national AGED CARE alliance

National Aged Care Alliance

A Summary of Options for Long Term Financing of Community and Residential Aged Care

A discussion paper prepared for the National Aged Care Alliance
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September 2006

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This paper does not represent the expressed opinion of any member of the National Aged Care Alliance (the Alliance). Alliance discussion papers canvas a range of issues relating to a topic and aim to provide balanced information on the issue being explored. Such papers do not include an Alliance opinion on the topic. A discussion paper is generally prepared to assist the Alliance with the development of a position or to initiate broader discussion.

Preface

The National Aged Care Alliance (the Alliance) considers it timely to promote discussion of reforms in aged care, and in particular discussion of the long term financing of aged care. This issue has been an unresolved feature of the last decade of aged care services in Australia.

The options for the long term financing of aged care have to be inclusive of the need to expand community care services and determine the balance of care provision between community aged care and residential aged care. There is unfinished work following Professor Hogan's *Review of Pricing Arrangements in Residential Aged Care* (Hogan 2004), particularly around the further development of planning ratios for community aged care to complement the existing residential aged care planning ratios. While there is reasonable certainty that older people wish to remain in their own homes for as long as possible, there is considerable uncertainty about how older people in the future will want to express their choices in terms of different combinations of accommodation and care.

While many of the options in this paper are relevant to both the funding of community and residential aged care, most have been developed in the past with a focus on residential care.

The need is for financial options that provide flexibility for a balanced care system that can respond to:

- the crucial role of family carers in helping people to stay living in their own homes;
- the changing preferences of older people in their accommodation and care choices;
- changes in epidemiology, including the increasing prevalence of dementia, other neurodegenerative disorders, and frailty;
- the consequent complexity of care and the need for multidisciplinary management and care of people needing help;
- increasing concerns about the supply of the aged care workforce;
- the tendency for substitution of high cost institutional health care services by care in the community: including palliative care, rehabilitation, hospital and treatment services, and post acute care services in the home;
- the needs of a culturally and linguistically diverse older community; and
- the challenges of providing services in rural and remote communities.

The starting point for this paper was the Alliance forum: *Aged Care: who pays?* held in August 2005. The paper also draws on relevant material from Professor Hogan's *Review of Pricing Arrangements in Residential Aged Care* (Hogan 2004). It complements material covered in a previous report by Jan Webster commissioned by the *Alliance on Options for Financing Long Term Care: for older people in Australia* (Webster 2002).

This paper firstly looks at the cost of care and considers the factors likely to drive costs. It is recognised that a wide range of factors will determine costs and often these factors will interact. Particularly important are the issues that centre on the role of family carers and reductions in their availability.

This paper does not address the funding for health care provision for older people. The Alliance has addressed the organisation of health care provision for older people in their 2006 publication: AHMAC and Beyond - A Strategic Framework for Health Care for Older People: at home, in residential care, in hospital and in transition between settings (www.naca.asn.au). Effective health care and assessment has the potential to improve the efficiency and effectiveness of community and residential aged care. This is acknowledged in Recommendation 6 of the Review of Pricing Arrangements in Residential Aged Care (Hogan 2004) for funding supplements for "short term medical needs such as IV therapy, wound management, intensive pain management and tracheostomy…. specific care needs such as for dementia sufferers exhibiting challenging behaviours or for residents requiring palliative care… the care needs of people from diverse or disadvantaged backgrounds".

This paper lists thirteen options for funding these costs involving: increased contributions from the Australian Government (the Government), increased contributions from consumers and increased productivity of the industry. Many of these options are relevant to community care although their genesis has been residential care.

Judgements about the different options in this paper will vary but they need to be considered against principles that reassure the wider community that Australia will continue to have a world class system of aged care that is based on commonly shared values. The balance of judgement about the options will reflect values that relate to:

- retaining universal services in preference to a two tiered system;
- ensuring that appropriate, high quality care can be provided to meet individual need;
- ensuring a system that results in equitable access to care;
- recognising and supporting the role of informal carers;
- responsiveness to the needs of special groups; and
- providing a safe and rewarding environment for those working in the industry.

The Alliance hopes that by providing basic information and presenting possible options in an accessible way, it will be possible to stimulate a broader debate. Comments on the paper should be provided to nacasecretariat@anf.org.au by 30 October 2006. The Alliance looks forward to your contribution to this important issue.

