australia, *Committee Hansard*, 2 April 2013, p. 23.

> important principle of the bill, and now we need to ensure that it is carried out in practice.[37]

6.43 The National LGBTI Health Alliance (Alliance) noted:

> This [is] an important step in increasing visibility of LGBTI Australians within the aged care sector and improving access to culturally appropriate, inclusive and non-discriminatory services…By including all special needs groups in one location under the legislation, the Parliament is sending a clear non-partisan message that all special needs groups should be viewed to be of equal importance to the aged care sector.[38]

6.44 The operation of the special needs category as it relates to LGBTI people was not entirely clear. The committee heard that :

> It must be remembered that for older LGBTI people it is not always easy to declare their sexuality at a vulnerable time in their lives such as when dealing with aged-care providers. Indeed, they may not wish to do so.[39]

6.45 The committee received evidence that in spite of this advancement of the position of LGBTI people in the aged-care system, barriers to accessing appropriate services remain as a result of past-experience and the availability of appropriate care.

6.46 The committee learnt that many LGBTI people were apprehensive about accessing aged-care and other services. The Alliance explained that for many older LGBTI people much of their life was punctuated by discrimination, harassment, criminalisation, and at times involuntary medical treatment.[40] An example illustrating how a person's previous experiences may influence the way they view institutional care was provided by GRAI;

> [T]his guy was taken by his family and committed to a mental institution. He had electric shock treatment because he was a homosexual. Later on in his life, he was locked up by the police – and so on and so on. This is the age group that we are potentially dealing with and their historical experience is very different from perhaps what you think now. I think that is the main point we would like to get across: that you need to be cognisant and sympathy to what has gone on for those people who were growing up.[41]

6.47 The composition of the aged-care system may contribute to these apprehensions held by some people. As the Alliance explained:

> Around 33% of aged care services are provided by faith-based organisations nationally. However on a local level this ranges somewhere between 25% – 100% in a particular aged care region. Most if not all religious aged care providers are committed to providing high quality

37 Dr Comfort, GLBTI Retirement Association Inc., *Committee Hansard*, 29 April 2013, p. 52.

38 National LGBTI Health Alliance, *Submission 88*, pp 1–2.

39 Dr Comfort, GLBTI Retirement Association Inc., *Committee Hansard*, 29 April 2013, p. 52.

40 National LGBTI Health Alliance, *Submission 88*, p. 2.

41 Dr Comfort, GLBTI Retirement Association Inc., *Committee Hansard*, 29 April 2013, p. 52.

> person centred care irrespective of the client's sexual orientation, gender identity or intersex status. However, many older LGBTI people are fearful of accessing a faith-based provider. This presents a unique problem in aged care, as some LGBTI people will have restricted geographical access to an alternative provider exacerbated by the lack of availability of service in most areas.[42]

6.48 The Alliance's written submission noted that while most faith-based providers have publicly stated their non-discriminatory policies towards LGBTI people – and some have actively sought to engage with LGBTI people – such policies do not provide necessary assurances for LGBTI people to be confident that these services are appropriate for them. As the Alliance explained:

> Many older people have difficulty recognising the distinction between a church body who espoused opposition to their basic human rights over the years and the care arm affiliated with that church. Accordingly…older LGBTI people are hesitant to access faith-based aged care services knowing that such an organisation has a legal right to discriminate against them.[43]

6.49 In 2012 the Government released the Exposure Draft of the Human Rights Anti-Discrimination Bill 2012 (Anti-Discrimination Bill). One of the proposed amendments included in the Anti-Discrimination Bill were provisions to limit the ability of Commonwealth-funded aged care services from being able to discriminate in the provisions of these services.[44] The Senate Legal and Constitution Affairs committee received comments for and against these provisions, but agreed with the approach taken by the Commonwealth, noting that 'it is fundamentally important that all older Australians maintain the right to access aged care services on an equal basis.'[45]

6.50 A number of submissions to the inquiry into the Anti-Discrimination Bill demonstrate why some older LGBTI people may still have cause for concern in accessing faith-based aged care facilities. For example, the Australian Catholic Bishops Conference stated that:

