Inquiry into Caring for Older Australians
Productivity Commission
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Submission

I welcome the Productivity Commission's inquiry into Aged Care. This is an important matter that will affect increasing numbers of Australians over the coming decades.

My submission covers two areas:

- Accommodation bonds for low care (hostel) places, including top-up interest-free loans, and

- Funding Arrangements

Background

My interest in Aged Care comes from 15 years experience in having responsibility for two elderly relatives suffering from dementia (each not related to the other). Each has required low care (hostel) accommodation when their dementia reached the stage that needed that type of care after assessment by ACAT. Fortunately, both hostels are well managed and have provided good care.

Accommodation Bonds

I support the concept of Accommodation Bonds. This type of private funding brings more capital into the aged care system.

However, there are some problems with the structure of the accommodation bond system.

Top-up interest-free loans. When our second relative entered her hostel she was required to pay an accommodation bond and a top-up (additional) interest-free loan to the hostel operator. The top-up interest-free loan was presented as an additional compulsory payment required for entry to the hostel. At the time there were no other dementia-specific hostel places available within about 40 km of our Sydney home so choice was non-existent and her need was urgent.

The top-up interest-free loan is not subject to retention deductions and is only repaid when she leaves the care facility. However, as opposed to the treatment of accommodation bonds, the top-up interest-free loan is treated as a normal financial asset by Centrelink and is included in the assets means test for pension purposes as well as being deemed for the pension income test. So while the resident receives no interest on this loan, the age pension can be reduced due to the means tests. In addition, the deemed interest from the loan is used in determining income tested daily care fees.

I believe that these top-up interest-free loans are exploiting older people needing low-level care. The accommodation bond structure should not be compromised by these top-up loans.

Recommendation 1: Top-up interest-free loans should be banned.

No Maximum Accommodation Bond. Currently there is no upper limit to the accommodation bond. The rules effectively set an asset threshold of $37,500 before an accommodation bond can be levied, as this is the asset amount one must be left with after the accommodation bond is determined.

The average size of new accommodation bonds has been increasing at a rapid rate, as shown in the following table.

Year	Average New Accom Bond	% Increase year on year	Median New Accom Bond	% Increase year on year
1 Oct 97-30 Jun 98	$54 500	-	na	-
1998-99	$58 400	7.2	na	-
1999-00	$59 728	2.3	na	-
2000-01	$69 200	15.9	na	-
2001-02	$82 989	19.9	na	-
2002-03	$98 775	19.0	na	-
2003-04	$112 613	14.0	$110 000	-
2004-05	$127 618	13.3	$118 000	7.3
2005-06	$141 690	11.0	$122 500	3.8
2006-07	$167 450	18.2	$132 000	7.8
2007-08	$188 798	12.7	$155 000	17.4
2008-09	$212 958	12.8	$200 000	29.0

na = not available

Source: Department of Health and Ageing reports.

The average new accommodation bond has increased at a compound rate of about 13% per annum over this 12 year period, which is some 10% per annum in real terms. This represents substantial real growth, which is perhaps unsustainable in the longer term.

The median new accommodation bond has grown at an accelerating rate over the last three years. This could indicate that the cohort of smaller bonds has increased rapidly in size, shifting the median much higher.

The information about accommodation bonds that low-level care providers give varies greatly. This is apparent from a scan of provider websites. Few providers give detailed information on their websites about the size of the accommodation bonds they require. Most give basic information and no doubt provide the details to actual enquirers.

A few providers state that it is in the care seekers interest to pay a high amount of accommodation bond due to the pension asset means test rules. While this is true, it also means that the amount paid is locked up until the resident leaves the low-care facility.

There is anecdotal evidence that accommodation bonds in excess of $1m have been sought in Sydney, primarily from people in high value homes. It is possible that the size of accommodation bonds is related to what the market can bear. This means that some low-care facilities have access to much larger amounts of capital than others.

I believe that there should be a maximum accommodation bond payment, along with the associated payment options that are currently available. Reasons are:

- The daily income tested care fee is capped by government regulation, but subject to half yearly review. It is inconsistent that accommodation bonds are not capped.

- Average sizes of accommodation bonds are increasing rapidly, which means there is a lack of equity of treatment between care entrants from year to year.

- While a person's need for low-level care usually arises as a result of a crisis (for example, due to the death or incapacity of a primary care-giving spouse), rapidly escalating, uncapped accommodation bonds make planning difficult.

- Uncapped accommodation bonds could provide an incentive for low-level care providers to select prospective entrants on the basis of the size of the bond potentially available. While a cap would not eliminate this potential completely, it would reduce the incentive.

- Uncapped bonds can leave residents with fewer financial assets, although other payment options are available. Once the bond is paid, the money is locked up. The resident does not have access to that capital to pay for things like future expensive medical care (above that provided by Medicare or DVA) or provide financial assistance to family members (for example help in the event of unemployment).

- Uncapped accommodation bonds can be viewed as a wealth tax, even though they are repayable when the resident leaves the low-care facility (less the retention amount). This approach does not apply to the provision of any other highly regulated service.

Setting a maximum accommodation bond with automatic half-yearly reviews would help alleviate these problems.

Recommendation 2: Accommodation bonds should be capped in size.

Size of Maximum Accommodation Bond. A simple method for determining the maximum accommodation bond is required. The asset threshold before an accommodation bond can be sought by a low-care provider is $37 500, which is 2.25 times the maximum annual single basic age pension (rounded to the nearer $500). The accommodation bond sought must leave the entrant with assets of at least $37 500. This threshold amount is reviewed regularly.

Given the 2008-09 average accommodation bond of $212 958, I suggest a target maximum related to that figure of $300 000, which is about 40% greater than the latest average. The amount of $300 000 is 8 times the $37 500 figure.

