Response to Draft Report on the Inquiry into Caring for Older Australians

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This response focuses on five areas in which further development of options is seen to be warranted

1. The Inquiry as an example of evidence based policy development

2. Recognition of the part played by the Carer Allowance in supporting carers' contributions to caring for older Australians and as a form of Consumer Directed Care

3. The need for further consideration of aids and equipment

4. The need for further consideration of options for broadening the funding base of aged care

5. The timeframe of the Inquiry and the timetable for implementation.

1. The Inquiry as an example of evidence based policy development

As the Inquiry is itself an example of policy development informed by a wide range of evidence, Chapter 13: Aged Care Policy and Evaluation should come near the beginning of the report as a preface to all the chapters that follow, rather than being left to near the end.

2. The part played by the Carer Allowance in supporting carers' contributions to caring for older Australians and as a form of Consumer Directed Care

The Draft report gives scant attention to the role of Carer Allowance in supporting carers. Yet FACSIA Budget Statements report that in 2008-09, expenditure on CA was $1,799,614,000. This is precisely $10,773 more than the $1,788,841,000 spent on HACC as reported in the HACC Annual Report for 2008-09.

As there are no restrictions on how CA can be spent, it is effectively a very substantial, but largely unrecognised, component of consumer directed funding in the Australian aged care system. Yet large numbers of individuals who receive HACC services or care packages do not have access to this consumer directed component of care, even indirectly, as they do not have a carer who meets the CA eligibility criteria. An alternative by way of a Community Living Allowance paid directly to the individual needing services, regardless of whether or not they have a carer, would provide a more consistent approach to giving all dependent clients some access to consumer direction associated with cash benefits.

The extent of this imbalance is seen when the data from the 2009 DACS, FACSIA data on CA recipients and the HACC MDS are compared.

1. Take up of Carer Allowance

The 449,948 recipients of CA in 2008-09 represent a take up rate of 58% among the 771,400 Primary Carers reported in the 2009 DACS. As not primary carers as defined by the DACS meet the criteria for eligibility for CA, take up of CA among eligible carers is higher. As CA is widely recognised by ACATs and other agencies providing advice and assessment to carers, such as Carers Associations and NRCP agencies, take up may be as high as 90% of eligible carers. Take up has grown steadily over time and both eligible population and number of recipients have increased over time with eligibility criteria, such as removal of co-residence requirements.

2. Spread of spending and service use

The 449,948 CA recipients compares to 862,500 HACC recipients in 2008-09. Spending on CA is thus far more concentrated than spending on HACC and favours some segments of the HACC target population over others as the majority of HACC clients either no carer or not a primary carer who is likely to be eligible for CA. Of the total HACC target population of 1.9m, it is estimated that:

a) 30% have no carer and use HACC;
b) 15% have a carer and use HACC;
c) 25% have a carer but do not use HACC (but may use NRCP, DVA HC, or package), and
d) 30% do not have a primary carer (or any carer) and do not use HACC (but may use other programs)

These figures indicate that:

- Expenditure on CA is comparatively concentrated on the 40% of the target population who have a primary carer (groups b + c), and close to four out of ten of these carers also use HACC.
- HACC expenditure is in contrast spread more widely across the 45% of the target population who access the program (groups a + b). Of these clients, twice as many do not have a primary carer as have a primary carer and are likely to need (but not necessarily gain access to) higher levels of services at the same level of dependency.
- Many of those who do not have a primary carer or any carer and do not use HACC (group d) are likely to have moderate rather than severe or profound levels of activity limitation. These individuals are less likely to need direct assistance from another person in carrying out daily living activities, although carers may still provide support in other areas. Notwithstanding this carer contribution, these figures suggest that balance of care provided by carers vis-a-vis formal services is more even than suggested by the oft stated claim that by far the major part of care is provided by informal carers.

3. Anomalies associated with CA

A number of anomalies warrant note in the context of proposals to extend user charges for services that are regarded as providing for everyday living activities, such as cleaning and meals.

