Productivity Commission Submission to the Review of Pricing Arrangements in Residential Aged Care

June 2003

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Foreword

The *Review of Pricing Arrangements in Residential Aged Care* provides a timely opportunity to examine long-term financing options for the aged care sector, taking into account increased expectations about service levels and the underlying cost pressures faced by the sector.

In preparing this submission, the Commission has drawn on experience and insights from various activities in this important area of social policy. These include the Commission's public inquiry into *Nursing Home Subsidies,* a major Conference on Ageing, co-hosted with the Melbourne Institute in 1999, and previous staff research on expenditure trends and projections for long-term care.

The Commission has focused this submission on three areas of the Review's terms of reference where it considers that it can make a useful contribution. The first is an assessment of the current funding and delivery arrangements for aged care services. Second, the Commission analyses the implications of ageing, trends in disability rates and other key influences on the future demand for and cost of services. Finally, the Commission has examined the merits of a number of reform options, including broader changes needed in the long-term.

Gary Banks
Chairman
June 2003

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Abbreviations

ABS	Australian Bureau of Statistics
ACATs	Aged Care Assessment Teams
ACG	Allen Consulting Group
ACSA	Aged and Community Services Australia
AIHW	Australian Institute of Health and Welfare
ANHECA	Australian Nursing Homes and Extended Care Association
ATSI	Aboriginal and Torres Strait Islander
CHA	Catholic Health Australia
CACPs	Community Aged Care Packages
CCI	Compulsory Care Insurance
CCTs	Coordinated Care Trials
COPO	Commonwealth Own Purpose Outlays
DHA	Department of Health and Ageing
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
EP	English Proficiency
FACS	Family and Community Services
GDP	Gross Domestic Product
HACC	Home and Community Care
HIAA	Health Insurance Association of America
IPP	Innovative Pool of Places
MIAESR	Melbourne Institute of Applied Economic and Social Research
MPS	Multipurpose Services
NACA	National Aged Care Alliance
NATSEM	National Centre for Social and Economic Modelling

OECD	Organisation for Economic Co-operation and Development
OSI	Office for Seniors Interests
PC	Productivity Commission
RCS	Resident Classification Scale
SNA	Safety Net Adjustment
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
TMUI	Treasury's Measure of Underlying Inflation
UN	United Nations
VHC	Veterans' Home Care
VPCI	Voluntary Private Care Insurance

Overview

Key points

- Most aged Australians requiring care services obtain them from informal carers, often with support from publicly-funded community care programs.
- Only around 6 per cent of Australians aged 65 and over live and receive care in residential aged care facilities. However, 26 per cent of those aged 85 and over receive residential care, accounting for over 50 per cent of residential places. Residential care accounts for nearly 70 per cent of public spending on all aged care services.
- An examination of Australia's aged care system reveals several problems:
  - unduly limited access, particularly to high level residential care, dementia-specific care, community care services, and in particular parts of rural and remote Australia;
  - inequities in charges/fees between low and high level residential care and between residential and other forms of aged care services;
  - inconsistencies and inappropriate incentives in funding and delivery;
  - regulatory provisions which constrain service choices; and
  - concerns about financial sustainability.
- Increases in demand due to an ageing population are likely to be manageable over the next two decades. Anticipated increases in costs, compounded by ageing, are likely to present more significant funding challenges, under current policy settings, in the third and fourth decades of this century.
- In the short term, four areas in which the existing aged care system could be modified to improve equity, efficiency and sustainability are: pricing arrangements covering accommodation payments; mechanisms for adjusting the basic subsidy for residential care and special needs funding for smaller remote residential facilities; coordination and planning across programs, including the possibility of regional pooling; and choice in relation to extra service places.
- Broader systemic changes will be needed to secure the system's effective performance. Some of these changes would also enhance the system's longer term sustainability. These changes include:
  - unbundling residential care costs (that is accommodation, living and personal care costs) and providing targeted public subsidies for the personal care component;
  - adopting an entitlement, rather than provider-based, funding model in association with a move to unbundle residential care costs; and
  - removing the current regulatory impediment to private health insurance funds offering voluntary private residential care insurance.

Overview

The largest providers of care for the aged (persons aged 65 years and over) in Australia are family, friends, neighbours and community organisations (informal carers), and the majority of care is home-based. Currently, around 26 per cent of aged Australians use the two main government-funded community care programs — Home and Community Care (HACC) and Community Aged Care Packages (CACPs).

Publicly-funded residential care — the focus of this submission — is provided to just 6 per cent of the aged. However, this proportion increases to 26 per cent for those aged 85 and over, who account for over 50 per cent of residential places. Residential care provides a bundle of services covering accommodation (the equivalent of rent or mortgages), living (food, linen and heating/cooling) and personal care (that is, additional services associated with looking after the frail or disabled) expenses.

In 2001-02, nearly $8.5 billion, or about 1.2 per cent of Australia's GDP, was spent on aged care services. Governments accounted for about 70 per cent of this expenditure, while most of the remainder was funded from user contributions. The majority of expenditure — nearly 70 per cent — was for residential aged care. The next three largest modes of care, by cost, were carer support and informal care (about 14 per cent of the total), HACC (about 12 per cent) and CACPs (about 3 per cent).

Although there is considerable uncertainty about the future demand for, and cost of, residential aged care, under current policy settings, the ageing of Australia's population and increasing cost pressures have been estimated to increase Commonwealth expenditure on residential aged care from around 0.58 per cent of Australia's GDP in 2001-02 to 1.45 per cent by 2041-42 (Treasury 2002a).

The *Review of Pricing Arrangements in Residential Aged Care* (the Review) is timely. It provides an opportunity to reflect on the effectiveness of the current aged care system and on recent reforms aimed at improving care outcomes. It also provides an opportunity to consider options for handling emerging cost pressures, including those associated with an ageing population.

The focus of this submission

This submission focuses on three areas where the Commission considers it can make a useful contribution to the Review:

- analysing the current funding and delivery arrangements for aged care services against relevant criteria;
- analysing the implications of ageing, trends in disability rates and other key influences on the future demand for, and cost of, residential and other aged care services; and
- examining the merits of reform options which include selective changes to existing arrangements, as well as broader changes.

The Commission's report on *Nursing Home Subsidies* (PC 1999), an Ageing Conference (PC and MIAESR 1999), and a Staff Research Paper covering expenditure trends and projections for long-term aged care (Madge 2000) have previously addressed some issues in these areas.

Assessment criteria

A distinctive feature of the funding and delivery of aged care services is the extensive level of government control and regulation of supply and demand, especially for residential aged care services. A key issue for the Review, and this submission, is the performance of this regulatory system in meeting the Commonwealth Government's primary goals — the provision of accessible, affordable, appropriate and high quality care.

In its evaluation of the current system and of various reform options, the Commission has employed five commonly applied criteria — equity, efficiency, choice, quality and sustainability.

These criteria largely correspond with those proposed by the Review. However, for equity and efficiency they have been interpreted more broadly. The equity criterion has been extended to encompass the balance between public and private financing, as well as the extent of redistribution between different generations (intergenerational equity). The Commission's efficiency criterion includes allocative, technical and dynamic efficiency, whereas the Review's criterion is limited to notions of transparency and accountability, and to the effective integration and co-ordination of programs.

Assessing the current system

The Commission's analysis of the current system has identified several problems.

There are consistent reports of *access problems* with aged care services, reflecting in part, the regulatory constraints on the supply of these services. Long waiting lists for residential care are common. State governments report that a number of aged people remain in hospitals because there are insufficient residential care places, although patients receiving nursing-home-type care in public hospitals can be charged for this care after a continuous period of occupancy exceeding 35 days. And, the aged living in private homes report shortfalls in community care services. The mismatch between eligibility and availability appears more pronounced for high level residential care, dementia-specific care, and community care services, especially in certain areas of rural and remote Australia.

The current system is also characterised by a *number of inequities*. In particular, those aged people living in residential care receive subsidised support for accommodation, living and personal care expenses, whereas those living at home must meet their own accommodation costs, plus most of their living and personal care costs. Providers can collect accommodation bonds from low care residents and from those high care residents purchasing extra services, but not from high care residents receiving basic care. When residents remain in care for more than five years, bond retentions and accommodation charges can no longer be levied. With increasing dependency ratios, existing intergenerational transfers between current taxpayers (who meet most of the costs of residential aged care) and the aged, are expected to become larger.

Current funding and delivery arrangements for residential aged care services give rise to a *number of inconsistencies and inappropriate incentives,* which impair the efficiency of these services. The subsidisation of accommodation (and living) costs for those in residential care relative to those receiving community care services, has the potential to distort user choice between the various aged care services. Differences in user capital contributions encourage providers to admit residents who can afford to pay high bonds (that is, to 'cherry-pick' residents), thereby constraining the ability of some to gain access to residential care. Also, the current subsidy regime and associated Resident Classification Scale effectively penalise providers who supply services directed at improving the health and independence of their residents.

Divisions in responsibility between the various levels of government give rise to cost-shifting practices, gaps in care (such as for rehabilitation and convalescent care) and poor coordination in program administration and delivery. There are also problematic interfaces between aged care services and health and public housing

programs. Users often have difficulty gaining information and/or access, as there are at least 30 different aged care programs, each with varying access points and eligibility criteria. These system characteristics also impose high administrative costs on providers.

Recent initiatives have expanded the range of care choices available to the aged. Even so, the Commonwealth Government continues to regulate the availability and fees applying to those who wish to choose extra service places when in residential care. These regulations have the *capacity to constrain service choices*.

Adherence to the planning formula *impairs the capacity of providers to respond to changes in user demand*. With the recent shift in emphasis towards community care, those entering residential care tend to be older and frailer, and thus more likely to require high level care. However, the majority of places funded under the planning formula remain allocated notionally towards low level care.

Sustainability of the current system is also an issue. The main concerns about the financial sustainability of the existing arrangements relate to: limitations on the level of capital funding available for high care places, particularly in view of the need to meet new building standards by 2008; the appropriateness of the current subsidy indexing mechanism (in 2002, the gap between nursing wage rates in the acute care sector and the aged care sector was around 12.5 per cent); and, the viability of small rural and remote aged care homes, which face both higher operating costs and limited access to capital contributions (given the lower incomes and limited asset bases of many clients in these areas).

Over the medium to longer term, sustainability concerns centre on projected increases in demand and costs, compounded by rising user expectations about the quality of care.

The future demand and cost of residential care

There is considerable uncertainty about the future demand and cost of residential aged care. The future demand for aged care services, particularly residential care, is likely to be driven primarily by two factors: the size and structure of the aged population; and, its disability status. Other factors will modify these underlying drivers.

The demographic impact of the ‘baby boomers’ on the ageing population is projected by the ABS to peak between 2021 and 2031, when persons aged 75 or over (who account for the bulk of residential care admissions) are projected to increase from around 1.8 to 2.6 million. The peak growth in those aged 85 and over will occur a decade later.

An expected decline in disability rates amongst the aged is likely to moderate the effects of ageing. There is a high correlation between severe disability rates and the use of residential care. Some researchers consider that negligible to moderate reductions in disability rates are likely, but others consider relatively large reductions are possible. Even so, any realistic reductions in disability rates will lessen, but not overcome, the effects of ageing.

A number of other factors will also influence the ultimate demand for residential aged care. Opposing socio-demographic forces make it difficult to assess the likely impact of the future availability of family carers on the demand for places. On the other hand, in the face of rising incomes/wealth, demand for alternative living arrangements — such as retirement villages and home-support services — is likely to increase. A continuing emphasis on community care services by governments is expected to reduce pressure on low level residential care places, in particular.

While recognising the considerable uncertainty which inevitably attaches to assessments of the likely future demand for residential places, the Commission estimates that, compared to the 128 500 places used by the aged in 2001, demand in 2021 could range from a low of 161 000 places to a high of 198 000. The corresponding range for 2041 is from 232 000 to 337 000 places.

The sustainability of future funding requirements will also be influenced by cost-related factors. In this regard, the $1.75 billion (80 per cent) increase in Commonwealth Government expenditure on residential aged care between 1991-92 and 2001-02 was accounted for mainly by increases in unit costs. Recurrent costs per client are expected to continue to increase. This is driven partly by real increases in labour costs, required to address the current limited supply of nurses and constrained opportunities for improving labour productivity. A second important factor is a change in client mix, where a rising proportion of high care residents is expected to add to costs.

Additional capital expenditure will be required to build new aged care homes to meet increased demand (particularly for high level care) and to refurbish existing facilities to meet higher care standard expectations.

The Commission's demand projections suggest that increases in overall residential care use are likely to be manageable for the next two decades. However, anticipated increases in the costs of providing care, compounded by ageing, are likely to present more significant funding challenges (under current policy settings) for the aged care system in the third and fourth decades of this century. That said, the financial burden associated with funding residential care services, whether borne by taxpayers or by the aged and their families, will be influenced by GDP growth. If

Australia's GDP growth is similar to that of the last decade, it is less likely that provision of these services will be a strain.

Improving the aged care system

Over the past decade or so, Australia's aged care system has been subjected to an array of reforms which have sought to address various problems with the funding and delivery arrangements. However, there is scope for making further improvements to the system.

Changes to Australia's aged care system are needed to address several remaining problems with the current system, as well as to improve its longer term sustainability. Opportunities exist for making changes within the present funding and delivery framework, as well as for broader changes extending beyond this framework.

Making improvements within the current framework

In the short term, there are four areas in which the existing aged care system could be modified to improve equity, efficiency and sustainability. They cover:

- pricing arrangements for residential aged care;
- mechanisms for adjusting residential aged care subsidies;
- coordination and planning across aged care programs; and
- residential care choices available to the aged.

At present, there are two forms of accommodation payments for residential aged care services — accommodation bonds, with related bond retentions, for low care residents and those purchasing high care extra service places, and accommodation charges for those purchasing basic high care services. Current weaknesses in *pricing arrangements for residential care services*, and between these services and other aged care services, could be lessened by:

- extending the period for which bond retentions and accommodation charges can be levied; and
- placing accommodation payments for low and high care residents on an equal footing.

Currently, providers are only permitted to levy bond retentions or accommodation charges for a maximum period of five years. The average length of stay in residential care in 2001-02 was 26.8 months, although nearly 20 per cent of

residents stay for more than five years. If residents continue to require accommodation beyond the five year period and they can afford to make some contribution to the cost of their accommodation, the continuation of a payment would be consistent with the expenses incurred by those who receive care in their own homes. Accordingly, the Commission considers it appropriate to remove the limit on the period for which these payments can apply.

Under the existing arrangements, a resident requiring low level care typically faces higher accommodation payments than one requiring high care. This outcome is not only inequitable, it also limits funds available for the upgrade/construction of high care facilities, which are already in short supply.

There are a number of possible options for addressing this pricing anomaly. While ‘ageing in place’ (where people remain in a facility as their care needs increase) could provide a de-facto short-term solution, it would not overcome the problem as, over time, the aged are likely to enter residential care later and be frailer — that is, enter directly into high level care. Even now, over 60 per cent of all new residents enter aged care homes as recipients of high level care.

Another option would be to introduce bonds for all high care residents. This proposal was vigorously opposed in 1997. At the time, the primary concern was that, as a significant number of high care residents have only a short life expectancy, the need to finance the bond (perhaps by selling the family home) would exacerbate pressures on the family.

The recent emergence in the financial sector of equity release schemes could lessen these concerns. They could help many of the frail-aged to tap into the wealth they have amassed in their family homes, without having to sell them.

Introducing bonds for high level care assumes that they are an efficient means of sourcing capital contributions from residents. However, there appears to be little relationship between the size of existing bonds and the cost of providing accommodation for residents. Indeed, providers would appear to be cross-subsidising high care residents from the bonds provided by those requiring low level care, which are themselves inflated by the ‘scarcity premium’ created by current supply controls.

An alternative to bonds for high care residents would be to raise the cap on the high care accommodation charge, to bring it to a level equivalent to the daily or periodic value of accommodation bonds. However, a significant shortcoming would be that the amount obtained by providers in this way is unlikely to accurately reflect the costs of supplying accommodation, given that such bonds may include a scarcity premium.

The adoption of a rental charge, applied on a similar basis for high and low care places, may represent a better way of tackling the inequities and inefficiencies of the current arrangements. Such a charge would need to vary to reflect variations in capital costs by location. Even so, variable charges along these lines are unlikely to adequately address the current inequities and inefficiencies. The pricing issue is of such importance, however, that it warrants an exploration of the case for more fundamental reform. This issue is addressed later in the overview.

The *current mechanisms for adjusting residential care subsidies* suffer from a number of deficiencies. The continued use of the Commonwealth Own Purpose Outlays system for indexing the basic subsidy carries with it the risks that: providers may not remain viable; providers may attempt to cut costs by reducing the quality of care to the frail aged; and, the capacity of the aged care sector to attract and retain qualified nursing staff may be further impaired.

This submission sets out a case for the Review to examine alternative methods for indexing the basic subsidy, while retaining incentives for efficiency gains and establishing a periodic review of the industry's cost base.

The costs of providing the same level of care vary considerably across Australia, and particularly for facilities located in rural and remote areas. The special needs funding mechanism recognises these problems. The present system, involving a viability supplement and targeted capital assistance, goes some way towards providing adequate special needs funding, but there appear to be continuing problems with its sustainability.

In its *Nursing Homes Subsidies* report (PC 1999), the Commission recommended the establishment of a separate special needs funding pool as a response to these specific cost pressures. In the Commission's view, an approach based on this proposal continues to be worthy of investigation. Support would be focused on high-cost homes in rural and remote areas where demand for care is insufficient to support facilities of an efficient size, and on homes required to deliver services additional to the standard care services allowed for under the basic subsidy regime.

The *coordination and planning of aged care services* could be enhanced through the further development of existing consultation and management arrangements between Commonwealth and State governments. In particular, there is scope for fuller integration of the planning and funding frameworks, with clearer specification of interjurisdictional responsibilities.

A proposal for more extensive administrative reform involving the allocation of funds for aged care services to a single pool, rather than to the multiple and separate pools currently applying, has been advanced by a number of commentators. The

pool would be managed on a regional basis, with governments being freed to focus more strategically on the appropriate level of funding and on a national structure of user charging and eligibility. Such a system could improve responsiveness and yield a better matching of resources to local needs. Coordination and accountability for outcomes could be enhanced.

The potential merits of this proposal warrant further analysis by the Review, including the possibility of undertaking pilot projects.

At present, *consumer choice,* in terms of care options within residential facilities, is relatively limited. While operators of residential facilities can provide extra service places (offering higher standards of accommodation, food and services), the Commonwealth regulates their availability, fees and service requirements. Subject to ensuring an appropriate supply of standard care places, providers should be free to determine the number of extra service places they wish to provide, together with the nature and price of these services, in response to 'market place' demands from residents. The Commission again commends to the Review the proposals for reform in this area set out in its *Nursing Home Subsidies* report (PC 1999).

Going beyond the current framework

To effectively address some of the problems within the current system and improve its sustainability, broader systemic reforms are needed. They should address three fundamental questions:

- What to subsidise — which cost elements should be included in the cost base for establishing the extent of public subsidy to be paid for residential care services?
- What form should the subsidy take — should it be paid to providers or as an entitlement to users?
- How should public and private exposure to the risks of residential care costs be managed?

Residential aged care costs comprise a package of different components: accommodation (the equivalent of rent or mortgages); living (food, linen, heating and cooling); and, personal care costs (that is, the additional costs of being looked after due to frailty or disability). Applying different principles to these cost components would address the inequities and inconsistencies in pricing between low and high level residential care, and also between residential and community care.

Accommodation and living costs are fairly predictable and are currently met by those living in the community, including (with some exceptions), those receiving community care. The Commission considers that those persons living in residential

aged care should also be responsible for meeting these costs, with means-tested access to safety net provisions consistent with those generally applying across the community.

In contrast, many of the costs of personal care are essentially unpredictable and may be overly burdensome. Consequently, some argue for universal needs-based access to such care. However, concerns about the long-term sustainability of the aged care system may provide a case for targeting public assistance. Targeting of subsidies to those most in need improves the cost effectiveness of such assistance. One such mechanism would be higher copayments based on capacity to pay. As discussed below, these payments could be met from personal savings or private insurance.

The Commission recognises that adoption of such a reform would require resolution of a number of practical issues, such as defining and separating out the different cost components. There would also be transitional issues relating to the pace of change and appropriate income and asset tests. Notwithstanding these matters, the concept is fundamentally sound and warrants further investigation by the Review.

Currently, public subsidies for residential aged care are paid to providers. An alternative would be an entitlement system involving payments to users. An entitlement system has the potential to increase consumer choice and provider responsiveness to users, and allow the Commonwealth to withdraw from its over-regulation of bed numbers and place types. It would involve direct payments to individuals, using some combination of cash or a voucher. As currently applies to provider subsidies, payments would continue to be subject to eligibility criteria based on the level of disability.

However, consumer sovereignty has limitations when applied to the frail aged, as not all of those who act as their agents have incentives which are perfectly aligned with their principals.

In this respect, the Commission reaffirms the position taken in its *Nursing Home Subsidies* report (PC 1999), that an entitlement system involving direct payments to users is unlikely to yield significantly different outcomes to the current system of direct payments to providers. Nonetheless, should there be a move to unbundle the various components of care along the lines discussed above, the care components could be funded by way of entitlements to purchase care in a range of residential settings.

Current funding arrangements for residential care services are supported by two risk-bearing funding mechanisms — a dominant taxpayer-financed pay-as-you-go mechanism and a relatively small user charge or copayment mechanism. The taxpayer bears the full financial risks associated with the subsidy for residential care — including increases in usage rates related to population ageing and rises in unit

costs over time, while the user bears, amongst other things, the financial risk of changes in government policy relating to their contributions.

Various additional sources of funding (risk-sharing) — such as, private savings and private or compulsory insurance schemes — are used in a number of OECD countries, usually as adjuncts to publicly-funded programs. Significantly, they can supplement, rather than replace, targeted public subsidies for aged care services.

On equity grounds, there is a strong case for requiring users to bear more of the cost of some residential aged care services, particularly the accommodation and living components. The issue of sustainability also warrants closer attention given the potential longer-term projected demand for residential aged care, the rising costs for its delivery and higher expectations about the quality of care.

Individuals could opt to use their income and savings/assets to fund higher private (non-subsidised) costs of residential care, including any changes to costs arising from modifications to cost-sharing arrangements. The further development of equity release schemes could assist some frail-aged Australians to meet their care costs.

However, there is uncertainty over the need for and extent of expenditure required by individuals on future residential aged care (especially for the personal care component). Given this, there would be considerable inefficiency in every individual saving for the potential costs, if more cost-effective solutions are available.

In this context, some form of insurance would be desirable, provided it were able to spread risk cost-effectively across a broad range of individuals.

The purchase of voluntary private care insurance (VPCI) by individuals would enable those with an aversion to being exposed to aged care costs not covered by the public subsidy to take out insurance cover, including cover against the costs of using higher quality services. It has the potential, through risk pooling, to lessen the private costs of covering the risk of using aged care services, as well as to ease the pressure on public funding for these services.

Various problems, however, are likely to limit the feasibility of VPCI, including: the unpredictability of the total cost for insurers; affordability problems for consumers; differential risk ratings for males and females (who have different earnings, morbidity and mortality profiles); adverse selection; moral hazard and consumer demand limited by myopia, ignorance, a genuine lack of interest (due to other spending priorities), and uncertainty about the availability and types of future services in relation to uncertain need. International experience points to the limited effectiveness of this funding vehicle. VPCI, although currently available in a

number of different countries, including Belgium, France, Germany, Israel, Japan, UK and the USA, has a low uptake.

Overall, VPCI is unlikely to attract widespread interest. However, Australians should be given the option of taking out this form of insurance, as an alternative to precautionary savings and other forms of private insurance (such as disability insurance), to cover the possibility of incurring private costs for residential care. Accordingly, in the Commission's view, the regulatory impediment to private health insurance funds offering such cover should be removed.

A number of commentators have advocated the introduction of compulsory care insurance (CCI). Provided privately or publicly, CCI could be used to provide a broadly-based compulsory vehicle through which individuals would be required to make some financial contribution to the future costs of aged care. As such, it would lessen the intergenerational inequity associated with the current pay-as-you-go approach and avoid the significant potential adverse selection problems experienced under VPCI. If contributions to the scheme were means-tested and proportional to income, a broader cross-section of individuals would gain access to coverage, with contributions from those on higher incomes extending coverage to low income participants.

However, a CCI scheme would also present a number of problems. Key ones include: the public policy constraints of hypothecation; uncertainty about future costs of care when setting the tax or contribution rate; the moral hazard of future over-use; and, concerns about the possible creation of a two-tiered system of care, reflecting the vulnerable position of low income individuals. They also raise a wide range of design issues/questions.

While further analysis of the potential merits of CCI would seem warranted, it is not clear that such insurance would represent a significant improvement over the existing pay-as-you-go tax-financed and user copayment mechanisms.

1 Introduction

Australia's population, like that of most other industrialised countries, is ageing. Because of this, the past few years have seen a growing interest in, and recognition of, the importance of ageing policy. As the Commonwealth Department of Health and Ageing, in its submission to the House of Representatives Standing Committee on Ageing (DHA 2003d, p. 15), recently said:

> Ageing policy has been evolving over the last few years from being primarily a matter of interest to a few program delivery departments, to the realisation that the profound demographic changes over the next four decades will have significant social and economic implications potentially affecting all areas and levels of government.
>
> Long term strategies to address issues related to population ageing need to be viewed and developed in this broader context… .

One of the challenges associated with ageing that has become increasingly important is the financing and delivery of aged care services. As the OECD, in a report examining the evolution of policies for caring for frail elderly people (OECD 1996, p. 3), said:

> All industrial countries are experiencing demographic ageing, with considerable consequences for public policy. As the numbers in the oldest age groups grow, the level of resources devoted to the care of frail elderly people rises dramatically. Consequently, long-term care policy has assumed a far higher profile in recent years in OECD countries.

