Scope of submission

This submission is presented in two parts:

Part A: Critical margins for change in the aged care system

Many of the questions raised in the Discussion Paper point to critical margins that need to be addressed to bring about change in the aged care system. As the system will not change all at once, and only slowly, action at these margins is required to generate cumulative and system wide change to achieve preferred policy goals over the short, medium and longer term. The propensity for, or resistance, to change differs at these margins, and some have have been subject to much more discussion than others. Change at some of the margins has been driven by formal policies and program arrangements, but at others, external factors have played a greater role.

While additional funding is an important lever for change, past experience shows that other measures such as changes in program guidelines and regulation can have significant effects. Decisive and complementary actions at different margins in the short term are the beginning of longer term change, and decisive acion is especially needed now to overcome the inertia that has set in with the lack of action on recommendations made in the many reports that have been released in recent years.

The seven margins for change addressed in Part A are:

1. Margins for choice
2. Margins for change in the structure and dynamics of the aged care sector
3. Margins for alignment across programs
4. Margins for change in needs based planning
5. Margins for change in regulatory arrangements
6. Margins for change in workforce development
7. Strengthening the evidence base

Part B presents a proposal for new capital funding arrangements for residential care.

Figures on aged care cited in the submission are taken from reports of the Australian Institute of Health and Welfare unless otherwise indicated and selected sources are listed at the end of Part A and Part B.

1. Margins for choice

1.1 The pyramid of choice

Margins for choice can be identified when the 'care services pyramid' in Figure 1 in the Issues Paper is seen as a 'pyramid of choice'. One side of the triangle can be labeled 'consumer sovereignty', with diminishing individual capacity to make independent and informed choices as intensity of care needs increases, requiring increased advocacy and consumer protection. On the other side, 'source of provision' changes from provision of services to private household largely through the market at the base, to delivery through publicly subsidized programs at the apex.

Recognition that choices are much wider at the base of the pyramid and narrow at the apex is a starting point for assessing different margins for choice from the perspectives of both service users and providers. Two modes of care that have grown considerably since the 'care services pyramid' was first set out in 1996 demonstrate the varying effects of government policy on changes at different margins:

1. The expansion of the Service Integrated Housing segment is the result of increased number of older people being able to satisfy their needs by making choices from an increased range of purpose built retirement accommodation provided mainly, but not entirely, through the market, and offering different levels of services and mixing market and public program sources. This development has come about largely outside the public policy sphere and is an good example of the market being responsive to demand, and in turn shaping it.
2. In contrast, the growth of post and sub-acute care services has come about almost entirely through government intervention at the margins of the public hospital and aged care systems. Notwithstanding the growth in need for these modes of care on the part of older people, there has been little private provider response, in private hospitals through private health insurance funds, and there is very evident market failure.

The pyramid of choice shows that the prospects for increasing choice vary at different margins, and that shifts between some care modes are more easily realized, at less costly, than others:

- It is easier to realize greater choice by way of increased volume and diversity of care services at the base of the pyramid and more difficult near the apex.
- Rather than there being an open market for service provision across all levels of care, the scope for increased market provision is likely to vary across the levels of care, not only in relation to users' capacity to pay but also in terms of providers' interest in developing different modes of care.
- Choice in both care setting and intensity need to be taken into account, with choice more realized across adjacent margins (such as CACPs for low care) than changes involving wider shifts in care setting (such as EACH-D for high care).

1.2 Choice differs for different modes of care

Analysis of the Aged Care Services List accessed via the Department of Health and Ageing website shows that there is considerable choice in residential care at Local Government Area

level, with all but a few small rural and remote LGAs with small population having several RACH to choose from. For example, in all but three of Victoria's 79 LGAs, there were three or more residential care homes, and in 42 of these, there were more than 10 homes.

Choice of Care Package providers is more difficult to assess as most deliver packages across several LGAs but are listed in the LGA in which their services are based. Of the 79 Victorian LGAs, 42 had 2 or more CACP services, and of these, 19 had 5 or more. Another 10 had only one CACP service and 26 had none, not taking account of delivery of CACPs by providers based in adjacent LGAs.

Choice of HACC provider shows a different picture again, with variations by service types. In each LGA in Victoria for example, there are usually around 6-10 services:

- Local Government (or the equivalent major provider in other states) is usually the sole provider of home help, personal care, home maintenance and modifications.
- Nursing is usually delivered by a sole provider, the RDNS in Melbourne, and by a local health service in regional LGAs.
- A Community Health Service providing allied health and possibly day care and other social support services, as well as general health promotion and community health services.
- 3 or more day care and other social support services, delivered by a variety of providers including agencies serving CALD groups, reflecting the composition of the local population.
- 2 or more disability services.

As most clients use local services, the LGA picture sets the context for debate about whether there is sufficient choice of provider. Recognising that increasing choice could lead to increases in the number of providers, it is worth noting that not so long ago, the debate was about the complexity that clients faced due to the multiplicity of providers. In research carried out by the Allen Consulting Group for the Myer Foundation in 2003, choice of provider was not an issue and discussion instead focused on how flexibility in the way services were delivered could be increased through clients negotiating with the provider. These findings suggest that providers' interests in expanding greater choice of provider is driven in part by goals of increasing their share of service provision and funding, and that these interests may not always be the same as the interests of clients and their carers.

1.3 Models of consumer directed care

Consumer directed care is seen as a means of increasing consumer choice, but CDC involves far more than simply converting funding for services into cash. The 2005 OECD *Working Paper on Consumer Direction and Choice in Long term Care for Older Persons* (Lunsgaard, 2005) reports that 'the type of schemes, the level of support they provide and the number of users varies enormously across and within OECD countries'. Interestingly, Australia scores highly on the dimensions of payments for informal care and choice for people using publicly supported formal care, and ranks 4th out og 19 countries on the share of older people receiving public support. This report also shows that take up of cash payments is affected by a number of contextual factors in each country, including workforce participation among middle aged women, on which Australia ranks much lower, at 14th.

The diversity of design of CDC and related programs suggests that the conclusions reached in the Discussion Paper prepared for Alzheimer's Australia in 2003 still hold:

> 'CDC is a direction that we should explore further. Our experience with innovation in community care, and especially in dementia care, suggests that there are good prospects for developing new options. Rather than just importing overseas models, we need to graft them on to the elements of consumer direction that already exist in current programs and so grow our own hybrids that are best suited to local conditions and that will strengthen our culture of care'.

That Discussion Paper drew attention to the substantial, but largely unrecognized, element of CDC in the Australian community care system by way of the Carer Allowance. Take-up of CA is very high among eligible carers and aggregate expenditure on CA for carers of older people is comparable to expenditure on HACC for older clients. This pattern suggest a high acceptability of a combination of cash and services and that access to CA may moderate demand for cash alternatives to services.

A similar outcome is apparent in the UK where substantial cash disability benefits appear to moderate demand for direct payments on the part of older people. The disability benefits are paid directly to the disabled individual, raising questions as to whether the Australian system should be similarly "carer neutral" and give access to these benefits to individuals who do not have a carer and who may be significantly disadvantaged, such as those living in low cost supported residential services.

Further questions arise about the potential for cash benefits to be diverted into different forms of supported accommodation. The precedent here is set by apparently minor changes in supplementary allowances in the UK that shifted costs from local authorities to central government and lead to the number of places in private sector care homes doubling in just four years from 1980 to 1984, and fully occupied by individuals previously receiving care in their own homes. More recently, there have been reports from Germany of cash benefits being used to develop new forms of group housing. These experiences show that, while the majority may want to receive care in their own homes, some chose to exercise options for receiving care in a residential care setting, in part because of inadequacies of the accommodation that was 'their own home'. The issue then becomes ensuring that cash benefits are not simply paid over to operators of supported accommodation with little if any provision in care services that the benefits are intended to pay for.

Given the choice, many individuals currently living in lower standard supported accommodation or private rental accommodation could well opt to move into Commonwealth subsidized low care RACH if places were available and affordable. Unable to pay bonds, many non-homeowners who are reliant on the Age Pension have *no choice* other than whatever form of accommodation they can afford.

2. Margins for change in the structure and dynamics of the aged care sector

2.1 An overlooked dimension of the aged care system

The structure of the sector has received little attention in most of the reports released in recent years, and insufficient regard has been given to the important mediating effects that this structure has on how individuals gain access to government programs that are delivered through the diverse agencies that make up the sector and which vary considerably from State to State and between local areas. Far from being a 'cottage industry', the sector is very diverse, ranging from single agencies providing one service to a local area with funding in the tens of thousands, to large scale providers involved in numerous programs, delivering a range of services, receiving tens of millions of dollars in public funding and with management structures spanning regions and states. These latter agencies have aptly been labeled 'portfolio providers' by Catholic Health Australia in its initial submission to the Commission.

The effects of structural considerations on client choice, access and continuity of care warrant greater attention. Clients whose first take up services delivered by a large provider offering a wider range of services have different choices ahead of them and prospects of continuity from basic community care to high residential care. Another client may have to move from provider to provider as their needs change. Rather than progressing through a smooth continuum of care, the AIHW Pathways in Aged Care project identified 14 major pathways that accounted for 82% of clients followed over a two year period, out of a total of more than 1000 distinct pathways followed by the total cohort of 77,348 newly assessed clients.

Structural attributes also affect the choices that providers can make about their participation in different programs to achieve integration in their service delivery. Some large agencies have not only been innovators within aged care and achieved a high degree of vertical integration by delivering services at all intensities of care, but have also drawn on funding from other programs, such as State funded chronic disease management and healthy ageing programs to expand the range of services they are able to offer and achieve some degree of horizontal integration. These portfolio providers have much greater capacity to respond to new initiatives, raising questions about the future roles of small single service providers in more integrated service systems.

2.2 Provider integration

Many larger providers have achieved a degree of integrated service delivery by involvement in a number of aged care and other health and community services, but some major gaps remain in capacity to provide continuity of care. Difference in the scope of integration on the part of providers are evident in:

- The division in most states between the major providers of HACC nursing and providers of the core HACC services of home help, personal care and often delivered means, home maintenance and modifications. Few of these providers have packages or residential care, with the notable exception of Blue Care in Queensland.
- The large not-for-profit providers that account for the major share of packages and residential care but deliver only a small part of core HACC services.