- The Carer Allowance is not means tested. Assuming that CA is used in part to pay user charges, a client with a carer receiving CA is advantaged over a client with the same care needs and income who does not have a carer receiving CA.
- Means testing CA would have a minimal effect on recipients as the great majority are reliant on Centrelink payments, but would make for consistency between this form of expenditure and other forms of expenditure on community care.
- Clawing back CA in user charges for very modest levels of service use appears to run counter to the purpose of CA in assisting carers, and could pose a barrier to use of initial services which have consistently been found to have the most benefit on outcomes ranging from reducing carer stress to delaying admission to residential care.
- The proposals for increasing fees for services associated with everyday living activities and support as distinct from *health* care services raises the prospect of endless hair-splitting over trivial amounts of money, and disputes as to whether regular meals on wheels attract a fee but a diabetic meal is a health service and hence free of fees. It is unclear from the Draft Report whether all community nursing is to be fully funded as a health service, without user fees.
- The greatest anomaly is associated with the impact on non-co-resident carers whose relative has to sell their house to pay a bond in the event of admission to residential care. Such carers may be deprived of estates that go others who have not been carers and whose relatives do not require residential care. While co-resident carers are protected from having to sell the relative’s home, this anomaly is a particularly harsh and inequitable penalty, both financially and emotionally, on other carers who have contributed very substantially to aged care.

3. Aids and equipment

Aids and equipment need much fuller consideration in the discussion of restructuring of community care. Having the Commonwealth take over HACC would not resolve the issues of uneven coverage in HACC let alone the mix of other programs. Establishing a separate Assistive Technology Benefits Scheme along the lines of the Pharmaceutics Benefits Scheme would be a far more efficient and effective answer across both aged care and disability services.

The HACC Annual Report 2008-09 shows the very conspicuous variability between jurisdictions in the extent to which aids and equipment are included in HACC. States that do not cover aids and equipment in HACC have separate programs with differing conditions of access and expenditure, and further programs are based in state health systems. Access to aids and equipment is excessively complex and prevents many from accessing highly effective supports to independence that also reduce demand on both informal carers and other formal services.

The review of aids and equipment in the report on *Targeting in Community Care; A review of recent literature and analysis of the Aged Care Assessment Program Minimum Data Set* prepared for DoHA (Howe, Doyle and Wells, 2006) found extensive evidence of the effectiveness of aids and equipment used either on their own or in conjunction with care from carers or formal services. Studies that analysed large scale data sets from the US National Health Survey and other large scale population surveys included:

- Agree EM, Freedman VA & Sengupta M. 2004. Factors influencing the use of mobility technology in community-based long-term care. J Aging & Health.16:2:267-307.
- Agree EM & Freedman VA. 2003. A comparison of assistive technology and personal care in alleviating disability and unmet need. The Gerontologist. 43:3:335-344.
- Agree EM & Freedman VA. 2000. Incorporating assistive devices into community-based long-term care. J Aging & Health.12:3:426-450.
- Cornman JC, Freedman VA & Agree EM. 2005. Measurement of assistive device use: Implications for estimates of device use and disability in late life. The Gerontologist. 45:3:347-358.
- Freedman VA & Agree EM, Martin L & Cornman JC. 2006. Trends in use of assistive technology and personal care for late-life disability, 1992-2001. The Gerontologist. 46:1:124-127.

Given the advances in assistive technology over the last decade, it is likely that benefits have increased over the period since these studies were conducted. It would be timely to have the AIHW make a detailed analysis of the use of aids and equipment using data from recent Australian sources, notably the DACS 2009 and the HACC Annual Report 2008-09.

4. Options for broadening the funding base

The following comments address the Commission's invitation for further feedback on its assessment of the advantages and disadvantages of introducing a compulsory insurance scheme to broaden the current funding base for aged care.

These comments aim to add to the case for further consideration of alternative funding options that have been put forward in several submissions to the Commission both before and since the release of the Draft Report. These comments do not make any proposals as to what those options might be but argue that a wider range of options need to be given more serious consideration, including the development of options that are uniquely suited to Australian conditions.