The effective provision of aged care services is important not only for those receiving aged care, but also for those individuals providing informal care and arranging care for ageing family members, and for the taxpayers contributing to the funding of such care.

In 2001-02, the Commonwealth Government spent around $4.9 billion on aged care. The *Intergenerational Report* (Treasury 2002a) estimates that, under current policy settings, Commonwealth expenditure on residential aged care alone will increase from around 0.58 per cent of Australia's gross domestic product (GDP) in 2001-02 ($4 billion) to 1.45 per cent by 2041-42. The report claims that spending on health and aged care will account for much of the projected rise in overall Commonwealth Government spending over the next four decades.

There are, however, differing views about the implications of an ageing population for the cost and delivery of aged care services. Some commentators question the willingness and ability of younger generations to support the aged at current levels of expenditure (see, for example: Beck 1996; McCallum et al. 1998). Others are of the view that the problems are overstated (see, for example: Creddy 1999; Allen Consulting Group 2002).

While accurately estimating the future costs of aged care is fraught with problems, as stated in the *Intergenerational Report* (Treasury 2002a, p. 1):

> … forward planning … is important, to ensure that governments will be well placed to meet emerging policy challenges in a timely and effective manner. By maintaining sustainable government finances, the Government avoids compromising the wellbeing of future generations by the activities of the current generation.

The performance of Australia's current aged care system is also a key issue. Submissions to the *House of Representatives Standing Committee on Ageing: Inquiry into Long-Term Strategies to Address the Ageing of the Australian Population over the Next 40 Years*, have documented many problems with our current aged care system and offered suggestions which could result in significant improvements.

1.1 The review of pricing arrangements in residential aged care

As part of the 2002-03 Budget, the Commonwealth Government provided additional funding for subsidies to residential aged care facilities, pending a *Review of Pricing Arrangements in Residential Aged Care* to be conducted in consultation with the industry and consumers.

When announcing the Review in September 2002, the Minister for Ageing, Kevin Andrews MP, flagged that it would examine long-term financing options for the aged care sector, taking into account the improved care outcomes required from providers and the underlying cost pressures faced by the sector (Andrews 2002).

The Review is required to report to the Minister by the end of 2003. It will make recommendations on:

- the appropriate future public and private funding arrangements, including appropriate future indexation arrangements for the industry;
- possibilities for performance improvement in the industry, including the appropriate use of performance indicators; and
- long-term financing of the aged care industry.

1.2 The Commission's submission

This submission to the Review does not seek to address all of the matters covered in its terms of reference. Rather, the Commission has been deliberately selective, choosing to focus on three areas where it believes it can make a useful contribution. Accordingly, the submission focuses on:

- analysing the current funding and delivery arrangements for aged care services using the Commission's criteria-driven analytic framework;
- analysing the implications of ageing, trends in disability rates and other key influences on the future demand for, and cost of, residential and other aged care services; and
- examining the merits of reform options, including selective changes to existing arrangements, as well as broader changes.

As such, the submission seeks to build on past work undertaken by the Commission, notably through its inquiry into *Nursing Home Subsidies* (PC 1999), an Ageing Conference which examined the policy implications of the ageing of Australia's population (PC and MIAESR 1999) and the staff research paper covering *Long-Term Aged Care: Expenditure Trends and Projections* (Madge 2000). The Commission also reports annually on the performance of aged care services through the *Report on Government Services* (see, for example, SCRCSSP 2003).

The submission comprises a further six chapters:

- chapter 2 provides a broad snapshot of those structures and types of services provided by the aged care sector that are relevant to this submission;
- chapter 3 profiles relevant current funding and regulatory arrangements applying to aged care services and, in particular, residential aged care services;
- chapter 4 develops the Commission's set of criteria for assessing funding and delivery arrangements for aged care services;
- chapter 5 assesses the current funding and delivery framework against these criteria and identifies several important weaknesses;
- chapter 6 discusses future challenges in handling aged care services, particularly residential aged care services, in the context of reviewing the main drivers of long-term demand and costs for these services; and
- chapter 7 outlines and discusses various options for addressing weaknesses with the existing system and thereby improving the funding and delivery framework.

Reflecting the nature of the Review, much of the submission focuses on issues relevant to the provision of residential aged care services. However, given important

interdependencies between the services provided by this and other parts of the sector, as well as between the aged care sector and other sectors, the submission also addresses some wider issues. Some discussion of these interdependencies and their importance is presented in the next section.

1.3 Key terms and the interdependencies between aged care services

As a backdrop to the remainder of this submission, it is useful to clarify the meaning of some key terms — such as, 'the aged' and 'aged care services' — and to recognise several important interdependencies between different types of aged care services.

Typically, 'the aged' are defined as those persons aged 65 years or more. However, people included in this population grouping are far from homogenous. For example, significant differences in living arrangements, lifestyles, family circumstances, cultural and social practices, and health status exist amongst the aged. Reflecting these differences, there are important variations in the needs of the aged and in their use of aged care services.

Therefore, from a policy perspective, it is useful to distinguish between different age groups amongst the aged when assessing arrangements for residential aged care services. In this submission, a distinction is sometimes drawn between three sub-sets of the aged: those aged 65–74 years, those aged 75–84 years and, those aged 85 years and over.

For the purposes of this submission, the term 'aged care services' is taken to include three distinct care modes:

- informal care of the aged by family, friends, neighbours and community groups;
- community care, which is provided mainly in the care recipient's own home; and
- residential care for the aged.

There are various important interdependencies between these care modes, as well as with other aspects of the health and welfare systems. For example, inadequate provision of community care services to supplement informal carer services may result in persons being admitted unnecessarily to higher cost residential care services. Similarly, inadequate provision of residential care services may result in people being admitted unnecessarily to, or retained in, even higher cost acute (hospital) care. There is also scope for substitution between the different care

modes. For example, some community care programs provide care equivalent to low or high care services provided in residential facilities. Consequently, decisions about the level of funding and resourcing of such programs, as well as the setting of admission/eligibility criteria, can affect the demand for residential care places (and vice versa). Reflecting these interdependencies, where relevant, the submission addresses some wider issues extending beyond the residential aged care mode.

2 The aged care industry — a snapshot

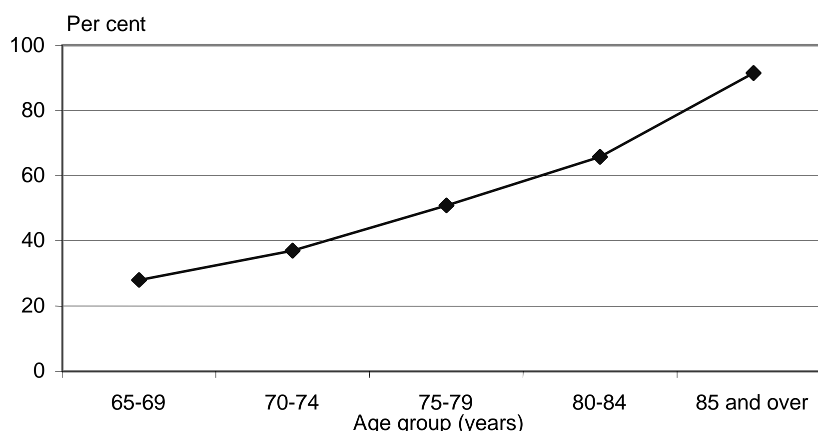
This chapter's overview of services and providers serves as a basis for the Commission's analysis of the aged care industry in later chapters. Reflecting the scope of the Review, the focus is on government regulated and subsidised services.

2.1 Aged care — what does it cover?

Almost half of all aged Australians — around 46 per cent — require assistance with everyday activities. Most of this assistance is provided by family or friends. On Census night 2001, of the 2.4 million aged people in Australia, 92 per cent were living in private homes, including retirement villages. Just 6 per cent were living in registered — that is, government subsidised and regulated — aged care homes. The remaining 2 per cent were accommodated within the unregulated private sector.

The aged's need for assistance increases with age. For example, only 32 per cent of those aged 65 to 74 years require some form of assistance, compared with around 92 per cent of people aged 85 years or more (figure 2.1).

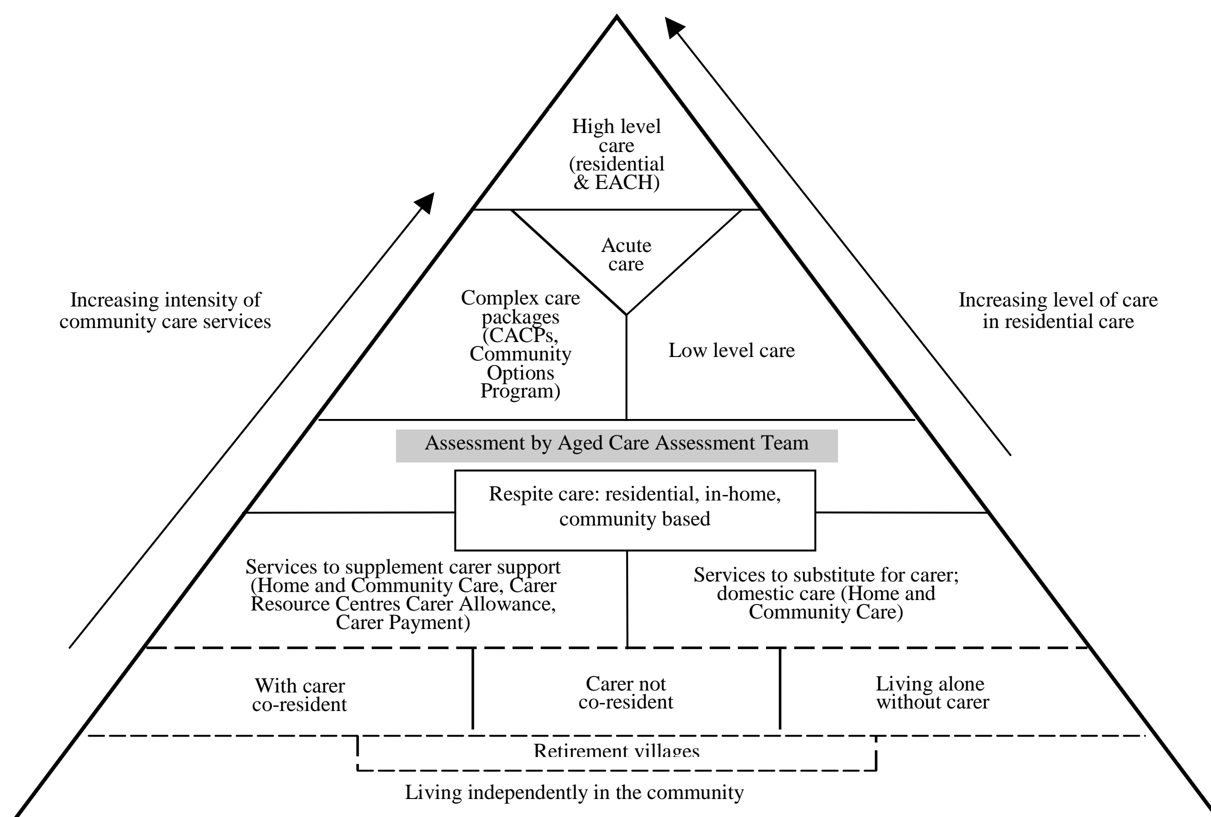
Figure 2.1 **Need for assistance, by age, 1998**



Data source: ABS (1999a).

The aged care service continuum is shown in figure 2.2. The closer the service is to the top of the triangle, the greater the level of care required and hence, the more resource intensive it tends to be.

Figure 2.2 **Modes of care in the aged care system**



Source: Adapted from Bishop (2000).

Most aged care services are provided by two sectors[1]:

- an *informal* sector, where care is provided at no cost to the aged by family, friends, neighbours and some community organisations[2]; and
- a *formal* sector, where at least some payment is required for services to be supplied.

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[1] Assistance to the aged also includes services provided by various agencies which are not funded or regulated by the Commonwealth Government. The Supported Residential Services system within Victoria, which has some 7000 beds (McCallum and Mundy 2002), provides care roughly equivalent to the Commonwealth-funded ‘low level care’ service. Similar services exist in most States and cover both the luxury and more basic service ends of the market. However, little is known about the size, make-up and operation of the unregulated sector and it is not covered in this chapter.

[2] The Commonwealth Government supports the contribution of informal carers by way of financial payments and the provision of respite care for the aged persons in their care (see box 2.1).

2.2 The informal sector

Extended family and friends are the main providers of in-home support or assistance for the aged in Australia. According to the latest ABS Survey of Disability, Ageing and Carers (ABS 1999a)[3], of those aged Australians living in the community and receiving assistance, 83 per cent received assistance from informal care providers and 59 per cent from formal care providers. Forty three per cent received assistance from both informal and formal sources (table 2.1).

Table 2.1 **People aged 65 and older living in households and receiving assistance, activities by provider type, 1998**
Per cent

	Personal activities			*Activities to maintain living at home*						
Provider type	*Self-care*	*Mobility*	*Commu-nication*	*Health care*	*Trans-port*	*Paper-work*	*House-work*	*Property mainten-ance*	*Meals*	*Any activity*
Informal providers										
Female partner	33	20	38	19	10	26	15	11	24	17
Male partner	24	18	12	8	16	14	22	16	18	18
Daughter	28	33	45	14	33	36	23	13	28	26
Son	5	15	7	5	16	13	10	20	8	20
Other[a]	9	34	25	6	37	16	12	26	12	40
Totals	*90*	*95*	*100*	*49*	*93*	*97*	*73*	*71*	*83*	*83*
Formal providers										
	25	*20*	*np*	*67*	*16*	*8*	*46*	*48*	*28*	*59*
Both informal and formal providers										
	15	*15*	*-*	*16*	*9*	*5*	*19*	*19*	*11*	*43*

a 'Other' informal provider includes other female relative, other male relative, female friend and male friend. **np** Not available for publication, but included in total where applicable.

Source: ABS (1999a).

Most informal assistance is for self care, mobility, communications, transport, paperwork and meal preparation. Only in the area of health care do formal carers provide a larger proportion of support than informal carers (table 2.1), although formal carers also play significant roles in property maintenance and housework.

In 1998, around 125 000 primary carers provided informal care to people aged 65 years and over. Nearly half of these primary carers spent 40 hours or more each week providing care. The majority of primary carers were women (predominantly

[3] The next ABS Survey of Disability, Ageing and Carers is not expected to be available until 2004.

female partners and daughters), and most carers were over 65 years of age. The likely impacts on the informal care sector of rising workforce participation rates of females and the higher expected wealth of the aged are examined in chapter 6.

Government support is provided to carers by way of respite services for their aged 'client' and through carer-specific payments and allowances (see box 2.1 and chapter 3). This support recognises the contribution made by informal carers. It also influences the ongoing feasibility of providing informal care and thereby affects demand for formal modes of aged care, particularly residential services.

Box 2.1 **Support for carers**

Respite care involves the provision of residential and other care services for people in need of such care, but who intend to return to the community. It gives frail older people and their carers a break from their usual care arrangements. The Commonwealth Government provides respite support to frail older people and their carers through the Residential Respite Care and National Respite for Carers programs.

Residential respite provides short-term care in aged care homes. It may be used on a planned or emergency basis to help with carer stress, illness, holidays or the unavailability of the carer for any reason. Admissions to residential respite care were estimated to be around 44 500 persons in 2001-02.

Under the National Respite for Carers Program, Commonwealth Carer Respite Centres and Carer Resource Centres have been established which provide carers with information, support and assistance in finding respite services in their local areas. The Commonwealth Government also funds, through the National Respite for Carers Program, some 400 respite services targeted at carers.

Community-based respite care is also available. It includes a range of services such as day care centres, in-home respite, activity programs and flexible residential respite in community-based facilities. Respite care in the community is largely provided through the Home and Community Care Program and Community Aged Care Packages.

Carers also receive direct financial support through the Carer Payment and Carer Allowance schemes. The Carer Payment is an income support payment for carers who, because of the demands of their caring role (performed in the disabled person's home), are unable to support themselves through full participation in the workforce. The Carer Allowance is a payment available for people providing daily care and attention (in their own homes) to a person with a substantial disability. The allowance may be paid on top of the carer payment (see chapter 3 for funding details).

Sources: AIHW (2002a); DHA (2002).

2.3 The formal sector

There are two components to the provision of formal aged care services:

- accommodation services; and
- care and support, ranging from basic services, such as delivered meals, to complex specialist medical services.

The two components are often bundled together, as for residential aged care. They can also be funded separately but provided together — such as the provision of general practitioner services in aged care homes — or provided separately, as for the aged living in their own homes but accessing community care services.

Access to and the provision of most of these services — particularly those for residential care — are subject to extensive government regulation. For example, eligibility for subsidised residential services is determined by Commonwealth Government-sponsored aged care assessment teams, on the basis of an objective assessment of need. The extent of subsidy provided is related to the assessed need of applicants and their financial circumstances. As this submission assesses the funding and regulatory arrangements relating to these services, they are examined in some detail in chapter 3.

Community care services

Currently, around 26 per cent of aged Australians use the two main government-funded community aged care programs — Home and Community Care (HACC) and Community Aged Care Packages (CACPs). These programs provide care to the aged in their own (or carer's) homes or in community facilities.

The HACC is a joint Commonwealth/State program administered under the *Home and Community Care Act 1985*. The program provides services to people with disabilities who can be appropriately cared for at home. Services provided include home nursing, personal care, home and centre-based respite care, domestic help and maintenance services, delivered meals, transport and shopping assistance, and paramedical services.

In 2001-02, about 2900 organisations provided services under the HACC to just over 583 000 clients (table 2.2). While the aged are not the only clients of HACC, they make up the majority (around 75 per cent) of those receiving HACC services. Around two-thirds of HACC clients are female.

The majority of HACC services are provided by the 'not-for-profit' sector (SCRCSSP 2003). A number of these community, religious and charitable

organisations claim they are under financial stress and that there is significant unmet demand for the services (see chapter 5).

Table 2.2 **HACC client characteristics, 2001-02**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total HACC clients	*140 240*	*167 753*	*111 272*	*48 241*	*70 276*	*16 704*	*12 985*	*3 182*	*583 156*
HACC clients by age	%	%	%	%	%	%	%	%	%
Under 50 years	10.0	12.5	9.8	11.0	13.3	11.0	21.7	22.8	11.6
50 to 70 years	16.0	18.9	18.0	19.5	20.0	20.8	25.6	37.6	18.6
70 years and over	74.0	68.6	72.2	69.5	66.7	68.2	52.7	39.6	69.8
HACC clients by gender									
Male	31.2	33.8	36.1	32.8	34.7	33.1	35.9	42.6	33.8
Female	68.8	66.2	63.9	67.2	65.3	66.9	64.1	57.4	66.2
Indigenous clients as a proportion of all clients									
Indigenous males	6.7	1.3	3.7	4.7	1.6	1.2	0.7	40.8	3.8
Indigenous females	7.4	1.0	3.0	3.5	1.3	1.1	0.6	45.2	3.6
Total Indigenous	*7.2*	*1.1*	*3.2*	*3.9*	*1.4*	*1.1*	*0.6*	*43.5*	*3.7*

Source: SCRCSSP (2003).

CACPs, which were introduced in 1992, provide individually tailored packages of more intensive support for aged persons who prefer to remain at home, but who require care equivalent to low level care provided in an aged care home. The cost to the Commonwealth Government of providing low level care services via CACPs is estimated to be $30 per client per day, compared to $100 per client per day for a low level care client in subsidised accommodation (Fitzgerald 2002). In 2001, CACPs were used mainly by the 75 to 84 age group and predominantly by females (see table 2.3).

Table 2.3 **CACP recipients by age and sex, 30 June 2001**

Age	*Female*		*Male*		*Persons*	
	No.	*%*	*No.*	*%*	*No.*	*%*
< 65 years	757	*5.2*	609	*9.9*	1 366	*6.6*
65 – 74 years	2 097	*14.4*	1 127	*18.4*	3 224	*15.6*
75 – 84 years	6 305	*43.2*	2 391	*39.0*	8 696	*41.9*
≥ 85 years	5 443	*37.3*	1 999	*32.7*	7 442	*35.9*
Totals	*14 602*	*100.0*	*6 126*	*100.0*	*20 728*	*100.0*

Source: AIHW (2002d).

In 2002, 900 organisations provided more than 26 000 CACPs to around 1.5 per cent of aged Australians. Some 44 per cent of the packages were provided by community-based organisations, 38 per cent by religious or charitable outlets, 12 per cent by State or local governments, and 6 per cent by the private sector (SCRCSSP 2003).

The Department of Veterans' Affairs also provides a range of community care services for the veteran community through the Veterans' Home Care (VHC) program. Services available under this program include community nursing, in-home and residential respite care, allied health services, home modifications and transport for health care, domestic assistance, personal care, garden and home maintenance, care coordination, and delivered meals. In 2001-02, more than 56 000 veterans were approved to receive VHC services (SCRCSSP 2003).

Flexible care

Flexible care addresses the needs of the elderly in alternative ways to the care provided through residential and community care. There are three main types of flexible care arrangements — Extended Aged Care at Home (EACH) packages, Multipurpose Services and Innovative Care places.

The EACH program is a pilot program set up to test the feasibility of providing 'high level care' to the aged in their own homes. Currently, the program offers care packages to 290 clients at ten sites across Australia (DHA 2002). An evaluation of the program has demonstrated that many frail aged people who would otherwise have needed high level residential care, can be successfully and cost-effectively maintained in their own home (DHA 2002). As a result, 160 new EACH packages have been funded for 2002-03 as direct substitutes for residential aged care places. Issues surrounding cost-effective substitutes for residential care are discussed further in chapter 5.

The Multipurpose Services (MPS) program is a joint Commonwealth, state and territory initiative designed to deliver a mix of mainstream care services to rural and remote communities, many of which cannot sustain the delivery of individual services. They provide for economies of scope — bringing together a range of health and aged care programs — where services may not be viable individually. In 2001-02, some 1391 places and packages were allocated to 65 providers across Australia. Many of the remote communities in the Northern Territory served by an MPS program are Aboriginal communities receiving funds under the Aboriginal and Torres Strait Islander Aged Care Strategy (specifically, the ATSI Flexible Care program). Chapter 5 also examines the equitable and efficient provision of appropriate aged care in rural and remote areas of Australia.

The Aged Care Innovative Pool, established in 2001-02, is a national pool of flexible care places designed to facilitate pilot testing of innovative service provision. Currently, a total of 382 places have been allocated to 12 pilot projects. Two examples are:

- Innovative Care (Rehabilitation) Service pilots — testing a range of delivery models designed to meet the needs of aged Australians who have completed a hospital stay but are not yet ready to return home; and
- Innovative Care (Dementia) Service pilots — focusing on supporting people with dementia to stay at home as long as possible.

Residential care services

Residential aged care is available for aged people with physical, medical, psychological or social care needs which are not met in the community. There are two main types of residential care in Australia — low level care and high level care. Low level care includes the provision of suitable accommodation and related services (such as cleaning, laundry and meals), as well as personal care services (such as help with dressing, eating and toileting). High level care includes accommodation and related services, personal care services and nursing care and equipment. Under the Resident Classification Scale (RCS), a person requiring 'high level care' is rated RCS 1 to RCS 4, while a person requiring 'low level care' is rated RCS 5 to RCS 8.

At 30 June 2002, almost two-thirds of all residents in aged care homes were classified as 'high care' (table 2.4). Over the three years since 1999, this proportion has grown by only 3.8 per ent. The most significant changes in the make-up of users over this period have been in the lowest and highest care categories, where the proportions of residents classified RCS 8 and RCS 7 have fallen by 52 per cent and 18 per cent respectively, while the proportion of RCS 1 residents has increased by 36 per cent. The proportion of residents in the RCS 5 category — that is, those low care residents requiring the highest level of care — has also increased significantly, by 19 per cent over the last four years (table 2.4).

Table 2.4 **Proportion of residents in each Residential Classification Scale (RCS) category, June 1999 to June 2002**

Per cent

RCS category	*June 1999*	*June 2000*	*June 2001*	*June 2002*	*Change 1999 to 2002*
RCS 1	14.2	17.2	18.8	19.3	35.9
RCS 2	25.7	25.4	25.1	24.9	-3.1
RCS 3	16.5	15.4	14.7	14.5	-12.1
RCS 4	4.6	4.6	4.6	4.6	0.0
High care	***61.0***	***62.6***	***63.2***	***63.3***	***3.8***
RCS 5	8.8	9.8	10.5	10.5	19.3
RCS 6	10.2	10.5	10.8	10.8	5.9
RCS 7	16.9	14.9	13.9	13.8	-18.3
RCS 8	3.1	2.2	1.6	1.5	-51.6
Low care	***39.0***	***37.4***	***36.8***	***36.7***	***-5.9***

Source: DHA (2003b).

Currently, about 64 per cent of high care residents enter from hospital, 26 per cent from low care places and 10 per cent direct from the community. For low care residents, about 30 per cent enter from hospital and the remainder direct from the community (DHA 2002).

'Ageing in place' was one of the specified objectives under the Commonwealth's *Aged Care Act 1997*, whereby residential service providers are able to offer the full range of care within the one facility, enabling residents to remain in place as their care needs increase. Previously, residents were required to move from hostel care to a nursing home as their dependency increased. The success of this policy is evidenced by the recent growth in 'mixed care facilities' — that is, establishments with less than 80 per cent high care residents and more than 20 per cent low care residents.

A profile of older Australians in residential care is provided in box 2.2.