- The main role of private sector providers is in residential care, particularly high care, with only minimal provision of packages and even less in HACC. Some of the larger private providers involved in retirement accommodation are expanding assisted living as an alternative to low care. The uncertain role of small, stand alone and private high care RACH in an increasingly integrated service system is evidenced by the substantial decline in such services over the last decade.
- The diversity of integration and barriers to continuity of care can be illustrated by reference to the structure of provision in Victoria:
  - Only 23 of the 79 Local Governments that deliver the major part of HACC, except nursing, have packages and only around half of these have RACH.
  - The 21 largest not-for- profit providers (>200 RACH places) account for some 60% of packages, 11% of low care and 21% of high care places, but HACC involvement is mostly in day care and social support services;
  - The 17 largest for profit providers (>200 RACH places) account for some 30% of high care and 20% of low care places, but just 1% of packages.
  - Interestingly, service integration is well advanced in regional Victoria due to the role of integrated services that bring together a full suite of services. As well as 7 MPS, Victoria has 35 designated Small Rural Health Services that deliver not only community and residential care but a variety of other health services to local communities. The importance of these integrated providers is also very evident in Western Australia where 28 MPS are significant providers of community and residential care in regional and remote areas.

Two main margins need to be addressed to overcome the present discontinuities and extend providers' capacity to deliver more integrated care:

1. The solution proposed by large not-for-profit providers is to increase their role in the delivery of core HACC services. This interest has grown with the expansion of packages would enable these providers to realize economies of scale in delivery of these services to package clients as well as enhancing continuity of care. It would however address only part of the discontinuities.
2. Any move to address this margin needs to be matched by increased access to packages for the major HACC providers that currently provide considerable continuity of care by supporting large numbers of package-equivalent clients, who are not only unable to access a care package but would likely have to change provider if a package became available.

Several other aspects of service integration at the provider level need to be addressed to enhance access and continuity of care for individual clients, including:

- CACP clients who need nursing care often have to deal with two providers as few HACC nursing providers have packages and few package providers deliver nursing care as it is excluded from CACPs. Restructuring of care packages needs to remove the current exclusion of nursing and allow all providers to deliver the full range of services.
- Increased service integration at provider level is likely to enhance cost-effectiveness by reducing the cost of case management currently required to coordinate services for clients who receive services from a number of providers.

- Ways in which remaining providers can be drawn into more integrated delivery arrangements need to be addressed. As these providers include a wide mix from some ethno-specific providers to small private high care RACH, there is no single solution and a variety of approaches will be required.
- Probably due to the smaller number of providers and greater roles of State government providers, integration of services at regional level is often more advanced outside metropolitan areas than in regions within capital cities. Numerous initiatives to bring about closer working relationships between providers in metropolitan regions, such as Victoria's Primary Care Partnerships, have met with varying success and have often been demanding for the agencies involved.

2.4 Program integration and consolidation

The streamlining of program administrative arrangements for Commonwealth community care programs that began with the implementation of The Way Forward from mid 2004 needs to be taken further. Two of the main measures required to establish a national community care program will affect all providers, but the third has a more selective impact.

1. The first measure is to bringing HACC and packages together in a way that facilitates access to initial services, with assessment and other controls then proportionate to the cost and complexity of service use.
2. The second measure is to restructure the tiers of care packages. The questions here are whether tiers should be retained, and if so how they should be defined, or whether a population based formula should be approached.
    - If tiers are to be retained, they should be defined through analysis of characteristics of community care clients and the services they receive. As discussed below, residential care does not provide an appropriate basis for setting levels of care in the community.
    - A population based funding formula, along the lines of the Victorian RREF should be considered alongside redefinition of package tiers. Notwithstanding the adequacy or otherwise of available funding, resource allocation to individuals receiving HACC services is continuous rather than set according to *a priori* levels of funding. HACC providers have to allocate available funding to meet individual client's needs as far as possible, and extending across the full range of current care packages. Population based funding can provide effective incentives for providers to be economical and efficient in service delivery and avoid the risk of gaming associated with some case mix systems.
3. Integration of other small Commonwealth community care programs needs to proceed hand in hand with the development of a new national program. This integration is required to address the proliferation of small programs that has come about over the 25 years since HACC brought together a variety of separate programs in the early 1980s. All these programs are delivered by providers with Approved Provider Status, but only a few of all Approved Providers are involved in any of the separate programs. These programs each present somewhat different margins for integration. By way of example, the Day Therapy Centres Program covers just 140 services serving some 16,000 clients at any one time. All DTCs are operated by Commonwealth Approved Providers who also operate care packages and/or residential care. The services delivered through DTCs would become a service type within an integrated community care program, alongside allied health services currently

delivered trhough HACC. Such integration would reduce administration effort on the part of providers who would report all services under a single set of program arrangements instead of having to report under different programs.

2.5 The margins for market provision

One of the strengths of the Australian aged care system is the way that it uses sliding scales for means testing and setting fees, and applies these measures only after care needs are identified. This approach means that the same services cater for clients across the income range, from fully subsidied to fully user pays. This outcome avoids the invidious division that arises where means testing imposes cut-offs that exclude paying clients from using the same providers even though paying their way, and also the difficulties experienced by those whose income places just above the cut-off and then requires them to pay the same fees as those with much higher incomes. As with the apparent preference for combining cash benefits and services, clients and carers in Australia appear satisfied with being able to purchase services from the same providers who deliver subsidised services.

The extent to which providers have moved to develop market services is not documented but does not seem to match the claimed size of the potential care market. There are no regulatory barriers to prevent providers offering additional services to clients on a user pays basis, and the experience of the few providers, not-for-profit as well as for profit, who have pursued market based provision warrant further exploration. Apart from Extra Services RACH, the three areas where some market based provision is evident are:

1. Development of retirement villages, and increasingly assisted living apartments, as an alternative to low care RACH, with bonds for low care setting a market benchmark cost.
2. Provision of user pays domestic and personal care services in retirement villages.
3. Making additional services available to package clients who wish to 'top up' the level of services they receive, with fees paid by either the client or family carers who are willing and able to pay for assistance in their caregiving roles. Spreading the cost of full-fee hours of service over the total hours received in these cases realises a significant discount, and purchase from the same provider retains quality standards and other protections.

It is unclear whether the lack of market development on the part of aged care providers is because of perceived limited capacity of many users to pay, or because such demand as does exist is met through other channels including the 'unregulated' sector and formal providers are unable to compete.

2.6 The interface between aged care and disability services

The reasons for disability and aged care operating as separate systems to date and into the future are far more compelling than any reasons for bringing them together. The interfaces between aged care and disability services have been dealt with at some length in a separate submission made to the Commission's Inquiry into disability services rather than in this submission precisely because it is younger people with disabilities who are ageing who are affected by these interface issues, not older people who only only take up services at older ages.

Not only are the groups of clients of aged and disability services different in many ways, there is relatively little overlap in the agencies serving the two groups, and both clients and providers are represented by separate peak bodies.

Apart from the major HACC agencies delivering core HACC services, different providers deliver different kinds of residential and supported accommodation services to the two client groups. Where major not-for-profit organisations serve both client groups, they do so through separate business entities within the overall organisation. Apart from HACC as a common source of funding, most providers who receive funding through the CSTDA do not receive aged care funding and most aged care agencies do not receive CSTDA funding. There are different interfaces with other service sectors: interaction with education and employment services is critical for younger people with disabilities whereas it is acute and sub-acute health care services that are most likely to be called on by frail older people.

Many disability services are managed by clients and their representatives, particularly parents, and these models of management are very different to aged care services. At the same time, disability services peak bodies generally recognize the aged care system as being much more of 'a system', with more consistency in service planning, resource allocation, assessment and individual service access than is found in disability services.

3. Margins for alignment across programs

3.1 Alignment of funding levels across community and residential care

The level of funding for community care in aggregate and for individual clients with varying levels of dependency certainly requires attention to provide a better match between clients' care needs and the cost of meeting those needs, but the ACFI does not provide a suitable instrument for this purpose. The view that assessment of need for community care could be based on the ACFI with clients assigned to the same care level receiving the same funding in the community as in residential care is based on several misconceptions about the ACFI.

1. The ACFI is the second part of a two stage process of assessment for admission to residential care and is applied only after an ACAT assessment determines that the individual's care needs can no longer be practically met in the community. The ACFI is based on observation of the resident over an extended period, not applied ahead of service provision.
2. The ACFI assesses the level of personal and nursing care required to meet the resident's dependency based care needs. Services such as meals provision, domestic assistance by way of cleaning and laundry, a purpose built environment and a level of social contact and monitoring, are integral to the residential care setting and covered mostly by the basic daily fee rather than ACFI funding. Yet services providing these kinds of support make up the major part of HACC services.
3. The relationship between dependency as measured by the ACFI and service needs is more direct in residential care than in community care, due to factors such as availability or otherwise of informal carers, the suitability of home environments and so on.

4. The ACFI is not designed to assess the need for services such as carer support or home modifications that may be critical for clients whom an ACAT assessment established can be supported in the community.
5. While the ACFI and packages assign funding to individual clients, both operate on a case mix system than exact amounts being spent on specific clients. In the case of CACPs and EACH packages, it appears that providers balance costs across quite wide mixes of clients whose care costs above and below the funding levels. Even with more finely graduated levels, case mix types of funding at a provider level will not readily translate into individual budgets as some clients may receive too little funding and others too much funding to cover the cost of services they use.
6. ACFI funding would not buy the same level of services in the community, notably 24 hour staff presence and group activities.
7. The appropriate way to establish a better basis for funding community care, whether by per capita funding adjusted for need as per the Victorian RREF, case mix bands related to dependency, or individual budgets, is an analysis of current relationships between costs, service use and dependency of clients in the community, and taking account of factors such as carer availability and home environments that strongly influence the kinds of services required to enable the individual to remain in the community. Work to this end is currently underway and should be used to model further approaches rather than applying the ACFI to a purpose it was never designed for and for which it will not prove effective.

3.2 ACAT assessments do not provide a reliable basis for alignment of funding

The approvals and recommendations made by Aged Care Assessment Teams do not provide reliable guide of need at either individual or population level. Data from the national report on the ACAT program for 2007-08 are detailed below and compared with admissions reported in AIHW statistical overviews. *Approvals* are recorded for all the care options that require ACAT approval and which are considered appropriate for the client's needs. A *recommendations* is made for only one care option that is seen to be the most appropriate response to the client's immediate needs.

ACAT approvals and recommended care outcomes, 2007-08

Outcome	Approved	Recommended	Admitted	Excess No.	Excess % (rec/adm)
High care	60,000	49,000	30,000	19,000	40%
Low care	76,500	36,000	18,000	18,000	50%
CACPs	52,000	33,000	20,000	13,000	40%
Resi respite	127,919	56,000	51,000	5,000	10%

ACAT recommendations exceed the numbers of clients admitted to all programs by more than 40%, except for resident respite care where the excess is only 10%. There is also considerable variation between Teams in the rate at which they recommend different care options. If ACAT

recommendations were to be treated as entitlements, a very substantial increase in resources would be required.