Members of the Alliance

- Aged and Community Services Australia
- Aged Care Association Australia
- Alzheimer's Australia
- Anglicare Australia
- Australian Association of Gerontology
- Australian Council on the Ageing
- Australian Divisions of General Practice
- Australian Healthcare Association
- Australian Medical Association
- Australian Nursing Federation
- Australian Physiotherapy Association
- Australian Society for Geriatric Medicine
- Baptist Care Australia
- Carers' Australia
- Catholic Health Australia
- Diversional Therapy Association of Australia
- Geriaction
- Health Services Union
- Liquor, Hospitality and Miscellaneous Union
- Lutheran Aged Care Australia
- OT Australia
- Pharmacy Guild of Australia
- Royal Australian College of General Practitioners
- Royal College of Nursing Australia
- UnitingCare Australia

1 Factors influencing costs

The Australian Government spent some $6.3 billion on aged care in 2005-2006, and this is estimated to rise to $6.9 billion in 2006-2007, an estimated increase of 9.5%. Some $4.5 billion of the 2005-2006 expenditure, or 71%, was spent on residential care subsidies, the other 29% being spent on community care, information and support about ageing, and workforce initiatives. (Department of Health and Ageing, 2006).

In addition to Australian Government spending, consumers contributed around $2 billion toward the costs of care, mainly residential care, while State and Territory Governments contributed some $0.5 billion to community care.

In total, governments and consumers spent around $9.4 billion on aged care in 2005-2006. Given the predicted rise in this expenditure over future years, it is crucial to look at the cost factors that are driving this expenditure, and possible ways of funding these costs.

This paper focuses on the direct costs to governments and consumers, rather than trying to encompass total direct and indirect costs to the whole community.

The future cost of aged care can be looked at in terms of two main factors:

- the amount of care provided, and
- the cost of each unit of care provided.

1.1 How much care will be provided?

Estimating the future amount of aged care provision is a difficult task as up to this point the Australian Government (the Government) has applied strict supply controls on subsidised care. It does this through controlling the number of subsidised aged care places, controlling entry to subsidised places though Aged Care Assessment Teams (ACATs) and through placing budget limits on grant programs. Very little long term residential aged care is provided outside the Government's subsidised system and only a relatively small proportion of formal (ie. paid) community care is provided to the frail aged unsubsidised.

Under the current system, estimating the amount of subsidised care to be provided in the future becomes a matter of predicting what level of supply the Government is going to decide to fund.

Currently, the Government has indexed the number of residential care places, Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) places by the growth in the population aged 70 years or more. From 1987 to 2004, the limit was 100 places per thousand people aged 70+ years. From 2005 onwards, this figure has been increased to 108 places per thousand people aged 70+ years, with residential care target provision being reduced from 90/1000 to 88/1000 and community aged care packages being increased from 10/1000 to 20/1000.

With regard to the Home and Community Care Program (HACC), Australian, State and Territory Government funding has been maintained at 6% real growth per annum over the last ten years. Some 70% of HACC funding is spent on providing care to people 70 years and over.

1.2 What factors might cause governments to vary the amount of care to be subsidised?

1.2.1 Increased demand

Increased demand can be triggered by several factors. Woods (2005) focuses on four drivers of demand:

- an ageing population;
- disability prevalence (and disease);
- the costs of care; and
- the mix of care.

Hogan's (2004) list includes these but expanded the list as follows:

- growth in the aged population, especially the very old;
- changes in health status;
- changes in living arrangements and access to informal care;
- preferences for types of care;
- income and assets of the older population; and
- price to the consumer of services.

1.2.2 Growth in the aged population

The Productivity Commission has projected ABS population figures to show growth in different age groups. The key figure is the increase in people 80 years and over from 680,000 in 2004 to 2,600,000 in 2045. This growth does not occur evenly, but peaks between 2025 and 2035 (due to the 'baby boomer' generation) (Woods 2005). The 80 plus age group is crucial in predicting demand for aged care services, as in June 2003, some 73% of residential aged care residents were 80 years and over, as were 60% of CACP recipients, and 39% of HACC clients (AIHW 2004; Department of Health and Ageing 2004).

If current age specific rates of admission to aged care programs remain constant, this projected growth in the 80 plus population would foreshadow a massive increase in demand for aged care services.

1.2.3 Disability and disease

There has been considerable debate in Australia as to whether increasing life span means an increase in disability years, or whether disability 'compresses' into the last two years of life, irrespective of how long a person lives.

Hogan (2004), after reviewing international and Australian studies, estimates an improvement in age specific disability rates of 0.25% per annum. Australian evidence (see Department of Health and Aged Care 1999) suggests that disability years are remaining fairly constant and are in fact compressing into the last two years of life. This suggests that increased demand for aged care will come from the increasing number of the very old, not so much from increasing disability prevalence.