Box 2.2 **A profile of residential care users**

- At 30 June 2002, there were 136 587 permanent residents and 2 435 respite residents in subsidised aged care homes — about 6 per cent of all aged Australians.
- The majority (around 85 per cent) of permanent residents are aged 75 years or over. Around 10 per cent of residents are aged between 65 and 74 years.
- More than 70 per cent of permanent residents are female.
- Around two-thirds of residents are widowed at the time they enter residential care (29 per cent of men and 71 per cent of women).
- At 30 June 2002, nearly one half of all new residents were 'concessional' or 'assisted' residents.
- In 1999-2000, at birth, the probability of someone entering a residential care facility was around 24 per cent for men and 42 per cent for women. This probability rises with age — at age 75 it is one in three for men and one in two for women.
- In 2001-02, the average length of stay for permanent residents was 26.8 months; up 1.6 per cent a year over the last three years. The distribution of lengths of stay has also changed, with fewer permanent residents staying for very short periods and more staying for longer periods (more than two years). More than 80 per cent of permanent resident separations are due to death.
- At 30 June 2002, 63 per cent of residents were classified as requiring high level care (RCS 1–4). Of these, nearly 70 per cent were in the highest care categories (RCS 1–2). Just over one-third of all residents required low level care, with residents classified as having the lowest level of care needs (RCS 8) accounting for less than 2 per cent of residents.

Sources: AIHW (2002b,d); DHA (2002, 2003a); SCRCSSP (2003).

Provision of residential care

At 30 June 2002, there were 1338 accredited providers operating almost 3000 residential care facilities. There is no readily available data on the number of private non-accredited/non-subsidised aged care facilities operating in Australia — establishments which cater mainly for those who can afford to pay the total cost of their aged care requirements (that is, those who would otherwise fail the income and/or assets tests for subsidised care).

Residential aged care providers include religious, charitable and community institutions (all 'not for profit' providers), a wide variety of private 'for profit' providers, and State and local governments. The majority — nearly two-thirds of all residential aged care services — are provided by the not-for-profit sector. About a quarter are provided by the private for-profit sector and about 10 per cent by governments.

There is considerable variation between high and low care residential facilities. High level care places are dominated by the private for-profit sector, which has nearly half of the beds, followed by some 40 per cent in the not-for-profit sector and the remainder with State governments. Low level care places are dominated by the not-for-profit sector, which has around 90 per cent of places in these facilities, while State governments and the for-profit sector each account for some 5 per cent of places.

The location and size of aged care homes affects the range of services provided and their costs. They also raise issues such as equity of access, quality of service and viability of operation, which are discussed further in chapter 5.

In terms of location, around 72 per cent of residential care places are in metropolitan areas, 27 per cent in rural locations and 1 per cent in remote areas (as defined by various classifications systems for 'remoteness'). However, there is considerable variation between the States and Territories. For instance, in Tasmania, 54 per cent of residential places are located in rural areas, while in the Northern Territory, nearly 50 per cent are located in remote areas (table 2.5).

Table 2.5 **Size and distribution of residential aged care services by State and Territory, June 2002[a,b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Residential facilities (No.)	933	831	500	267	295	99	23	14	2 962
Places (No.)	50 730	35 681	26 330	12 111	13 557	3 855	1 495	380	144 139
Occupancy rate (%)	96.4	95.2	96.3	94.9	98.0	97.7	96.5	92.4	96.1
Places by locality (%)									
Metropolitan areas	74.8	72.9	60.0	80.4	79.4	45.2	100.0	50.3	71.9
Rural areas	24.7	27.1	37.0	16.0	20.6	54.3	-	-	26.9
Remote areas	0.5	-	3.1	3.6	-	0.6	-	49.7	1.2
Service size (%)									
1-20 places	8.8	12.0	9.6	13.5	8.8	22.2	4.3	50.0	10.9
21-40 places	30.0	44.8	33.8	33.3	41.7	37.4	13.0	21.4	36.3
41-60 places	29.3	30.7	28.6	33.3	31.2	25.3	21.7	28.6	29.9
61+ places	31.9	12.5	28.0	19.9	18.3	15.2	60.9	-	22.9

a The occupancy rate is defined as the number of residents in care as a proportion of available places. **b** Excludes Multi-Purpose Services and flexibly funded services.

Source: SCRCSSP (2003).

In terms of size of operation, only 11 per cent of aged care homes have less than 20 residents, while 36 per cent have 21 to 40 residents, 30 per cent from 41 to 60 residents and 23 per cent have greater than 61 residents. Again, there is much variation between the States and Territories, with the main outliers being the ACT,

where 61 per cent are large facilities with more than 60 residents, and the Northern Territory, where around 50 per cent are small facilities with less than 20 residents (table 2.5).

The most recent ABS survey found that, in June 2000, residential aged care providers employed around 131 200 persons, assisted by around 32 600 volunteers (almost all of whom provided services to not-for-profit facilities) (table 2.6). Some 88 per cent of employees were involved in direct community services provision (that is, in providing nursing and personal care services). Nearly 80 per cent of employees were employed on a part-time basis.

Table 2.6 **Employment in the residential aged care industry, by 'for-profit' and 'not-for-profit' providers, 1995-96 and 1999-2000**

	For-profit		*Not-for-profit*		*Totals*	
	1995-96	1999-2000	1995-96	1999-2000	1995-96	1999-2000
Employees						
Direct community services provision	39 139	34 137	52 861	76 730	92 000	110 867
Contract	na	1 313	na	2 996	na	4 309
Other	11 171	2 432	29 143	13 622	40 314	16 054
Total	*50 310*	*37 882*	*82 004*	*93 348*	*132 314*	*131 230*
Volunteers						
Direct community services provision	657	603	10 537	22 325	11 194	22 928
Other	623	91	22 444	9 609	23 067	9 700
Total	*1 280*	*694*	*32 982*	*31 934*	*34 262*	*32 628*

Source: ABS (2000a).

As shown in table 2.6, there was significant restructuring of the industry's workforce between 1995-96 and 1999-2000. Over this period, employment in the for-profit sector contracted by 25 per cent. At the same time, the not-for-profit workforce grew by 14 per cent, but with a much greater emphasis on employment in direct community services provision, at the expense of managerial, administrative and other care support staff.

The next chapter examines funding and regulatory arrangements for aged care.

3 Current funding and regulatory arrangements

There is considerable diversity in the funding and regulatory arrangements for aged care in Australia, particularly with regard to:

- the type of care provided (residential care, community care, flexible care or carer support);
- funding sources (public, private and a mix of the two);
- the extent of government subsidy and user contributions;
- how capital requirements are met; and
- the nature and extent of regulations applying to the different types of care provided.

These arrangements are made more complex by the wide range of care programs and the differing characteristics of care recipients (particularly their dependency levels and socio-economic circumstances), as well as through the various regulatory arrangements determining access to, quality of and pricing/charging regimes for, aged care services.

As a basis for analysing the performance of the current aged care system in chapter 5, this chapter outlines the main features of the current funding and delivery arrangements for each of the key aged care services (sections 3.1 to 3.5). It also reviews the regulatory arrangements applying to subsidised aged care services (section 3.6) and examines recent trends in expenditure for these services (section 3.7).

3.1 A profile of aged care funding

The subsidised aged care system in Australia is funded from a number of sources — Commonwealth, State, Territory and local governments, user contributions and charitable donations. Overall expenditure on aged care services was around $8.5 billion in 2001-02, or about 1.2 per cent of GDP (table 3.1). Government sources accounted for slightly more than 70 per cent, with user contributions and charitable donations accounting for the remainder. The majority of expenditure —

nearly 70 per cent — was for residential aged care. The next three largest modes of care in terms of total expenditure were: payments and allowances to informal carers, respite care and informal care (about 14 per cent of the total); HACC (about 12 per cent); and, CACPs (about 3 per cent).

Table 3.1 **Expenditure on aged care in Australia, 2001-02**

Care mode	*Government*[a]	*Non-government*	*Total expenditure*	*Care mode expenditure to total expenditure*	*Total as a proportion of GDP*[b]
	$m	$m	$m	%	%
Assessment services	42.0	–	42.0	0.50	–
Residential Aged Care[c]	3 997.4	1 800.0	5 797.4	68.31	0.83
Home and Community Care[d]	1 012.4	25.0	1 037.4	12.22	0.15
Community Aged Care Packages	246.0	40.0	286.0	3.37	0.04
Other community care[e]	96.2	4.8	101.0	1.19	0.02
Flexible Care[f]	37.2	0.5	37.7	0.44	–
Respite Care[g]	152.6	23.1	175.7	2.07	0.03
Carer Payment and Allowances[h]	560.0	–	560.0	6.60	0.08
Informal care	–	450.0	450.0	5.30	0.07
Totals	*6 143.8*	*2 343.4*	*8 487.2*	*100.00*	*1.22*

a Where applicable, and to the extent possible, estimates are for total Commonwealth, State, Territory and local government expenditure. **b** Gross Domestic Product (GDP) was $698 billion in 2001-02. **c** Residential aged care data includes expenditure on persons less than 65 years of age, who accounted for 5.6 per cent of residents in aged care homes in 2001-02. **d** Estimated aged care share of total government HACC expenditure. **e** Includes Veterans Home Care, Day Therapy Centres, Care Package Establishment Grants, Safe at Home and Assistance with Care and Housing for the Aged Care programs. **f** Data does not include funding for Aboriginal and Torres Strait Islander Flexible Aged Care Services. **g** Data includes funding for residential and community respite care, and respite carer information services. **h** About 45 per cent of total carer payments and allowances are paid to carers looking after the aged. **–** Nil or less than 0.01 per cent.

Sources: AIHW (2002a); Commonwealth of Australia (2002); DHA (2003b); Productivity Commission estimates.

The Commonwealth is the largest provider of funds. In 2001-02, it provided around $5.5 billion, or about 65 per cent of total funds. While non-government sources of funding involve some sizeable absolute contributions (notably for residential aged care, informal care, CACPs and HACC), they are a relatively small source of funds for most aged care services.

Comparing expenditure on aged care services across OECD member countries is hampered by a lack of comparable data. To the limited extent possible, the latest available data (Jacobzone, Cambois and Robine 2000) suggest that Australia's total expenditure on aged care services as a percentage of GDP in the mid-90s was less than for most OECD member countries. Of those countries listed in table 3.2, only Canada and Finland spent a GDP proportion similar to Australia. The remainder

spent higher proportions, with the 'welfare states' of Norway and Sweden, together with the Netherlands, spending considerably more in proportionate terms. Other less industrialised OECD countries, such as Greece (0.17 per cent), Portugal (0.39 per cent) and Spain (0.56 per cent), spent proportionately less (Jacobzone, Cambois and Robine 2000, p. 171).

Some of the divergence in spending shares partly reflects differences in the underlying age distribution of the population. Australia, along with Canada and the USA, has a relatively low share of its population aged 65 years and over and 80 years and over. Even so, Australia's spending relative to its aged population is low compared with most of the OECD countries reported in table 3.2.

Table 3.2 **OECD long-term care[a] indicators in the mid-1990s**

Country	*Total spending on long-term care as a percentage of GDP* [b]	*Share of the population aged 65 and over* [c]	*Share of the population aged 80 and over*	*Country GDP share to 65+ population share, relative to Australia*[d]	*Country GDP share to 80+ population share, relative to Australia*[e]	*Share of public spending in total spending on long term care*	*Share of spending on residential care in total public spending on long term care*
	%	%	%	Index	Index	%	%
Australia	0.9	11.7	2.6	100	100	81	73
Austria	1.4	14.7	3.4	124	119	na	na
Belguim	1.2	15.8	3.6	100	97	55	53
Canada	1.1	12.3	2.7	114	118	69	67
Finland	1.1	14.2	3.1	103	104	81	86
Netherlands	2.7	13.2	3.2	266	248	67	76
Norway	2.8	15.6	4.0	233	202	100	63
Sweden	2.7	17.0	4.5	206	173	100	na
United Kingdom	1.3	15.7	3.8	108	99	77	70
United States	1.3	12.5	3.0	137	127	53	67

a Long-term care spending refers to the care needed to help the aged lead an independent life, at home or in an institution. It excludes informal help. For home care, it should include all home care services, including district nurse services, excluding nursing costs. Public costs include all costs incurred by public institutions, municipalities, sickness funds or old-age funds. Private spending refers to out-of-pocket payments or payments by private long-term care insurance, when the definitions are available. **b** Average for 1992–95. **c** Average for 1994–96. **d** Calculated by taking each country's ratio of aged care expenditure to GDP, to share of total population aged 65 years or more, then dividing by Australia's corresponding ratio and multiplying by 100 . **e** Calculated by taking each country's ratio of aged care expenditure to GDP, to share of total population aged 80 years or more, then dividing by Australia's corresponding ratio and multiplying by 100. **na** Not available.

Source: Jacobzone, Cambois and Robine (2000).

In the mid-90s, the public share of total aged care expenditure varied considerably between the OECD countries in table 3.2 — from a low of 53 per cent in the USA, to a high of 100 per cent in Norway and Sweden. Australia, at 81 per cent, was at

the high end of the range. The residential care share of total public spending also varied considerably between the selected OECD countries, ranging from a low of 53 per cent in Belgium, to a high of 86 per cent in Finland. Australia, at 73 per cent, was just above the group median.

3.2 Residential care services

Most of the funding for residential care is provided by the Commonwealth Government via residential care subsidies and capital grants to providers. In 2001-02, the Commonwealth provided nearly $4 billion[1], or just under 70 per cent of the total cost of residential care services. Residents provided most of the remainder via daily care fees and accommodation payments, with some funding from state and territory governments (for public sector beds), charitable sources and private donations.

Government subsidies

The Commonwealth Government pays a basic subsidy to service providers for each day that a bed is occupied in a residential facility. The basic subsidy payment is dependant on the level of care required by a resident in relation to the Resident Classification Scale (RCS), the State or Territory where the aged care home is located and whether the care provided is respite or permanent.

In 2001-02, basic subsidies ranged from $8395 per annum for an RCS-7 category person located anywhere in Australia (no subsidy is paid for an RCS-8 category person), to $41 975 per annum for an RCS-1 category person in Tasmania (table 3.3). Low care subsidy rates (RCS levels 5–7) are the same across all States and Territories, while high care subsidy rates (RCS levels 1–4) currently vary across States and Territories. Under the Commonwealth Government's Funding Equalisation and Assistance Package, subsidy rates for high care are being adjusted towards a uniform national rate by 2006.

There is a range of additional or supplementary subsidies that are paid to providers in particular circumstances. These can add up to an additional $4100 a year per person (see box 3.1).

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[1] Includes $3.5 billion appropriated through the Health and Ageing portfolio, and $470 million from the Veterans Affairs portfolio for funding veterans' residential care, but excludes residential respite ($76 million) and flexible care ($31 million) funding, which are discussed separately later.

Table 3.3 **Annual Commonwealth basic subsidy cost per resident, RCS category by State and Territory, 2001-02**

Dollars

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
RCS-1	40 150	41 610	37 960	39 420	39 055	41 975	39 420	40 515
RCS-2	36 135	37 595	34 310	35 770	35 405	37 960	35 770	36 865
RCS-3	31 390	32 485	29 565	30 660	30 295	32 850	30 660	31 755
RCS-4	22 265	22 995	20 805	21 535	21 535	23 360	21 900	22 630
RCS-5	13 505	13 505	13 505	13 505	13 505	13 505	13 505	13 505
RCS-6	10 950	10 950	10 950	10 950	10 950	10 950	10 950	10 950
RCS-7	8 395	8 395	8 395	8 395	8 395	8 395	8 395	8 395
RCS-8	0	0	0	0	0	0	0	0

Source: SCRCSSP (2003).

Box 3.1 **Residential care subsidy supplements**

Supplements that may be added to the basic subsidy amount include:

- a concessional resident supplement, payable in respect of both concessional residents (that is, persons in receipt of income support payments who have not been homeowners for at least the past two years and have assets of less than two-and-a-half times the annual single basic age pension) and assisted residents (that is, persons meeting these criteria, except that their assets are between two-and-a-half times and four times the annual single basic age pension);
- a charge exempt resident supplement, payable in respect of those persons who were permanent or respite care residents in an approved nursing home before the commencement of the *Aged Care Act 1997* and who then entered another residential care service as a recipient of permanent care where they are otherwise eligible to pay an accommodation charge;
- supplements for residents receiving oxygen treatment, enteral feeding and respite care;
- a payroll tax supplement, payable in respect of all permanent residents where an approved provider has incurred a payroll tax liability;
- a transitional supplement, payable in respect of those care recipients who were in nursing homes or hostels on the day before the commencement of the *Aged Care Act 1997* or, after this, where the service was uncertified on the day the care recipient entered it;
- a hardship supplement, payable in respect of those residents who would experience financial hardship if asked to pay the full daily care fee or accommodation payment;
- a pensioner supplement, payable in respect of those residents who are not entitled to rent assistance with their income support payment; and
- a viability supplement, to support smaller remote facilities which might otherwise be non-viable.

Source: DHA (2003a).

Reductions in subsidy can result from the provision of extra services, receipt by a resident of a compensation payment and income-testing of residents who entered residential care on or after 1 March 1998.

The basic and supplementary rates of subsidy are adjusted annually (usually on 1 July each year) having regard to movements in the Commonwealth Own Purpose Outlays index formula, which uses the Australian Industrial Relations Commission's Safety Net Adjustment as a proxy for measuring non-productivity wage growth and the Consumer Price Index as a proxy for movements in non-wage costs. Commonwealth subsidies increased, on average, by 2.3 per cent on 1 July 2001 and 4.5 per cent on 1 July 2002. Issues surrounding the adequacy or otherwise of this indexation methodology are discussed in chapter 5.

The average annual subsidy paid by the Commonwealth for each care recipient has increased significantly over the last six years. The real increase in subsidy for low care residents far exceeded that provided for high care residents (see table 3.4). In terms of overall outlays, the cost to the Commonwealth of the subsidy increased by around 37 per cent in real terms over the same period.

Table 3.4 **Average real Commonwealth subsidy paid for each residential aged care recipient, 1995-96 to 2001-02**

2001-02 prices[a]

Type of care recipient	*1995-96*	*2001-02*	*Real increase*	*Percentage real increase*
	$	$	$	%
High care resident	30 378	38 685	8 307	27
Low care resident	7 729	13 380	5 651	73

a GDP price deflator.

Source: DHA (2002).

The Commonwealth also provides capital assistance to service providers. Of the $3.6 billion of residential aged care subsidies provided in 2001-02, $254 million was the capital component, with a further $26.3 million through targeted grants (DHA 2002).

Targeted capital assistance grants are provided to assist those homes unable to attract sufficient residents who can pay accommodation payments. Examples include homes in rural or remote areas, and those with a relatively high proportion of financially disadvantaged residents. Some funds are also available to providers unable to meet the costs of necessary capital work. These grants are essentially distributed on the basis of demonstrated need.

Residents' contributions

Older people entering residential aged care facilities currently contribute around 30 per cent towards the costs of their care. These contributions partially recognise that such facilities provide meals and accommodation which residents would have to pay for wherever they lived.

The 1997 Aged Care Structural Reform Package introduced an entry contribution, as well as income testing of daily resident fees, for all types of residential care. Prior to these changes, both capital charges and income testing applied only to residents in hostel (low level care) facilities.

Residents' payments consist of two main components.

- A *care payment,* which comprises a basic *daily care fee* plus an additional *income-tested fee* that may be payable. All residents must pay at least the basic daily care fee, fixed at 87.5 per cent of the aged pension (which currently equates to $31.09 per day for a single pensioner). Residents with private income in excess of the income-tested free area for the pension may be asked to pay an income-tested fee of 25 cents in the dollar, up to a maximum of three times the pensioner daily rate less their basic care fee, or the costs of care, whichever is the lower. The majority of residents — around 65 per cent — are full pensioners.
- An *accommodation payment,* which effectively represents a resident's contribution to the capital costs of aged care facilities and comes in two forms.
  - Residents entering residential care at a low level of care, or on an extra service basis, can be asked to pay an *accommodation bond*, the balance of which must be refunded if the resident dies or leaves the facility. The bond amount is agreed between the service provider and the resident at the time of entry, and can be paid as either a lump sum (90 per cent of bonds are paid in this way) or via periodic payments, or a combination of both. While there is no fixed amount for an accommodation bond, residents cannot be charged a bond which would leave them with less than $27 000 in assets (the family home is excluded only under certain circumstances, for example, when the resident's partner or dependant children are living in it). The provider can take a maximum of $13.45 per day ($4910 per year) out of the bond for the first five years, as well as retain all interest earned on the full bond amount for the total period of care.
  - Residents requiring high level care (with the exception of those occupying an extra service place) are asked to pay an *accommodation charge* of up to $13.45 per day, depending on their asset levels. As with accommodation bonds, residents must be left with assets of at least 2.5 times the annual pension rate (for example, currently $28 288 for a single aged pensioner) and

the family home is exempt under certain circumstances. The accommodation charge cannot be levied for more than five years, after which residents effectively obtain 'life membership'.

In 2001-02, nearly 65 per cent of aged care homes derived income from accommodation bonds, with the average new bond in that year being $82 989 — an increase of 20 per cent over the previous year. In the same year, around 60 per cent of homes derived income from accommodation charges, with the average daily charge being $12.20 — an increase of 5 per cent over the previous year.

The equity, efficiency and effectiveness consequences of these different charging practices for recipients of low and high level care are explored further in chapter 5.

3.3 Community care services

The funding arrangements for community care services are less clear, as 'whole-of-episode' costs are unknown due to the limited data available on daily costs, charges and the duration of care. Users of community care services are generally charged modest fees that are set by individual providers, having regard to guidelines that vary between programs.

Funding arrangements for various community care services for 2001-02 are summarised in table 3.5.

Table 3.5 **Community care services funding, 2001-02**

$ million

Mode of care	*Government expenditure*	*Estimated funding by users*	*Total funding*
Home and Community Care (HACC)	1 012.4	25.0	1 037.4
Community Aged Care Packages (CACP)	246.0	40.0	286.0
Veterans' Home Care (VHC)	61.6	3.1	64.7
Other community care programs[a]	34.6	1.7	36.3
Total	*1 354.6*	*69.8*	*1 424.4*

[a] Includes Day Therapy Centres, Care Package Establishment Grants, Safe at Home, and Assistance with Care and Housing for the Aged programs.

Sources: DHA (2003b); Productivity Commission estimates; SCRCSSP (2003).

Funding of HACC is shared by the Commonwealth, State and Territory Governments and users.[2] Charging for these services is on a uniform national basis.

[2] Local governments also contribute to the funding of HACC services, but no data are available on the extent of their contribution.

In 2001-02, total government expenditure on HACC services for the aged was around $1 billion (table 3.5), of which the Commonwealth contributed 60 per cent and State governments 40 per cent. There are no official statistics showing the amount of money raised from user charges for these services. Estimates of user charges vary considerably. Howe (2000) estimated that 20 per cent of HACC services are funded by user charges. Fitzgerald (2002) used an average client contribution rate of around 10 per cent in estimating that the combined government and client expenditure on HACC services in 2000-01 was around $333 per person 70 years and over. DHA (2003b) estimates that user contributions represent about 2.5 per cent of total HACC costs (table 3.5).

Commonwealth funding for CACPs was $246 million in 2001-02 (table 3.5). The packages are funded at a flat rate of around $30 per client per day (approximately $10 900 per year). They are also part-funded (approximately 15 per cent) by client contributions. Each CACP has a managing organisation that may charge additional fees, subject to limits specified under the *Aged Care Act 1997*. Currently, fees for aged pensioners cannot exceed 17.5 per cent of the weekly pension. For those on higher incomes, fees must not exceed 17.5 per cent of the aged pension plus 50 per cent of their income in excess of the aged pension rate. Providers are required to allocate around 35 per cent of CACPs to financially disadvantaged clients.

The Commonwealth Government, through the Veterans Affairs portfolio, provided nearly $62 million for the VHC program during 2001-02 (table 3.5). This figure includes expenditure of $9.4 million on in-home respite care and emergency home care services. User contributions are estimated to account for about 5 per cent of program expenditure.

A number of 'other' community care programs exist, including — Day Therapy Centres, Care Package Establishment Grants, Safe at Home and Assistance with Care and Housing for the Aged. Government expenditure on these programs totalled nearly $35 million in 2001-02 (table 3.5). Day Therapy Centres accounted for the bulk ($29 million) of this expenditure. User contributions accounted for an estimated 5 per cent of total expenditure.

3.4 Flexible care services

The main flexible care programs are Extended Aged Care at Home (EACH), Multipurpose Services (MPS) and the Innovative Pool of Places (IPP)[3]. Funding for these programs is summarised in table 3.6.

[3] Flexible care places are also funded through the Aboriginal and Torres Strait Islander Flexible Care Services program, for which separate funding data was not readily available.

Table 3.6 **Flexible care services, 2001-02**
$ million

Mode of care	*Government expenditure*	*Estimated funding by users*	*Total funding*
Extended Aged Care at Home (EACH)	8.9	0.5	9.4
Multipurpose Services (MPS)	28.3	–	28.3
Innovative Pool of Places (IPP)	na	na	na
Total	*37.2*	*0.5*	*37.7*

– Nil or minimal. **na** Not available (only one service, the Home and Rehabilitation Support Service in South Australia, received funding in 2001-02).

Source: DHA (2002; unpublished data; estimates).

In 2001-02, the Commonwealth Government spent $8.9 million on EACH packages (table 3.6). Each package is estimated to cost the Government around $85 per day (Kendig and Duckett 2001), with a user contribution of about $5. This compares to an equivalent cost for residential high level care of about $163 per day.

The Commonwealth Government spent $28.3 million on the MPS program in 2001-02 (table 3.6), mainly in rural and remote areas. DHA advised the Commission that user contributions were either non-existent or minimal given the target population of largely Aboriginal and concessional aged persons.

3.5 Carer support services

The Commonwealth also provides support for the aged via assistance to their carers. This assistance is provided in two ways, through:

- the provision of respite care for older people being looked after by informal carers; and
- financial assistance paid direct to carers.

Funding for these carer support services is summarised in table 3.7.

Commonwealth funding for respite care and information services was $153 million in 2001-02, of which $76 million was provided to fund residential respite care in aged care homes and $77 million for respite carer information services, including funding for community respite (table 3.7). For residential respite care, user contributions are estimated to be around 23 per cent of total expenditure.