However, the level of excess recommendations over admissions prompts questions as to whether these figures do indicate that need far outstrips service availability, or reflect over-recommendation and over-approval by ACATs.

- Some of the factors that need to be taken into account in interpreting these figures lend support to the view that they are valid indicators of need:
  - The client and their carers agree to the recommendations, so the client is very likely to accept the recommended care option if it becomes available.
  - There are substantial numbers for whom care at home is no longer possible and who, given the option, would enter residential care. Many of those for whom no place is available remain at home by default, not by choice, and are not receiving care in what has been assessed as the most appropriate care environment.
  - Given that the level of approvals, recommendations and admissions for residential respite far exceed the recommendations for permanent care, many are clearly opting to remain in the community. If ACAT recommendations became an entitlement to a level of funding, it is not clear that the additional number who might choose to remain in the community would be sufficient to make way for those who wanted to exercise the choice of a recommendation for admission to residential care.
- In contrast, other factors contributes to possible over-recommendation:
  - The recommended and approved care options are valid for 12 months, and so represent not only needs that require an immediate or short term response, but also include an estimation of needs that may arise over a year.
  - The one year validity is intended to avoid the need for reassessment, but in this population, needs are very likely to change, and reassessment may be desirable and necessary. This problem could be addressed by trimming the period of validity to six months, and given that clients appear to take up recommended services within a short time, or not at all, this measure would not have adverse consequences, and could have benefits by prompting reassessment when needs changed. Further, it would not affect ACAT workloads as the client intake would simply be divided into two six month lots; the rate at which clients present for reassessment is already high and would be unlikely to change.
  - Although ACATs are expected to oversee clients until care recommendations are implements, this does not always happen and ACAT are not as aware as they might be of the difference between their recommendations and actual outcomes for individual clients and for their total client load.
  - This gap could be closed by allocating ACATs with notional numbers of places for different modes of care, allowing margin for flexibility and for non-take up. Having allocations of this kind would require ACATS to be more discerning in their recommendations and manage allocations across their client load, and increase the likelihood that clients would indeed receive the services that were recommended.

3.3 Entry points to HACC

While there has been on-going discussion of ways of improving access to aged care services, it is not always clear whether the focus is on determining eligibility or assessment of care needs and the appropriate service responses. Further, some of this discussion appears to see accessing services as something that is one-off and happens at a single point in time and space, rather than as an on-going process in which individuals and their carers are often using a range of support, such as their GP, and investigating other options.

Clients do not enter the formal aged care service system from a vacuum but from within their local communities in which they already have established contacts with agencies such as local government and community health services which provide many other services besides those delivered through the formal aged care programs. Initial assessment by these agencies can in turn canvass responses from a wider range of services on the basis of known provision in the local area. A two tier system is needed, with easy entry to basic services and comprehensive assessment then triggered by a combination of changes in care needs and increases in service use, not necessarily linked only to possible admission to residential care.

The 2010 National Assessment Conference included many presentations that demonstrated how ACATs have developed triage or tiered responses to the inquiries they receive. Many of the initial contacts are by phone, but many also involve face to face contact. These models featured effective referral networks to local service providers for clients who did not need a full ACAT assessment or to follow on from the recommendation made. These models provide a sound basis for further development of entry points and one-stop shops that are on the ground.

3.4 Maintaining independence, health promotion and rehabilitation

While assessment for HACC and Care Packages is giving increasing attention to ways of delivering services that can maintain independence and reduce use of services, a fundamental issue in this discussion is the need to recognise that service inputs are only a very small part of the lives of most HACC clients. Rather than condemning clients to dependency, small inputs of home help, social support and other seemingly simple supports have repeatedly been shown to play an important part in keeping these individuals integrated in the community the rest of the time. There is no evidence whatsoever of unwarranted use of HACC services on the part of individuals with low dependency; rather, research in Australia and elsewhere has repeatedly found that many people with high levels of dependency receive very limited services, but that these supports are very effective in maintaining them in the community.

The nature of the evidence

The most convincing evidence on the outcomes of interventions promoting independence is value of aids and equipment, with extensive evidence coming from Australia and the US. A National Assistive Technology Benefits Scheme similar to the PBS would advance not only the use of effective aids and equipment but also promote research and development in Australia has been proposed (see relevant section in submission to Disability Inquiry).

Results of evaluations of many other kinds of interventions are more variable. Initial experimental projects often show positive outcomes but these outcomes are rarely confirmed in randomised controlled trials or when scale expands. The loss of effect is in part because of the difficulties in identifying clients who can benefit, and increasing number of clients tends to add

to the number for whom there is little if any effect. The focus has often been on people receiving personal care yet this is a small group of all HACC users although a larger share of package clients. Careful reading of the literature shows that many of the projects have been either been for post-acute care or management of specific chronic diseases rather than across broader and more mixed populations of the kind served by HACC.

There is a need for some caution in putting a wellness label on all community care and and adding a price for the new label, but not either delivering much that is different or achieving any different outcomes. While there are margins for improvement for some selected client groups, they are mostly narrow margins, and a much more selective approach would seem more appropriate. Engendering a well approach requires identification of clients who can benefit rather than a blanket approach across all community care.

Other programs focus on health promotion and rehabilitation

Community care is not the only program that can and does focus on enhancing independence. There are many other health promotion programs, chronic disease programs and so on, often delivered through community health services, and the question is how the focus on ageing could be strengthened in these programs.

There is also growing provision of restorative approaches in post acute care and slow stream rehabilitation. Evaluations of post acute/transition care in Australia as elsewhere have however found it hard to show significant gains, again largely due to client selection. Rather than community aged care having to add these service components, assessment has to include the option of referral to other services. This is not to say that wellness models should not be part of community aged care, but given the high demand on these programs already, expansion of the other programs is needed to take the load off community care rather than adding more and more to the load.

When HACC was established, rehabilitation services were excluded to avoid cost shifting from the health care sector. Notwithstanding recommendations of the National Hospitals and Health Reform Commission to expand sub-acute services within the health sector, this risk remains. Acute hospital have largely failed to expand geriatric medical services over the last 15 years, and the development of these services is negligible in private hospitals. These failures give little confidence that the hospital sector will not shift costs to the aged care sector wherever possible, and measures are needed to protect against this eventuality. A case in point is that the beds for the Commonwealth Transition Care Program are mostly being filched from RACH beds rather than being provided in hospital settings.

An alternative approach to expanding access to wellness services for older people within community care services is for aged care providers to become involved in other programs and draw in other funding streams. A model is provided by Aged Care and Housing in Adelaide which has secured funding from a State chronic disease management program and uses the MBS items to deliver allied health in wellness programs run alongside its aged care services. The advantage of the provider operating a portfolio of services is that assessment can be wider in scope and referrals then made to the service that is most appropriate to the client's needs. But this appraoch takes more funding, not stretching aged care funding further and further.

4. Margins for change in needs based planning

4.1 Effectiveness of needs based planning

The needs based planning system, incorporating ratios of provision for a defined age population, has proved effective in bringing about change in the aged care system through consistent application over time and geographically. Rather than abandoning ratios as a central element of the planning process, the need is to revise the ratios. At the same time, ratios should be kept simple for application at larger geographic scales and other factors then taken into account in applications at local level, rather than developing overly complex ratios.

The focus here is on margins for change in the national planning system, recognizing that application at the regional and sub-regional level has been and will continue to be moderated by consideration of further factors. This flexibility is seen in the current identification of geographic locations with high need, special needs groups and other key issues in the Aged Care Allocation Rounds.

Both the base population used in the denominator of the planning ratios and the mix of services taken into account in the numerator need to be revised.

4.2 The population base for planning: the denominator in the planning ratios

There is a strong case for moving from age 70+ to 75 years and over. Age 70 and over has been in place since the late 1970s when the ratio of nursing homes beds to the population aged 65 and over was changed to age 70 and over. From 1970 to 2006, life expectancy at age 65 has increased by some 6 years for both men and women, to reach 83 for men and 87 for women.

A move to age 85 and over as proposed by the National Hospitals and Health Reform Commission is problematic on a number of grounds:

1. It defines a very small segment of the total population and is subject to some instability in trends over time and between regions. The rate of increase in the 85+ cohorts will decline around 2015 when the small Depression generation reaches 85, and the uneven geographic spread of the very old population would lead to the number of beds required in some regions falling below present provision at some times, but with rapid increases in subsequent years. Such short term instability in a planning tool is problematic not only in rural and remote areas with small total populations but in suburban areas that have experienced distinct waves of settlement that are echoed in ageing.
2. Moving to 85+ could particularly disadvantage lower socio-economic areas where life expectancy is lower but the burden of chronic disease and the need for aged care is higher in relatively younger old cohorts.
3. Around 25% of those aged 85+ are already resident in aged care homes. If the picture of need is not to be unduly influenced by the existing distribution of aged care places, quite complex adjustments to population data will be required at LGA level for planning purposes to exclude this segment of the population.
4. To the extent that it is desirable to have a single formula for planning all aged care programs, age 85+ is unsuitable for community care as clients are somewhat younger, in part because of

entry of very old individuals into residential care. Only 31% of HACC users aged 70+ are aged 85+ compared to 55% of permanent RACH residents.

5. Time lags in updating Census data and in the planning process mean that the population aged 75 and over is effectively the population aged 80 and over by the time services are operational on the ground.

A further approach is to weight the selected population on the basis of factors know to affect need for aged care services. For example, data from the Census or the ABS Disability, Ageing and Carers Survey (DACS), could for be used to define a base population in terms of a given level of activity limitation. Another example is the Relative Resource Equity Formula used to allocate growth funds in the HACC program between regions in Victoria. In this more complex approach, the base population defined on the DACS data is weighted for number of socio-economic indicators.

Further development of complex approaches requires detailed modeling to investigate the extent to which different weighting variables counterbalance each other, and how different variables should be weighted. In most such models, volume is driven essentially by the size of the population in any area and taking account of other factors may results in only marginal changes. Increases in complexity with the use of additional indicators of need may well outweigh advantages of transparency and understanding on the part of the wide range of stakeholders involved in aged care.

4.2 The level and mix of services: the numerator in the planning ratios

There have been a number of changes to the level and mix of services included in the numerator of the planning ratios over time. A recent demonstration of the capacity for change driven by the planning process is the growth of CACPs since CACPs were incorporated into the planning ratio, from 2,542 in 1995 to 40,280 in 2008. The ratio of package places per 1000 population aged 70+ has increased from 10 out of a total of 108 places to 21 per 1000 in 2008, with an additional 4 high care packages per 1000, out of a total of 113 places.