Given the wide scope of the Inquiry overall, and its aims to develop a system of aged care that is more efficient, equitable, effective and sustainable, it is extremely disappointing that the only options proposed for generating additional capital funding are tinkering with the current arrangements for Accommodation Bonds, Bonds for residents admitted directly to high care, and increased Accommodation Charges for supported residents. Rather than looking to wider horizons, bonds for high care are a narrow band solution that is focused within the existing system. Rather than bringing new thinking to the field, bonds for high care are a 'back to the future' option. The estimates presented in Appendix D indicate that the changes to bonds will have a very minor impact and raise the question as to whether they amount to a worthwhile change that will make a significant contribution to the sustainability of aged care funding.

Bonds for high care: a narrow band solution

The draft report fails to show how bonds for high care meet the criteria of contributing to greater efficiency, equity, effectiveness and sustainability. Appendix D gave no details of the additional capital funding that would be generated by the expected level of bond income, or of how this capital income would flow into aged care facilities in areas where they were needed.

Additional reliance on bonds amounts to a "narrow band' solution:

1. Bonds focus on a narrow class of assets of older home owners, namely their houses. But realisation of substantial housing assets is a very inefficient and ineffective source of funding for meeting the capital cost of say a two year stay at around $30,000 (assuming the proposed daily accommodation charge of $42, approx. $15,000 p.a.).

2. Bonds draw capital from a narrow group of aged care users who do or could pay a bonds. AIHW reports that only 15,600 new admissions paid a bond in 2008-09, that is, only 25% of the total of 57,000 admissions over the year. The additional number of those admitted directly to high care who would pay under the PCs recommendations is not going to double the 15,000, and estimates in Appendix D of the Draft Report indicate minimal impacts of proposed changes to bond arrangements.

3. The additional funding from new bond payers may be less than anticipated and several factors suggest that relatively fewer of those admitted to high care will pay bonds:

- Many of those who are unable to pay bonds have already been squeezed out of low care and remain in accommodation of varying quality until they require admission to high care and will be unable to pay bonds on admission.
- Even for those who have their own homes, these homes do not always provide suitable environments for care, leaving very frail older people effectively trapped and socially isolated, and at increased risk of admission to high care because they could not gain early entry to low care.
- At the same time, more of those who can afford to pay are likely to opt for retirement villages as an alternative to low care. These individuals can prolong their stay by drawing on assisted living services, including subsidised care packages, as an alternative to low care, and so minimizing their stay in high care if it becomes necessary.
- Various arrangements are in place for rolling over capital payments made on entry to retirement villages where providers also operate RACH. This capital flow is a recycling of funds already paid to providers rather than additional funding for RACH, and draw downs and retention amounts further reduce the amounts available to flow on to residential aged care.

4. Bonds leave funding to a narrow time band at the end of the individual's life and a time of extreme stress for the individual and their family (if they have one). The great majority of residents admitted directly to high care have relatively short stays, due to their high dependency. A very high proportion are cognitively impaired and their lack competence to negotiate payment of bonds then requires costly involvement of third parties. About 30% of all admissions leave within 9 months, and those admitted directly to high care are very likely to have even shorter stays, so many will not reach the time allowed prior to a bond becoming due. Having more residents who stay in RACH for relatively short periods will increasing the costs of management of bonds and so create inefficiencies.

5. Additional funds from high care bonds will flow disproportionately to a narrow band of providers. The biggest winners will be private sector providers who are over-represented in the delivery of high care, and especially providers who offer high care only, so only a narrow band of new provision will be fostered. Channelling additional capital to small providers is likely to run counter to the restructuring that has occurred over the last decade as many small providers have exited the industry and may prop up inefficient operators.

6. There are also questions as to how likely providers of high care only are to invest in areas of lower socio-economic status that are under-provided, so issues of uneven geographic provision will remain. It is highly unlikely that private providers who have opted for Extra Services provision will embrace provision for supported residents even with additional funding for accommodation. Provision for these residents will be pushed on to a narrower band of providers, and especially public sector providers in rural and remote areas.