Table 3.7 **Carer support funding, 2001-02**
$ million

Mode of care	*Government expenditure*[a]	*Estimated funding by users*[b]	*Total funding*
Respite care services	152.6	23.1	175.7
Carer Payment and Allowances[c]	560.0	–	560.0
Total	*712.6*	*23.1*	*735.7*

a Includes Commonwealth Government expenditure on residential respite care ($75.9 million) and respite carer information services ($76.7 million). **b** Estimated maximum possible user contribution. **c** About 45 per cent of total carer payments and allowances are paid to carers looking after the aged. **–** Nil.

Sources: Commonwealth of Australia (2002); DHA (2002; estimates); SCRCSSP (2003).

Both the Carer Payment and the Carer Allowance are fully funded by the Commonwealth Government and administered through Centrelink. In 2001-02, funding for aged-related payments and allowances totalled about $560 million (Commonwealth of Australia 2002).

The Carer Payment is subject to both income and asset tests, and has a maximum payment equivalent to the aged pension — currently $220.15 per week for a single person. Informal carers can have a break from caring duties (such as during a period of respite or while the care receiver is in hospital) for up to 63 days in a calendar year without losing their payment.

The Career Allowance is a non-taxable payment of $87.70 per fortnight, which may be paid on top of the Carer Payment and, while not subject to an income or assets test, is subject to extensive eligibility criteria regarding the extent of care provided.

3.6 Regulatory arrangements — a broad profile

Australia's subsidised aged care sector is subject to extensive regulation, particularly for residential aged care services. Access to and the prices/charges for aged care services are controlled to promote a variety of objectives while restraining the level and rate of growth of government expenditure on the various subsidies. The Commonwealth Government:

- controls the supply of residential aged care services via an approvals system which includes accreditation and certification processes;
- controls the supply of residential aged care places and community care packages via a planning formula;
- sets minimum ratios for places made available for concessional residents — that is, for persons who cannot afford to pay an accommodation bond or charge;

- limits the number of extra service places that providers can offer and the maximum fee that can be charged for these places;
- administratively sets the price (level of subsidy) paid to care providers and the maximum price that users can be charged by providers for care;
- sets the entry criteria for access to subsidised care and requires an aged care assessment team to assess (against the criteria) who should receive care and thereby be eligible for a subsidy; and
- regulates, along with State and Territory governments, the quality of care services and accommodation standards, and monitors provider performance against the standards.

The supply of residential care services is controlled through various approval processes. To receive the Commonwealth Government subsidy, residential services must be accredited. To obtain accreditation, facilities must meet the Accreditation Standards incorporating the Residential Care Standards, the building and care standards required for certification at the time of accreditation and a Management Systems, Staffing and Organisational Development Standard. A residential care facility must also obtain certification as meeting specified minimum building standards, in order to be able to charge users accommodation charges or bonds, be eligible for Commonwealth funding supplements for concessional and assisted residents, and be able to offer extra service places. All residential services were assessed for certification in 1997 and are currently working to achieve continuous improvement targets. These were introduced in 1999 as part of a 10 year plan to improve building quality standards.

The Commonwealth Government controls the supply of subsidised care through the setting of target ratios for the number of residential care places and CACPs available relative to the size of the older population. The current target ratio is 100 residential places and CACPs for every 1000 persons aged 70 or over — split into 40 high care places, 50 low care places and 10 CACPs.[4] To control supply in relation to these targets, the Commonwealth determines the annual allocation of new residential care places and CACPs to providers. The process of allocation initially involves the States and Territories (on the advice of independent Aged Care Planning Advisory Committees) allocating new places between regions and special needs groups, followed by an assessment (by the Department of Health and Ageing) of competitive applications from approved providers against criteria which include experience, expertise, suitability of premises and availability of concessional places. Once the new places are allocated, providers can make them operational by either

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4 The operational ratio at 30 June 2002 was 98 places per 1000 persons aged 70 or over (DHA 2002).

adding to existing facilities or building new ones. They also have the right to transfer or sell operational places on the open market. About 1 per cent of operational places changed hands in 1999-2000 (DHA 2003b). The majority of transfers were between private for-profit providers.

Following allocation, providers are required to comply with a number of conditions relating to the proportion of places provided to:

- people with special needs;
- concessional and assisted residents (from 16–40 per cent of places, depending on the region);
- people needing a particular level of care;
- people receiving respite care; and
- other people specified in the notice of allocation of places to the provider.

The Commonwealth administratively sets the price (the level of residential and community care subsidies) that is paid to care providers. These subsidies are then subject to indexation on a yearly basis. The Commonwealth also sets the maximum price that users can be charged by providers for care and accommodation. Details of the maximums and indexation arrangements can be found in DHA (2003b).

The ability of residential care providers to offer consumers greater choice, such as through the provision of extra services, is constrained by regulations limiting the number of extra service places to 12 per cent of the residential care places in each State or Territory. To date, allocations have not exceeded 6 per cent (although currently demand is not usually above this level). The Commonwealth sets the maximum fees that residential care providers may charge for extra services, while subsidy payments are reduced as fees increase for extra service users.

Commonwealth-sponsored aged care assessment teams (ACATs) play an important role in the rationing of allocated places. They are responsible for determining eligibility for residential aged care, CACPs and EACH packages, and make recommendations in relation to HACC services. ACATs use criteria embedded in the Residential Classification Scale to rank clients according to their care needs. The needs and wishes of the individual being assessed, as well as those of their carer and family, are taken into account. In 2000-01, 123 ACATs staffed by State, Territory and local government employees assessed nearly 194 000 people (172 000 of which were persons 70 years and over) (DHA 2002).

Commonwealth, State and Territory regulations influence the quality of care services and accommodation standards for residential care. They include accreditation and certification processes, and cover the supply of necessary

equipment, specification of services, the qualifications of staff and building design and standards.

The Commonwealth, states and territories use an agreed set of standards to regulate HACC service quality — the Home and Community Care National Service Standards. In broad terms, the standards define service quality and indicate expected outcomes, and are included in all agreements between providers and the relevant government. The States and Territories may also have requirements additional to the nationally agreed standards. Compliance with the standards is monitored and subject to periodic review. Similar arrangements apply to CACPs and other community care programs.

3.7 Expenditure trends for aged care services

Total government and private expenditure on all aged care services increased from an estimated $5.8 billion in 1996-97 (Madge 2000) to $8.5 billion in 2001-02 (table 3.1). In real terms, this represented an increase of around 6 per cent per annum.

There have been four main changes to the underlying structure of aged care expenditure over the last five years — that is, since the Aged Care Structural Reform Package was introduced in 1997 (box 3.2).

Box 3.2 **Aged Care Structural Reform Package**

The main elements of the 1997 Aged Care Structural Reform Package were:

- integration of hostels/nursing homes into one residential aged care system;
- a new single residential classification system (formerly there were two);
- the introduction of resident accommodation payments (entry contributions) for all residential care (formerly applying to hostels/low level care only);
- income testing of daily resident fees payable for all types of care (formerly applying to hostels/low level care only);
- a new system of accreditation designed to ensure proper standards of care;
- less onerous paperwork requirements on residential facilities; and
- improved consumer protection arrangements.

Source: Commonwealth of Australia (1996).

First, there has been a relative shift in government funding from residential care services towards community care services. While residential care expenditure continues to dominate overall government expenditure on aged care services, its

real rate of growth since 1997 has been much less than for community care services (table 3.8).

Table 3.8 **Government real expenditure shares on residential care and community care services, 1997-98 to 2001-02**

2001-02 prices[a]

Year	*Residential care*[b]	*Residential share of total expenditure*	*Community care*[c]	*Community share of total expenditure*	*Total expenditure*
	$ million	%	$ million	%	$ million
1997-98	3 330.5	77.7	955.5	22.3	4 286.0
1998-99	3 665.1	77.9	1 038.2	22.1	4 703.3
1999-00	3 805.8	77.7	1 091.5	22.3	4 897.3
2000-01	3 827.7	76.8	1 153.8	23.2	4 981.5
2001-02	3 997.4	76.0	1 258.4	24.0	5 255.8

[a] GDP price deflator. [b] Data includes DHA and DVA expenditure on residential aged care subsidies for permanent residents, but excludes some respite care expenditure. [c] Community care data is for expenditure on CACPs and HACC.

Source: SCRCSSP (2003).

Second, there has been a significant increase in the relative importance of user contributions as a source of funds for residential care. In 1997-98, user contributions covered 24 per cent of residential care expenditure, rising to about 31 per cent in 2001-02 (table 3.9). Most of this increase was accounted for by increases in residents' contributions to capital costs.

Table 3.9 **Public/private expenditure contributions for residential care, 1997-98, 1999-2000 and 2001-02**

Current prices

Year	*Government residential care expenditure*	*Government expenditure as a proportion of total expenditure*	*Non-government residential care expenditure*	*Non-government expenditure as a proportion of total expenditure*	*Total residential care expenditure*
	$m	%	$m	%	$m
1997-98	3 326	76	1 070	24	4 396
1999-00	3 564	75	1 176	25	4 740
2001-02	3 997	69	1 800	31	5 797

Sources: DHA (2003b); SCRCSSP (2003).

Third, there has been a significant increase in funding (albeit from a small base) for a growing range of flexible and innovative care packages. This growth has been directed mainly at the special needs of disadvantaged groups in rural and remote locations, through the MPS program. In 2001-02, additional funding was provided

for flexible care places through the Innovative Pool program, with the places being used to test alternative service models for providing aged care and other health services. As evident from table 3.10, real expenditure on these packages increased by 146 per cent over this period.

Table 3.10 **Real expenditure on flexible care services, 1997-98 to 2001-02**
$ million (2001-02 prices)[a]

Year	*EACH*	*MPS*	*IPP*	*Total expenditure*
1997-98	–	15.1	–	*15.1*
1998-99	–	16.4	–	*16.4*
1999-00	–	22.5	–	*22.5*
2000-01	8.6	25.3	–	*33.9*
2001-02	8.9	28.3	na	*37.2*

a GDP price deflator. **–** Nil. **na** Not available (confidential).

Source: DHA (2002; unpublished data).

The fourth main area of change has involved significant increases in expenditure on carer support, particularly in Carer Payment and Allowances and respite care services. Over the five years to 2001-02, real expenditure on Carer Payment and Allowances increased by an estimated 123 per cent, while for respite care services it increased by about 43 per cent (table 3.11).

Table 3.11 **Real expenditure on carer support**
$ million (2001-02 prices)[a]

Year	*Carer Payment and Allowances*[b]	*Respite care*[c]	*Totals*
1997-98	250.9	122.9	373.8
1998-99	276.3	141.0	417.3
1999-00	380.1	156.3	536.4
2000-01	468.1	170.9	639.0
2001-02	558.7	175.7	734.4

a GDP price deflator. **b** About 45 per cent of carer payments and allowances are paid to carers looking after aged persons. **c** Data includes actual Commonwealth Government expenditure (except for 1997-98 where the figure is an estimate), estimated user contributions for residential and community respite, and actual government expenditure on Respite Carer Information Services.

Source: DHA (unpublished data; estimates); various DSS and FACS Annual Reports.

4 A framework for assessing funding and delivery arrangements

This chapter presents and briefly discusses the criteria used by the Commission to assess current and alternative funding and delivery arrangements for aged care services.

4.1 Criteria for assessing aged care funding and delivery

Core government goals as set out in the *National Strategy for an Ageing Australia* (DHA 2001b) include the provision of accessible, affordable, appropriate and high quality care. The *Aged Care Act 1997* also states that decisions relating to the funding and delivery of aged care services need to have regard to the limited resources available to support services and programs and the need to consider equity and merit in providing access to these resources.

Drawing on these broad goals and objectives, as well as on various papers and reviews which have themselves suggested criteria or guidelines for assessing funding arrangements for aged care (see, for example: PC 1999; The UK Royal Commission on Long-Term Care 1999; Australian Institute for Primary Care 1999; Webster 2002), the Commission proposes to use the following set of five criteria:

- equity;
- efficiency;
- quality;
- choice; and
- sustainability.

These criteria correspond broadly with those proposed by the *Review of Pricing Arrangements in Residential Aged Care* (DHA 2003b). The Review, however, combines quality and choice into a single criterion, and deals with equity and efficiency in a manner which is narrower than the Commission's criteria.

In relation to equity, the Commission includes two additional dimensions — the desirability of having a funding mechanism that does not give rise to unfair redistributions between different generations (that is, promotes intergenerational equity) and an appropriate balance between public and private funding.

Box 4.1 **Broad goals and objectives for aged care**

The *National Strategy for an Ageing Australia* (DHA 2001b) sets out four broad goals for 'World Class Care':

- A care system that has an appropriate focus on the health and care needs of older Australians and adequate infrastructure to meet these needs.
- A care system that provides services to older people that are affordable, accessible, appropriate and of high quality.
- A care system that provides integrated and coordinated access, assistance and information for older Australians with multiple, significant and diverse care needs.
- A sustainable care system that has a balance between public and private funding and provides choice of care for older people.

The Commonwealth's specific objectives in relation to aged care, as set out in the *Aged Care Act 1997,* include to:

- Promote a high quality of care and accommodation and protect the health and well-being of residents.
- Help residents enjoy the same rights as all other people in Australia.
- Ensure that care is accessible and affordable for all residents.
- Plan effectively for the delivery of aged care services and ensure that aged care services and funding are targeted towards people and areas with the greatest needs.
- Encourage services that are diverse, flexible and responsive to individual needs.
- Provide funding that takes account of the quality, type and level of care.
- Provide respite for families, and others who care for older people.
- Promote 'ageing in place' through the linking of care and support services to the places where older people prefer to live.

Sources: Commonwealth of Australia (1997); DHA (2001b).

The Commission's efficiency criterion encompasses allocative, technical and administrative efficiency, whereas the Review's criterion is limited to notions of transparency and accountability, and effective integration and coordination of programs and activities.

The Commission draws on these criteria to assess the performance of the current funding and delivery arrangements for aged care services in chapter 5, and to evaluate various options for reforming these arrangements in chapter 7.

Equity

Equity is a multifaceted concept. In the context of examining funding and delivery arrangements for aged care, it takes in:

- *Equity of financial access* — that access to care is not denied because of an individual's inability to pay. This does not imply that all users of aged care services should be equally subsidised. Rather, given that an individual's ability to pay varies, it is likely to involve the targeting of funds to those individuals least able to pay for themselves. The use of income and asset tested care charges for residential aged care places recognises this principle.
- *Equity of physical access* — that the necessary physical and human resources for the provision of care are available in a suitable location. This does not mean, for example, that it is inappropriate for the range of aged care services to vary in response to the cost of delivering these services or the number of individuals seeking a given service in a particular location. Rather, it is about ensuring the availability of appropriate facilities with acceptable standards of care.
- *Equity in terms of standards of care* — that the care provided meets an acceptable standard of care benchmark that addresses the needs of each person. This does not rule out allowing people to pay for extra services over and above acceptable quality standards.
- *Equitable contributions to financing* — that the overall funding mechanism encourages broadly even contributions between groups over time (that is, promotes equity between generations, formally referred to as intergenerational equity). Also, that there is an appropriate balance between public and private funding.

Efficiency

The efficiency criterion is essentially about making the best use of our limited resources. It has a number of dimensions:

- *Allocative efficiency* — requires that funding arrangements provide incentives for achieving an allocation of resources among the different modes of aged care (and between health and other related services) that produces the combination which best meets users demands and results in an efficient overall level of aged care spending. For example, funding arrangements should not discourage the use

of informal care relative to residential care if the former would be more cost-efficient in addressing the needs and preferences of the aged.

- *Technical efficiency* — involves the delivery of an appropriate level and quality of care services at the lowest possible cost, by using the most productive techniques and least cost combination of inputs. It does not mean producing the lowest quality service or at the least cost to government. Related to this, the funding system needs to provide appropriate incentives for providers and users alike to encourage the efficient delivery of services and avoid the wasteful consumption of care.
- *Dynamic efficiency* — refers to the capacity to improve efficiency over time. This can mean finding better products and better ways of producing goods and services. It can also refer to the ability to adapt quickly, and at low cost, to changed economic conditions.

Any funding arrangement carries with it a set of incentives which influence the behaviour of service providers and users. It is important, therefore, for these arrangements to be structured so they do not underwrite inefficient management or work practices in the provision of services, lessen incentives for productivity improvement and/or encourage quality skimping and cost shifting. The challenges associated with ensuring the cost-effective provision of services are likely to be magnified where: funding and administrative decisions involve multiple levels of government; there is scope for substitution between multiple programs designed to satisfy differing objectives; and, administrative decisions substitute for market mechanisms. Such challenges clearly arise in the context of the funding and provision of aged care services.

From an administrative efficiency perspective, it is clearly desirable for funding arrangements to avoid unduly complex or ambiguous procedures and rules. Unnecessary complexity gives rise to avoidable costs for providers and consumers alike.

Quality

Quality care is central to the wellbeing of the aged. The quality of care provided should be consistent with the standards of accreditation and apply equally throughout Australia.

Funding arrangements must be able to support standards of benchmark care and facilitate the maintenance of quality standards over time. For example, an increase in the standard of care required to meet accreditation and certification requirements could be compromised unless funding arrangements provide the necessary funds to

underwrite revised standards of care. However the nexus between care standards and funding is often not clear cut. The scope for providers to meet an increase in the quality of care standard without a matching increase in funding is influenced by opportunities for improving the current use of resources through productivity improvements. Consequently, the design of an effective funding arrangement for residential aged care services involving a significant taxpayer-financed subsidy is likely to require the use of appropriate mechanisms for adjusting the subsidy rate over time, to take account of material changes in the operating environment of providers, including changes to quality standards.

Choice

Funding arrangements should also facilitate choice — that is, they should allow service providers to differentiate their offerings and allow older Australians to choose what best suits their needs. There should be choice in the level and form of care offered (that is, residential, community or respite), the standard of accommodation offered (above a minimum) and in who provides the care.

Freedom of choice can play an important role in promoting the development of a diverse and responsive industry, even within funding arrangements aimed at supporting equitable access to a guaranteed minimum quality of care. It is important to ensure that regulations designed to safeguard access to standard care do not unduly constrain the scope for competition between service providers (through experimentation, innovation and service differentiation), to address the diverse needs of users.

Sustainability

Funding approaches need to be able to provide reliable and predictable funding for the aged care system which ensures sustainability over the longer term. The funding arrangements need to be able to cope with changes to quality standards and the cost of delivery, having regard to the ageing of the population.

The sustainability of funding arrangements for aged care represents an important social issue. In its *Intergenerational Report*, the Commonwealth Government indicated that (Treasury 2002a, p. 1):

> By maintaining sustainable government finances, the Government avoids compromising the wellbeing of future generations by the activities of the current generation.

Amongst its key priorities for ensuring fiscal sustainability was (Treasury 2002a, p. 2):

> … developing an affordable and effective residential aged care system that can accommodate the expected high growth in the number of very old people (people aged 85 or over).

A number of analysts have questioned the sustainability of the existing funding arrangements for aged care services. The implications of the ageing of Australia's population in this context are explored in chapter 6.

5 An assessment of the current system

Against the criteria developed in the previous chapter — equity, efficiency, quality, choice and sustainability — this chapter assesses the current funding and delivery arrangements for aged care services.

While Australia's aged care system is highly regulated, internationally it is well regarded (Myer Foundation 2002). Over the past decade or so, the system has been subjected to an array of reforms, which have sought to address various weaknesses in the funding and delivery arrangements. However, there is scope for further improvement, including enhancing the system's capacity to handle future challenges, such as increasing costs and an ageing population.

In its submission to the House of Representatives Standing Committee on Ageing, Aged and Community Services Australia (ACSA 2003, p. 1) said:

> … there are significant pressures on the industry now and a number of problematic features of the present arrangements which need to be addressed if we are to continue to provide high quality care to the increasing number of older people who will require care over the next forty years. Our system of care did not get where it is today through complacency and resting on our laurels.

5.1 Equity

Access to aged care services

There are consistent reports of problems of access to aged care services (box 5.1). These include long waiting lists for residential care places, unnecessarily long stays in acute care and shortfalls in the availability of community care services (including respite care).

Box 5.1 **Access problems for aged care services — some anecdotal evidence**

Aged and Community Services Australia (ACSA 2002b, p. 2), in an Industry Response to the Two Year Review of Aged Care Reforms, said:

> The experience of older people and their families around Australia suggests strongly that access to services remains a key problem.

While providing an account of her experience in securing a high care place for her father, Julia Blunden (*Sunday Age*, 2 December 2002, p. 9) said:

> After a lengthy (hostel) stay, my father was reclassified as needing high level care. I was handed an official guide to aged care by a social worker and told to get him on the waiting lists of six nursing homes in the next fortnight. In the following weeks, I visited about a dozen nursing homes and learnt a lot … . Many homes I rang had closed waiting lists and were not offering inspection visits. Others had long waiting lists even for tours. Some nursing homes are linked to hostels, whose residents are given preference to outsiders. … Individual nursing homes vary in their requirements for paperwork to join waiting lists, but in many cases it is quite a chore. Almost all recommend ringing every couple of weeks to reconfirm interest.

An article in the *Canberra Times* (Curry*,* 27 October 2002, p. 18) noted:

> There are 50 ACT residents currently waiting for urgent high-level-care placements in nursing homes. There are another 500 assessed as being suitable for high care, however, not all of these people would accept places if offered to them because they access community services.

Michael Walsh, CEO of the Alfred Hospital in Victoria (Marino, 17 November 2002a, p. 4), was reported as saying:

> … shortages caused by nursing home closures and an ageing population in the area had increased pressure on the hospital over the past few years. Older people were being assessed faster and moved out of acute beds and into interim beds where possible. Community support was also being used more often to help older people waiting for nursing homes, stay at home or in low-dependency care longer.

In regard to the elderly occupying hospital beds while awaiting access to residential care, Gary Templeton, CEO of Gippsland Southern Health Service (Marino, 17 November 2002a, p. 4), said:

> We've certainly had a lot of pressure over the last year in what we refer to professionally as bed blockers. We've had significant numbers that are in hospitals at any one time.

Meigan Lefebure, CEO of the Aged Care Association of Victoria (Marino, 17 November 2002b, p. 1) commented:

> … nursing homes could have waiting lists of up to 40 people — a significant figure when nursing homes averaged around 45 beds. … There just aren't enough beds available for people who need nursing home care.

Allen Consulting Group (ACG 2002, p. 56) reported:

> Consultations suggest anecdotal evidence of shortages of supply in residential high care, dementia-specific care and HACC services, in particular. There are also reports of considerable variation in the provision of residential care across regions, resulting in access issues in particular areas, especially some parts of rural and remote Australia and inner parts of metropolitan areas.

While it is difficult to measure access, there are some indicators which suggest that the supply of aged care services (within the limits of the Commonwealth Government's planning ratio and funding allocation) is insufficient to meet demand. They are:

- The survey of Disability, Ageing and Carers conducted by the ABS in 1998 found that for older people living at home and requiring assistance, around 29 per cent reported that their needs were only being partly met, while 4 per cent reported that their needs were not being met at all.
- In 2001-02, less than half (47 per cent) of those assessed as being eligible for a Community Aged Care Package (CACP) had received a package within one month of their Aged Care Assessment Team (ACAT) assessment and only 75 per cent had received a CACP within three months of their assessment.
- For residential care places, in 2001-02, around one half of persons requiring high level care were placed in an aged care home within a month of ACAT approval. Over 80 per cent were placed within three months and over 90 per cent within nine months. For low care places, only one-third were placed within one month of an assessment, while just over 60 per cent were placed within three months (table 5.1).
- The average time elapsed between when an individual received an ACAT approval and their entry into residential care services increased between 1999-2000 to 2001-02 (figure 5.1). Across this period, a small proportion of individuals have entered care within a week of approval, while a large proportion have waited between three and nine months for placement. The Australian Institute of Health and Welfare (AIHW 2002a), however, argues that the time elapsed between an ACAT assessment of a person as eligible for residential care, and that persons entry into residential care services, is not a good indicator of timeliness of access (box 5.2).
- State governments report that a significant number of hospital beds are occupied by patients who are unable to access a residential care place.[1] The Department of Health Western Australia (2003, pp. 3-4), in its submission to the Review, for example, indicated that, during 2002, around 4 per cent of Western Australia's

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[1] Under the Australian Health Care Agreements 1998–2003, State and Territory governments are responsible for ensuring the provision of public hospital services free of charge to public patients on the basis of clinical need. An exception is long stay patients who no longer require acute care and who have been admitted to hospital for a continuous period of more than 35 days. These patients are classified as nursing-home-type patients unless a doctor certifies that they continue to require acute care. Where services are provided to these patients in public hospitals, State and Territory governments are permitted to charge patient fees (after the 35th day of continuous admission), in accordance with those determined by the Commonwealth Minister for Health and Ageing in consultation with each state and territory.

metropolitan public hospital beds and 18 per cent of the State's beds in psychogeriatric facilities were occupied by people awaiting places in residential care, at a cost to the State of around $31 million. The ACT Government announced recently that public hospitals in the ACT had lost 789 bed-days to nursing-home-type patients in the December 2002 quarter, an increase of around 100 bed-days on the previous quarter (Cronin 2003).

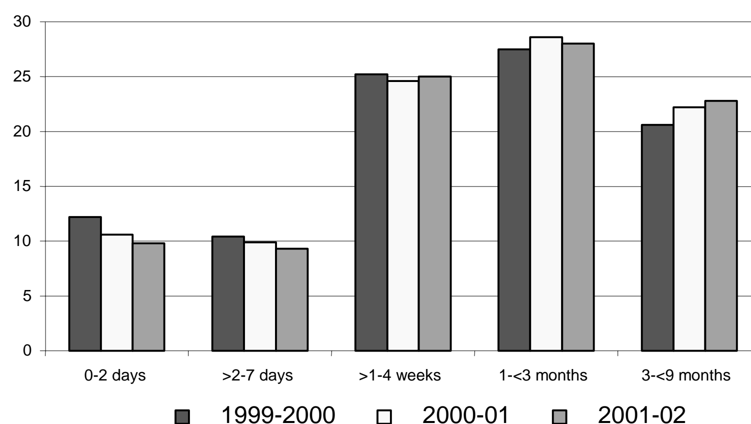
Table 5.1 **Elapsed time between ACAT approval and entry into a CACP or residential aged care service, 2001-02**
Per cent

	0–2 days	*>2–7 days*	*>1–4 weeks*	*>1–3 months*	*>3–9 months*
CACP service recipients	10	9	28	28	20
Residential service					
High care	13	12	30	26	16
Low care	7	6	20	29	31

Source: SCRCSSP (2003, table 12A.37).