Neither the level nor mix of services is however necessarily *right*, and it has to be emphasized that being essentially normative, the specifications have a strong tendency to reinforce existing patterns. Among the issues for consideration in coming to new ratios are:

1. While the ratios have been successful in directing provision to areas of lower provision, a large part of this shift has been to areas only marginally below the planning benchmarks rather than to the most under-provided areas. Additional measures, and not just funding measures, appear to be required to stimulate service development in some very disadvantaged areas.
2. A major question for needs based planning is how the services and funding of the HACC program might be brought into the process. A population based approach along the lines of the Victorian RREF appears more practical than very detailed specification of a case mix system. Allocation of services to individual clients can the proceed on the basis of consistent application of standardised assessment processes proportional to the client's dependency and apparent care needs. Individual funding could be continuous as currently occurs in HACC rather than in fixed levels of care as in packages.

3. Variations between regions in service provision on the ground provide a natural experiment for assessing what constitutes better provision. Better understanding of how having more or less of some services affects need for other kinds of services could lead to the adjustments in both the level and mix of services, and recognition of bands of provision rather than just single specifications.

4.3 Modeling different scenarios

The usefulness of projections of outcomes under the current ratios as a baseline for comparison with other scenarios is well demonstrated in the three sets of projections presented in a recently released report prepared by Access Economic for Alzheimer's Australia (2010). The outcomes show that the margins for change are affected by not only by the populations used in the denominator but also by whether projections are made for a single cohort over a given age or take account of changes in age-specific rates of disability and disease such as dementia. For example:

- projections based on the population aged 85 and over result in an additional 13,800 places by 2030; this difference of only 3% over the full 20 year period is marginal.
- projections based on dementia prevalence result in an additional 48,900 places, a difference of 10%; the larger increase relfects the inclusion of age-specific rates of dementia in the projection.

These outcomes point to a number of factors that need to be taken into account in projections:

1. It is questionable whether the number of places available at one point in time provides the best basis for projections as this approach perpetuates that level of provision rather than allowing for dynamics in the use of services.
2. The trend of declines in age specific rates of use needs to be recognized. AIHW (Statistical Overview, 2007-08, p. 132) reports declines in age-specific rates use of RACH for each 5 year age group from 1998 to 2008, ranging from 14% at age 65-69 to fully 23% at age 80-84; interestingly, and although accounting for only a very small part of the RACH population, the rate of use for the population aged under 65 remained stable over the decade.
3. Short term fluctuations in provision reflect the outcomes of varying allocations in ACARs a few years earlier and point to the need for better management of the ACAR process.
4. Over the longer term, residential care provision has fallen from around 103 /1000 70+ to around 83 per 1000. This long term decline has been halted since around 2003 by considerable efforts made by the Commonwealth to achieve the ratio of 88 RACH places per 1000, raising the question as to whether the ratios have propped up provision instead of allowing for a continuation of the observed downward trend.

As well as projections based on different denominator populations, projections are required for different service mixes in the numerator.

1. This mix has been changed a number of times since the first planning ratio of 50 nursing home beds per 1000 aged 65 and over was introduced in the mid 1970s.
2. The inclusion of care packages in the ratios has more than offset the reduction in the RACH component of the total ratio, but no account is taken of either HACC or other forms of retirement accommodation that to some extent serve as alternatives, particularly for low care.

3. The actual or notional allocation of RACH places for respite care and post-acute care nibble away at the edges of the ratios.
4. Rather than specifying a separate figures for the different kinds of packages and for low care and high care, a more useful approach could be to set bands for minimum levels for residential care and community care provision and allow a margin to be filled by one or other type of service in response to expressed user demand and provider responses. Such a margin would provide a flexible balancing mechanism that is lacking in the present planning system and overly strict adherence to the specifications appears to be artificially holding rates of residential care provision higher than they might otherwise be.
4. Finally, the mix and levels of services in the current ratios are the product of several modifications mostly due to shortfalls in realisation of earlier ratios, but lacking in any practical validation. The time to test the ratios in the field is well overdue and the development of new ratios needs to be informed by investigation of how well service provision is seen to meet need in a sample of regions with recognisably different balances of services.

4.5 Recognition of cultural and linguistic diversity

There is growing recognition that the dichotomy of 'mainstream' or 'ethno-specific' services is artificial and reflects neither the nature of service providers nor patterns of service use by CALD clients. Only some service types lend themselves to fully ethno-specific delivery, and the majority of CALD clients receive services from 'mainstream' services. Many 'mainstream' services have adopted various strategies to enhance responsive to cultural diversity, most commonly by employing staff with a wide range of language skills and from cultural backgrounds of the local communities in which they work. There are now many examples of best practice that provide a base for furthering culturally responsive service delivery.

The profile of the older CALD population is continually changing in line with past migration patterns and shifts in the ageing of different communities. A starting point for improved recognition of CALD clients in service planning is a comprehensive analysis of current use of services by different CALD groups. The AIHW is well placed to carry out such an analysis.

Recognition of CALD communities in the broad planning process is only part of the response to the special needs of different groups which need to be pursued with specific community groups and providers at local level.

4.6 Indigenous Australians

The use of the indigenous population aged 50 years and over in the needs based planning process is a high priority for review. Research carried out at Charles Darwin University provides a range of evidence showing that aged care services are not an appropriate response to the chronic health problems of indigenous Australians aged 50-69. The need for further development of alternative approaches to service delivery, along the lines of MPS and involving indigenous controlled agencies, is also indicated.

5. Margins for change in regulatory arrangements

5.1 The burden of regulation or the benefits of accountability?

The language of the 'burden of regulation' has to be balanced with the language of the 'benefits of accountability' for those who use aged care services and for the wider community as well as government. In order to establish the burden of regulation on aged care providers, it would be useful to distinguish between:

1. Regulation that is common to all businesses;
2. Regulation that is common to all businesses that receive public funding for delivering services such as child care, education, disability services and health care to vulnerable groups; and
3. Regulation that is specific to aged care, and that is:
    - ongoing and affects all providers all of the time; here it might be noted that the ACFI is not only a regulatory tool but is primarily a care planning tool.
    - periodic, such as Accreditation Site Audits that affect most providers only once every three year.
    - occasional, such as Certification and regulation relating to building works, although many aspects of planning regulation are common to all building development.

The differing frequency and intensity of the three areas of regulation specific to aged care present different margins for change, and the effects of changes of different kinds will vary across the aged care system. The need is to identify a small number of regulatory changes that would have widespread and deep effects.

The extent to which the regulatory burden experienced by aged care providers is related to management skill and operational systems also needs to be recognized, to separate the need for improvements in these areas of provider performance from the need for regulatory reform.

5.2 Reducing the frequency of Accreditation Site Audits

A simple option for reducing the demands of Accreditation would be to reduce the frequency of full Site Audits from every three years as at present to every four or five years. As well as reducing direct and indirect costs for providers, this change could in fact increase identification of poor quality care as it would free resources of the Standards and Accreditation Agency for additional support visits. Analysis of all cases of sanctions from 1999-2008 has found that non-compliance with the outcome standards is rarely identified at Site Audits given the extensive preparation that is undertaken, and is mostly identified at Support Visits. Reducing the frequency of Site Audits would thus not pose a risk to quality of care and could instead make the standards monitoring process more effective.

5.3 Regulation of retirement specific living options

The Term of Reference relating to whether regulation of retirement specific living options should be aligned more closely with the rest of the aged care sector is taken up in separate presentations to the Commission based on the report of the Australian Housing and Urban Research Institute

on Service Integrated Housing for Australians in Later Life. (AHURI research Report 141 available on www.ahuri.edu.au)

6. Margins for change in workforce requirements

6.1 Relative and absolute shortages

A major finding of the 2008 aged care workforce survey conducted by the National Institute of Labor Studies was that a very substantial proportion of the aged care workforce, particularly personal care workers in residential care, wanted to work more hours, and thereby increase their take-home pay. The gap between hours worked and hours wanted represents a large reserve workforce, making shortages in these workforce categories relative rather than absolute. Relative shortages can be addressed to a considerable extent by changes in employment practices to give staff longer hours of work; while involving extra costs, the returns are likely to be worthwhile in terms of reduced turnover and reduced recruitment costs and increased staff satisfaction.

6.2 Competing with like fields of employment

The NILS survey shows that in many respects, the aged care workforce is very similar to the total female workforce. These findings mean that only relatively small changes should be required to make aged care a preferred area of employment compared to other fields requiring similar levels of skill and offering similar work conditions and pay rates.

Average turnover reported in the NILS study was similar to that for the female workforce as a whole, but variability of turnover within the aged care sector was not reported. A joint project between NILS and La Trobe University is currently underway involving further analysis of the 2008 survey data to identify the extent of variation in turnover and associated factors, taking account of variables related to work settings (provider agencies) as well as worker characteristics. The findings will assist in identifying factors that providers can address compared to external factors, such as general labor market conditions.

6.3 Benchmarks for staffing

The widespread calls for staffing benchmarks to be set for residential care could begin to be addressed by further analysis of the NILS survey data. While DoHA has had NILS undertake a variety of analyses, it appears reluctant to have staffing levels analysed. Have this work carried out is a high priority and a pre-requisite to commissioning any further workforce surveys from NILS or any other agency.

In the first instance, *normative benchmarks* can be identified on the basis of current practice, given that all providers receive the same funding in relation to resident dependency. Establishing normative benchmarks would enable factors associated with staffing above or below the norms to be identified. Better understanding of the range of staffing levels achieved with present funding, and why some RACH have higher staffing than others, is essential before additional resources are made available, and can assist in ensuring that any additional resources are used most effectively.

Model benchmarks can then be developed by a variety of methods, including moderation of the normative benchmarks through expert review and identification of best practice.

Comparative benchmarks can be investigated through review of literature, but considerable differences in resident mix, the role of residential care in health and aged care systems and care practices need to be taken into account in any comparative analysis.