There is however one important exception to the 'compression of morbidity' hypothesis and that is the strongly age-related spectrum of neurodegenerative diseases. Over the age of 75 there is little change in the prevalence of systemic disorders, including cardiovascular and respiratory diseases, but age 75 heralds a near exponential rise over the subsequent two decades in the prevalence of neurodegenerative conditions, including movement disorders, visual and hearing impairments, cognitive decline, and dementia (Waite 1997).

There is now some evidence that it may be possible to reduce the risk of dementia (Woodward 2005) but further research is needed. On the other hand, as people with dementia are becoming physically healthier, they can be expected to live longer, along with the rest of the population, thereby increasing the overall prevalence of the disease.

Dementia will progressively become the biggest disability driver of demand for aged care services. The increase in incidence of dementia with increasing age over 70, combined with better care and a longer life span will, in the absence of any effective preventive programs, create a huge demand for dementia care by 2050. A 2003 Access Economics report commissioned by Alzheimer's Australia estimated that the number of those with dementia will increase from 212,000 in 2006 to over 730,000 in 2050 unless effective methods of prevention and treatment are found in the meantime. Some 65% of residents in aged care homes are estimated to have some degree of dementia (Access Economics 2003).

Similar comprehensive epidemiological projections are not available for other neurodegenerative disorders including movement and gait disorders, such as Parkinson's disease, and severe, often combined, vision and hearing loss.

Another crucial health status consequence of the new demography and epidemiology will be a high prevalence of individuals with two or more major illnesses and disabilities, with associated 'frailty'. This will place them in a position of high risk of sudden and frequent decline in health status, and implies the need for a complex, integrated, medical and multidisciplinary health service with a capacity for pre-planned preventative and responsive service provision (Mitnitski 2002; Rockwood 2006).

1.2.4 Changing preferences for care

Government policy and the advocacy of consumer groups since the mid 1980s has been predicated on the view that older people prefer to remain in their own homes for as long as they possibly can. This was also the view taken by Hogan. A person's 'own home' may be a self care unit in a retirement village or other congregate living for older people.

The Australian Government has increasingly recognised this preference for staying at home by making real increases in the growth of HACC funding and programs and making increases in the provision ratio for CACPs and EACH packages from ten to twenty places per thousand people aged 70 years and over. At the same time there has been a decrease in the provision ratio for residential care from 90 to 88 places per thousand people aged 70 and over. However expenditure on residential care has also grown, with the result that community care still represents less than 25% of aged care expenditure and has done so since the early 1990s.

This preference for care in one's home rather than in residential care has implications for future costs of aged care services. Although there appears to be little difference in care costs to Government there are significant cost implications for families and carers through the provision of informal care in the home. Capital costs for governments however in terms of buildings, are considerably less for community care than for residential care.

1.2.5 Availability of informal carers

Unless older people have significant financial resources their ability to exercise their preference for care in their own home depends largely on the availability of family members and friends to provide that care. The Australian Bureau of Statistics (ABS 2004) Survey of Disability, Ageing and Carers in 2003 found that people 60 years and over with disabilities received assistance from informal carers for 78% of the activities of daily living for which they needed assistance. Of the assistance they received for these activities, informal care comprised the following:

- 18% by a female partner;
- 19% by a male partner;
- 23% by a daughter;
- 19% by a son; and
- 38% by other relatives or friends.

(Some people were helped by more than one informal carer for some tasks.)

A report by the National Centre for Social and Economic Modelling (NATSEM) commissioned by Carers Australia in 2004 projected that between 2001 and 2031 there would be a 150% increase in older people needing care but only a 57% increase in the availability of informal carers (NATSEM 2004).

A study conducted by the Australian Institute of Health and Welfare (AIHW 2004) suggested there could be three possible scenarios:

a) an overall decline in the willingness of people to care;

b) a decrease in the number of carers due to reduced willingness of employed females to leave the workforce; or

c) an increase in the number of carers due to higher numbers of co-resident spouses in the population (ie. more older people surviving as couples).

Bowers (2005) from Carers Australia considers that the crucial factors influencing the availability of carers include:

- the capacity to pay for community care;
- the degree of financial and community support for carers themselves;
- the ability to combine caring with employment; and
- technological and pharmaceutical developments that would assist the caring task.

If the availability of family carers does significantly diminish in the future, then the cost implications of replacing them with paid carers will be considerable.

1.2.6 Income and assets of the older population

Two somewhat contradictory factors appear to be in operation when looking at the relationship between the wealth of older people and use of services.

Firstly, the wealthier you are the more care services you can afford. Secondly, the poorer you are, the more likely you are to be ill or disabled.