Figure 5.1 **Elapsed time between ACAT approval and entry into a residential aged care service, 1999-2000 to 2001-02**

Percentage of people placed in care



Data sources: Gray (2001, p.34); SCRCSSP (2003; table 12A.37).

Box 5.2 **Interpreting entry period data for residential care**

In 2002, the Australian Institute of Health and Welfare (AIHW) released the report *Entry Period for Residential Care*. The AIHW found that the 'entry period' for residential care — the time elapsed between an ACAT assessment of a person as eligible for residential care, and that person's entry into an aged care home — while commonly used as a performance indicator of timeliness of access, is often unrelated to actual waiting times for residential care.

According to AIHW, one of the main determinants of a short entry period is whether residents have an ACAT assessment performed while they are in hospital, rather than when living at home. Longer entry periods are strongly related to whether residents have used a CACP or residential respite care prior to admission.

Because an ACAT approval is valid for up to one year, those eligible for residential care often do not act on the recommendation immediately, but rather use the time to visit different homes and consider their options. Some people are prepared to wait a considerable period of time in order to enter the home of their choice. This is particularly relevant for low care residents, where the need for care is not so urgent. Others who are recommended for residential aged care may decide not to enter such a facility, preferring rather to take up a CACP and/or rely on informal care.

The AIHW confirmed that the increased availability of community care and respite care has a significant effect in delaying entry into permanent care. The AIHW also found that the supply of services in a particular region had a negligible effect on the entry period.

The AIHW suggested that 'waiting time' — the time between a person actively seeking residential aged care and their actual entry to aged care — would be a more appropriate performance indicator of timeliness of access. However, such data are currently not available on a systemic basis.

Source: AIHW (2002a).

A mismatch between demand for and supply of aged care services appears more pronounced in the areas of high level residential care, dementia-specific care, Home and Community Care services and in particular parts of rural and remote Australia (ACG 2002; National Rural Health Alliance 2003).

There are cost implications associated with shortages in the aged care system, particularly at the high care end and in community care.

As the Chamber of Commerce and Industry of WA (2002, p. 9), in its submission to the House of Representatives Standing Committee on Ageing, argued:

> … attempts to control the cost of service provision by capping the number of subsidised places can, and does, backfire. Clients' needs are met instead either in acute facilities under Care Waiting Placement or through community care packages. The

costs of these may be considerably higher (in the case of acute care) or a little lower (community packages) than dedicated aged care facilities. Most importantly, they may not be providing the most suitable services for the clients concerned.

Queuing is not necessarily a fair means of rationing a scarce resource when providing support and assistance to older Australians.

In the light of concerns about access to aged care services, many in the industry have called for a review of the planning arrangements for aged care, particularly the current ratios used to determine the allocation of Commonwealth-funded places.

User charges

Against the equity criteria outlined in chapter 4, there are several areas where user charges for residential care could be seen as deficient:

- Providers can collect accommodation bonds from low care residents and from high care residents receiving extra services, but not from high care residents receiving basic care. A resident entering the system as low care would typically face considerably higher user charges for accommodation than a resident entering the system as high care (box 5.3). As Catholic Health Australia (CHA 2003, p. 5) said:

  > … providers are encouraged to cross subsidise from low care residents the costs of high care facilities. … not all high care residents are worse off financially than the low care residents paying accommodation bonds. Thus the perverse situation occurs where better off residents are being supported by those least able to pay upfront lump sums for accommodation.

- Bond retentions and accommodation charges can only be levied for a maximum of five years. Providers can, however, continue to earn interest on the full bond amount for the entire period of care. With ageing in place, there is currently an increasing number of residents remaining in the same residential facility for periods of longer than five years — currently around 20 per cent. The concept of full taxpayer funding of accommodation after five years raises a number of equity issues.
- Older people using community care receive subsidised personal and health care, but generally meet their own accommodation and living expenses (such as, food and heating). For those in residential care, in addition to receiving subsidised personal care, they may also receive a subsidy for accommodation and living expenses. Applying more consistent subsidisation arrangements between residential and community care has the potential to improve equity.

Box 5.3 **Accommodation bonds and charges — an illustrative example**

The following example illustrates the different accommodation payments that could be faced by residents, depending on whether they enter an aged care home as a low or a high care resident.

Both **Mrs Jones** and **Mrs Tan** have total assessable assets of $200 000. They both end up staying in care for a period of 26 months (approximating the average length of stay for a permanent nursing home resident in 2001-02).

Mrs Jones requires low level care. The maximum accommodation bond she can be asked to pay is $172 500 (which is the total value of her assessable assets minus a required preserved asset level of $27 500). However, she is asked by her provider to pay a bond of $83 000 (this amount being the average lump sum bond paid by residents in 2001-02). She agrees to pay the full amount via a lump sum payment (89 per cent of residents required to pay bonds in 2001-02 paid via a lump sum).

The amount of bond returned to her, or her estate, on leaving is $76 604 (factoring in the maximum retention amount for bonds valued at no less than $29 520, of $246 a month or $2952 a year). The direct cost to her of posting an accommodation bond is therefore, $6396.

Mrs Jones also foregoes interest on the lump sum payment, adding to the overall cost of financing her care. One way of estimating this cost is to look at what Mrs Jones would have earned had she invested the bond in an interest-bearing account for 26 months. Assuming a hypothetical rate of 4 per cent per annum, the total interest foregone would be approximately $7 200 (before tax) over a 26 month period.

Adding the bond retention amount plus the forfeited earnings on her lump sum, the cost of accommodation to Mrs Jones is $13 596 (before tax).

Mrs Tan requires high level care. She can be asked to pay a maximum accommodation charge of $13.45 per day. Assuming Mrs Tan receives high level care within the same facility for 26 months, her total accommodation cost is $10 636 (before tax).

Under this example, Mrs Jones pays around 33 per cent more than Mrs Tan for essentially the same accommodation services.

Intergenerational equity

Current subsidies are financed on a ‘pay-as-you-go’ basis. Current taxpayers pay for the care of the aged in the system now — that is, there are intergenerational transfers between people of working age (taxpayers) and older people. With relatively small changes in the underlying age structure of the population over time these transfers do not necessarily present a problem — today’s subsidisers are, in effect, tomorrow’s beneficiaries. However, the relatively rapid growth of the older population over the next few decades will mean that there will be relatively fewer

people of working age paying taxes and relatively more people requiring aged care (that is, an increasing dependency ratio). In the absence of changes to funding arrangements, existing subsidy rates will also place increased pressure on the governments' fiscal position. This means that, in the event of no change to the current arrangements, future generations are likely to face either increased taxation or reduced government support for publicly-provided services. The extent of funding pressure will, of course, be affected by the growth performance of the economy.

Also, the costs arising from the excess burden of collecting the taxes used to finance government subsidies, suggests that there are advantages in having better financial mechanisms to enable older people to pay (including in advance) for their aged care, should they require it.

A recent report by Harding, King and Kelly (2002) indicates that people moving into older age groups over the next few decades will be wealthier than previous generations (see chapter 6 for more detail). Related to this, there is a case for requiring older Australians to take on a larger share of the cost of their care in the future, to promote improved intergenerational equity.

5.2 Efficiency

Under the current funding and delivery arrangements for aged care there are a number of inconsistent and inappropriate incentives at play.

Funding arrangements influencing the balance between residential and community care

Most older people have a preference for remaining in their own homes for as long as possible (see, for example, McCallum 2002). In recent years, governments have also sought to support older people wanting care in their own homes by directing additional resources to the community care sector. That said, about 70 per cent of government funds for aged care go to residential care, and government subsidies for residential care continue to be higher than those for community care.

As discussed earlier, older people using community care services generally have to meet their accommodation and living costs, while the government heavily subsidises these costs for those living in residential care facilities.

The overall public and private costs of community care are generally presumed to be lower than those for residential care. Although, as observed by the ACG (2002, p. 67):

…. it is important to recognise that the two sets of costs are being incurred for different bundles of services — residential care, for example, includes services such as housing and meals which an older person (or a carer) would usually provide themselves while living at home and receiving community care services.

A comparison of the *total* costs associated with the different delivery models for aged care (and analysis of who is incurring the various types of costs) would require these differences to be taken into account, along with the impact of different types of care on the use of other services (such as hospital care).

The ACG go on to observe that this issue appears to have attracted little attention in Australia (ACG 2002, pp. 67–70). Even so, by drawing on some international studies and on the Group's own work, it is possible to make a number of general observations about the relative costs of residential and community care. In summary, they are:

- Costs incurred by government on aged care are generally substantially lower for care delivered in the community.
- An elderly person using community care is more likely to have cause to access the health system than a person in residential care, where a certain level of health care is provided in the cost.
- When accommodation costs are included in the analysis, the comparison is less clear-cut.
- Support from informal carers is likely to be greater where the elderly person uses community care services.
- Various 'hidden' costs are associated with community care (for example, accommodation and living costs, potentially higher health care costs and a larger contribution from informal carers). Taking these costs into account, the total cost of providing community care for some elderly persons is likely to substantially exceed the cost of caring for them in an aged care home.

There is also the issue of who meets the costs of care and the impact of this on care choices. Currently, the costs of accommodation and living expenses are usually met by the elderly in the case of community care, but are only partially paid for by users in the case of residential care. Also, in contrast to residential care, for community care a large proportion of the costs of personal care are met directly by the elderly, or their carers.

A system which fails to adequately recognise the contribution of informal carers could undermine their incentives to care for the elderly and ultimately result in a higher overall care cost for the community. Gray and Kendig (2002, p. 7) argue that:

> Society should encourage and enable the informal care process where it is the preferred response by older people and their family. This may assist in minimising the cost of overall care to the community. However, the need for fairness should be respected, such that those families that choose to contribute to care are not significantly disadvantaged.

Differences in the relative size of private and public contributions towards accommodation, living and personal care costs for the different types of care is inequitable and has the potential to distort choices between residential and community care by the elderly and/or their carers. A financial bias towards residential care works against the objective of maintaining the independence of the elderly (which is important for both the individual and the community, as independence typically means less public support is required). Removing the subsidy for accommodation and living costs for those in residential care who have the financial means to pay for such costs, would achieve greater neutrality between residential and community care services (see chapter 7).

Incentives faced by providers of residential care

Existing rates of subsidies are designed such that the highest subsidy is provided for residents with the highest relative care need. While this clearly reflects many of the costs associated with higher care needs and avoids providers picking low cost residents for the same subsidy level, it also has a down-side. As CHA (2003, p. 21) said:

> The current RCS classification and subsidy regime include a number of perverse disincentives. Rehabilitation and improvement in function of residents is financially penalised with a lower subsidy level following the annual re-assessment.

Given the restrictions on the supply of residential places and the differences in capital contributions for low and high care places, providers of aged care have an incentive to 'cherry-pick' residents who can pay a high bond. Providers also have an incentive to take residents who can be cared for at a cost below the level of RCS reimbursement ahead of higher cost residents. To quote again from CHA, in its submission to the Review, (2003. p. ii):

> … investor owned organisations are arranging their affairs to maximise the benefits of the residential program. They set their accommodation rack rates and discriminate accordingly. By accepting only those residents able to pay a high bond, these groups retire capital debt quickly and secure the full equity value of the property. In essence their primary business is property development through aged care services.

This suggests that, the current funding arrangements, by providing an incentive for providers of residential care to secure a particular resident profile, could be compromising the ability of some of the elderly to gain access to this care.

Divisions in responsibility between levels of government

Divisions in responsibility between the various levels of government results in:

- incentives for cost-shifting between State governments and the Commonwealth;
- gaps in care for older people, such as in rehabilitation and convalescent care; and
- poor coordination of planning of residential and community care, and a lack of integration across programs.

As discussed in chapter 3, the Commonwealth Government has primary responsibility for funding residential care. The States are responsible primarily for acute health care and public housing, while both levels of government (in concert with local governments), contribute to community care services. ACSA (2002a, p. 2) reflects the views of many when it claims that:

> The underlying dynamics of cost-shifting between different levels of government creates a pressure to provide services, or referrals, on the basis of who pays rather than what might be in the interests of clients and patients.

As hospitals have become focused increasingly on providing acute care and shorter lengths of stay, pressure has arisen to move some older patients to facilities that are able to accommodate longer recovery periods at lower cost. However, long waiting lists for residential care and supply constraints on the availability of sub-acute/rehabilitation services delay departures from the acute care sector of the health system. Such delays may not be in the long-term interests of elderly patients (box 5.4), or taxpayers. Not only are the patients in an environment (acute care) which is less suited to meeting their daily care needs, but also the cost of a bed-day in a hospital is estimated to be almost double the cost of a residential care bed.

There are a number of trial programs currently aimed at addressing this problem. For example, in Adelaide, the Acute Transition Alliance is currently seeking to improve links between hospitals and residential aged care through a collaboration ranging across aged care and health services. The project aims to reduce both unnecessary long-term admissions to residential care and avoidable admissions to hospital. In Victoria, the Post-Acute Care Program, is another example of an integrated service pilot (McCallum and Mundy 2002, p. 6).

Box 5.4 **Gaps in aged care services — a hypothetical case where rehabilitation services would result in a very different outcome**

Differences in the financial responsibilities of the Commonwealth and State governments give rise to gaps in the provision of step-down, convalescent and rehabilitation services for older people. Consequently, older people may be prematurely placed into residential care.

This example covers a situation where, under the current arrangements, Mr Smith would be placed into residential care when this would not be necessary if appropriate step-down care was available.

Mr Smith, aged 89 years, had a stroke two years ago. He can manage his own basic personal care, but relies on his frail wife for most other activities. When he has a fall and injures his back, he is referred by his GP for admission to the local hospital. X-rays do not show any fracture, but when given the 'good news' that there is 'nothing wrong', his wife expresses concern that, as he cannot walk, she cannot look after him. After a variety of attempts to find a way to send him home, he is begrudgingly admitted to hospital after a 36 hour period on a trolley. He has become slightly confused and incontinent. The staff mention that he is taking up an expensive hospital bed and that a good solution would be to find a residential care place.

But, if step-down care was available the situation could be quite different.

For example, it could be that after careful assessment in the emergency department, Mr Smith is directly admitted to an aged care unit. With adequate pain relief, support and encouragement to remobilise and take care of himself, after 12 days he has recovered almost to his usual level of health and independence. Additional assistance is offered to his wife in bathing her husband for two weeks after discharge, with visits by a physiotherapist every second day. The situation returns to normal after four weeks.

Source: Gray (2003, pp. 4–5).

Measures such as preventative health care (for example, exercise programs for the elderly and programs aimed at preventing incontinence) and supportive housing (involving home modifications, aids and appliances), can enable the elderly to remain in their homes for longer. They also have the potential to reduce the rate of hospitalisation and demand for residential care services. As CHA (2002, p. 25) argued:

> There is an important nexus between the provision of appropriate housing and the balance between home-based and residential aged care. In so far as older households are more supported in their homes, with health services, renovations and relocations if need be, the less reliant and the longer the deferral of nursing home services.

Improvements in these areas will require better coordination of the planning and provision of services for older people across the various levels of government and across the aged care, health and housing systems.

The mix of Commonwealth, state and local government responsibilities has resulted in a 'patchwork' of around 30 different aged care programs, with a range of eligibility criteria, user charges, access points and reporting requirements. This situation also results in high administrative costs for providers.

Improved coordination of community care programs would aid users in their search for information on, and access to, the various programs. In this regard, the Myer Foundation (2002, p. 14) noted:

> Bluntly, it is very difficult for many older Australians who need care to get access to the advice, support and care services they need. Our aged care system is fragmented, with no easy points of access and in many regions, too few resources to meet needs. The same older person might need community and residential care at different stages in their life, but to get it they have to negotiate with different organisations and tiers of government, with different rules and protocols. Where and how each older person lives has a significant impact on their health and the level of care they need – but there is no systematic coordination of health and housing policy and planning which would address the varying needs of older people. These issues underpin the changes required to Australia's current aged care system.

The establishment of Commonwealth Carelink Centres in 2001 as a one-stop-shop, is likely to help users in accessing appropriate care. The Centres are intended to link health professionals, general practitioners, other service providers, carers and individuals in need of assistance with the agencies providing care and support in a given region.

The Minister for Ageing recently released a consultation paper, *A New Strategy for Community Care* (DHA 2003c), which proposes a number of reforms for the community care system. Underpinning the reforms is a national framework for the delivery of all Commonwealth, state and territory programs. It seeks to establish common points of access, assessment processes, eligibility requirements, standards of service provision, user fees, accountability processes and a common information system across all similar programs. The four key elements of this national framework are:

- service provision aligned with levels of need;
- the establishment of regional access centres;
- standardised assessment and information management; and
- streamlined administration.

Inconsistency across programs

There is some inconsistency in eligibility rules and charging practices between the health sector and aged care services. Kendig and Duckett (2001, p. 39) explain:

> Consider a person who has a stroke and ends up requiring ongoing care. Ignoring the different funders (Commonwealth, State and local governments …), the consumer faces a bewildering array of different financial policies. If admitted to a public hospital as a public patient, the patient is not expected to make any financial contribution. The same is true for his or her episode of acute rehabilitation (if any). If the patient is deemed to require residential care, the transition from the 'health' sector to 'aged care' is not seamless. Capital and recurrent contributions may be required from day one in residential care. If community care is required, there may be different expectations of financial contributions depending on the service auspice: hospital-in-the-home generally do not require a patient/client contribution in contrast to home and community care requirements.

More consistent access and payment arrangements across health and aged care services would improve the efficiency and equity of the aged care system.

5.3 Quality of care

Service quality, particularly in the area of residential care, continues to be a concern for residents and their families. Well publicised failures in providing adequate residential care have resulted in questions being raised about the accreditation process and the need for greater and more frequent scrutiny of quality. The extension of accreditation to the community care sector is also considered to be important.

Future generations, with higher incomes and assets, are likely to expect higher quality standards.

Some providers claim that the current levels of government funding and user contributions are inadequate to meet the standards of care required to achieve accreditation and certification, let alone the expectations of residents and their families.

Many of the concerns relate to the magnitude of the capital costs of refurbishing and rebuilding to meet new building standards that are to apply from 2008. Gray (2001) estimates that further investment of around $80 to $90 million per year until 2007-08 will be required. This estimate is based on the assumption that aged care homes which do not currently meet the 2008 standards will need to spend around $35 000 per bed to upgrade. Providers argue that the upgrade costs are considerably higher, although no official industry estimate is available.

Providers also argue that the use of the Commonwealth Own Purpose Outlays (COPO) price index to adjust subsidies threatens the quality of care, because it is not linked to the total costs of providing aged care (see section 5.5).

5.4 Choice and flexibility

Under the current arrangements, there are limited forms of community or residential care available to those in need. Recent initiatives, such as the Extended Age Care at Home (EACH) and Retirement Villages Care Pilot programs, have broadened these care choices (DHA 2003d).

The lack of choice can be traced to the regulatory and funding arrangements which constrain competition and flexibility within the system and lead to long waiting lists. These forces ultimately reduce the incentives of providers to respond to users needs. In commenting on the implications of these aspects of the system, the Chamber of Commerce and Industry of WA (2002, p. 6) noted:

> The financial incentives that stimulate improvement and innovation in conventional market driven industries do not drive change in the aged care industry.

One avenue of choice is extra service places, involving the offer of higher standards of accommodation, food and services to residents for an additional fee. Providers can also seek an accommodation bond from all residents purchasing extra service places.

The Commonwealth Government, however, regulates the availability, fees and requirements that apply to extra service places (chapter 3). The proportion of residential care places currently allocated extra service status is limited to 12 per cent of all places[2]. There is also a maximum additional fee a provider can charge a resident for receiving 'extra service' care and the basic care subsidy is reduced by 25 cents for each dollar of extra service income received by the provider. Effectively, the arrangements place a ceiling and an implicit tax on extra services (see chapter 7).

Providers report that, apart from concerns as to the size of the market, other factors also prevent them from entering 'extra service' provision in large numbers. These include:

- the large amount of detailed documentation required to apply for extra service certification;

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[2] Industry participants report that current levels of extra service provision fall well below this figure, and are likely to range between 4 and 6 per cent. The Minister for Ageing foreshadowed raising the cap on extra service places from 12 to 15 per cent in May this year (Andrews 2003).

- a lack of clarity in the legislation with regard to requirements for 'extra service' standard refurbishments, upgrades and expansions; and
- uncertainty caused by the five year period after which reapplication for approval to provide 'extra service' places must occur.

Future generations with a greater capacity to pay for aged care services are likely to demand a greater range of accommodation/living options and different ways of combining them with the provision of care. This is clearly evident already at the low end of the care spectrum. For example, in recent years, there has been growth in the development of private retirement villages where the aged pay for their own housing and have access to some care services.

Many in the industry argue that current planning ratios limit the capacity of the system to respond to changes in user demand. For example, the Anglican Aged Care Services Group, in its submission to the House of Representatives Standing Committee on Ageing (2002, p. 1), claimed:

> The planning ratios used for low care, high care and CACPs are totally inconsistent with client demand and trends. …
>
> The reality is that more older Australians require CACPs/EACH programs than nursing home care. However, the government regulated supply mix consists of 50 low care, 40 high care and 10 CACPs for each 1 000 people aged 70 and over. Providers react to government controlled supply by building hostels because they are generally at present the only viable residential aged care service because of accommodation bonds.

Ageing in place (the policy which allows low care residents to stay in place when their dependency increases), has, however, provided some flexibility to the strict division between high and low care places.

5.5 Sustainability

Within the industry, and the community in general, there is some debate about the capacity of the current aged care system to meet both the present and future care needs of older Australians. Particular concerns relating to the current level of funding include:

- the viability of the high care residential sector;
- inadequate indexation of subsidies; and
- cost pressures facing small facilities in rural and remote areas.

Concerns about funding for aged care in the medium to longer term are largely related to the escalating unit costs of care and the ageing population.

The viability of high care residential facilities

As a result of the differing funding arrangements that apply within residential care (accommodation bonds for low care places and accommodation charges for high care places), capital funds available to providers of high care places are considerably more limited than those available for low care places. The average income from accommodation bonds per low care resident is estimated to be almost three and a half times the average income derived from accommodation charges per high care resident (table 5.2).

Table 5.2 **Income derived by providers from accommodation bonds and charges, 2000-01**

	Total income	*Income per resident*
	$m	$
Accommodation bonds	251.3	5063
Accommodation charges	125.2	1484

Source: ACG (2002, p. 57).

This has reportedly led private providers to move into the provision of low care places (or extra service high care places) and religious and charitable providers to provide independent living units to cross-subsidise high care places. For example, the Australian Nursing Homes and Extended Care Association (ANHECA 2002, p. 6) claims that:

> From across the sector providers are saying that it is not a viable decision to build long-term care places unless this issue of capital creation is resolved.

And (p. 10):

> In the 2002 Aged Care Approvals Round only 6 approvals took place for stand-alone high care facilities across Australia. For the industry this raises alarm bells as it is confirmation of what ANHECA has been saying for 2 years: namely that without the provision of bonds on a similar basis to bonds in low care, high care building work is going to come to a stand-still.

High care places are currently reported to be in short supply. Further, as discussed in the next chapter, it is at the high care end where the growth in future demand for residential care is likely to be concentrated.

Inadequate indexation of subsidies

A source of ongoing debate between the industry and the Commonwealth is whether the current indexation of subsidies (based on the COPO price index)

compensates adequately for actual cost increases in the sector. Based on work undertaken for the period 1996-97 to 1999-2000, the National Aged Care Alliance (2002, p. 2) argues:

> … the current funding system for residential aged care is an inadequate basis on which to provide quality care because the funding is inadequately indexed and does not reflect the real costs of providing care. The viability of aged services will continue to deteriorate as the funding gap grows and as Australia's population ages.

According to providers, the gradual wearing away of the subsidy has resulted in downward pressure being placed on wages and staffing levels (particularly registered nurses), with adverse effects on the quality of care. The industry has had difficulty in competing with the acute health care sector to attract and retain qualified nursing staff. In 2002, the gap in nursing wage rates between the acute and aged care sectors was around 12.5 per cent (Fitzgerald 2002).

On the question of productivity improvement, one conclusion in the *Two Year Review of Aged Care Reforms* (Gray 2001, p. xxviii) was:

> A major challenge for the future would appear to be the issue of indexation. The current gap between Average Weekly Earnings and the Safety Net Adjustment is sustainable within the industry, but the level of return on investment earned by the industry would be eroded by a significant widening of the gap between wages and inflation, especially in high care. This is not an unexpected outcome in an industry characterised by a high ratio of labour to capital costs and comparatively few avenues for substituting capital for labour or making other major efficiency gains.

In its *Nursing Home Subsidies* Report (PC 1999), the Commission recommended that basic subsidy rates should reflect nursing wage rates and conditions applicable in the aged care sector, but only to the extent that these do not exceed the rates and conditions applying in the acute care sector. It also recommended that basic subsidy rates should be adjusted annually according to indices which clearly reflect the changes in the average cost of the standardised input mix, less a discount to reflect changes in productivity (see chapter 7).

The viability of small facilities in rural and remote areas

Under existing funding arrangements, small residential facilities in rural and remote areas are said to be facing particular problems in remaining viable because of higher costs and restricted access to capital contributions (ACSA 2003). Some of the specific cost pressures which residential facilities in these areas face — in addition to pressures stemming from smallness — include (PC 1999):

- a more limited capacity to manage the resident mix, because of a smaller population pool to draw on and a sense of 'duty' found in smaller communities;

- more variable occupancy rates, particularly for respite care beds;
- additional costs associated with bringing in and accommodating agency staff to cover leave and other absences;
- more expensive food and basic services, such as power, water, telephone and fuel;
- higher transport costs for capital equipment;
- a lack of access to skilled tradespeople to maintain equipment and facilities, and higher costs for service calls;
- the reduced life of equipment and fittings, due to harsher climatic conditions;
- higher staff recruitment and training costs; and
- the costs of transporting residents back to communities for ceremonies, family contact visits and the like.