7. Strengthening the evidence base

Rather than there being a lack of data on aged care, the real lack is useful analysis of the large amount of data that is already available. Three measures that would strengthen the evidence base for developing aged care policies and programs are:

7.1 Expansion of the role of AIHW

Additional funding should be provided to the AIHW to carry out high quality research into critical issues in aged care. The Institute's report on *Dementia in Australia: National data analysis and development* was a landmark study and provides a model for research using the wide array of data that is collected but which is subject to minimal analysis. Two priorities are:

1. An analysis of the use of aged care services by people from linguistically and culturally diverse backgrounds, following a methodology and design parallel to the dementia project. Such a project would provide a national picture and could also report on differences between ethnic communities and geographic areas. Without a comprehensive and in-depth analysis of this kind, interpretation of small scale studies of widely varying designs and rigour remains problematic.
2. An analysis of the HACC MDS that goes beyond the current HACC MDS Annual Bulletins that mostly tabulate single variables. The very limited analysis of the HACC MDS which covered 831,500 clients in 2007-08 is all the more conspicuous when compared to the detailed AIHW Statistical Overview of Community Care Packages, which served one fifth as many clients, some 42,000, as at June 2008. AIHW is well placed to address methodological problems that appear to give an inaccurate account of levels of HACC service use. The Bulletin notes that reports of average service use do not reflect actual client experience, and no account appears to be taken of the time period over which individual clients use services during the annual collection period, and alternative measures are required to give a more accurate and meaningful picture of service use in terms of "equivalent full year clients". By way of illustration:
    - The HACC MDS 2007-08 Annual Bulletin reports that 87,314 clients used a total of 4.6million hours of service over the year, giving average use of just 53 hours per client per year, a seemingly low use of just one hour a week.
    - If the ~88,000 personal care clients comprise 4 groups of 22,000 who used services for 3m, 6m, 9m and 12m, the number of equivalent full year clients becomes 54,250 (5,500 + 11,000 + 15,750 + 22,000) and average hours of use per full year client increases to 85 hours.

7.2 Timely access to data and release of reports

Access to administrative data bases for research and evaluation purposes needs to be streamlined and simplified so that more timely information can be made available for policy and program development. Further, the Department of Health and Ageing should be required to release reports on all research and evaluations that it commissions within a set timeframe and actively

disseminate these reports. In the event that the Commonwealth and/or other parties involved in advisory committees overseeing joint projects have any reservations about the findings reported, these matters should be set out in a formal response and released with the report. The failure to release these reports raises questions of accountability for the funding involved and of responsiveness to the many agencies and individuals who contribute to such projects.

Without access to these reports, discussion is less well informed than it should be. A case of particular relevance to the present Inquiry is the Evaluation of the National Dementia Initiative. The research consortium submitted its penultimate report to DoHA in May 2009 and a final version, incorporating only minor revisions, was submitted in October 2009. The report has not yet been released.

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Part B: A proposal for an Aged Care Investment Scheme

Part B of this submission addresses the questions put forward in the Commission's Discussion Paper concerning who should pay for aged care, changes to user contributions to the cost of accommodation in residential care, and how the public and private exposure to the financial risks associated with aged care might best be managed. It puts forward proposals for an Aged Care Investment Scheme as a means of funding capital development for aged care. The main focus is on capital for provision of residential aged care homes because this area persists as the most problematic aspect of aged care funding. The scheme would generate additional capital funds and phase in a restructure of current Commonwealth capital spending and user payments.

The Introduction set out the background to the proposal, highlights how it responds to the changing context of ageing of the baby boomers and how it responds to issues raised in the review of Australia's future tax system. Some key features of the proposed Aged Care Investment Scheme are then described and the scheme is then considered from the perspectives of current and future generations of older people, aged care providers and government.

The Productivity Commission Inquiry is a significant opportunity for discussion and hopefully some resolution of issues of funding of aged care that have been debated for almost two decades. The aim of this proposal is to contribute to this discussion; some of the questions for further discussion are flagged, but many others remain to be raised. Further discussion and development is required not to determine whether this particular proposal works or not, but how alternative funding arrangements could be made to work better than the present funding system.

The submission is presented in five parts:

1. The changing context of financing aged care
2. Key features of an Aged Care Investment Scheme (ACIS)
3. Why would ACIS be an improvement on present arrangements and other options?
4. What can Australia learn from international experience?
5. Conclusions

Constructive comments made by a number of individuals on an earlier draft of this proposal have contributed to this submission. These individuals are listed at the end of the submission and their contributions are acknowledged with appreciation.

1. The changing context of financing aged care

1.1 Background

This proposal is not the first to put forward ideas for alternative ways of funding aged care including insurance or levy based systems.

- In 1993, the second stage of the Mid Term Review of the Aged Care Reform Strategy canvasses issues of financing long term care (DHHLGCS, 1993: 86-99) and recommended:

  > That in order to contain public outlays on aged care while ensuring continued equity of access to services and protection of the capacity of older individuals to meet user contributions to the cost of services, consideration be given to the development of a method of financing aged care that includes a component drawn from superannuation contributions paid over the individual's working life. (Rec. 6.1, p. 99)

- It is over a decade since the Productivity Commission convened a conference on Policy Implications of the Ageing of Australia's Population at which Howe and Sargeant (1999) presented a paper that called for a third pillar of social insurance to be added to aged care funding to strengthen the two existing PAYG pillars, namely tax funding and user payments (mainly transfer payments by way of the Age Pension). That paper included an option for funding only capital expenditure.

- Other proposals based on levies on the working population have been proposed from time to time, but have been not separated capital funding from other components of the cost of aged care. An early example was the EQOOL model developed by McCallum and others (1998). More recently, Access Economics (2009) has canvassed a number of options in reports commissioned by Alzheimer's Australia, with the first three of six options involving levies:
  1. Increases in the Medicare Levy;
  2. a levy on superannuation payouts;
  3. Healthy Ageing Savings Accounts (HASAs), a form of voluntary and private insurance dedicated to aged care.
  4. reverse mortgages;
  5. bonds for high care;
  6. means testing for high level community care (CACP and EACH/D).

- Other submission to the Productivity Commission Inquiry include new funding proposals. For example, The Bethanie Group have proposed a social insurance scheme based on a levy on the working age population to cover the full cost of their future aged care.

1.2 The changing context of population ageing

While the Aged Care Investment Scheme proposed here builds on these earlier discussions, it puts forward new options that take account of the compounding effects of changes in the retirement income system over the 25 years and especially over the last decade, and the advance of the baby boom cohorts into retirement. These changes mean that:

1. More older Australians are reaching retirement with higher incomes and so should be able to make a greater contribution to the cost of aged care.
2. Their higher retirement incomes are due in part to their superannuation being boosted by substantial tax concessions on contributions and paying no tax on income drawn from superannuation when they retire.
3. The time frame over which increased need for aged care on the part of these cohorts will be manifest has shortened; it will be only 15 years until those now aged in their early 60s reach the ages from which use of residential aged care increases rapidly.

In response to these changes, the rationales for the ACIS are that:

1. It will provide a means by which all those reaching retirement will make an equitable and direct contribution to the cost of aged care at a time they are most able to, that is, early in their retirement, rather than the last few years or months of their lives.
2. It will drawn on superannuation incomes that have benefitted from significant tax concessions rather than imposing an additional burden on the working population, and will relieve future working age groups of having to meet additional capital costs for the large baby boom cohorts.
3. It will enhance sustainability of funding of aged care not only through adding a third pillar to the current pillars of tax funding and user payments, but because the new pillar will grow at a faster rate than the population needing care.
4. It will generate additional capital funding in a much shorter term than a funded social insurance scheme applied to the working age population which would have a protracted time horizon to maturity and exposure to greater risks. By investing immediately in capital development, the ACIS will ensure that accommodation will be available when the baby boom cohorts come to need it with reduced exposure to risks associated with fluctuations in the economy over time, and particularly at the time of admission to care.

1.3 Sharing responsibility for funding aged care

Issues raised in the review of Australia's future tax system

Responsibility for funding aged care are currently shared between taxpayers and service users. The review of Australia's future tax system (the Henry Review) released in May 2010 stated three clear principles that guided its examination of the current responsibilities and possible reforms:

- People with limited private means should be provided with assistance so they can receive an adequate level of care at no financial cost to them.
- Ensuring access to an adequate level of care irrespective of means is a 'public good' ..... and should be funded by the community through general taxation.
- Where people do have means, they should be user charged for the services they receive. Further, individuals should be able to purchase a higher standard of service provided they pay the full additional cost.

The expected increase in wealth of the older population does not necessarily mean that more of those who come to use residential aged care will be able to pay more of the cost at the time of use. Wealthier individuals may make choices outside the formal aged care system by way of converting their housing assets into various forms of retirement accommodation and paying for varying levels of support services, and so reduce the likelihood or at least duration of use of residential aged care. While such a trend could reduce the overall level of demand for residential care, it would mean that those are admitted would increasingly be those with lower incomes and lower assets, particularly lower levels of home ownership, and less capacity to pay for their care. Any marked shift of this kind would result in a greater rather than lesser need for public responsibility for provision. There is however no evidence of an upward shift in the incomes of residents of aged care homes to date, with the proportion reported as self funded retirees in AIHW Statistical Overviews fluctuating very marginally around 9-10% over the last decade.

The Henry Review identified shortcomings in current arrangements arising from interactions between the aged care, income support and taxation systems. Four of the main issues identified specifically in relation to bonds were:

- Payment of bonds in excess of $90,000 results in residents paying more for their accommodation than those levied with an accommodation charge.
- The depletion of residents assets to avoid means testing by charging bonds that leave residents with only $36,000, the minimum amount that residents must be allowed to retain.
- The recognised practice of providers 'cherry picking' residents who can pay high bonds.
- The absence of any offsetting of government subsidies against income earned from bonds, regardless of the amount of bonds paid, apart from the reduction of subsidies paid to residents in extra services homes by 25% of the extra services fees that are charged

These problems raise the wider question about the effectiveness of bonds as a means of capital funding. Providers argue that income earned from bonds enables them to cross-subsidise capital development for residents who do not pay bonds, but can be argued that this redistributive function should not be left to aged care providers and rely on residents who pay bonds, but is the responsibility of the general taxation and transfer system.

A further concern is that the exemption of bonds from the Age Pension assets test has lead to bonds becoming a mechanism for avoiding the means test, and comes at a considerable cost to taxpayers. This mechanism works in much the same way as non-interest bearing deposits were used as a means of maximising Age Pension entitlements until the introduction of deeming. Residents of aged care homes who are left with few assets, and hence little income from those assets, will not only qualify for a part or full Age Pension, but will also avoid having to pay means-tested fees. Providers can be seen as 'double dipping' by maximising interest earned on bonds, possibly well in excess of the Accommodation Charge, at the same time as receiving subsidies for care and basic daily fees paid from the Age Pension.