Hogan (2004) concluded that older people with higher levels of income tend to make greater use of low level residential care than those with lower income levels. He also concluded that the evidence suggests that older people with lower incomes are more likely to seek high level residential care. This latter conclusion is consistent with the international literature which indicates that a person's health is positively correlated with their wealth and income.

Prior (2005) has produced estimates of family wealth by age group from 2000 to 2030. His data shows a considerable shift during this period toward increased wealth of family members 65 years and older.

Harding et al (2002) found the distribution of wealth across the Australian population has shifted markedly toward older Australians. The share of wealth held by those aged 65 and over has increased from 17% of the population in 1986 to 27% in 1997.

Lim-Applegate et al (2005) analysed longitudinal pension data and concluded that the June 2004 cohort of Australians reaching age pension age were, on average, significantly wealthier in real terms than earlier corresponding cohorts. They expect this trend to continue, particularly with the maturation of the Superannuation Guarantee Levy.

These authors also found that people on the aged pension are drawing down their wealth in retirement, although this drawdown is occurring at a fairly slow pace. If this pattern persists, conclude the authors, people on the aged pension would be able to retain significant assets through many years of retirement.

Consistent with these trends, the Australian Government's Intergenerational Report (2002) estimated that, under current eligibility rules, the proportion of people receiving a full age pension would decline, while the proportion with a part pension would increase significantly.

The removal of tax exiting superannuation funds, and the abolition of Reasonable Benefit Limits on superannuation, as announced in the 2006 federal budget, will also have the effect of increasing the wealth of older people.

1.2.7 Price to the consumer

Given the highly subsidised aged care system in Australia and the relatively low price to the consumer (compared to total cost), it is very difficult to determine how variations in consumer price will affect consumer demand.

After reviewing the literature, Hogan (2004) estimated 'elasticity in demand' at 0.5%. That is, for every one percent increase in the price to consumers, there will be a 0.5% reduction in demand.

International literature indicates that this price effect is considerably less for people with high levels of disability who, presumably, have few alternatives to purchasing care.

1.2.8 Summary

The demand for aged care services will be greatly affected by the increasing number of very old people aged 80 years and over in the population. This in turn will lead to changes in epidemiology including increasing prevalence of dementia, other neurodegenerative disorders, and frailty, which will place increasing demands on the aged care system, including its capacity to provide for the health services needs of future clients.

There is no reliable evidence about how consumers will respond to combinations of accommodation and care in the future. It seems probable that with increasing affluence, consumer preference will move increasingly to care in the home, which does not incur the capital costs of residential care, but this will depend to a large extent on the future availability of informal carers. For the less affluent, the probability of fewer informal carers may lead to a greater reliance on residential care.

1.3 Costs of care provided

1.3.1 Overall cost

Hogan (2004) pointed out that the unit cost of aged care services is driven by:

- the cost of labour;
- the cost of materials;
- the cost of capital; and
- the effect of regulatory constraints.

Based on 2002-2003 data he estimated annual unit costs (ie. the cost of a place fully occupied for a year) to be:

- $1528 for each recipient of HACC.
- $12,832 for each CACP;
- $27,313 for each low residential care recipient. and
- $54,120 for each high residential care resident.

Hogan projected these estimates of costs to 2042-2043. His projections show costs rising a little faster than CPI, though increases in HACC costs remain small.

Hogan predicts that if the current system is to continue there will be an overall shortfall in funding of some $6 billion by 2022-2023, rising to $14 billion in 2032-2033.

These estimates of costs are based on existing levels of care being maintained. The Productivity Commission (1999) has argued for a more normative approach to costs where the Australian Government prescribes a 'benchmark of care' that it is willing to fund. Costs should then be worked out on the basis of providing this benchmark of care.

The Australian Government takes the view that the benchmark of care is spelled out in the accreditation and certification standards, which are consistent with current funding.

1.3.2 Cost of labour

Hogan points out that labour costs comprise around 75% of residential care costs and a slightly higher proportion for community care. Hogan proceeds on the assumption that labour costs will grow around 2.5% per annum above CPI.

Iliffe (2005) from the Australian Nursing Federation estimated that it would cost some $825 million to close the wages gap between nurses working in aged care and nurses working in other sectors.

The wages of personal care attendants, who make up the majority of the aged care workforce, are also low. Personal care attendants earn a minimum of $13.53 per hour, and are employed on a predominately part-time basis. The wages of other staff (eg. cleaning and kitchen staff) are similarly lower in the aged care sector than some other comparable sectors of employment.

Hogan (2004), Iliffe (2005) and Woods (2005) all point out that current shortages of skilled staff are likely to push up wages even further in the short term.

Prior (2005) also sees labour costs rising faster than labour supply due to demand, and as a result of the increasing educational and skill levels required for aged care workers.