If insufficient allowance is made for significant regional cost differences, equity of care will not be achieved across Australia.

Lower values for rural properties and residences in remote areas also mean that providers of residential care in rural and remote areas are often only able to levy relatively small accommodation bonds. In this regard, ACSA (2003, p. 10) reported:

> In rural Tasmania, one provider received a $9 000 bond while some inner city areas can attract bonds in excess of $500 000, with the average for Australia being approximately $83 000.

Gray (2001) estimates that the average capital income disadvantage, against the national average, faced by rural residential care facilities is around 16 per cent.

Under the current funding arrangements, government viability supplements and targeted capital assistance are provided to rural and remote residential facilities in recognition of their higher operating and capital costs. However, many within the industry consider that these remain inadequate. In the 2002-03 Budget, the Government announced an extra $100 million (over four years) for the Rural and Regional Building Fund. ACSA (2003, p. 4), however, argue:

> … significantly more than this, at least $450 million, is required if any significant progress is to be made.

The impacts of ageing on the sustainability of the current arrangements

There is a considerable debate about the sustainability of the current funding arrangements for aged care in light of the prospective ageing of the population and upward pressure on the costs of providing aged care services. This issue is examined in the next chapter.

6 Demand, utilisation and costs

Australia's population is ageing. Some analysts have warned that this will threaten the sustainability of Australia's expenditure on social programs, including aged care. McCallum et al. (1998, p. vii) refer to the 'challenge' for governments to maintain current levels of aged care funding and service provision, as the population ages. In an article looking at the challenges for OECD countries as a whole, Beck (1996, p. S3) envisages a 'demographic time bomb'. She goes on to observe:

> Over the next 30 or 40 years, the demographic changes of longer lives and fewer births will force most countries to rethink in fundamental ways their arrangements for paying for and looking after old people.

Others suggest that the problems have been overstated (see, for example: ACG 2002; Creedy 1999; Dowrick and McDonald 2002; Treasury 2002a). For instance, Creedy (1999, p. 23) concludes:

> Some growth in social expenditure, relative to GDP, is expected, but it seems excessive to view this in terms of leading to a social security crisis. Nevertheless, careful planning will be required to deal with the changing composition of social expenditure.

The aim of this chapter is to contribute to the Review's consideration of sustainability by:

- exploring the factors that will shape the future demand for residential care (section 6.1);
- examining the implications of future demand for the use of residential care (section 6.2); and
- examining the drivers of future residential aged care costs and outlining some of the implications for government spending (section 6.3) .

Appendix A provides further analysis of some of the influences on the future demand for residential care, while additional information covering the residential care use projections is presented in appendix B.

6.1 Factors influencing future demand

The main purpose of this section is to assist in an understanding of the key factors driving future demand for aged care services, particularly for residential care. The analysis presents a synthesis of the results of various studies, including the latest statistical evidence and the Commission's own demand projections.

An ageing population broadly determines the potential numbers of elderly persons who may eventually enter residential aged care in the coming decades. However, other important factors — most of which are common to other goods and services — will also influence future demand (box 6.1). These include the health status of the elderly, their tastes and preferences, their incomes and wealth, the price and availability of substitutes, and the institutional and regulatory framework.

Box 6.1 **Factors influencing the demand for residential aged care — a selection of recent studies**

UK Royal Commission (1999)

- Demography
- Health expectancy
- Supply of unpaid care from families and friends
- Availability of community care services

Madge (2000)

- Ageing population
- Disability amongst the aged
- Use of subsidised services
- Choices in care modes
- Income and wealth of the aged

Allen Consulting Group (2002)

- Demographic trends
- Health status of older people
- Income and wealth of the aged
- Availability of informal care

DHA (2003b)

- Population ageing
- Changing patterns of health/disease
- Changing technology
- Changes in family relationships
- Complementary/substitute services
- Changing consumer expectations and resources

Significantly, the price of residential care does not directly feature in box 6.1. While price is a fundamental determinant of the demand for almost any good or service, for aged care services it is usually considered as part of the wider institutional and regulatory framework within which users demand aged care services.

Ageing of the population

A fundamental determinant of the demand for aged care services is the size and structure of the aged population at any one time. Available evidence suggests that Australian society, in common with many other societies, is ageing and that this process is set to continue into mid-century, at least. Australian Bureau of Statistics (ABS) population projections indicate that the aged population — those 65 years and over — is expected to increase strongly in both absolute terms and relative to the overall population (ABS 2000b).[1]

The aged population in Australia is projected to more than double between 2001 and 2041 — from 12 per cent of the total population to almost 25 per cent (table 6.1). Similarly, the dependency ratio, which provides some indication of the potential 'burden' of the aged on the working population, is projected to rise from 0.18 to 0.41, or nearly 130 per cent, over the same period.

Table 6.1 **Population share of 'the aged' and dependency ratios, 2001 to 2041[a]**

	2001	*2011*	*2021*	*2031*	*2041*
Share of population aged 65 and over to total population (%)	12.4	14.3	18.4	22.3	24.8
Aged dependency ratio[b]	0.18	0.21	0.28	0.36	0.41

[a] Data are based on ABS Series II population projections. [b] The aged dependency ratio is the number of persons aged 65 and over as a proportion of the working population aged 15–64.

Source: ABS (2000b).

Sustained increases in numbers, for all cohorts of the aged population, are expected over the period 2001 to 2041 (table 6.2). The aggregate number of persons aged 65 and over is projected to increase from 2.4 million in 2001 to 6.2 million in 2041, an increase of around 160 per cent.

Significantly, the rate of growth of those aged 85 years and older — who currently account for 50 per cent of residents in aged care facilities (AIHW 2002d) — is particularly high, especially from 2021 onwards. The number of persons in this age group is expected to more than double over the period 2021 to 2041 — from around 479 000 in 2021 to more than 1 million by 2041.

[1] The ABS (2000b) produces three series of population projections, using different assumptions about future levels of births and migration (and a constant assumption about death rates). However, in practice, there is little difference between the three series. The Series II (medium) projections are used throughout this chapter. Series I (high) and Series III (low) projections can be found in appendix B.

Compared with other OECD countries — particularly those in western Europe — Australia currently has a relatively 'young' population structure, with only a small proportion of the aged population being 80 years or over (Borowski and Hugo 1997). However, the aged population in Europe is expected to grow relatively slowly in the coming decades.

Table 6.2 **Australia's aged population, 2001 to 2041[a]**

Age group	*2001*	*2011*	*2021*	*2031*	*2041*
Number	'000	'000	'000	'000	'000
65–74	1 305.3	1 667.2	2 427.7	2 783.1	2 916.3
75–84	837.5	979.6	1 314.1	1 945.4	2 262.5
85+	260.3	389.2	478.6	676.6	1 034.4
65+	2 403.1	3 036.0	4 220.4	5 405.1	6 213.2
	2001–2011	*2011–2021*	*2021–2031*	*2031–2041*	*2001–2041*
Change	%	%	%	%	%
65–74	28	46	15	5	123
75–84	17	34	48	16	170
85+	49	23	41	53	297
65+	26	39	28	15	159

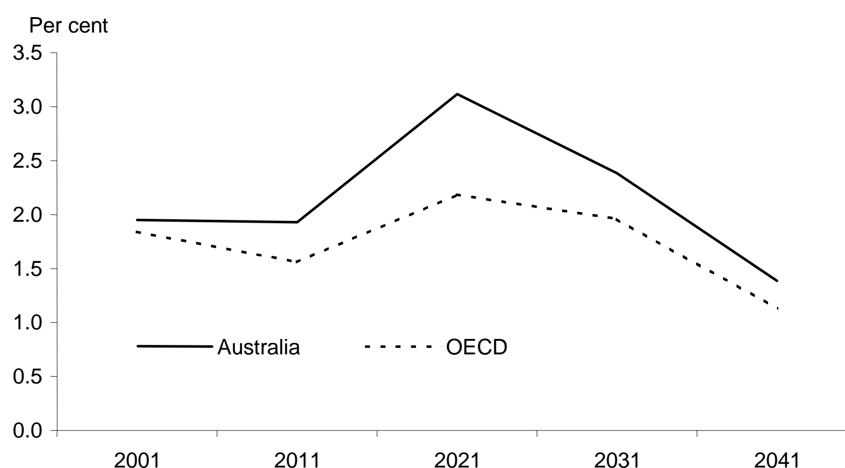
[a] Data are based on ABS Series II population projections.

Source: ABS (2000b).

That said, Australia's aged population is projected to record one of the largest increases amongst OECD countries between 2001 and 2041 — around 1.4 times greater than the OECD average (figure 6.1). The greatest difference is expected to occur between 2011 and 2021, which coincides with the period when Australia's 'young' old group (those aged 65 to 74 years) is expected to grow at its fastest rate. After 2021, Australia's rate of increase is expected to undergo a significant decline and begin to fall in line with the OECD growth rate.

Despite the projected rapid growth in Australia's aged population, its share of total population projected for 2041 (24.8 per cent) will still be lower than many OECD countries. For example, the share of the population aged 65 years and over in Japan, the Netherlands and France in 2041 is projected to be around 32 per cent, 28 per cent and 26 per cent, respectively (UN 1998).

Figure 6.1 **Comparison of growth rates in the population aged 65 years and over, Australia and total OECD, 2001 to 2041**



Data source: UN (1998).

Disability rates and health status

Most studies of the demand for aged care identify disability rates amongst the aged as one of the key determinants. There is a high correlation between severe disability rates and the use of residential aged care. Hence, reductions in disability rates over time could potentially provide a major offset to the increase in demand for residential care implied by Australia's ageing population.

Table 6.3 reports the extent of different types of disability suffered by the aged in Australia between 1981 and 1998. While the incidence of severe/profound disability has only risen slightly over the past two decades, the incidence of mild/moderate disability has almost doubled, despite a marginal decline since 1993.

Table 6.3 **Proportion of the population aged 65 years and over with differing degrees of disability, 1981 to 1998[a]**

Degree of disability	*1981*	*1988*	*1993*	*1998*
Severe or profound	16.2	17.9	17.1	19.6
Mild or moderate	15.4	27.3	27.5	26.0

a Rates are age-standardised to the estimated resident population for March 1998. That is, the figures provide a perspective of changes in the weighted average of age-specific disability rates, using a fixed set of population weights. The data have been corrected for major methodological differences between the surveys.

Sources: ABS (1999a); AIHW (1999); Productivity Commission estimates.

The data for Australia in table 6.3 is in contrast with the majority of international evidence, which clearly points to an overall decline in age-specific disability rates among the aged during the 1980s and early-1990s (Jacobzone, Cambois and Robine 2000). The most significant reductions occurred in France, Germany, Japan and the United States, while Canada and Sweden experienced moderate reductions. Australia is grouped with the Netherlands and the UK as countries which have experienced very moderate or no improvements in disability rates on the whole.[2]

Looking to the future, a relevant consideration is the issue of the 'compression of morbidity'. This hypothesises that, as life expectancy increases, there is no increase in the number of disability-affected years. As noted by Madge (2000), the weight of international evidence is that the disability-free years of the aged increase with life expectancy. In particular, severe/profound disability tends to be concentrated in the last two to four years of life, regardless of how long a person lives. This suggests that relevant age-specific disability rates will fall.

Given the differing views about future disability rates and the compression of morbidity, tables 6.4, 6.5 and 6.6 provide projections of the number of severe/profound disabled persons for different age groups, according to three scenarios — no disability rate reductions, moderate reductions and high reductions.

Table 6.4 **Aged persons with severe or profound disability, by age group; *'no reductions in disability rates'* scenario, 2001 to 2041**

Age group	*2001*	*2011*	*2021*	*2031*	*2041*
Numbers	'000	'000	'000	'000	'000
65–74	142.0	181.4	264.2	302.9	317.4
75–84	215.8	252.4	338.7	501.3	583.0
85+	168.9	252.4	310.5	438.9	671.0
65+	526.7	686.3	913.3	1 243.1	1 571.4
	2001–2011	*2011–2021*	*2021–2031*	*2031–2041*	*2001–2041*
Change	%	%	%	%	%
65–74	28	46	15	5	123
75–84	17	34	48	16	170
85+	49	23	41	53	297
65+	30	33	36	26	198

Source: Productivity Commission estimates based on Series II projections in ABS (2000b).

[2] Differences in levels of disability rates across countries often reflect differences in the criteria of disability. For example, the criteria chosen by France and Japan are rather restrictive compared with those of other countries (Jacobzone, Cambois and Robine 2000).

Assuming no reductions in disability rates are experienced — in line with the scenario used by the OECD for its ‘static’ disability projections for Australia (Jacobzone et al. 1998) — the number of persons aged 65 years and over with severe/profound disabilities is projected to increase by nearly 200 per cent between 2001 and 2041, an increase of over 1 million people. The highest increase would occur for those aged 85 years and over, with growth of almost 300 per cent. These increases are attributable entirely to growth in the number of aged Australians.

On the other hand, assuming some disability rate reductions occur, the ageing effect is muted. Under the ‘moderate disability rate reductions’ scenario — which is based on an assessment by the AIHW (1999) — the number of disabled persons aged 65 years or over increases by 170 per cent between 2001 and 2041. Over the same period, the increase in the disabled aged under the ‘high disability rate reductions’ scenario — which assumes that Australia is able to secure reductions corresponding to those experienced in the USA in recent years — is 114 per cent.

Table 6.5 **Aged persons with severe or profound disability, by age group; ‘*moderate reductions in disability rates*’ scenario, 2001 to 2041**[a]

Age group	*2001*	*2011*	*2021*	*2031*	*2041*
Numbers	‘000	‘000	‘000	‘000	‘000
65–74	142.0	172.1	244.3	280.3	283.7
75–84	215.8	239.4	313.1	464.0	521.3
85+	168.9	239.4	287.1	406.2	599.9
65+	526.7	650.9	844.5	1 150.5	1 405.0
	2001–2011	*2011–2021*	*2021–2031*	*2031–2041*	*2001–2041*
Change	%	%	%	%	%
65–74	23	42	15	1	102
75–84	12	31	48	12	145
85+	44	20	41	48	260
65+	25	30	36	22	170

[a] The ‘moderate reduction in disability rates’ scenario is based on AIHW (1999) projections, which assume a decline of 0.25 per cent per annum.

Source: Productivity Commission estimates based on Series II projections in ABS (2000b).

Table 6.6 **Aged persons with severe or profound disability, by age group; '*high reductions in disability rates*' scenario, 2001 to 2041**[a]

Age group	*2001*	*2011*	*2021*	*2031*	*2041*
Numbers	'000	'000	'000	'000	'000
65–74	142.0	158.9	202.5	203.3	186.5
75–84	215.8	235.1	293.7	404.8	438.5
85+	168.9	235.1	269.2	354.4	504.6
65+	526.7	629.0	765.4	962.5	1 129.5
	2001–2011	*2011–2021*	*2021–2031*	*2031–2041*	*2001–2041*
Change	%	%	%	%	%
65–74	12	27	0	-8	31
75–84	9	25	38	8	103
85+	39	15	32	42	199
65+	19	22	26	17	114

[a] The 'high reductions in disability rates' scenario is based on the annual rate of decline in the disability rate experienced by the United States in the last decade (0.47 per cent per annum).

Source: Productivity Commission estimates based on Series II projections in ABS (2000b).

Preferences for different forms of care and living arrangements

A recent Australian study by McCallum (2002) indicates, not unexpectedly, that the majority of people aged 70 years or over would prefer to stay in their own home for as long as possible. The study found that 59 per cent of elderly Australians would prefer to receive community care services at home over other options (including residential care). McCallum also observed that a strong growth in preferences for independent living in Australia could be expected as the 'baby boomers' get older.

These results are consistent with the findings of other international research. For example, De Jong Gierveld, De Valk and Blommesteijn (2001) found that many older people in the USA and Europe prefer to continue living independently because of a desire for autonomy and self-reliance, as well as a wish not to become a burden on the younger generation.

Australia's 'baby boomers' may possess certain characteristics that distinguish them from previous generations of retirees. For example, they may have expectations of a higher quality lifestyle and possess higher levels of income and wealth that will allow these expectations to be met. They are also expected to be healthier, more physically active and have a more diverse range of cultural and social interests.

These characteristics are likely to influence their preferred type of care and living arrangements in their old age. Accordingly, past patterns of demand for residential

aged care may not be a good guide to future demand. As Brink (2002, p.18) observes:

> The different attitudes of baby boomers to their parents' generation will extend to ageing. Healthier for longer, they won't be happy to sit around in a one-room-with-bathroom facility until they absolutely have to, if ever … When one in five, or even four in the population is 65 and over, they will have voter and consumer power to demand that their needs are met effectively and equitably.

It is difficult to estimate the magnitudes of such impacts. In any case, preferences are one thing, but their realisation is another. The following sections discuss some factors that may assist (or impede) the efforts of the future aged to maintain relatively independent living arrangements outside formal care.

Availability of community care

The preferences of the elderly to remain in their own homes for as long as possible are being accommodated by several key government programs.

The Home and Community Care (HACC) program and Community Aged Care Packages (CACPs) provide low level care for the elderly in their own homes. In addition, the recently introduced Extended Aged Care at Home (EACH) program provides high level care to a small number of the elderly in their own homes. These programs are discussed further in chapters 2 and 3.

The HACC is by far the largest of these community care programs and has been extended significantly in recent years. Between 1997-98 and 2001-02, the number of clients receiving HACC services recorded a twelve-fold increase (table 6.7). Moreover, the intensity of use also increased significantly, with the share of the highest-using clients rising from under 5 per cent to around 23 per cent.

Table 6.7 **Service use by HACC clients, 1997-98 and 2001-02**

	1997-98		*2001-02*	
Hours of service	*Number of clients*	*Share of clients*	*Number of clients*	*Share of clients*
	No.	%	No.	%
Clients consuming 40 or less hours per month	46 830	95.7	449 579	77.1
Clients consuming more than 40 hours per month	2 088	4.3	133 577	22.9
Total	*48 918*	*100.0*	*583 156*	*100.0*

Source: SCRCSSP (2003).

This growth in community care programs is expected to continue in future years, partly in response to the preferences of the elderly, and also because the generally lower costs, and smaller claim on revenue relative to residential care, will make such programs relatively attractive to governments. The programs are considered fundamental in delaying entry to residential care.

Availability of informal carers

As noted in chapter 2, informal care is the major source of assistance for the elderly. Many studies show that, if health deteriorates and assistance is needed, the elderly rely primarily on family members — mainly on their partners, as well as other family members (De Jong Gierveld, De Valk and Blommesteijn 2001).

Family support also appears to be an indicator/predictor of the likelihood of using residential aged care services. Stone (2000) draws on data from a report by the National Academy on Aging (1997) to show that 50 per cent of elderly people with long-term care needs in the USA who lack a family network live in nursing homes, compared to only 7 per cent of those who have family carers.

Changes in attitudes to, and the potential availability of, informal care are therefore of key significance to the future demand for residential care in Australia. The two primary sources of informal carers are:

- the spouse or partner; and
- other family members (usually children).[3]

The Commission's analysis of these influences suggests that there will be opposing socio-demographic forces at work with respect to the future availability of informal carers. However, on balance, their combined impacts are expected to be neutral.

Spouse or partner as carer

The majority of carers of the aged (around 60 per cent) are aged 65 or over, and most are spouses or partners (AIHW 2001).

ABS projections on future living arrangements (ABS 1999b) suggest there will be little change between 2001 and 2021 in the proportion of the aged living with their spouse — around 47 per cent in the case of people aged 65 years or over and around

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[3] The rate of use of residential aged care also appears to be clearly related to the differing ethnic origins of residents, suggesting that potential family support for the elderly in the future may be heightened by the expected increasing share of overseas-born in the elderly population (see appendix A).

19 per cent for people aged 85 years or over. However, Madge (2000) noted that if the trend towards increasing divorce and separation rates is maintained, a higher proportion of the elderly may be without partners in 2031 and 2041.

Then again, an alternative indicator of the extent of informal care — the gender balance of the aged — suggests that this may not be the case. Redfoot and Pandya (2002) argue that the narrowing ratio of men to women in old age, due to increased male life expectancy, has reduced the proportion of the aged without a partner and contributed to the declining use of residential care in the USA. Furthermore, they expect this trend — and its relationship to institutionalisation — to continue over the next few decades. Thus, if the supply of informal care rises through spouses providing assistance in the home, there may be less demand for residential care services (Lakdawalla and Philipson 1999; 2002).

The trend of an increasing ratio of males to females in the Australian aged population between 1981 and 2001 is projected to continue through to 2041 (table 6.8). This will be most marked in the population aged 85 years and over, where the ratio of males to females is expected to increase from 0.45 in 2001, to 0.68 in 2041. The AIHW (1999) noted that the more even gender balance in future aged populations may have implications for trends in both formal and informal care.

Table 6.8 **Ratio of males to females in aged population, by age group, 1981 to 2041**

Age group	*1981*	*1991*	*2001*	*2011*	*2021*	*2031*	*2041*
65–74	0.83	0.87	0.93	0.97	0.95	0.94	0.96
75–84	0.62	0.66	0.72	0.80	0.86	0.86	0.86
85+	0.37	0.40	0.45	0.52	0.59	0.66	0.68
65+	0.73	0.75	0.79	0.84	0.88	0.87	0.87

Source: ABS (2000b).

Availability of care from other family members

While the aged rely primarily on their partners for care assistance, they also receive support from other family members.

The average number of children is sometimes used as an indicator of potential family support for the aged (Redfoot and Pandya 2002). However, as the majority of family support is provided by females — women account for two-thirds of disability carers (ABS 1999a) — the future availability of informal care from family members may be better estimated by examining changes in the ratio of the aged population to potential female carers.

Estimates of the aged population to potential female carers between 1991 and 2041 are shown in table 6.9. This ratio is projected to more than double from 2001 to 2041, indicating a likely fall in the availability of family carers, with those aged 85 years and over at most risk.

Table 6.9 **Ratio of aged population to potential female carers, by age group, 1991 to 2041[a]**

Age group	*1991*	*2001*	*2011*	*2021*	*2031*	*2041*
65–74	0.22	0.21	0.24	0.33	0.37	0.38
75–84	0.11	0.14	0.14	0.18	0.26	0.30
85+	0.03	0.04	0.06	0.06	0.09	0.14
65+	0.36	0.39	0.43	0.57	0.71	0.82

a In line with the AIHW (1999), potential female carers are defined as those aged between 20 and 69.
Source: ABS (2000b).

As noted by Madge (2000) and the AIHW (1999), the available number of female carers will be affected adversely by the trend to increasing labour force participation by women. The AIHW suggests that there is scope for further female participation increases in Australia and noted that female participation in several OECD countries is above that currently prevailing in Australia.

It is significant, however, that most of the increase in female labour force participation in Australia since 1983 has been attributable to growth in part-time employment — the ratio of part-time to full-time employment increased from 54 per cent in 1983 to 78 per cent in 2001 (ABS 2003). The predominance of part-time work may allow many women to combine work with carer activities.

Moreover, Treasury (2002b, appendix B) argues that women's carer responsibilities may themselves serve to limit the growth in female employment:

> Labour force participation rates for women in most age groups have increased significantly over the past 20 years, with most growth occurring in part-time labour force participation. This trend is projected to continue, but may be limited over the longer term by child-raising and caring activities in which women traditionally play a large part.

Income and wealth

The role played by income and wealth as determinants of future residential aged care demand is twofold.

- Socioeconomic improvements are among the strongest predictors of declines in disability rates (see, for example, Redfoot and Pandya 2002).

- The expected increase in the affluence of the aged over time is likely to reinforce their preference for independent living (see, for example, Jacobzone and Oxley 2002). Increased financial autonomy of older persons will potentially make informal and community care more tenable, allowing the purchase of home care services or allowing the elderly to reside in alternative (assisted) living arrangements, such as retirement villages, for a longer period of time.

The distribution of wealth has shifted markedly towards older Australians since the mid-1980s. The estimated average real wealth of aged Australians has increased by about 90 per cent between 1986 and 1997 (Harding, King and Kelly 2002).

These trends are expected to continue over the next 30 years (Kelly 2002). Between 2000 and 2030, the average real family wealth of aged Australians is projected to grow at a significantly faster rate than that of younger Australians. The aged's share of total family wealth is estimated to increase by more than 50 per cent over this period. Furthermore, it is estimated that families aged 75 and over in 2030 will have more than double the real assets of their 2000 counterparts (Kelly 2002).

On balance, the Commission expects projected wealth increases to result in a more affluent elderly population in the coming decades. While this is likely to give rise to differing impacts on the demand for total aged care services, a relative dampening of the demand for residential aged care places seems probable.

Summary of potential impacts on future demand

Overall demand for residential care services is driven principally by ageing and changes in disability levels:

- The impact of the 'baby boomers' on the ageing population is expected to peak between 2021 and 2031, when persons aged 75 and over (who account for the bulk of residential care admissions) are projected to increase from around 1.8 million to 2.6 million. The peak growth in those aged 85 years and over will occur a decade later, between 2031 and 2041.
- The extent of any changes in disability rates in the future is uncertain. Nevertheless, reductions in disability rates are not expected to offset increases in the ageing population over the next 40 years, thus leading to an overall increase in the number of aged persons with disabilities. This is most marked for those persons aged 75 years and older.

However, important changes in other demand drivers are expected to somewhat dampen the pressure on residential care:

- Alternative living arrangements are likely to be preferred increasingly by the future-old and be increasingly attainable due to higher average income/wealth.
- Government policies aimed at shifting the balance away from residential care to community care services look set to continue.
- Changes in the extent of informal care are uncertain but, on balance, they are likely to have a neutral impact on the demand for residential aged care.
- The increasing affluence of the aged in the coming decades is expected to result in reduced disability, thus lowering the demand for residential care.