The effects on cost to government of depletion of assets can be illustrated by combining the separate calculation of care and accommodation costs given in the examples in the Henry Review in Table F7-3 and F7-4, and including the basic daily fee paid from the Age Pension or from the resident's own income. Examples 1A and 1B in the table below shows how paying a bond affects qualification for a full or part Age Pension and for mean-tested care subsidies.

The extension of bonds to high care homes is seen as a means of addressing capital funding problems for providers, but Examples 2A and 2B show that charging of bonds that depleted residents' assets could have adverse consequences for government outlays as taxpayers would have to bear the cost of more residents qualifying for increased pensions and their reduced capacity to meet means-tested fees.

While a range of intermediate outcomes would be realised with different balances between the amount paid as a bond and the amount retained by the resident, these examples highlight the differences in outcomes due to inconsistencies in treatment of assets. Assets paid over as a bond are exempt from the means test, whereas income-earning assets of those who do not pay a bond, typically those in 'standard' high care homes, are not exempt. There are marked differences not only for residents and providers but also for government and taxpayers.

Example 1A: Current scenario Asset depletion, as for resident ageing-in- place in low care	Example 1B: Alternative scenario Asset retention, as for resident admitted to high care
Self-funded retiree with assets of $400,000, pays bond of $300,000, with return on investments to provider at 7%.	Self funded retiree retains assets of $400,000
- Resident left with assessable assets of $100,000, generates income of $7,000 - qualifies for close to full Age Pension from which the basic daily fee is paid - largely avoids means-tested care fees	- Resident qualifies for only part Age Pension - pays total of $40,164, comprising 8. $13,843 basic daily fee 9. $9,811 accommodation charge and $16,510 means-tested care fees
- Provider earns $24,588 from interest on the bond, plus a draw down of $3,588 p.a.; total annual bond income of $28,176 worth ~ 3 x Accom. Charge/ Supp.	- Provider loses capital income of $14,777 ($28,176 interest from bond plus draw down, offset by $9,811 Accom. Charge paid by resident)
- Cost to taxpayer ~ $53,000, comprising $16,750 full Age Pension and $36,139 in subsidised care fees.	- Saving to taxpayer of ~ $40,000, eliminates a large part of the cost borne by the taxpayer under current scenario 1A.
Example 2A: Current high care scenario	Example 2B: Alternative high care scenario
Self funded retiree with income of $60,000 and who has not paid a bond	Resident has income earning assets of $857,000 to generate income of $60,000 (at 7%) Pays bond of $820,000, assets reduced to $37,000.
- Resident not eligible for Age Pension, pays $13,843 basic daily fee $9,811 Accom. Charge and $16,510 means-tested care fees	- Resident becomes eligible for Age Pension, no longer pays means-tested care fees.
- Provider income of $59,793, comprising $40,164 from resident as above and $19,629 care subsidy.	- Provider income of $110,970 comprising $13,843 basic daily fee $36,139 care subsidy and $60,988 interest on bond plus draw down, ~ 6 x Accom. Charge/ Supplement.

- Cost to taxpayer of $19,629 care subsidy, ($35,371 less than alternative scenario 2B)	- Cost to taxpayer close to $55,000, comprising Age Pension and full means-tested care fees.

Concerns about the interaction of pension eligibility, assets depletion and aged care charges lead the Henry Review to call for reforms to funding arrangements to address these and other problems and to improve the fiscal sustainability of aged care. The need to insure against longevity was also raised and the Productivity Commission was charged with considering aged care insurance.

ACIS as an aged care insurance scheme

ACIS has many features of an insurance scheme that shares risk among individuals. Contributions would be spread across a much larger segment of the population early in retirement instead of relying heavily on the much smaller number of individuals who pay bonds or meet their own accommodation charges. The risk of using residential care is much higher than suggested by the small proportion living in aged care homes at any one time; at age 65, there is a 25% chance of admission to permanent care before the end of life, and this risk increases markedly with advancing age, and more for women than men.

By way of comparisons:

- At the 2006 Census, there were close to 1m people aged 60-64 and another 800,000 aged 65-69.
- 58,000 residents in aged care home in 2006-07 paid bonds and another 36,000 paid accommodation charges in 2006-07,
- some 60,000 were Concessional (now Supported) residents whose accommodation fees were met by government.

Introduction of ACIS would bring two further important benefits.

- ACIS offers a means for rebalancing the way in which responsibility for aged care funding is shared between taxpayers and users and restoring the redistributive function to the taxation system, with decisions on spending capital funding made in the context of provision of a social good rather than left to aged care providers.
- It would add to the resources available for aged care in much the same way as the Medicare Levy was introduced to meet the additional cost of providing universal health cover.
- By providing an opportunity to restructure current arrangements, the problems related to bonds could be addressed and alternative ways for covering the cost of accommodation and recognising different standards of accommodation developed for application across both low and high care homes to provide more flexible payment arrangements for users and providers. Experience with retirement incomes suggests that deeming arrangements could be used to address the depletion of assets associated with bonds and to recoup means-tested fees to achieve parity with fees paid by residents who do not pay bonds, before providers earn returns. A range of other measures that could allow for higher accommodation charges and a higher ceiling on means-tested fees are taken up below.

2. Key features of an Aged Care Investment Scheme (ACIS)

2.1 Where would the funds come from? Mixed sources including contributions from superannuation funds

It is proposed that the ACIS would be funded by a combination of

- Direct contributions from superannuation payouts;
- Commonwealth funds now made available for Zero Real Interest Loans (ZILs);
- Restructuring of current Commonwealth payments for Accommodation Supplements; and
- Phasing in a flow from a proportion of Accommodation Charges (bonds and income tested charges) currently paid by residents to providers

It is not intended that ACIS would cover all capital funding. Providers would still draw on borrowings and any reserves they held.

The new funding component is for **direct contributions** to be made from superannuation at the *time of payout* rather than a levy paid by the working age population. Contributions would be collected by the ATO from Eligible Termination Payments via super funds, including self managed funds, and drawn only for a fixed period post retirement (say 10 years, regardless of the age of retirement) or until an individual's account balance fell to a predetermined threshold. Different arrangements would be required for payouts taken as lump sums and income streams.

The rationales for drawing contributions from superannuation income at the time of payout include:

- Most importantly, contributions would be an intra-generational transfer and not impose any additional inter-generational burden.
- Collection at the time of payout allows accumulation of maximum retirement incomes whereas collection at an earlier time would reduce eventual payouts.
- Contributions would share the risk of the future cost of aged care more equitably than present arrangements by drawing smaller amounts from a larger number of people, early in old age when they have more income, rather than from the smaller number who are admitted to residential care at much older ages, when they have lower incomes and far more of whom then need taxpayer support to meet the cost of accommodation as well as care costs.
- Contributions would be highly progressive as those with the highest retirement incomes, and who benefit most from tax concessions on contributions and payouts, make the highest contributions. The main redistribution would be from men with higher retirement incomes derived from superannuation to women with lower retirement incomes and little or no superannuation income.
- Contributions would be a very small charge on otherwise tax free income from superannuation. Although not necessarily set at the same rate, direct contributions can be

seen as extending the recently announced 3% increase in the Superannuation Guarantee Charge into the early years of retirement.

- While more retirees will have higher retirement incomes in future, there will be some who have little if any income above the Age Pension. To achieve universal coverage, and avoid any division between those who have and have not made direct contributions to ACIS, a co-contribution could be considered.

2.2 How would funds be spent? Invested in capital

Funding for aged care is readily divided into three components which are funded in different ways under present arrangements, and which need to be addressed in different ways to meet future demands.

Costs of daily living are paid as Basic Care Fees, set as a proportion of the Age Pension, or the equivalent amount from the resident's own income.

Costs of care are set on a dependency based scale, the Aged Care Funding Instrument and paid by the Commonwealth as care benefits, offset by means-tested care fees.

No changes are proposed for either of these components as PAYG arrangements are appropriate to both and are not problematic. To replace either or both of these components with a levy for forward funding thus does not only not solve a problem but runs the two risks: the more likely risk is of not accumulating enough, and hence requiring topping up at a future date, or the less likely risk of accumulating too much, leading to funds being redirected to other expenditure to avoid cost inflation in aged care. Neither of these risks gives confidence in forward funding as an appropriate way of meeting the future care and daily living costs.

PAYG approaches are appropriate as all residents of aged care homes will have at least Age Pension income, and the cost of care has to be consistent with contemporary standards and is thus difficult to provide for in a funded system. Means testing can also be applied on the basis of residents' incomes at the time of use of care. Means testing consistent with the Age Pension is equitable not only across the aged care resident population but with the wider system of social security payments.

Unlike the costs of care or daily living, the use of aged care accommodation is shared by many residents over time and so it is appropriate that funding is also shared. Further, and also unlike means testing of care fees, current arrangements for Accommodation Bonds are seen to be highly inequitable between those pay bonds and those who pay accommodation charges, those who do and who not come to need residential care at the end of their lives, and between their heirs, with housing assets being a major form of intergenerational wealth transfers in Australia. An alternative scheme to fund capital is required on grounds of equity, efficiency and sustainability. In a recent report on Long Term Care for Older People, the OECD argues that insurance approaches are most appropriate for funding the costs of accommodation as this risk is easier to calculate than the full cost of care (OECD, 2005b, p.14)

Costs of capital development are currently met from a variety of sources:

1. Commonwealth sources:
   - Accommodation Supplements paid by the Commonwealth to residents with low income and low assets

- Commonwealth Zero Real Interest Rate Loans (ZILs)
- Capital assistance grants

2. User payments:
   - Accommodation Bonds
   - Means-tested Accommodation Charges paid by residents in high care homes
3. Provider borrowing and reserves.

There is mounting evidence of the weaknesses of these arrangements, and that they cannot sustain the needed levels of future capital development. The multiplicity of sources *per se* makes planning and management difficult for users, providers and government. A number of factors have exacerbated the difficulties reported by the sector for many years. The global financial crisis has been widely cited as affecting access to capital. Expectations that the report of the Senate Standing Committee on Finance and Public Administration would result in increased Commonwealth funding may have meant a stand-off from making capital commitments on the part of some providers. Delays in announcement of Aged Care Approvals Rounds have also added to uncertainties, and approval of fewer than anticipated residential care places in the 2008-09 Round may have compounding and possibly contradictory effects on subsequent rounds if more beds are made available to catch up, but providers are more cautious and less willing to apply for beds.

There is also some uncertainty about how fully some funds intended for capital are applied to the intended purpose, and the time horizon over which investments are made. While ZILs necessarily go to capital projects, the other Commonwealth payments intended for capital are spread thinly across all providers, only a proportion of whom are undertaking capital works at any one time or plan to make capital investments in the short term. Providers committed to capital works commonly use bond income to retire debt, but others are left to manage their capital flows as they see fit, over varying time frames, subject to the liquidity requirements of the Aged Care Act 1997.