1.3.3 Costs of capital and other costs

Taking into account the cost of land, buildings, plant, equipment and working capital, Hogan (2004) estimated that over the next ten years, the capital requirements of the sector would be in the order of $9.2 billion.

Prior (2005) sees non labour costs rising with the increasing need for specialised equipment and drugs and as consumers demand more and better services.

2 Possible sources of funding for aged care

2.1 Current situation

According to Hogan (2004), the Australian Government in 2002-2003 contributed 68.4% toward the costs of aged care (both residential and community), State and Territory Governments 5.4%, and consumers 26.2%.

2.2 Continuation of the status quo

Assuming current arrangements continue, these proportions are projected to change as follows:

	2002-2003	2012-2013	2022-2023
Australian Government	68.4%	64.8%	59.0%
State and Territory Governments	5.4%	5.4%	4.9%
Consumers	26.2%	30.0%	36.0%

Source: Hogan 2004.

These figures show an increasing shift in funding away from government to consumers over the next twenty years. However the projected shortfall of funding of $6 billion by 2022-2023 means considerable increases in funding will be necessary from all sources.

In the options discussed below it should be realised that changing the method of funding could also lead to changes in other aspects of the system, including quality of care and capacity to meet the range of needs of a diverse community, and may have implications for the workforce. In most cases there is little or no evidence indicating whether such changes would occur, but it is generally accepted that the various options should be judged in terms of their effect on these factors, as well as their financial impact.

2.3 Option 1: Increased contribution from governments

The Australian Government's capacity to contribute depends largely on the Government's budgetary position at any one point in time, and the political priority that is accorded to aged care relative to other demands on government funds. This in turn depends on the Government's projected expenditure compared to the projected revenue from all sources, including taxation. The amount of revenue collected depends largely on the health of the economy, which can be measured by the Gross Domestic Product (GDP).

Projecting GDP growth is a difficult exercise and relies on basic assumptions about the economy remaining true for the length of the projections.

Hogan (2004) looks at three different sets of assumptions relating to population growth and ageing. He concludes that economic growth will slow, with or without ageing, due to slowing population growth. The sharpest slowing he projects, will occur between 2015 and 2025, as the 'baby boomers' retire. However Hogan also points out the ratio of real GDP to the size of the population will continue to slightly increase for the next five years, with decreases after that until 2036.

Accurate predictions of economic growth are notoriously difficult to make. Hogan's 'best guess' prediction is a GDP growth of 3% per annum (the 2006 federal budget forecasts 3.25% for 2006-2007).

Hogan concludes that notwithstanding this strong economic growth in the short term, and continuing large budget surpluses, the Australian Government will not in the long term be able to maintain its share of responsibility for the funding of aged care services without increases in tax rates and tax bases and/or cuts to other spending programs.

Hogan points out that state and territory finances are less affected by the ageing of the population than the Australian Government. The negatives for state budgets such as hospital costs will occur later than for the Australian Government, and there are offsetting savings in terms of reduced educational costs.

It should be pointed out that Hogan's projections are based on the continuation of existing Government policies however those policies are subject to change. Similarly, forecasts about the Australian economy are not set in stone, and may have to be changed as circumstances change.

2.4 Option 2: Increase in the Medicare levy

In order to meet the estimated shortfall in aged care funding in 2002-2003, Hogan estimated that the then current Medicare levy of 1.5% would need to be raised by 1.5%, taking it to 1.5225% of taxable income (in 2002-2003 the Medicare levy was estimated to raise $5.185 billion).

Hogan points out however that the rate itself would need to steadily increase as follows:

	Increase	Resulting levy
2012-2013	17.3%	1.79%
2022-2023	21.0%	2.16%
2032-2033	25.0%	2.70%
2042-2043	16.3%	3.13%

There is some evidence that taxpayers are willing to accept increases in 'hypothecated' taxes where the revenue is directed to a specific purpose, such as hospital care or aged care. Howe (2005) points out that people "hate taxes but like levies", however some see such fixed rate levies as disadvantaging low wage and salary earners who have little opportunity to reduce their taxable income.

Hypothecated taxes are also disliked by many economists, including Treasury officials, as well as governments, as they reduce 'fiscal flexibility' in terms of government being able to make decisions on relative priority areas of need.

Howe (2005) lists some other methods whereby Government might raise revenue specifically for aged care. These include:

- trading off part of an age pension increase;
- mandatory payments from superannuation lump sums; and
- stamp duty on exiting instead of entering the housing market.