Other accommodation payment options should remain in place.

Recommendation 3: The maximum accommodation bond from time to time should be 8 times the asset threshold amount (currently $37 500).

Self-funded retirees. Assessing the amount of accommodation bonds and charges as well as basic and income tested daily care fees is well-defined for full and part-pensioners receiving benefits from Centrelink or DVA. Individuals or members of a couple are treated as such, so that if one member of a couple moves into residential low or high care, the other member of the couple continues to receive his or her half of the couple's pension, subject to "separated due to illness" rules.

Self-funded retirees are treated differently regarding daily basic and income-tested fees. A self-funded retiree receiving a private superannuation pension from a superannuation fund receives that pension in his or her name only. For self managed superannuation funds, each member of a couple could receive a pension from that fund, but each pension is received in that pensioner's name only. When a self funded retiree moves into residential care, his or her full private pension is used in determining the basic and income tested daily care fees. Their partner (if not receiving a private pension in their name) can be left with a substantially reduced income to live on. Likewise, if a member of a couple who is not receiving a private pension moves into residential care, the remaining private pensioner's income is not taken into account when care fees are assessed. Overall, this is an inequitable situation.

Recommendation 4: The assessment test to determine daily basic and means tested fees for self-funded retirees be changed so that private pension income for a couple is split equally between the couple members.

Funding Issues

The Productivity Commission's issues paper "Caring for Older Australians" notes that total aged care funding by governments has increased by about 6% per annum in real terms since 1995-96. It is likely that these cost pressures will continue.

Some drivers of cost escalation are:

- More aged care candidates - increasing numbers in higher age groups and increasing longevity producing more frail aged people.

- Strengthening regulation – ensuring quality and consistency of service delivery that meets rising community expectations.

- Inflation – of service inputs, for example, higher wage costs due to higher skill demands and increasing staff ratios, as well as rising allied care costs.

- Community standards – as living standards rise, the community expects its aged population to be looked after commensurately.

Accommodation bonds and charges and daily income-tested care fees have shifted a part of the cost burden to users of services. However, these are still narrow in focus and could be extended further.

Aged care costs can be paid from two broad sources: public (tax-payer funded) and private (individuals or organisations). In addition, costs in aged care can be divided into two basic types: operating expenses (which are ongoing) and capital expenditure (infrastructure). The effect of these sub-divisions can be considered within the five broad categories of care. Public and private expenditure per person receiving aged care can be broadly categorised in terms of lower or higher cost as:

Care Type	Operating Costs	Capital Costs
Home based		
Public	lower	lower
Private	lower	lower
Community packaged		
Public	medium	lower
Private	lower	lower
Flexible care		
Public	medium	lower
Private	lower	lower
Residential low care		
Public	higher	higher
Private	medium	higher
Residential high care		
Public	higher	higher
Private	medium	medium

Notes:

1. This assessment ignores provision of specialised medical and pharmaceutical services, which would be incurred regardless of care type.

2. Home based care includes carers' payments.

3. Community packaged care public operating costs include staffing and associated costs, which pushes it into the medium range. This also applies in the Flexible care area.

4. Residential low care private operating costs cover basic and means tested daily care fees, which tend to consume a large part of recipients' incomes. Private capital costs are higher due to accommodation bonds.

5. Residential high care private operating costs cover daily care fees and accommodation charges, which also tend to consume a large part of recipients' incomes. Private capital costs are in the medium range due to the limited use of accommodation bonds.

From this broad analysis, it is clear that basic cost control involves maximising usage of home and community based care options. There are a number of barriers to achieving this, including availability of carers to provide the home based and community supported care.

Residential low care costs are now being well supported by daily care fees and accommodation bonds, which reduces the strain on public resources. Means testing for payment of accommodation bonds and daily care fees is well established. It is likely that residents in this area are paying as much as could now be expected. However, even with this means tested user pays structure, high government subsidies are required.

Recommendation 5: In the shorter term, residential high care costs should be included in the accommodation bond structure (as modified by my recommendations above).

Recommendation 6: For the longer term, the Commission should investigate whether some sort of fundamental structural change could contain costs in a meaningful way.

Long Term Care Insurance

Long term care (LTC) insurance can provide benefits to insured people based on deficits in prescribed activities of daily life, for example, dressing, eating, bathing, toileting, mobility, food preparation. The insurance can be purchased by periodic (monthly, annual) or lump sum payments, at younger ages or around retirement age. Benefits can be limited by waiting periods (the wait after an event occurs before benefits become payable), by benefit periods (the time limit on payment of benefits) and by what is covered.

In theory, LTC could mitigate the risks of aged care costs at the individual level. However, LTC has not proved popular in Australia. Its main markets are North America and UK, but even there take up is limited.

Broadly, LTC in Australia faces problems of:

- Marketability – life insurance in general has become a "hard sell" in view of superannuation coverage, even though that coverage can be inadequate.

- Perceived need – not all people will need expensive aged care services and recognising the future need can be problematic.

- Underwriting – little or no underwriting leads to higher premiums due to the spread of risks insured. Tight underwriting results in lower premiums due to the lower risk profile of insured people, but more applicants for insurance are rejected on risk grounds.

- Cost – in any event, LTC tends to be expensive.

- Taxation treatment – for insurers and benefit recipients can be a negative issue. Government subsidies would be expensive and difficult to justify.

- Lead times – LTC insurance takes a long time to mature in terms of having a sufficient spread of coverage generating meaningful insurance benefits to policyholders. It could be decades before LTC helped pay aged care costs at any practicable level.

In short, LCT is unlikely to be a major part of aged care in Australia unless some concerted effort is taken by government and insurers.

Recommendation 7: If considered warranted, the Commission should investigate in a detailed way the potential for LCT to help fund aged care in Australia.

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