> People considering a move into a church aged care residential facility have an expectation that the particular ethos of that church will be upheld at the facility. If a resident is not prepared to abide by that ethos, the Church aged care facility should have the freedom to refuse to accept that person.[46]

---

42 National LGBTI Health Alliance, *Submission 88*, p. 2.

43 National LGBTI Health Alliance, *Submission 88*, p. 3.

44 National LGBTI Health Alliance, *Submission 88*, p. 3.

45 Senate Legal and Constitutional Affairs Legislation Committee, *Exposure Draft of the Human Rights and Anti-Discrimination Bill 2012*, February 2013, pp 62, 94.

46 Senate Legal and Constitutional Affairs Legislation Committee, *Exposure Draft of the Human Rights and Anti-Discrimination Bill 2012*, February 2013, p. 64.

6.51 The Alliance recommended legislating anti-discrimination provisions for aged-care to protect the rights to access of older LGBTI people. This view was also articulated by the GLBTI Retirement Association Incorporated (GRAI), who argued:

> There should be no exemptions given to providers who are receiving government support in their provision of service. This applies specifically to faith-based agencies…We therefore ask the committee to recommend that the Aged Care (Living Longer Living Better) Bill 2013 include provisions that will ensure that faith-based providers of aged care do not have recourse to exemption under the Sex Discrimination Act if they receive Commonwealth support.[47]

6.52 Toward the end of the committee's inquiry, the government tabled a proposed amendment to its Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Bill 2013. This bill is at the time of writing still under consideration by parliament. Discrimination legislation currently exempts religious organisations from a range of anti-discrimination provisions when they engage in ' an act or practice that conforms to the doctrines, tenets or beliefs of that religion or is necessary to avoid injury to the religious susceptibilities of adherents of that religion'. The proposed amendment would remove religious organisations from the shield of that exemption when they are providing Commonwealth-funded aged care.

Recommendation 9

6.53 The committee recommends that the Senate amend the bill in the terms described in the government's tabled amendment.

Other disabilities

6.54 Older Australians have a higher rate of disability than those of younger age cohorts. The Australian Bureau of Statistics reports that:

> The disability rate increases steadily with age, with younger people less likely to report a disability than older people. Of those aged four years and under, 3.4% were affected by disability, compared with 40% of those aged between 65 and 69 and 88% of those aged 90 years and over.[48]

6.55 The increased prevalence of certain disabilities among the aged is highlighted by figures provided by Vision Australia that quantify the incidence of blindness and low vision in the general population over the age of 60:

- 60-69yo – 3.39 per cent;
- 70-79yo – 5.67 per cent;
- 80-89yo – 9.59 per cent; and

---

47 Dr Comfort, GLBTI Retirement Association Inc., *Committee Hansard*, 29 April 2013, p. 52.

48 Australian Bureau of Statistics, *4430.0 – Disability, Ageing and Carers, Australia: Summary of Findings, 2009*, http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4430.0Main%20Features22009?opendocument&tabname=Summary&prodno=4430.0&issue=2009&num=&view (accessed 8 May 2013).

- 90+yo – 14.82 per cent.[49]

6.56 As these figures illustrate, there is a strong correlation between ageing and disability, and any effective aged care system needs to take this fact into account.

6.57 The committee heard concerns that Australians ageing with a disability may fall through the cracks of the embryonic National Disability Insurance Scheme (NDIS) and the *Living Longer, Living Better* (LLLB) reforms:

> Vision Australia submits that, without changes to Living Longer, Living Better reforms, senior Australians who are blind or have low vision…will fall through the cracks between the aged-care system and disability care. We have been unable to identify any meaningful response that will give effect to ensuring that seniors will have access to the specialist disability supports they need to achieve their right to stay safe, independent and active in a manner remotely comparable to that which will be afforded younger Australians under disability care.[50]

6.58 Similarly, the Macular Disease Foundation Australia told the committee:

> Despite repeated statements by the Prime Minister and Minister Macklin as recently as yesterday that the NDIS is for all Australians, the legislation explicitly excludes people who acquire a disability after the age of 65. As such, they will be denied the support services and aids which otherwise would have been provided by the NDIS as an entitlement for life had they acquired the disability at, say, 64 years and 11 months. These people will be required to access support services and aids via the aged-care system and will have to co-contribute to this support.[51]