2.5 Option 3: Increased contributions from consumers

Hogan (2004) points out that even under the current system, the contribution of consumers to the cost of residential care will increase from $2.1 billion in 2002-2003 to $36.4 billion in 2042-2043, a real increase of 174.3%. This results from the growing wealth of older Australians and a corresponding increase in the number of residents assessed under the current aged care system as having the financial capacity to pay. Hogan points out that some 80% of older people have no assessable income. By 2032-2033 that figure will have dropped to 53%.

In terms of assets, in 2002-2003 only 56% of older people had assets worth more than ten times the annual age pension. By 2032-2033 that figure will have increased to 75%.

Hogan warns however, that despite this increasing affluence, there will still be a considerable number of older Australians with almost no assets and little or no assessable income. By 2032-2033, some 40% of older Australians will have assessable assets less than 2.5 times the annual pension and 53% of older Australians will have no assessable income.

Further, Hogan points out that residents in aged care facilities are in general older and have fewer assets and lower incomes than average older Australians.

Prior (2005) adds there will be a considerable shift in estimated family wealth from the 45-64 age group to the 65 plus age group.

2.6 Option 4: Stronger means and assets testing for eligibility for subsidy

The means testing arrangements for residential aged care contain many anomalies. For example, in 2002-2003, no resident, no matter how high their income, could be asked to pay more than 255% of the pension in means tested fees. This had the effect of restricting the maximum resident contribution to around $17,000 per annum. Hogan suggested this amount could easily be raised to $25,000. In today's terms, this amounts to raising the maximum resident means tested contribution from $18,700 to $27,500.

In looking at the level of contribution where the Government subsidy begins to be withdrawn, Hogan argued that it is important to make these arrangements consistent with means testing for the age pension. (Measures in the 2006 federal budget go some way to achieving this.)

Hogan suggests that the current arrangements, where the Government subsidy is reduced by 25% of the individual's private income above the income test free area, could be strengthened by making this rate of reduction greater, preferably through a tapered system. Hogan considered that tapered means testing arrangements going as high as 50% would be feasible and would have saved the Government some $32 million in 2002-2003. This would rise to $1.2 billion by 2042-2043.

In considering any changes to means testing, the Government has to consider the impact of means testing subsidies in providing disincentives for people to increase their income either through work or savings.

2.7 Option 5: Bonds for high care

Several contributors to the Alliance (title) Forum raised the issue of extending the system of accommodation bonds to high care. Currently, accommodation bonds can only be required from people admitted to low care places, or extra service places.

Hogan (2004) argued that all consumers of residential aged care should have available to them the full range of payment options (ie. bonds, periodic payments, daily charges), irrespective of whether they are occupying a high care or a low care place. The current arrangement where residents admitted for low care contribute more toward the capital costs of their care than residents admitted for high care is seen as inequitable.

Hogan estimated that the industry derived around $90 million in retention amounts on bonds in 2002-2003. In addition, he estimated that some $2.7 billion dollars in bonds was being held by providers. At an interest rate of 4.5% per annum this would yield an additional $121 million per annum. Given that around 60% of admissions are for high care (AIHW 2004), extending bonds to high care could be expected to double these amounts.

The most frequent objections to extending accommodation bonds to high care are as follows:

- low care is largely a housing option, whereas high care is largely about care;
- long stay residents in hospitals are not charged accommodation bonds, though the care is similar;
- some 19% of high care admissions stay less than three months and 27% less than six months (AIHW 2004), yielding little return for the provider; and
- an accommodation bond that forces a person to sell the family home is politically undesirable and equivalent to a 'death duty'.

2.8 Option 6: Unbundling the costs of care

This option involves separating residential aged care into two or three separate cost centres and funding these cost centres from different sources.

Under the two stream option, the costs of care would be separated into care costs (nursing and personal care) costs and 'hotel' costs (such as accommodation, food, heating etc). The Government would largely fund care on the basis of assessed need and possibly on a means tested basis. The consumer would pay for their 'hotel' costs, with the proviso that the Government would provide a safety net for people with very low income and assets.

Woods (2005) proposes a three stream option, dividing 'hotel' costs into accommodation costs (equivalent of rent, mortgage payments etc) and living costs (food, linen, heating etc). As in the two stream option, the government would largely fund care, with the consumer largely responsible for the rest.

There are two advantages of these 'unbundling' options. Firstly, they enable an alignment of residential aged care with community aged care in that in both forms of care the consumer would be responsible for accommodation and 'hotel' costs. This opens the way for the Government to pay a single subsidy for care, with the consumer free to choose whether they wish to receive that care at home or in a residential aged care facility.

Secondly, these options provide a rational approach to eliminating inconsistencies in accommodation payments between high and low care.