These demand offsets to ageing will also affect the mix of high and low level care. For high level care, a combination of factors seems likely to push out the time before it is required by the disabled — that is, many elderly persons will eventually require high care, but at an older average age than at present. For low level care, alternatives (such as, community care options) will increasingly act as effective substitutes for residential care. This is likely to result in many elderly persons by-passing low level care altogether and entering aged care homes as high care residents at an older average age, and possibly more frail, than at present. The Commission considers that the net result is likely to be a significant increase in the demand for high care relative to low care places.

6.2 Future residential aged care use

The previous section examined the nature and likely impacts of key determinants of demand for residential aged care services. This section examines the implications for future residential care use, with two important caveats:

- First, an underlying demand for residential aged care is not automatically translated into an equivalent number of places being made available and used. Whether the supply of residential care services will meet the future demand for them is difficult to predict, although some indicators point to unmet demand in recent years (see chapter 5). There is, in fact, a number of reasons why utilisation will always differ from demand, including: the impact of institutional factors; the relationship between ageing, disability levels and institutionalisation rates; changes in the length of stay; and the availability of alternative forms of care and living arrangements. These issues are discussed in more detail in appendix A.
- Second, in estimating the impacts of prospective demand changes on future residential care use, the current institutional and regulatory environment (profiled in chapter 3) — which strongly influences the supply of, and demand for, residential aged care services — is assumed to remain unchanged over the period under consideration. This is, of course, unlikely.

Box 6.2 Key variables and scenarios for residential care projections

Disability rates

Trends over the past decade or so in Australia have shown a marginal rise in severe/profound disability rates and a marginal decline in mild/moderate disability rates. This picture contrasts with most international evidence, which shows continuing declines in disability rates. In the Commission's view, it seems unlikely that disability rates in Australia will rise in the period ahead. Nevertheless, a conservative approach of no change in disability rates over the projection period is assumed for the first scenario.

There are a number of reasons why disability rates seem more likely to decline over the projection period. Improvements in illness prevention, disease management, surgical procedures and mobility aids are likely to have a positive impact on the health and mobility of older Australians. Accordingly, two scenarios assume a decline in disability rates. The first assumes moderate disability reductions (0.25 per cent per annum) based on AIHW (1999) estimates. The second, a more optimistic scenario, adopts the annual rate of decline experienced by the United States in the last decade (0.47 per cent per annum), a country with reliable data and an economic/cultural environment similar to that of Australia (OECD 1998).

Institutionalisation rates

The last decade has witnessed a decline in Australia's institutionalisation rate — which measures the number of people in residential aged care institutions as a proportion of the total aged population. Further declines seem feasible and plausible given preferences for non-institutional care and growth in informal and community care options. Accordingly, all three scenarios assume a decline in the institutionalisation rate.

The first scenario assumes that the trend reductions by age group (net of the impact of declining disability) between 1991 and 2001 will persist over the projection period. The second assumes that the rate of reduction (net of the impact of declining disability) will taper off over the projection period, with annual growth arbitrarily selected as being 75 per cent of the historical trend (by age group). The third assumes that the decline (net of the impact of declining disability) will gather pace, with annual growth arbitrarily selected as being 125 per cent of the historical trend (by age group).

Under all scenarios, however, the 85 years and over age group is assumed to grow at 25 per cent of trend. This is consistent with the consensus in the literature that this age group is likely to experience significantly muted declines in institutionalisation.

Key variables and scenarios

Transforming potential demand changes into overall residential care use projections requires assumptions to be made about two major parameters — possible changes in

disability rates and the proportion of the aged population likely to be institutionalised.

The Commission has developed three scenarios for each of these parameters based on its analysis of the key demand drivers and an examination of other factors, such as recent Australian trends and recent changes in other OECD countries. The assumptions underlying these scenarios are spelt out in box 6.2, while their impacts on future disability and institutionalisation rates are presented in appendix B.

Residential aged care projections

As various combinations for disability rates and institutionalisation rates are possible, a significant number of residential aged care projections can be derived. This submission presents a range of projections covering the period 2001 to 2041. They are discussed in summary form below with a full tabulation of the projections presented in appendix B.

The lowest estimates of overall residential aged care use occur under a combination of high disability reductions (based on recent US experience) and high reductions in institutionalisation rates (based on 25 per cent above recent trends). The highest estimates of future use arise under a combination of no disability reductions and only low reductions in the institutionalisation rate (based on 25 per cent below recent trends).

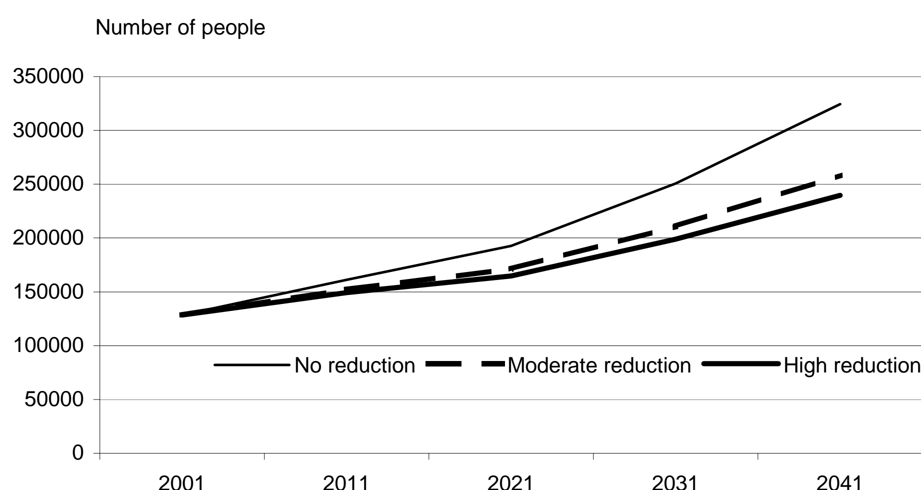
From a 2001 base of 128 539 aged care residents, these estimates yield a range of from 161 000 to 198 000 residents in care by 2021. The corresponding range for 2041 is from 232 000 to 337 000 residents. These data imply average annual growth rates of 1.1 to 2.2 per cent between 2001 and 2021, and 1.5 to 2.4 per cent between 2001 and 2041. These compare with an average annual growth rate for aged care residents of 1.7 per cent between 1991 and 2001.

Given the considerable uncertainty surrounding the magnitude of future changes in the key variables, it is difficult to say which scenarios will be 'most likely' or 'least likely' within these ranges (or even whether the ranges capture the full possibilities). However, some guidance on the sensitivity of the estimates of future residential aged care numbers can be provided by examining a scenario which assumes a continuation of recent trends in institutionalisation rates combined with different assumptions for disability reductions. The resulting projections are shown in figure 6.2 and, by age group, in table 6.10.

A few conclusions are suggested by these illustrative estimates:

- Under all disability rate scenarios, the rate of increase in aged care residents is expected to accelerate from 2021 onwards, with persons aged 85 years and over principally responsible for this post-2021 upswing.
- The variation in disability rate scenarios magnifies the range of utilisation estimates in the later decades of the projection period. Thus, the relatively narrow range of 165 000 to 193 000 aged care residents in 2021 expands to a range of 240 000 to 324 000 residents by 2041.

Figure 6.2 **Projections of aged care residents 65 years and over, under different scenarios for disability rate reductions, 2001 to 2041[a,b]**



[a] The projections are based on a continuation of trend reductions in the institutionalisation rate (by age group). See appendix B for other institutionalisation rate scenarios. **b** The scenarios for reductions in disability rates were estimated using age specific disability rates for people aged 65–74, 75–84 and 85 years and over.

Data source: Productivity Commission estimates.

The Commission's estimates of residential aged care use are somewhat lower than those of other recent studies. Assuming moderate reductions in disability rates, in concert with trend declines in the institutionalisation rate, the Commission's projections suggest that the number of persons in residential aged care will increase to around 171 000 in 2021 and 259 000 by 2041. For 2021, the residential care estimates of other studies are 217 000 persons (OECD 1998, trend disability reductions), 188 000 persons (Madge 2000, medium disability reductions)[4] and 237 000 persons (ACG 2002, 'base' case).

[4] The Madge projection for 2021 was derived using data contained in his table 2.8 (Madge 2000, p. 23).

Table 6.10 **Projections of aged care residents, by age group, under different scenarios for disability rate reductions, 2001 to 2041[a,b]**

Disability rate scenario	*2001*	*2011*	*2021*	*2031*	*2041*
	No.	No.	No.	No.	No.
No disability rate reductions					
65–74	13 679	17 201	24 661	27 834	28 716
75–84	47 254	46 652	52 818	65 992	64 774
85+	67 606	97 302	115 219	156 821	230 852
65+	128 539	161 156	192 698	250 647	324 342
Moderate disability rate reductions					
65–74	13 679	15 594	20 266	20 736	19 393
75–84	47 254	44 220	47 454	56 199	52 287
85+	67 606	92 295	103 665	133 833	186 872
65+	128 539	152 108	171 385	210 768	258 552
High disability rate reductions					
65–74	13 679	15 089	18 975	18 786	17 000
75–84	47 254	43 435	45 784	53 259	48 672
85+	67 606	90 678	100 064	126 921	174 116
65+	128 539	149 201	164 823	198 966	239 788

a The projections are based on a 'continuation of trend reductions' in the institutionalisation rate (by age group). See appendix B for other institutionalisation rate scenarios. **b** The scenarios for reductions in disability rates were estimated using age-specific disability rates for people aged 65–74, 75–84 and 85 years and over.

Source: Productivity Commission estimates.

6.3 Residential aged care costs

Expenditure on residential aged care services — and future funding requirements — have distinct demand and supply side influences. The National Aged Care Alliance (2001, p. 7) noted:

> … the adequacy of recurrent funding is affected by the demand for places in residential aged care — adjusted for client dependency and other characteristics — and changes to input costs associated primarily with labour and consumables.

Beyond pure demand-side influences, the sustainability of future funding requirements will also be influenced by cost-related factors. If the recent past is any guide, cost-related factors will be a key driver of overall expenditure and funding requirements.

Over the 10 years from 1991-92 to 2001-02, the $1.75 billion (80 per cent) increase in government expenditure on residential aged care was accounted for mainly by increases in unit costs ($1.35 billion), with the remainder (only $0.4 billion) attributable to additional usage.

Future residential care costs

In examining influences on future residential aged care costs, it is helpful to distinguish between recurrent and capital costs.

Recurrent costs

Recurrent costs per client within the residential aged care sector are expected to increase significantly over the period to 2041, driven partly by broad cost movements and partly by changes in the resident mix.

Recurrent costs consist mainly of wages, superannuation, purchases of supplies and equipment, energy costs, contracted services and depreciation on buildings and equipment. The ratio of wage costs to non-wage costs for this sector is estimated at around 75:25 (PC 1999). While this ratio may vary from region to region, or even facility to facility, it provides an indication of the dominance of wages in the recurrent costs of the residential aged care sector.

Table 6.11 shows recent movements in the wage cost index for the health and community services sector (a proxy for labour cost movements in the residential aged care sector). Over the period from 1997 to 2001, wage costs increased by 13.5 per cent (or around 3 per cent per annum) in real terms.

Table 6.11 **Cost index deflator for residential aged care expenditure**

Year	*Wage cost index for health and community services*
1997	100.0
1998	103.6
1999	107.1
2000	109.7
2001	113.5

Source: ABS (2003b).

Looking to the future, labour costs in the residential care sector are expected to increase significantly in the short term. This is due to:

- the need to maintain some level of competitiveness for specialised employees in the residential aged care sector compared with those in the acute care sector — the current disparity limits the ability of the former to retain/attract staff;
- an expected shortage of labour (particularly nurses) will place further pressure on wages; and

- limited opportunities for capital substitution, or other means for improving labour productivity.

The resident mix is another important driver of recurrent costs, with the average cost of the subsidy for providing for a high care resident being approximately three times that for a low care resident (see chapter 3). The demand analysis in section 6.1 suggests that there is likely to be lower levels of demand for low care places in the coming decades compared to that for high care.

A rise in the proportion of high care residents would require additional specialised labour inputs to service their needs, thus increasing average expenditure per client. Commonwealth subsidies have already increased significantly in recent years (see chapter 3), but, looking to the future, they may have to increase at an even faster rate to match these likely cost increases.

Capital component

Additional capital spending will be needed to extend existing aged care facilities, as well as to build new facilities, to meet projected increases in demand. Further expenditure will be necessary to meet future increases in quality standards.

There are varying estimates of the average cost of providing new residential care places, partly reflecting differing building costs around the country. However, according to ACG (2002), the Commonwealth Government's assumption of an average cost for new places of $68 500 in 1998-99 is significantly below industry estimates of around $100 000. Accordingly, the ACG assumed arbitrarily that the cost of expanding capacity would be 30 per cent higher than the Commonwealth's estimate.

Adopting the ACG approach, the average cost of providing a new residential care place in 2001 would have been around $96 000. On this basis:

- the extra capital cost (in 2001 dollars) required to accommodate from 161 000 to 198 000 persons in residential care by 2021 would range from $3.1 billion to $6.7 billion; and
- the extra capital cost (in 2001 dollars) required to accommodate from 232 000 to 337 000 persons in residential care by 2041 would range from $10 billion to $20.1 billion.

Some implications for government spending

Considerable uncertainty attaches to future changes in the demand for, and cost of, residential care and, in consequence, to future levels of government spending on residential care. Nevertheless, the anticipated change in the resident mix towards more high care clients and the expected increases in real labour costs are likely to result in unit cost growth in the residential aged care sector exceeding recent trends.

The ratio of high care to low care residents has increased over the past decade. In 2001, persons requiring high level care accounted for approximately 61 per cent of aged care residents, compared with approximately 59 per cent in 1991. The Commission believes this trend is likely to continue (box 6.3).

Box 6.3 **Scenarios for high care/low care ratios**

The increasing substitution of alternative and community care for low level residential aged care has resulted in an increase in the proportion of residential aged care clients entering these facilities as high care residents over the last decade. The resulting increases in the high care/low care ratio seem likely to persist, although the extent of the increase is uncertain. Accordingly, all three scenarios assume a continuing increase in the high care/low care ratio.

The first scenario is based on the assumption that the trend growth in this ratio, by age group, between 1991 and 2001, will persist over the projection period, 2001 to 2041. Given the boost to community care provided by policy initiatives in recent years, the continuation of trend might be regarded as a reasonably optimistic scenario. The second scenario assumes that the rate of increase in the ratio will taper off over the projection period, with annual growth arbitrarily selected as being 0.75 per cent of the historical trend (by age group). The third scenario assumes that the rate of increase gathers pace in the period ahead, in response to a continuing emphasis on informal and community care performed in the care recipient's own home and the possibility of stronger preferences for such care. Annual growth is arbitrarily selected as being 1.25 per cent of the historical trend (by age group) for this scenario.

The three scenarios for the high care/low care ratio profiled in box 6.3 produce a variety of possible resident mixes at different points in the future, with the highest estimate being 75 per cent in high level care by 2041.[5]

For illustrative purposes, figure 6.3 shows estimates of government expenditure on residential care in 2000-01, relative to actual expenditure, under three resident mix assumptions that may conceivably be attained in the future (see appendix B, table B.6). The data indicate that a variation in the resident mix towards a greater share of high level care clients would have increased recurrent expenditure in 2000-01 by between 3.7 and 12.6 per cent, or from $141 million to $481 million.

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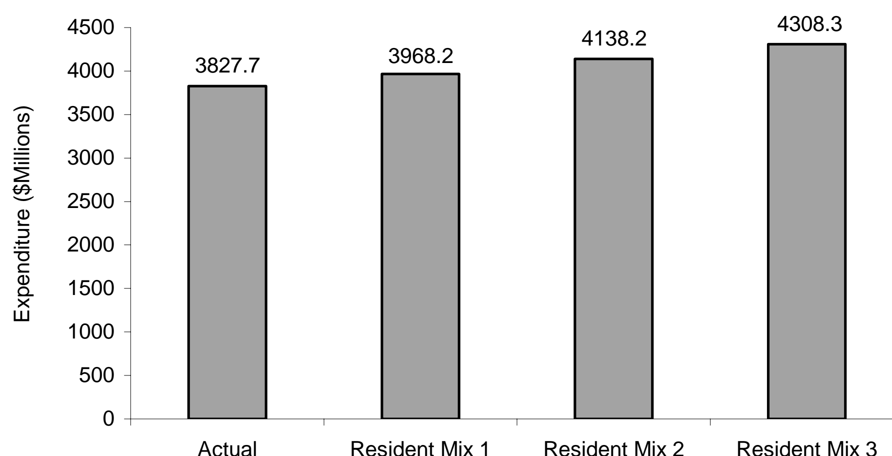
[5] The assumed resident mixes and projections of high level/low level care residents under different scenarios over the period 2001–2041 are contained in appendix B.

It is also possible to provide an indication of how higher wage growth (and a changing resident mix) in the residential aged care sector might affect future government spending. Given the current nursing employment pressures in the residential care sector, it can be hypothesised that there will be a ‘catch-up’ in the wages of residential care nurses relative to the wages of nurses in the public hospital sector. It is assumed here that the wages gap between the two groups — around 12.5 per cent in 2002 (ACG 2002) — will disappear by 2011 and that the wages of residential care nurses will then grow in line with the rest of the economy until 2041. Wage increases of non-nursing residential care workers are assumed to match wage growth in the rest of the economy throughout the 2001–2041 projection period.

Figure 6.3 **Government expenditure on residential aged care, actual and estimated expenditure in 2000–01 under different resident mix assumptions[a,b,c]**



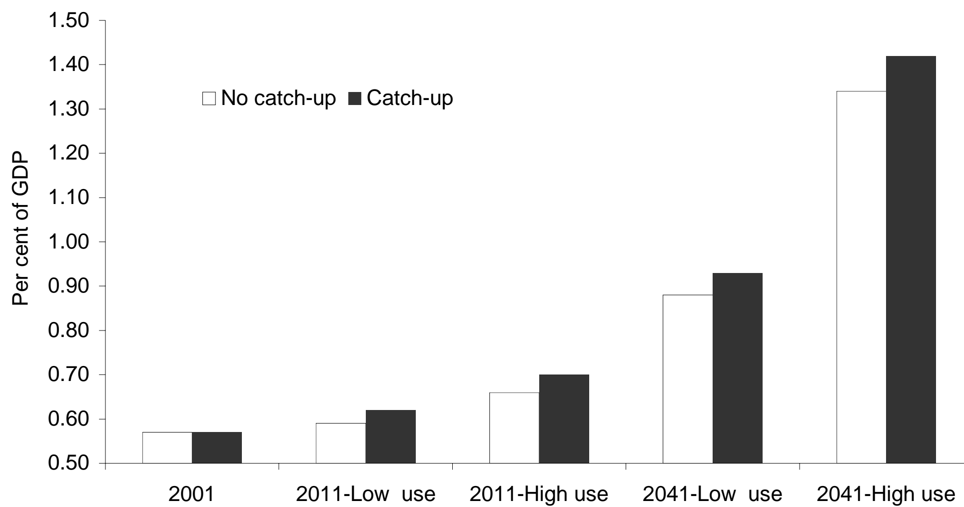
[a] Resident mix refers to the ratio of high level care to low level care residents. The actual mix of residents in 2000-01 was 61 per cent in high care and 39 per cent in low care. The other three estimates were derived using high care/low care ratios that may be attained during the 2001–2041 projection period under different scenarios (see appendix B). Resident Mix 1 assumes a ratio of 65:35 between high and low care, Resident Mix 2 assumes a ratio of 70:30 and Resident Mix 3 a ratio of 75:25. [b] Assumes 2000-01 subsidy rates for high and low care residents. [c] The expenditure figure for 2000-01 includes expenditure on residents under 65 years old and on veterans etc by the DVA.

Data sources: DHA (unpublished data); Productivity Commission estimates; SCRCSSP (2003).

The implications for government expenditure of this future wage increase scenario are contrasted (in figure 6.4) with expenditure projections which assume no wages catch-up, under illustrative assumptions of high and low increases in residential care use. The ‘no catch-up’ scenario represents the Commission’s demand projections used in conjunction with Treasury wages and productivity estimates (Treasury 2002a). The figure demonstrates that a ‘catch up’ wage increase for residential care

nurses over the period to 2011 would have relatively small expenditure ramifications in either the short or long term. Significantly, the differences in expenditure attributable to different rates of wages growth are dwarfed by differences attributable to demand and use variations.

Figure 6.4 **Residential aged care expenditure as a proportion of GDP, high and low residential use projections, under different wage growth assumptions, 2001 to 2041[a,b]**



a The high and low residential use projections are based on the range of projections prepared by the Commission (see appendix B). 'Low' refers to projected residential aged care use under the assumptions of high reductions in utilisation rates, high reductions in disability rates and a low increase in the high care/low care resident mix. 'High' refers to projected residential aged care use under the assumptions of low reductions in utilisation rates, no reductions in disability rates and a high increase in the high care/low care resident mix. **b** 'No catch-up' refers to a scenario in which wages in the aged care sector grow in line with wage growth in the rest of the economy between 2001 and 2041. 'Catch-up' refers to a scenario in which residential care nurses' wages (which represent about 55 per cent of total recurrent costs) are assumed to 'catch up' with the wages of public hospital nurses by 2011 (based on a gap of 12.5 per cent in 2002), but then increase in line with wage growth in the rest of the economy.

Data sources: ABS (*Econdata database*); DHA (unpublished data); Productivity Commission estimates; Treasury (2002a).

The Commission's demand projections suggest that increases in overall residential care use are likely to be manageable for the next two decades. Anticipated increases in the costs of providing this care, compounded by population ageing, are likely to present more significant funding challenges, under current policy settings, in the third and fourth decades of this century.

The Commission's projections indicate that Commonwealth spending on residential aged care could rise, under current policy settings, from around 0.6 per cent of GDP in 2001 to a range of around 0.9 to 1.4 per cent of GDP in 2041. These projections are broadly in line with those undertaken by the Treasury in its *Intergenerational Report* (Treasury 2002a), where expenditure on residential aged care was projected

to increase to just over 1.4 per cent of GDP in 2041-2. The Commission's somewhat lower GDP spending estimates for residential care primarily reflect the possibility of reductions in disability and institutionalisation rates, which were assumed by Treasury to remain unchanged over the projection period.

There are two important caveats to any assessment of the future financial burden on governments. First, average annual GDP growth between 2001 and 2041 is assumed by Treasury to be around 2.3 per cent. However, for illustrative purposes, if Australia's average annual GDP growth over this period were similar to that of, say, the 1991–2001 period (3.6 per cent), this would moderate the prospective effects of ageing on the cost of residential care. As a result, the Commission's projections of Commonwealth spending on residential care would change from a range of 0.9 to 1.4 per cent of GDP in 2041, to a range of 0.6 to 0.9 per cent. Similarly, the Treasury's residential care expenditure projection of around 1.4 per cent of GDP in 2041–42 would fall to 0.9 per cent.

Second, a larger proportion of the responsibility for funding residential care expenditures may be shifted onto the aged and their families in the future, to promote greater equity and efficiency, as well as to improve the sustainability of the funding system (see chapter 7).

6.4 Concluding comments

Overall, increases in the number of aged Australians using residential care combined with larger anticipated increases in the costs of providing this care, are likely to present growing funding challenges for the aged care system. The profile of the change in the structure of Australia's aged population suggests these challenges are likely to be stronger in the third and fourth decades of this century. While not the 'demographic time bomb' suggested by some commentators, the ageing of Australia's population is likely to necessitate changes to existing aged care policy settings to allow the system to more effectively handle these challenges. There is, in consequence, a need to carefully review and debate reform options directed at building a better funding and delivery system for Australia's aged care services.

7 Improving the aged care system

Changes to Australia's aged care system are required to address problems with the current system (chapter 5), as well as to strengthen the sustainability of the system given expected increases in demand and costs for aged care over the next 40 years or so (chapter 6). The main problems include:

- Limited access to subsidised aged care services — queuing (waiting lists) because of restrictions on supply and price controls.
- User charges that are inequitable and bear little relationship to the cost of providing care.
- Incentives within the system which:
  - create a bias in favour of residential care over community care;
  - discourage residential care providers from improving the health and independence of residents;
  - encourage providers of residential care to 'cherry-pick' residents, which may be compromising the ability of some older people to access residential care; and
  - encourage cost shifting between the various levels of government.
- Poor coordination between aged care programs, as well as between health, public housing and aged care programs. There are also different eligibility criteria between aged care programs, giving rise to high administration costs for providers and high information costs for users. Eligibility criteria and accommodation payment requirements are quite inconsistent between aged and health care programs.
- Regulations which constrain competition between providers (and dampen the incentive for providers to deliver services above the mandatory service standards, or to respond to changes in users needs) and inhibit flexibility.
- Limited capacity, under current funding arrangements, to meet either the current or future care needs of elderly Australians.

Drawing on the analyses in the two previous chapters, this chapter examines the scope for making improvements within the current funding and regulatory

framework (section 7.1) and for broader changes that go beyond this framework (section 7.2).

7.1 Making improvements within the current framework

In the short term, there are a number of ways in which the current funding and delivery system could be modified to improve equity, efficiency and sustainability. Four main areas for improvement are:

- pricing arrangements for residential aged care;
- mechanisms for adjusting residential aged care subsidies;
- coordination and planning across aged care programs; and
- residential care choices available to the aged.

While changes in each of these areas would yield worthwhile benefits, they are limited in focus and, as such, would not remove the root cause of several key systemic problems within the system nor substantially address constraints on the ability of the system to provide aged care for an ageing population.

Improving existing pricing arrangements

Extending the period for which bond retentions and accommodation charges can be applied

Under the current arrangements, providers can only charge residents bond retentions or accommodation charges for a maximum period of five years. While the average length of stay in residential care is considerably less than five years (26.8 months in 2001-02), the current trend is for residents to remain for longer periods, particularly since the introduction of an 'ageing in place' policy. Currently, around 12 per cent of residents remain in care for between five and eight years, while around 7 per cent stay in excess of eight years.