6.59 Anglicare also questioned how the new aged care regime would address the needs of people over the age of 65 who acquired a disability.[52] The National Council of Social Services (NCOSS) cautioned that:

> [T]here are significant numbers of people with disability who will not have access to the NDIS, and who will instead need to rely on aged care services. Aged care services have historically not been able to support people with non-ageing-related disabilities appropriately, nor are they funded to do so.[53]

6.60 Vision Australia argued to the committee that vision related disability is not currently well supported by the aged care sector, and that the LLLB policy does not seem to address this concern:

> [Aged] care has never adequately provided for the needs of vision related disability, and nothing that we have seen in the bills before this committee

---

49 Vision Australia, *Submission 81*, p. 6.

50 Mr Ah Tong, Vision Australia, Policy and Public Affairs Advisor, *Committee Hansard*, 2 April 2013, pp 21–22.

51 Mr Cummins, Research and Policy Manager, Macular Disease Foundation Australia, *Committee Hansard*, 2 April 2013, p. 57.

52 Anglicare, *Submission 75*, p. 3.

53 Council of Social Services New South Wales, *Submission 69*, p. 1.

> promote a shift from this. We are talking about a real paradigm shift about active ageing. Change needs direction, leadership and nurturing, and we do not see it here.[54]

6.61 MND Australia also noted that the aged care sector as it is currently is not equipped to deal with the needs of elderly people with a disability:

> From experience we know that the needs of people living with rapidly progressive neurological diseases such as [motor neuron disease] cannot be met by existing or traditional aged care services or facilities. Even with the proposed improvements and changes to the aged care system the focus remains on addressing needs related to ageing.[55]

6.62 The committee also heard that people who acquire a disability are more likely to be forced prematurely into residential care. A report by the Centre for Eye Research Australia concluded that:

> [Vision] impairment prevents healthy and independent ageing and is associated with the following: risk of falls doubles; [and] risk of hip fractures increased four to eight times.[56]

6.63 The Australian Blindness Forum attributed this to 'the failure of the aged care system to adequately address the specific needs associated with disability.'[57] Given that one of the goals of the LLLB reforms is to allow people to remain in the community for a longer period of time before entering residential care, it would appear that there is a need to consider the impact disability has on the ability of those ageing with a disability to remain in the community.

6.64 Vision Australia's submission argued that government support for vision impaired individuals was inadequate, and emphasized that although 70 per cent of their clients were over 65 years of age, only five per cent of the organisation's operating budget came from government aged-care funding.[58]

6.65 Vision Australia and the Macular Disease Foundation Australia (MDFA) both argued that the LLLB package of reforms should include a low-vision supplement in recognition of the needs of that cohort of individuals.[59]

Committee view

6.66 The committee notes that issues regarding the articulation between the aged care and disability care systems were also raised during the committee's inquiry into

---

54 Mr Ah Tong, Vision Australia, Policy and Public Affairs Advisor, *Committee Hansard*, 2 April 2013, p. 22.

55 Motor Neurone Disease Australia, *Submission 27*, p. 2.

56 Vision Australia, *Submission 81*, p. 6.

57 Australian Blindness Forum, *Submission 16*, p. 3.

58 Vision Australia, *Submission 81*, p. 7.

59 Mr Cummins, Research and Policy Manager, Macular Disease Foundation Australia, *Committee Hansard*, 2 April 2013, p. 60; Mr Ah Tong, Vision Australia, Policy and Public Affairs Advisor, *Committee Hansard*, 2 April 2013, p. 22.

the NDIS bills. The Government needs to monitor carefully the adequacy of supports being provided for people ageing with a disability.

Recommendation 10

6.67 The committee recommends that the ministers responsible for Disability Care Australia and the aged care reforms acknowledge the issue identified in the both Senate committee inquiries into these reforms, and urges ministers to continue their work to ensure that the two systems meet the needs of all people ageing with disability.