Such an approach would however result in a considerable shift in funding responsibility from Government to consumers. Hogan estimates that some 47% of the cost of low care and 24% of the cost of high care is accommodation services, estimating that some 31% of the cost of residential aged care is currently met by residents. (Note that Hogan also proposes consumers pay for 'personal and social services' which constitute some 33% of low care costs and 46% of high care costs.)

Removing Government subsidies for capital costs would mean that providers would need to raise capital from consumers or in the financial markets. 'Not for profit' providers may find this more difficult than 'for profit' providers. If this turns out to be the case, then the balance of provision between 'for profit and 'not for profit' could change significantly.

3 Options to assist consumers meet increasing fees

3.1 Option 7: Long term care insurance

Both Howe (2005) and Woods (2005) make out a case for long term care insurance (LTC) to be expanded in Australia. Howe lists the Netherlands, Austria, Germany, Japan, Israel, Luxembourg and France as countries that have all expanded long term care insurance. As Howe points out, the aim of LTC is to have people pay for their aged care while they are still earning.

There are two main difficulties with persuading people to take up LTC. (LTC is available in Australia but the take up rate is small.)

Firstly, both community and residential aged care are very heavily subsidised in Australia and out of pocket costs are relatively small. Secondly, it is difficult to persuade people to pay premiums when they are young for circumstances that may or may not arise when they are old. This is a similar issue to persuading young people to take out private health insurance, where the Government has introduced the Lifetime Health Cover scheme, where people pay lower premiums if they sign up while they are young, and premiums increase according to the age of joining.

3.2 Option 8: Aged care savings accounts

A variation on LTC is to encourage, or require, people to save in special long term care savings accounts. The Government could subsidise these accounts by waiving or reducing the tax paid on interest earned. Funds in such accounts could only be used for purchasing approved long term care services when the person is assessed as needing them.

Similar accounts, sometimes called medical, or health, savings accounts, have already been introduced fairly successfully in Singapore and have been proposed in Australia for long term health care needs (Buckmaster 2006).

It could be argued that individual aged care savings accounts would place responsibility on the consumer for managing their own health and aged care, provide an incentive for healthy ageing lifestyles, and enable consumers to exercise choice in the type of care they want.

One problem with such funds is deciding what happens to unused surplus funds when a person dies. People generally accept insurance as insurance, not savings. People could reasonably expect however that unused savings account funds would be inherited by their family. One option is to allow such funds to be transferred to special savings accounts held by a person's heirs.

Another issue is deciding how to handle instances where savings run out before all costs have been paid for. Some kind of safety net, similar to the concessional resident scheme, would need to be in place to protect such people.

3.3 Option 9: Equity release schemes

The most common equity release schemes in Australia are 'reverse mortgages', also known as home equity conversion products. These schemes allow people who are usually retired and who own their own home to borrow, based on the equity they have in their home.

A recent report by Datamonitor (2005) reviewed reverse mortgage schemes in Australia and New Zealand and concludes there is increasing demand for such products, particularly among retired 'baby boomers'. However, whereas reverse mortgages have previously been used by people in urgent financial need for home improvements, medical bills and care provision, people are more frequently using reverse mortgages to fund lifestyle changes.

Reverse mortgage schemes are only likely to be used for financing aged care where there is a much higher cost to consumers than there is now. There is no evidence that people entering low residential aged care are using these schemes in any significant number to finance their bonds.

4 Options related to improving productivity

4.1 Deregulation

Prior (2005) suggests productivity increases could result from less Government regulation and more competition. Currently the Australian Government controls the number of subsidised residential aged care places, the regional location of such places, the fees that can be charged, and who can be admitted. These controls have led to a situation where demand exceeds supply and therefore there is very little competition among providers.

Hogan (2004) considered there could be a saving of some $1.1 billion per annum if the industry were operating at 'maximum technical efficiency'. However this figure should be viewed with some caution as: facilities with higher certification scores; services in rural and remote areas; facilities providing services to residents from Aboriginal and Torres Strait Islander communities or residents with culturally and inguistically diverse backgrounds; services with a higher percentage of respite places; and (counter intuitively) services with more beds per room; were deemed in the measures used, to be less efficient. In the measures used, services provided to concessional residents were deemed the most efficient, which was attributed to a more "streamlined homogenous service" (Hogan 2004 p.76). Likely reasons vary but in most cases the 'efficiency' or 'inefficiency' was attributed to the nature of the service (Hogan 2004). Hogan (2004) advocated changes to increase productivity but recognised that some of what is deemed in the report as 'inefficiency' may be necessary in order to meet policy commitments to quality care and equity of access.