Even though the Aged Care Act 1997 requires bond income to be used for capital purposes, the 2009 ANAO report on protection of accommodation bonds found that these requirements were only weakly monitored. While more than 95% of providers met all prudential standards, this does not mean that all manage capital funds judiciously or maximise reinvestments in aged care facilities.

2.3 How can ACIS address current problems in capital funding?

The three inter-related aims of ACIS are:

1. To increase the funds available for capital investment by adding a component of direct contributions from superannuation payouts;
2. To bring current Commonwealth capital expenditures together in a pool of funds to be made available for investment by providers and so ensure that these funds are applied to capital purposes in a reasonable timeframe.
3. To reduce the reliance on bonds over the medium to longer term.

First estimates of the total size of ACIS and shares that might be derived from existing Commonwealth funding, from additional new funding and from user charges currently paid to

providers can be made from data in the Report on the Operation of the Aged Care Act 1997 (ROACA) for 2008-09. It is emphasised that ACIS is not expected to cover all capital expenditure, but that it could add to the resources currently available.

If in the first instance, ACIS was to cover half of the $3bn expenditure on buildings as of 2008-09, $1.5bn would be required. If ACIS was to increase available funding by 10%, an additional $300m would be required, bringing the total required to $1.8bn. This amount could be derived from three sources as follows.

1. The first source of funding for ACIS would come **Commonwealth capital funding** which totalled close to $900m in 2008-09 (as in ROACA, Table 22, p. 39, and p. 50). It can be expected that the $204m spent on ZILs and Capital Assistance grants would be fully available, with phasing in of the $692.5m Accommodation Supplements and Supplements relating to grand-parenting. While a maximum of 25% of providers undertook capital works in the year (allowing for no overlap between the 16.9% who completed capital works and the 10% who had works in progress), Commonwealth accommodation supplements flow to all providers. While some of this funding is used to service loans for work already undertaken, the balance that is not applied to investment in the short term would be available to ACIS. If say 50% of the 2008-09 spending was not committed to capital development, $346m would be available to ACIS. Total Commonwealth input would be $550m.
2. The second input to ACIS would come from a proportion of **user payments.** The annual value of means-tested accommodation fees (whether paid as charges or imputed from bonds) can be broadly estimated at $1bn, based on $10,000 per year ($27 per day x 365) for some 100,000 residents who were not supported by Commonwealth accommodation payments (AIHW Statistical Overview, 2007-08, p. 66, Table 4.12). Again assuming that 50% of this amount was not committed to capital development and this proportion was lodged with ACIS, this source would provide $500m.
3. **Additional funding** would come from the new component of **direct contributions** from superannuation payouts. The Australian Superannuation Funds Association reports benefit payouts of $9,776m on the part of funds with assets of over $50m in the March quarter of 2010, or close to $40bn a year. Securing the needed additional $800m from this source would require 2% of payouts.

Even these first estimates highlight the strength of having ACIS draw on multiple source by way of giving considerable flexibility in the share of the total to be drawn from each source and the rate at which they are phased in, with opportunities for either increasing the total amount in ACIS or offsetting higher shares from one source with reductions in another. This flexibility is particularly relevant to enabling adjustments in the phasing in of Commonwealth and user payment to take account of factors such as funds required to service providers' existing capital commitments and the rate of growth of super payouts, reflecting both demographic trends and fund performance.

A range of options could be modelled to show the outcomes that could be achieved over a 10 year phase-in period under different levels of direct contributions and taking account of projected growth in super fund payouts, and for different levels of income from accommodation charges paid by government and users. The effects of potential growth from direct contributions on offsetting the share of funding coming from accommodation charges as the ACIS matures is of

particular relevance to establishing the accommodation charges that would eventually have to be paid by those who had made direct contributions.

As ACIS is not intended to provide all capital and provider borrowing and reserves will continue to play a part, it will not undermine incentives for efficient operation to generate profits for reinvestment. Rather it will complement provider generated capital in three ways that are important not only for providers but for older people and government:

1. Compared to the present PAYG components of Commonwealth capital funding, ACIS will increases stability across the whole system not only against fluctuations in economic conditions but by drawing on contributions from growing ageing cohorts ahead of the age at which their needs for aged care will peak. Greater stability would limit the extent to which governments and providers can use events such as the GFC to impose more rationing (whether really justified or not), and in some cases allowing such excuses to cover up for poor management of funds over a long term horizon.
2. ACIS will bring greater transparency by ensuring that funding intended for capital is spent on capital and will reduce the risk that consumers and government could face provider defaults.
3. A scheme that provides for immediate capital investment avoids much of the risk associated with individual or social insurance options that promise to cover all or a high share of costs but might then fail to deliver and lead to widespread disillusionment. The experience of The Netherlands is illustrative here as older Dutch citizens who have paid premiums for long term care through their working lives and who expected the cost of care to be covered are now facing substantial co-payments should they come to need care and purchase services in a more market based system than the public services they expected.

2.4 When would funds be spent? A shorter time horizon

The ACIS would make funds available for immediate investment in capital development rather than having a much longer time horizon associated with accumulating a pool of funds for future investment or through individual insurance accounts. This difference is the main reason for labelling the proposal an Investment Scheme rather than a Fund which implies accumulation along the lines of the Future Fund or superannuation funds, with payouts not made until some future time. Immediate investment in capital development eliminates the risks associated with accumulation over much longer time horizons.

Individual insurance accounts intended to enable individuals meet all or some of the costs of accommodation at the time of use are not a suitable vehicle for funding capital on several grounds. Apart from the numerous and significant constraints in the operation of such an insurance scheme, including moral hazard on the part of users and perverse selection on the part of both insurance and aged care providers, a scheme that does not release funding until the time of admission can do little to underpin capital development that is undertaken on a timescale of several years.

Further, in contrast to insurance based proposals to cover the costs of care, which would see accumulated funds dispersed on current expenditure, ACIS spending on capital development means that funds are not dispersed but are available over a long time horizon in the form of buildings. On a 40 year building lifetime, many of the new aged care homes and upgrades completed since the Aged Care Act 1997 will be due for replacement from around 2040, and ACIS will support expansion of capital development ahead of and beyond this horizon.

3. How would ACIS be an improvement on present arrangements and other options?

3.1 For the current generations of older Australians

There is a growing body of evidence that shows those now moving into retirement are becoming more aware of the risk of needing aged care and the costs involved. For many of those in their 50s and 60s, awareness has been prompted by experience with their own parents in their 80s and needing residential care. This awareness is also accompanied by increasing concern about the cost of future aged care, and increasing interest in schemes that would enable some provision for this risk.

As the need for aged care can be seen as a "normal" risk of the last years of retirement, provision should be made for this eventuality. An ACIS would make good the lack of any current means to this end. It would give those in early retirement a means of making some provision for aged care needs that arise much later in their retirement. Making some payment in advance when they are more able to afford a small contribution from a higher income will reduce the risk of facing a high cost in future.

ACIS does not call for a high cost scheme to cover all costs. Nor would it make retirees complacent about everything being looked after years into the future regardless of changes in economic conditions, but at least it would provide some stability in the face of such shocks.

Being based on contributions from superannuation income, ACIS means that those who are going to use aged care soonest make a contribution to the cost, reducing the cost to taxpayers at large. There is a very transparent link between contributions and care needs that can be anticipated in a foreseeable rather than very distant time.

Reverse mortgage products cannot be seen as an alternative for the current generation of older people. As well as many restrictions on the operation of reverse mortgages, present arrangements for user payments for residential care mean that taking out a reverse mortgage relatively early in retirement may have an adverse outcome by way of reducing assets available at the time when they are most needed.

3.2 For future generations of older people

A recent study of the impact of the global financial crisis on employed Australian baby boomers found that the majority were increasingly risk averse: the most common action was to put more of their own money into superannuation, followed by decisions to delay retirement (O'Loughlin, Humpel & Kendig, 2010). These behaviours combined with increased compulsory superannuation contributions suggests that few people of working age will have the resources or be willing to contribute to a levy-based aged care insurance scheme, and more so if a future disability insurance scheme is funded through a population levy.

In contrast, the increase in the Superannuation Guarantee will see higher retirement incomes accumulated over the person's lifetime, increasing retirees capacity to pay direct contributions to ACIS. Importantly, as direct contributions are to be paid only at the time of retirement, they do not reduce retirement savings or earnings on those savings, but instead draw on maximum

accumulated retirement incomes. Further measures to enhance retirement incomes, such as the reduction in the rate of tax of superfund profits from 15% to 8.5% as proposed in the Henry Review, would increase capacity to pay a modest direct contribution on retirement.

Voluntary aged care insurance is unlikely to be taken up by working age people. Low take-up would go hand in hand with higher premiums and any tax funded incentives to boost take-up could promote adverse selection and eventually perverse outcomes by way of entry to services that were covered rather than the most appropriate service. The history of the involvement of private health insurance funds in aged care in Australia does not suggest likely future interest, nor are there any indications that private health insurers are currently seeking to enter the field. Further, experience with the private health insurance rebate indicates that incentives are unlikely to be successful and to come at a very substantial cost to taxpayers.

Current bond payments also have inequitable intergenerational effects. Adult children whose parents realise housing assets to pay bonds, and who may eventually receive the balance of the bond, are disadvantaged compared to those who inherit housing assets that have continued to appreciate until their parents death. While it is not necessarily the role of social policy to protect inheritance, equity considerations do need to be recognised. At worst, concerns about reduced inheritance can lead to financial exploitation of older family members to avoid having to pay a bond.

The benefits of ACIS for future generations can be summarised as:

1. It avoids any additional impost on working age groups, and particularly those who do not live long enough to be likely to use aged care. It also avoids the problem of other levy based systems which require taxpayers to continue to pay for present aged care at the same time as contributing to the cost of future aged care. .
2. A system based on a levy on working age groups would only mature over a long time frame and given that the Baby Boomers are already entering retirement, it would miss the boat, possibly to a considerable extent.
3. The inequities of the present system in relation to intergenerational transfers of wealth would be addressed by increased intra-generational transfers.

3.3 For aged care providers

More ready access to capital

The main advantage of ACIS over present capital funding arrangements is that it would make capital more readily available when and where it is needed. Capital investment is by nature uneven in time and place, and the current flow of capital from bonds and other sources is poorly matched to these temporal and geographic variations.