7. The experience in low care is that access is very limited for those who cannot pay a bond, and this experience is likely to flow on to high care, so that those who cannot pay a bond will be squeezed out. As a much higher proportion of those admitted to high care are admitted directly from acute care, there is a potentially significant problem of those waiting for high care backing up in acute hospitals. Those needing permanent high care

are not appropriate for transition care, and any move to use transition care beds to deal with such a back up will simply preclude transition care beds from performing their proper function in the aged care system.

8. Bonds for high care will do nothing to increase the flow of funds into aged care in general, and especially will not alleviate the burden on taxpayers for paying for the accommodation component of residential care for those who do not pay bonds. This group is likely to grow as the picture of assets held in home ownership by older Australians is set to become less rather than more positive. The proportion of older Australians (65+) who are outright owners is not increasing and may even decline in coming decades as some who are still purchasers in late middle age fail to achieve full ownership and move to other tenures with reduced assets. The proportion in rental housing and various forms of non-private accommodation have persisted at around 25% over the last two decades. Of the 15% who are renters, around half are tenants in public housing and of the 10% in Non-Private Dwellings, only half are in Commonwealth approved RACH.

9. The language of choice of accommodation is exaggerated. No-one can choose to live in a residential aged care home as access is subject to an ACAT assessment. The options for choosing to receive equivalent levels of needed care in other forms of accommodation that offer specialised environments are very limited. And choice for most is focused on homes in their own neighbourhood. While the Australian Pensioner Bonds would address some of the current problems with bonds, many others remain, including the lack of choice for home owners who will still face little choice but to sell their home. Increasing volatility in the housing market further means that not all may be able to sell, and certainly not at a time of their choice. This forced choice falls very inequitably on a narrow group of individuals.

10. Establishing a Commonwealth-backed reverse mortgage scheme for the express purpose of providing a line of funding for residential care seems likely to be a complex process and may attract little take-up by financial institutions or older individuals. One of the conditions of existing RM schemes is that the mortgagee must live in the house, and that the mortgage is repaid when they vacate the house so that the mortgage provider is not left holding mortgages over rental property. A RM scheme designed expressly for funding residential care would in contrast involve holding mortgages over non-owner occupied housing, making the mortgagor a quasi-landlord.

Alternative approaches: A broad band solution

The Inquiry has understandably been able to make only a limited investigation of possible insurance or levy based funding schemes, but it appears to have treated the evidence it did examine somewhat lightly. Reference to the seemingly undocumented South African HASAs is largely irrelevant to Australia and would be best deleted. Several features of Singapore's health insurance and retirement income arrangements are recognised in Appendix C as making it unique and hence again of limited relevance to Australia.

In contrast, the success of the Medicare levy introduced to provide universal health insurance, and of the Superannuation Guarantee to enhance retirement incomes of the great majority of Australians, provide highly relevant precedents for a funding change aimed at securing an

equally desirable social policy goal of enhancing the sustainability of aged care funding in the face of known projected growth of the older population. These examples also illustrate how Australia has been able to develop approaches suited to its particular conditions and also to modify these measures as conditions change over time.

Further in-depth investigation is required to provide carefully considered answers to the four sets of questions set out on p. 223. To this end, the Final Report could recommend that these questions be taken up by an Aged Care Investment Group along the lines of the Disability Investment Group that undertook the extensive background work that lead to the Commission's Inquiry into the National Disability Insurance Scheme. To paraphrase the Draft Report on p. 222: *Moving to a compulsory insurance scheme (The NDIS) will be a big change from the current (disability) arrangements and would raise significant design and transitional issues.* The magnitude and complexity of these issues did not cause the Government or the Commission to resile from proposing radical changes to disability funding, and the same kind of exercise is required to consider alternative funding options for aged care.

Consideration of a broad band of options is needed to move aged care funding in general, and capital funding in particular, from reliance on the two current 'pillars' of taxpayer funding and user charges to a multi-pillar approach. The intention is not to replace the current system with entirely new arrangements, but to strengthen the system by adding a further pillar.

Further consideration of a wider range of options needs to set aged care expenditure in the context of all social expenditures associated with population ageing. The Commission's concerns with equity in aged care funding both among members of the older generation and between generations needs to be compared with the gross inequities associated with tax expenditures relating to superannuation, as addressed in the submission of Dr Spies Butcher of Macquarie University. Another area of substantial and highly inefficient and inequitable tax expenditures is the Private Health Insurance Rebate.