Though Hogan (2004) suggests some market solutions and reduced regulation in financial and economic aspects of the aged care industry, the report argues that there is a need for regulation around quality of care and equity of access, recognising that "aged care activities are prone to market failure" (Hogan 2004 p.79). This is due to a number of factors, including what Hogan (2004) terms an "asymmetric" relationship between providers and consumers, where there may be vastly different levels of knowledge and information available. Also, cognitive impairment may be an impediment to informed choice for some consumers and there could be significant practical barriers for a consumer attempting to change their preference for care (Hogan 2004).

There may also be a view in the community that, due to the market failure inherent in the aged care industry, maintaining quality of care, equity of access and meeting the needs of a diverse community of older people requires a certain level of regulation, including financial and economic regulation. Productivity increases therefore and a greater consumer focused industry should be achieved through changes in regulation rather than reduced regulation.

4.1.1 Option 10: Deregulating supply

Deregulating supply could theoretically greatly increase competition among providers and bring about greater choice for consumers. This in turn could lead to greater efficiency in the way services are delivered. Increased competition may also encourage creativity in designing care products that consumers prefer, rather than the current fairly rigid boundaries between different types of subsidised care.

Deregulation of supply may enable the Government to approve people for subsidised care without specifying what form that care should take. This could enable consumers to choose residential aged care or aged care in the community, leaving it to market forces to determine the overall mix between residential aged care and community aged care.

This however, may potentially act to limit choice to those offered by the market, which could be restricted for those in rural and remote areas or those people with special needs. Choice for consumers may also be limited by other factors, as discussed in 4.1. As aged care is generally considered an essential public service, it could be argued whether a deregulated market, even though it could offer some consumers more choice, would adequately meet people's needs.

A further challenge for Government in deregulating supply is to retain effective management of the demand for subsidised care. This would have to be achieved through a much more rigorous eligibility assessment system than at present, which in turn would require increased funding for Aged Care Assessment Teams. Otherwise, the pressure from unlimited supply could create huge expenditure problems for Government. The current assessment system is influenced considerably by the availability of places.

Another main risk with deregulating supply is increased instability in the industry, with potentially more services opening and closing than at present. Protections would have to be put in place by Government to minimise disruption to resident care if aged care services went out of business.

4.1.2 Option 11: Deregulating supply and fees

Deregulating supply and fees could expand the choices available for the consumer. Such deregulation would inevitably see a much wider range of user charges corresponding to different levels of care. In such a situation, consumer choice and the ability and willingness to pay could drive financial efficiencies in the sector.

The main difficulty with deregulation of fees and supply is the need to ensure that adequate provision is made for people who cannot afford to pay higher fees. This may increase complexity in the aged care system rather than reduce it. The basic levels of care provision are likely to attract fewer providers than more expensive options, which could pose a significant risk to aged care provision in rural Australia.

The other important risk with this option is the possible development of two quite different levels of care, with people on low incomes receiving a lower level of care. Australians in the past have not been willing to accept this dichotomy in the health care system, except in the case of veterans.

4.1.3 Option 12: Economies of scale

Hogan (2004) reported that there was a potential for a 7% reduction in costs by operating services at an appropriate scale. Hogan suggested that between 30 and 60 places was the optimum size for a residential care facility.

4.1.4 Option 13: Australian Government as purchaser

Under this option, the Government would purchase services from providers for the particular clients it designates, for example people with low incomes. Contracts would be entered into for the provision of care for those particular clients. People not designated as Government clients would be free to purchase their own care from providers. Government regulation would only operate with regard to care provided to Government clients.

Arrangements similar to this currently operate in New Zealand where providers must conform to a contract which spells out the level and standard of care required in return for Government payment. The Medicaid system in the United States of America also functions this way, with American states purchasing long term care for people who come within their means and assets testing limits. In Australia, the Department of Veterans' Affairs purchases home care services for its clients under this kind of arrangement.

This option means that the Government would cease to subsidise all people needing long term care and focus its financial support on a defined group of clients. The disadvantage of this approach would be the possible creation of two different levels of care, with Government clients receiving a lower level of care.

4.1.5 Summary

The increasing cost of aged care in Australia can be met by a range of options, taken either singly or in combination. These comprise:

- increased Government spending either from general revenue or a special levy;
- increased consumer contributions, financed through long term care insurance or home equity release schemes; and
- increased financial efficiency in the industry through deregulation, increased competition, and increased choice for some consumers.

The Alliance hopes that by providing basic information and presenting possible options in an accessible way, it will be possible to stimulate a broader debate. Comments on the paper should be provided to nacasecretariat@anf.org.au by 30 October 2006. The Alliance looks forward to your contribution to this important issue.

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