At any one time, only a proportion of providers are undertaking any capital development, and only some of these have substantial commitments to new or replacement work. The 5% of providers undertaking new work in 2008-09 accounted for close to 60% of all spending on building, the 2% undertaking rebuilding accounted for 20% of expenditure and the 20% undertaking upgrading works accounted for the remaining share. The thin spread of Commonwealth capital funding contributes only a small part of the resources needed by providers who are undertaking major new building and replacement, and at the same, much of

this funding goes to providers who are making little if any investment at any one time or repaying past borrowing. A large proportion of providers are left having to manage larger or smaller amounts of capital income over long periods, and in recent capital markets, having to face the risk that the value of invested funds might fall at the time when they want to make a capital commitment.

ACIS could fund providers through a mix of grants, zero or low interest loans, and market rated loans, approved in conjunction with the aged care planning process to ensure development in areas of highest need. A starting point for setting funding levels would likely be a set of formulas that took account of factors such as size, location, site and building configuration, and regional building costs. The amount of funding and how it was paid could then be varied on the basis of the case made in individual funding applications in much the same way that financing for other building is assessed.

Having more ready access to capital funds through ACIS would enhance providers' readiness to respond to Aged Care Approvals Rounds, and their capacity to bring approved beds into operation in as short as possible a time. Operating in conjunction with the aged care planning framework, ACIS could reduce fluctuations in the demand for capital from year to year and moderate costly competition among providers for capital funds.

New ACAR approvals would not however be the only pathway to accessing ACIS funds. While the relationship to the ACAR might be closer in the early stages to assist in bringing newly approved beds into operation in a timely manner, ACIS funding could also be used to support developments that had been slow to progress due to difficulties of raising finance. Provision would also need to be made for redevelopments and upgrades. Of particular relevance is that the surge of new RACH built between 2001-2008 in response to the Aged Care Act certification requirements will become due for replacement from around 2040 and may require upgrades in the interim.

More ready access to capital is particularly important in ensuring development in lower income areas. ACIS would reduce reliance on providers to cross-subsidise development of homes in lower income areas and higher income areas. Rather than relying on the propensity of providers in better-off areas to invest in less well-off areas, ACIS would directly assist providers in lower income areas who are required to admit higher proportions of concessional residents and who are less able to raise bonds. The proportion of places to be made available at a standard accommodation fee could be increased across all areas and made a condition of access to ACIS funding.

Promoting diversification and innovation

ACIS would have the capacity to promote diversification and innovation in two important areas. First, while making funds available primarily for residential aged care homes, ACIS would be able to recognise that the boundary between residential and community care is becoming increasingly blurred with many providers involved in both fields. Residential care homes are increasingly including facilities for those living in the community by way of places for respite care, day centres, post-acute care and therapy services. By supporting investment in these other areas, ACIS would encourage diversification on the part of providers and gain potential economies of scale and integration. These economies are particularly relevant to the providers who want to go beyond the bed numbers allocated in ACARs to construct small numbers of additional beds and related facilities to enable them to participate in post acute care programs

and to experiment with other models of care. ACIS funding would apply to developments of this kind in Multi-Purpose Services in rural and remote areas, and there are good reasons for promoting similar kinds of diversification in developments in metropolitan areas.

Second, ACIS could promote innovation and best practice in building design, particularly in environmental sustainability and efficiencies in operating cost. An emphasis on cost-effectiveness appears to be a necessary counter to the apparent cost escalation flowing on from the construction of extra services homes. Given advances in building technology and rising standards of built environments in aged care homes and related facilities, a critical question for ACIS would be whether to fund lower cost buildings with shorter lifetimes, or higher cost buildings with longer lifetimes.

Flexibility in accommodation charges

Provider calls for greater flexibility in the level of accommodation charges and the ways in which these charges are paid are outlined by Aged and Community Services Australia in its Grand Plan for care of older Australians.

To the extent that ACIS makes additional capital funding available through direct contributions, the pressures for raising increased capital from user charges for accommodation would be moderated to some degree. At the same time, as direct contributions are intended to fund only a part of capital, there is a continuing need for providers to be able to raise a share. The shortcomings in bonds as a means of raising capital are increasingly recognised and a main aim of alternatives should be to reduce reliance on bonds. Having more options that apply across all aged care homes is, of itself, more desirable than the current rigid sets of different arrangements for low care, high care and extra services homes.

The introduction of ACIS should open the way for providers to charge higher fees for accommodation of different quality, and also give residents more choice in how they managed their assets and how much they paid for accommodation of the quality they wanted. Alternatives need to address the inconsistencies between the capped amount paid as accommodation charges, which limit providers income but leave residents with varying levels of disposable income, and uncapped amounts paid through bonds, which give providers higher incomes but can leave residents with very little disposable income. It has to be recognised that while some residents may be prepared to pay more for 'premium' quality accommodation, as currently occurs with Extra Services Homes, others may find it acceptable to pay less for 'standard' quality accommodation. The amount the resident pays beyond a fee set by government for 'standard' accommodation and how they pay it should be of the resident's choosing and not imposed in such a way that unreasonably depletes their assets or reduces their disposable income to a minimum amount.

Moves to allow providers to set higher accommodation fees have to be balanced by protections for residents and trade-offs for government. Trade-offs that would address the depletion of assets but which would still allow for payment of higher accommodation charges might include deeming arrangements to recoup means-tested fees from interest earned on bonds, or replacing the single level of assets that the resident must be allowed to retain with a sliding scale set in relation to the resident's assets and taking account of the Age Pension means test. Both of these options are more flexible than a flat rate cap on bonds.

3.4 For government and public spending

Control of outlays

Capital is the most problematic part of the present funding system and is already requiring additional inputs from the Commonwealth. Funding of ZILs is an annual allocation and so controlled, but even small increase in accommodation supplements have large aggregate effects and continuing budgetary implications, but do not necessarily ensure the additional funding is directed to capital investment. The multi-stream funding of ACIS gives the Commonwealth much greater scope to control its outlays and make adjustments between them.

Capital requirements from year to year can be readily estimated given that population growth and other parameters in the aged care planning process are readily known and any changes in these parameters such as changes in the ratio of beds to population can be modelled. Stability would be promoted as provider responses to Aged Care Approvals Rounds would be less subject to fluctuations in capital markets and other real or perceived factors that affect providers' decisions to commit to capital development.

In the event of lower than required inputs from direct contributions due to poorer performance of super funds, government could make counter-cyclic payments into ACIS which would provide an established vehicle for future spending along the lines of 2008 economic stimulus package. Conversely, in the event of higher than required income from direct contributions that resulted in ACIS being in surplus, other government inputs could be reduced or additional investments could be made, such as to increase quality of buildings. Over the longer term, Commonwealth inputs to ACIS would effectively serve a reinsurance function to even out short term ups and downs in contribution income and so stabilise the scheme.

Management of ACIS

The contributions from superannuation income would be most efficiently collected by the ATO from Eligible Termination Payments via super funds. The amount coming into ACIS for investment would build up fairly quickly as the better superannuated generation move into retirement.

ACIS could be run by an independent body, possibly by expanding the role of the Health Insurance Commission to a Health Insurance and Aged Care Investment Commission, with a governing board that included representatives of provider and consumer groups. Such a body would relieve the Department of Health and Ageing from responsibility for managing the current ZILs. While ACIS is not proposed as a funded scheme, the Future Fund provides a model for an efficiently managed scheme that has advantages of simplicity, transparency and fairness.

4. What can Australia learn from international experience?

While the OECD and other international agencies have published numerous reports on funding of aged care, very little attention has been given specifically to funding of capital. In response to an inquiry to the OECD, advice was received that research was currently underway to address precisely the lack of attention to capital funding. Three critical issues in investigating capital funding were noted as (1) the treatment of assets in determining eligibility for public financing, (2) the extent to which board and lodging are a private or public cost, and (3) whether the cost of lodging includes a capital component (F. Colombo, OECD, personal communication).

4.1 Consistency with arrangements for other health and social security funding

A significant feature of long term care funding arrangements in other OECD countries is that they mesh in closely with other health care and social security funding arrangements. Periodic reforms to aged care funding, such as the introduction of long term care insurance in a number of countries, has involved measures that are consistent with and sometimes associated with reform of other elements of such wider arrangements. While Australia can learn from the experience of other countries, the need for consistency and integration with wider systems means that it is very difficult to transfer one part of another country's system into the Australian system which itself has a number of unique features.

ACIS is seen as meshing well not only with the SCG and Medicare levies which have both achieved high acceptance in the Australian community, but also addressing intergenerational shifts in wealth.

4.2 Compatibility with cultural values

There is also a need for compatibility with cultural values, particularly the propensity to save and community expectations of the roles and responsibilities of government for provision of social goods vis-a-vis individual provision. The distinctive character of Singapore in both these regards mean that its health and social insurance schemes are almost unique and have very little transferability to other countries (Hong, 2001).

4.3 Timing in relation to demographic trends

Australia's demographic future is very different to European countries which did not experience similar post-war baby booms and so do not face the rapid growth in aged care costs projected for Australia. Face a baby-boom cost escalation, Japan moved to put its insurance scheme in place over a decade ago, but it remains essentially a PAYG scheme.

A number of European schemes based on very long term time horizons, such as the Netherlands scheme, are now facing difficulties not so much due to demographic trends which are highly predictable, but because of much more unpredictable economic trends and shifts in policies.

4.4 Attention to specifics

Notwithstanding the limited transferability of overall schemes from one country to another, careful examination identifies some features that could be incorporated in an Australian scheme. Three specific areas are noted:

Age of contribution: In the Japanese system, individuals do not start to make contributions until age 40, but continue to contribute past retirement age.

Level of existing provision of residential care: Another relevant but often overlooked aspect of reforms that have aimed to reduce residential care in favour of community care is the level of provision at the starting point. Need for capital investment will be lower where there is already seen to be excessive provision. Compared to Australia, this shift is easier to achieve in countries where initially higher provision is combined with slower growth of the very old cohorts. High levels of initial provision in countries such as Denmark have meant reforms have begun at a very different starting point.

Separate analysis of capital costs: Reports on many system gives accounts of total funding and it not easy to identify specifically how capital funding is generated. The need for more investigation of this question is being addressed by the OECD.

5. Conclusion

Australia appears to be further advanced in unbundling capital and care costs than most other countries. Brief observations on overseas experience suggest that the main lesson to be learned is that there are no ready-made answers and that Australia has to develop its own approaches to restructuring funding for aged care, just as other countries have done.

To this end, the proposals put forward for ACIS aim to fit well with Australia's provisions for health care and retirement incomes, and Australia's likely demographic and social future.

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