Notwithstanding the recent reduction in tax-favoured contributions to superannuation, these inequities are set to grow as high income individuals are able to maximise these benefits while low income workers are unable to make anything more than minimal contributions, and also bear a share of the cost of tax expenditures going to high income earners. These inequities are especially marked between men and women, and compounded when the need to sell their house may take away the only assets that many older women have while leaving the other assets of men untouched.

The Draft Report is correct in noting that the time has passed for introducing a standard contributory insurance scheme as it would not allow those who have already retired or are approaching retirement to accumulate sufficient funds to cover likely costs of aged care. The most effective option for handling the population bulge associated with the ageing of the baby boomers instead rests on drawing on the contributions that they have already made to superannuation and the subsequent earnings of their superannuation funds. These balances will peak at the time of retirement and there are strong grounds for recovering a small part of the substantial tax benefits on contributions and earnings that have added to these balances. This claw back could be made directly from superannuation fund payouts, or indirectly by a further reduction in the tax concessions on superannuation contributions, earnings and payouts, and directing the saving to aged care funding.

Developing an aged care investment fund linked to superannuation would provide a broad band approach and effectively achieve a universal funding base. It would draw on a substantial class of assets that have been supported by a range of direct policy measures, and complement the regulation of access to superannuation funds that aim to ensure that superannuation is used for its intended purpose. Options linked to superannuation would cover a broad segment of the older population and apply over a broader time span, say the first five or 10 years over which income is drawn from superannuation. Developing an aged care investment fund would further enable investment in a broader range of service provision, with a wider geographic spread.

Finally, the broader social policy benefits of a universal funding scheme need to be taken into account. At least four such benefits can be noted:

1. In terms of equity, a universal funding scheme does not step away from the principle that those who are able to afford to pay should pay; it simply changes the time and way in which they pay.
2. A broader social policy view recognises that the users of the aged care system are not only those who use services directly but that provision of aged care benefits the community much more widely. These wider social benefits include relieving carer burden and thereby reducing costs of mental health services especially, and assisting others to participate in the workforce, a major current social policy goal.
3. A scheme to which all contribute avoids the emergence of a two-tier system based on distinctions between those who rely on public funding and supposedly ‘self funded’ users who have in fact received substantial tax-payer funded benefits through other channels.
4. If individuals are to be required to pay more of the cost of their aged care in future, a universal scheme linked to superannuation provides protection against that risk, and especially the high cost risk of having to sell the family home.

5. Time frame and implementation

Australia has seen major reviews and shifts in aged care policy about every 13 years:

1. The House of Representatives Inquiry (the McLeay Inquiry) that reported in late 1982 lead to the Labour Government's Aged Care Reform Strategy, with a series of measures introduced from 1983 to 1996, a 13 year lifespan.

2. The Aged Care Act 1997 introduced some new measures as well as reformulating and formalising a number of changes that had already occurred, such as aged care packages and quality of care standards. The announcement of the Productivity Commission Inquiry in 2010 signalled that the changes generated by the Act had run their course over a 13 year life span.

3. If implementation of recommendations of the current Productivity Commission Inquiry have similar life spans, a further round of reform might be expected around 2025.

While there certainly is a need to look to the longer term, this time frame of reform cycles calls for a greater stimulus for change in the short term. Without a greater impetus early on, momentum for reform may flag and little may be achieved even over a ten year period. There have been fully 30 reports on aged care since the Hogan Review in 2004, but very little action.

The 40 year time frame of the Inquiry and the gradual start up poses a risk of being overtaken by the forces of inertia. And these forces are already evident in calls to slow down the implementation timetable set out in the Draft Report. The election timetable can also contribute to inertia.

The time frame to 2050 also covers two generation of older people – the baby boomers, and the pre-boomers. The pre-boomers seem to have been overshadowed by claims about the expectations of the boomers; there is little firm evidence as to what these expectations are, but some evidence that baby boomers are moderating their expectations in the wake of the GFC and recognising the need for measures to protect against likely future uncertainties.