If residents continue to require accommodation beyond a five year period, and they can afford to make a contribution to the cost of accommodation, then such a payment would improve equity relative to those in care for less than five years.

The removal of the five year limit would also remove a key source of inequity between residential and community care. Currently, accommodation costs are fully met by aged persons living at home and receiving community care services — including those receiving care equivalent to low and high level residential care

under the Community Aged Care Packages (CACPs) or Extended Aged Care at Home (EACH) programs, respectively.

Placing accommodation payments for low and high care residential places on an equal footing

As discussed in chapter 5, a resident entering low care typically faces higher user charges for accommodation than a resident entering the system for high care. This is inequitable.

The differences in accommodation payments also mean that capital funds available to providers of high care places are more limited than those for low care places (see table 5.3). High care places are already reported to be in short supply and this anomaly in user charges only serves to exacerbate the problem (ACG 2002). The differences are unlikely to be sustainable in the medium to longer term.

There are two broad options for addressing the adverse impacts of these differences:

- The first is to rely on the trend towards ‘ageing in place’ to provide a de-facto solution. To the extent that there is ‘ageing in place’, those who enter as low care residents and subsequently become high care in the same establishment, will have paid an accommodation bond. However, this has limitations in that the number of residents moving from low to high care within the same residential setting are not sufficient to solve the disparity problem in the short-term. The majority (over 60 per cent) of all new residents enter facilities as high care residents.
- The second option is to place capital funding for high care and low care places on an equal footing. This could be achieved through either the introduction of accommodation bonds for high care, or by lifting the cap on the current accommodation charge to bring it to a level similar to the periodic payment equivalent of the accommodation bond.

The introduction of accommodation bonds for high level care

Accommodation bonds have long been an accepted feature of hostel (low level) care costs, but have not previously been a cost component of nursing home (high level) care. The different user payment arrangements for accommodation across high and low care are, in many respects, a result of history. They reflect the fact that hostels were traditionally seen as a form of alternative housing for people with low care needs. In contrast, nursing homes were seen as being required because of an individual’s frailty and ill health (and hence, their shared similarities with hospitals). In this regard, Howe (1998, pp. 147–8) commented:

> Hostel entry is essentially a choice about a place to live. Realising assets, including the family home, for this purpose provides the means to securing another home; the average hostel stay is about four years. … Nursing home entry is less a matter of choice — and more a matter of need for the level of care that can be found only in that setting; two-thirds of admissions occur on discharge from acute care and half of all residents exit within six months, most through death; only some one in four stay for two years or more.

A proposal to introduce accommodation bonds for high care places was vigorously opposed in 1997. Arguments against their introduction were that:

- a significant number of residents entering such care only live a relatively short period of time; and
- the need for such care often occurs at a time of crisis (usually on discharge from acute care) and having to sell up the family home at such a time in order to pay an accommodation bond is inappropriate.

Catholic Health Australia (CHA 2003, p. 13) argued:

> In residential aged care, for a prospective resident to make a contribution of around $100 000, it usually means having to dispose of a major asset and for many average Australians this is the family home. To manage this option, let alone contemplate such a major decision when elderly, sick, frail and in the last weeks or months of life, is an unreasonable and unfair burden to place on an individual in such circumstances.

However, the setting up of a scheme which allows the elderly to tap into the equity they have amassed in their family homes, would enable accommodation bonds to be lodged for high care places (for an example, see box 7.1). That said, requiring low care residents to pay an accommodation bond for a place they can be expected to live in for several years, is different to requiring high care residents who are expected to require care for only a matter of weeks or months to pay large up-front accommodation bonds.

Of course, not all high care residents stay for only a short time. Accordingly, some in the industry (such as, CHA) have proposed that accommodation bonds be extended to high care places, but with exemptions for short-stay terminal residents (while noting the issues involved in identifying such residents). Another approach could be to allow high care residents the option of paying a daily or monthly charge for, say, the first six months of care, which reflects the cost of accommodation.

Box 7.1 **Equity release packages – an example**

Equity release packages, also called reverse mortgages, offer one way in which 'asset rich but income poor' individuals can convert their housing equity into liquid funds. Such products are widely available in both the UK and the USA.

In Australia, St George Bank currently offers a Seniors Access Home Loan, which has the following basic features:

- Individuals aged between 65 and 69 years who own their own home outright, may borrow between $10 000 and $80 000, or 15 per cent of the valuation of their property, whichever is less, while those aged 70 or over can borrow between $10 000 and $100 000, or 20 per cent of the valuation of their property, whichever is less.
- Individuals are charged a rate of interest which currently exceeds the standard variable home loan rate. This interest is charged to the loan balance, removing the need for the aged (or their family) to make interest repayments over the course of the loan.
- Both accrued interest and the loan amount must be paid back on death or when the house is sold.

Source: Zahos (2003).

The introduction of accommodation bonds for high level care also assumes that bonds are an efficient means of obtaining a capital contribution from residents. But, as discussed in chapter 5, restricted competition in the supply of places and the fact that providers can retain all interest earned on the full accommodation bond amount, gives incentives for providers to target those residents who have the capacity to pay large accommodation bonds, in order to boost their revenues. (There is no fixed amount for an accommodation bond — it is an amount negotiated between the provider and resident. The only limit on the size of an accommodation bond is that it cannot leave a resident with less than, currently, $27 500 in assets.) Bonds may also include a quasi-rent arising from the scarcity premium created by government controls on the supply of places.

While residents subject to bond payments currently have the option of converting them to periodic payments (covering the interest and retention amounts foregone), in practice, close to 90 per cent are currently paid-in-full as an up-front payment (possibly reflecting the mismatch between demand and supply). This situation is unlikely to change under the current arrangements.

Lifting the cap on the current accommodation charge

An alternative to introducing accommodation bonds for residents in high care places would be to raise the cap on their accommodation charge to a level equivalent to the daily or periodic value of an accommodation bond (inclusive of retained interest). However, as discussed previously, the amounts that providers can extract from residents via accommodation bonds may not accurately reflect the cost to providers of supplying the accommodation — it may also include a quasi-rent.

It is readily acknowledged in the industry that providers are encouraged by the regulations to cross-subsidise from low care to high care places (chapter 5). Increasing the cap on the high care accommodation charge to a level where it reflects the value of a low care bond to the providers, would address the inconsistent pricing arrangements and considerably boost providers' access to capital funds, but both high and low care residents would still face capital contribution charges that bear little relationship to the cost of supply.

If accommodation payments are to be set to better reflect the cost to providers of supplying accommodation under the current arrangements, cost information would be required. Detailed cost information would need to be considered by the Review if increasing the cap on the accommodation charge was a preferred reform option. However, setting an accommodation charge for high care places that better reflects the cost of supply (while a short-term option for increasing capital funding for residential high care) would not solve the problem of disparate capital contribution charges between high and low care residential places.

An accommodation rental charge — daily or periodic (with the option of a bond) — applied on a cost reflective basis across both high and low care places, may represent a better way of charging for accommodation. Providers would need to be able to charge variable rentals/bonds to reflect differences in location (and hence land values) and building costs. The issue of whether housing assets are treated consistently when applying a means test for care, as well as for pensions, would also need to be considered.

Any changes to capital funding for high care places would need to be accompanied by a re-examination of government subsidy arrangements for aged care homes where residents' capital contributions are very low, such as those in rural and remote areas and those with a high proportion of financially disadvantaged clients.

It is evident from the above discussion that, while incremental changes aimed at placing capital funding for high and low care places on an equal footing could remove inequities in user charges and improve capital funding for providers of high care places, it would not deal adequately with the problems associated with the

current capital charging arrangements. More fundamental reforms which seek to avoid these inequities and inefficiencies, such as unbundling the costs of aged care, are discussed in section 7.2.

Improving mechanisms for adjusting subsidies

Revising indexation arrangements for adjusting residential care subsidies

Despite long-standing industry concerns about its application to the aged care sector, the Commonwealth Own Purpose Outlays (COPO) indexation method continues to be used to adjust public subsidies for residential care facilities. Given the significance of the subsidy as a source of provider income, this method carries with it the risks that:

- providers may face ongoing viability problems caused by the inadequate indexation of subsidies;
- the quality of care may deteriorate as providers attempt to cut costs in the face of inadequate revenue; and
- the capacity of the aged care sector to attract and retain qualified nursing staff may be impaired.

In considering the issue of indexation in its report on *Nursing Home Subsidies* (PC 1999), the Commission recommended that the basic subsidy rates should be adjusted according to indices which reflect the changes in the average cost of the standardised input mix, less a discount to reflect changes in productivity.

Since then, modifications to the 25 per cent non-wage cost component of the COPO index have occurred, with the Treasury's Measure of Underlying Inflation (TMUI) being replaced by the Consumer Price Index in 2000-01. This change removed one source of potential criticism made, for example, by the National Aged Care Alliance (NACA 2001), that the TMUI removed items from the index which were of particular relevance to the residential aged care sector [1].

However, there have been no changes made to the method used for calculating the 75 per cent wage cost component of the COPO index. This continues to be based upon the Safety Net Adjustment (SNA) mechanism, which is intended to provide a proxy variable for non-productivity related wage growth. However, residential aged care providers need to be able to provide wage increases, to avoid the risk of losing

[1] The NACA (2001) suggested that use of the TMUI excluded a number of key cost items from the indexation process, including fresh fruit and vegetables, meat and seafood, mortgage interest charges, household fuel and light, and pharmaceuticals.

significant numbers of their nursing staff to the acute sector. Thus, if productivity gains within the residential aged care sector do not keep pace with other sectors (in particular, the acute care sector of the health system), the subsidy, as indexed, will be increasingly inadequate.

In the Commission's view, there continues to be a case for examining alternative methods for indexing public aged care subsidies. This issue should be taken up by the Review. In particular, the question of replacing the SNA component of the COPO index with alternative indices published by the ABS, such as the Average Weekly Ordinary Time Earnings Index, the Wage Cost Index or the Labour Cost Index, merits further investigation. Other alternative forms of indexation may also be feasible. They might, for instance, involve a combination of a weighted-average measure of wage movements (derived through annual surveys of wage rates across regional jurisdictions) with an appropriate index of non-wage costs.

While there is a clear need to replace COPO indexation with an alternative which better captures movements in industry-specific costs, two significant points of qualification arise:

- First, full compensation based simply on changes in the costs of individual items, such as labour inputs, without any allowance for productivity improvements within the sector, would lessen incentives for efficiency gains. While many providers claim that there are significant difficulties in attaining productivity improvements equivalent to those achieved in the acute sector, a productivity discount is still justified, and should be based on at least the average level of productivity gain, so that incentives are retained for providers to be more efficient than the average.
- Second, a periodic review of the industry's cost base would provide a framework for assessing the implications of possible changes in the care benchmark within the residential sector and changes in care expectations over time.

Improving the handling of special needs funding for high cost circumstances

As discussed in chapter 5, the cost of providing the same level of care varies considerably across Australia, with particular problems attached to providing care in rural and remote areas.

In dealing with the special circumstances of aged care homes in very high cost (to supply) regions, the present system relies on a mix of viability supplements to the basic subsidy and targeted capital assistance. A considerable level of aggregate funding is provided by these measures. Viability supplements provided $10.4 million of additional funding to a total of 533 aged care homes in 2001-02,

while targeted capital assistance of $26.3 million was allocated to over 80 homes in 2001-02, of which 80 per cent were in rural and remote areas (DHA 2002).

Even though this goes some way towards providing adequate special needs funding, there appear to be continuing problems with facility viability. In its 1999 report on *Nursing Homes Subsidies* (PC 1999), the Commission recommended the establishment of a separate special needs funding pool as a response to these specific cost pressures. The Commission considers that this continues to be a proposal worthy of further investigation. The pool would build on the current viability supplement, and its basic objective would be to provide additional support to:

- small, high cost aged care homes in regions where demand for care is insufficient to support facilities of an efficient size; and/or
- aged care homes required to deliver services additional to the standard care services allowed for in the basic subsidy regime.

Improving coordination and planning across programs

The mix of Commonwealth and State government responsibilities under the current system leads to incentives for cost-shifting. It also results in gaps in care for older people (such as in rehabilitation) and poor coordination of the planning and delivery of residential and community care (see chapter 5).

In recent years, administrative reforms — such as the establishment of Advisory Councils and Commonwealth/State Working Parties — have sought to improve communication and coordination between all levels of government. There is, however, scope for further reform within this area.

Specifically, better integration of care services, responsibilities and funding has the potential to improve access to, and the quality and efficiency of, aged care. As Wittenberg, Sandhu and Knapp (2002, p. 243) argue:

> An important aspect of any funding arrangement should be to ensure that the mode of care is chosen based on effectiveness, overall costs and client choice, and not through considerations of cost-shunting caused by perverse funding arrangements. The more that budgets and responsibilities are brought together and the more forms of care that are covered by these budgets, the less likely are perverse incentives.

One option for pursuing improvements in this area is to develop a more integrated planning and funding framework with clearer specification of responsibilities between jurisdictions. As the ACG (2002, p. 96) argued:

> … there needs to be consistency of responsibility across the various types of aged care if the current rigidities are to be reduced. One level of government needs to have responsibility for planning aged care provision across all forms of care and, ideally, across other related services such as health and housing. Without such a change, while there may be improvements at the margin, services and funding arrangements will inevitably remain fragmented, complex and inflexible. Too little attention will also continue to be paid to areas which are 'investments' in keeping older people healthier and more independent (and which keep costs down in the future), such as preventative medicine, low level community care and support for carers.

A model which consolidated the management and funding responsibilities of aged care under 'regional fund pooling', as proposed by Kendig and Duckett (2001), would involve:

- The pooling of all Commonwealth and state funds for aged care services into a single fund — including funds for residential aged care, Home and Community Care and CACPs and state funds for community health. This would replace the current system of multiple and separate funding pools.
- The distribution and management of the pooled funds on a regional basis. Responsibility for fund utilisation would lie with regional fund managers, acting in concert with advisory boards made up of a broad range of representatives from Commonwealth, State and local governments, providers and consumers.
- Commonwealth and State governments playing an active role in deciding the amount of funding in a given year, changes to the funding levels over time, and the structure of national fee schedules and assessment criteria. They would not, however, be as active as present in allocative decisions — that responsibility would lie with regional-level boards.

A potential advantage of this approach would be improved responsiveness. The active involvement of local providers and consumers in the allocation of funds is likely to permit better matching of resources to local needs and provide greater incentives to address gaps in the supply of services.

Coordination of, and accountability for, outcomes could improve given the closer link between funding and service provision. And pooling could provide greater flexibility in the future with regard to addressing service and funding boundaries between aged care, health and public housing services. Devolving responsibility to the regional level could also lead to reduced administration costs.

In terms of implementation, regional pooling has the added advantage of allowing scope for its staggered introduction, whereby minor changes to the framework of responsibilities could be a gradual precursor to wider reform initiatives. Considerable progress towards a limited-pooled framework has already been made

in several areas of Australia. In this regard, Kendig and Duckett (2001, p. 71*)* note that:

> … some States such as Victoria and New South Wales are already working towards regional re-organisations of their own services, consolidating and inter-relating their own programs and articulating them better with Commonwealth and local programs. Joint governmental planning arrangements with residential and community care are important steps in this direction, as are State and local efforts to better articulate health and welfare systems at the local level.

That said, some commentators (see, for example, Gibson 2002 and Mundy 2002) have expressed reservations about the merits of a regional funding pool. One concern is that the amalgamation of funding could carry with it the risk of a reduced total quantum of funding for the sector over time. Another is that pooling could create further layers of administration on top of the current Commonwealth and state structures. In addition, there are concerns that such an approach could create regional monopolies within aged care and stifle innovation. Gibson (2002, p. 99) claims:

> Historically, there is evidence that national level innovation becomes increasingly difficult in a highly regionalised system. While specific regional systems may foster innovation, others will remain heavily rooted in the status quo. In Australia, the implementation of the community options program was frequently characterised by periods of resistance from local service providers in areas chosen from the community options projects.

It has also been argued that regional pooling could lead to a breakdown of the broadly standardised system of aged care service delivery that currently exists.

Similar funding arrangements have been applied, albeit in a much more limited way, to other areas of health and aged care policy in Australia, through the Australian Coordinated Care Trials (CCTs) and the Multipurpose Service programs. However, previous attempts at developing a more effective assignment of funding and resourcing responsibilities between the Commonwealth and State governments for health and aged care — via the Special Premier's Conference and COAG processes — have not been carried through.

Regional fund pooling is considered by many to be particularly relevant in rural and regional Australia. However, the very mixed results of evaluations from the CCTs (DHA 1998), as well as reflections and observations included in the latest publication relating to these trials (Esterman and Ben-Tovin 2002), suggest that the benefits of a pooling framework may be less than expected.

Nonetheless, the Commonwealth Government allocated funds in its 1999-2000 Budget for additional CCTs through to 2002-03. They have focused on people with chronic or complex care needs, with a particular emphasis on disadvantaged older

people. The CCTs remain an effective mechanism for further developing and testing different service delivery and funding arrangements.

The Commission considers that the potential benefits of regional fund pooling warrant closer analysis by the Review. And, in this context, the implementation of several pilot programs would be worth considering.

Improving choice

When it comes to residential care facilities, the excess of controlled demand over controlled supply serves to limit choice. One means of extending choice is for aged care providers to offer extra service places (with higher standards of accommodation, food and services). This encourages providers to be more responsive to users needs.

However, the Commonwealth Government regulates the availability, fees and requirements that apply to these places. The role of regulation should instead be to ensure that access to standard care (that is, the benchmark standard of care which is available to all residents irrespective of their financial means) is not compromised. If subsidies, together with residential charges, give an adequate financial return on the provision of the benchmark standard of care, then the need for additional safeguards (such as the regulatory control of extra service places) is debateable.

That said, the concessional resident ratio requirements provide a secondary safeguard. As discussed in chapter 3, these regulations require residential facilities to care for a specified proportion of concessional residents who would not, in the normal course of events, be able to pay for extra services. The ratios are specified on a regional basis, with the differentiation across regions sometimes being only a fraction of a percentage point. In most parts of Australia, the actual number of concessional residents in aged care homes greatly exceeds these ratios.

If the benchmark standard of care is clearly specified, it is unlikely that any growth in demand for extra service places would create widespread problems for those seeking access to standard care. For this reason, the current quota system for extra service places appears to be an unnecessary addition to an already complex regime. Instead, providers of residential care should be allowed to freely determine the number of extra service places they wish to provide, with the DHA monitoring those places and the waiting lists for standard care.

The nature and price of extra services should also be a matter for providers to determine in response to the ‘marketplace’ demand from residents and their families. Under the current regulations, the basic subsidy is reduced by 25 cents for each dollar of extra service income. What this effectively means is that providers

must charge $1.25 for a service costing $1 to deliver. As such, the subsidy reduction is a de facto tax on quality, levied on those capable of paying for extra services. This is in addition to the generally-applicable reductions in basic subsidies for those on higher incomes.

In line with its recommendations in the *Nursing Home Subsidies* report (PC 1999), the Commission considers that:

- the controls on where within a facility such extra services are provided, and the price charged for such services be abolished;
- the current reduction in the basic subsidy for residents receiving extra service be abolished, as it represents an implicit tax on extra quality; and
- the quota on extra service places be replaced with a lighter-handed approach and a monitoring system aimed at identifying any cases where extra service provision is reducing access to standard care.

7.2 Going beyond the current framework

The reforms described above essentially involve making refinements to the existing system to promote better outcomes. However, in order to address some of the problems within the current system, broader systemic change is required. Also, future changes — such as, sizeable increases in costs for residential aged care services linked, in part, to population ageing — reinforce the need for broader improvements directed at improving the sustainability of the funding and delivery system for residential aged care.

Consideration of alternative funding and delivery systems raises a number of key questions:

- *What should be subsidised* — which cost elements should be included in the cost base for establishing the extent of public subsidy to be paid for residential care services?
- *What form should any public subsidy take* — for instance, should it be paid to providers or users of aged care services?
- *How should private and public exposure to the risks of residential care costs be managed?*

These questions are explored below.

What costs of aged care should be subsidised?

The costs to users of residential aged care are, in effect, a package of different cost components, including:

- accommodation costs (the equivalent of rent, mortgage payments and related expenses);
- living costs (such as, food, clothing, linen, heating and cooling); and
- personal care costs (the additional costs of being looked after because of frailty or disability).

By examining the costs of aged care as a set of unbundled components rather than as an aggregate, it is possible to explore the funding principles that should be applied to them.

In this context, accommodation and living costs are fairly predictable. They are also costs that the elderly not in residential care would have to incur (with some exceptions) themselves. Although some community care services do provide assistance with some elements of living costs, such as cleaning, transport and sitting services.

Accordingly, there is a strong argument that those in residential aged care, like those receiving community care, should be responsible for covering these costs (with a means-tested access to safety net provisions for residential and community care, consistent with those applying more generally across the community).

In contrast, many of the costs of personal care are unpredictable and may be overly burdensome (see box 7.2 for what might be covered under 'personal care'). In recognition of this, the UK Royal Commission on Long-Term Care (1999, para 6.32) maintained that, in relation to personal care:

> These are the costs which unpredictably and through no fault of their own, old people have to incur when unfortunately they can no longer be looked after at home or cannot be sent home after hospital treatment. They reflect the true risk and 'catastrophic' nature of needing long term care.

Consequently, many argue for universal access to standardised personal care services, based on need. The UK Royal Commission, for one, recommended that the cost of personal care be taken out of the means-tested system altogether.

A further argument for fully subsidising the personal care component of aged care costs is that most of the services involved are analogous to care provided to those persons receiving acute health treatment in public hospitals (albeit, usually on a

'short' duration rather than a 'continuing' basis) and thus, costs should be treated in a comparable way.

Box 7.2 A definition of personal care costs

The UK Royal Commission on Long-Term Care suggested that personal care should cover all direct care related to:

- personal toilet (washing, bathing, personal presentation, dressing and undressing and skin care);
- eating and drinking (as opposed to obtaining and preparing food and drink);
- managing urinary and bowel functions (including maintaining continence and managing incontinence), managing problems associated with immobility and management of prescribed treatment (for example, administration and monitoring medication); and
- behaviour management and ensuring personal safety (for example, for those with cognitive impairment — minimising stress and risk).

Personal care would exclude costs attributable to:

- cleaning and housework;
- laundry;
- shopping services;
- specialist transport services (eg dial-a-ride); and
- sitting services, where the purpose is company or companionship.

While such costs may contain an element of personal care, they are, in principle, 'living' costs.

Source: UK Royal Commission on Long-Term Care (1999).

That said, the provision of free personal care as part of free standardised public hospital care does not, of itself, establish a case for providing personal aged care services free of charge in residential aged care settings.

The provision of fully subsidised personal care could result in a surge in demand and add further costs to the aged care system. Personal care costs generally represent the most significant cost component of aged care — accounting for between 50 and 75 per cent of the total costs of residential aged care (see box 7.3). Concerns about the long-term sustainability of the aged care system in the light of the rising unit costs of providing residential care and population ageing, add to the case for targeting public assistance.

Box 7.3 Estimating component shares of the cost of care

A number of attempts have been made to estimate the approximate share of total cost contributed by the personal care, living and accommodation components.

- In Australia, Howe and Sarjeant (1999) estimate that the total cost of RCS 3 category residential care comprises around 72 per cent of care costs (of which 19 per cent are base level of care costs and 53 per cent are variable care costs), 18 per cent living costs and 10 per cent for capital costs.
- The UK Royal Commission on Long-Term Care (1999, para 6.40) split total costs into personal care, living and housing costs. In modelling the cost implications of its policy recommendations, the Commission assumed total average costs of £242 per resident per week in low level care and £337 per resident per week in high level care. Housing and living costs (combined) were estimated to account for around 50 per cent and 36 per cent of total costs for high and low care recipients, respectively. Personal care costs were estimated to be 50 per cent of total costs in low care and 64 per cent in high care.

While considerable variation is apparent in these estimates (in large part due to the imprecision of estimating costs which vary greatly across individuals and locations), the very high share of total care costs contributed by the personal care component is clear, as is the considerable role of labour inputs within the delivery of such care.

Sources: Howe and Sarjeant (1999); UK Royal Commission on Long-Term Care (1999).

In contrast, the UK Royal Commission on Long-Term Care (1999) argued that significant cost increases, in the event of full subsidisation of personal care, were unlikely because:

- personal care is not a desirable consumer good in itself (it is not about providing a maid, a cook and a gardener), it is only desirable when people have a need for it; and
- the need for care is not determined by price, but rather on the basis of assessment.

Fully subsidised personal care in residential care could further bias consumer's choice away from informal and community care and add to the disparity already existing in the treatment of these different forms of care. Consequently, any decision relating to a subsidy for the personal care cost component of residential care would need to consider the appropriate treatment of like services within the community and informal care sectors. Currently, some services for informal and community care are partially rather than fully subsidised. Further, a subsidy for personal care could also lessen the incentive for individuals to make provision for this cost component of aged care. And, a lack of targeting of those in most need would add to the general burden of taxation.

There are several ways of overcoming this bias against providing informal and community care. One such way is to adopt appropriate pricing of personal care for those in residential places, by:

- providing a subsidy for a minimum benchmark level of care, which individuals could 'top up' (along the lines of the current extra service arrangements);
- introducing income-adjusted copayments, up to a maximum (such that those needing expensive care are not faced with costs which are overly burdensome); and
- providing a subsidy that is restricted to certain forms of care, for example, only the nursing component of personal care. This was put forward as an option in a dissenting report by two members of the UK Royal Commission on Long-Term Care (1999), where nursing care was simply defined as 'nursing care provided by the nursing staff in nursing homes'.

A better funding system?

The potential benefits of unbundling aged care costs along the lines foreshadowed above — where the accommodation and living costs of residential aged care are funded to a greater extent by residents, subject to safety net provisions — include:

- Greater consistency in funding arrangements between residential and community care. This would remove any financial bias towards residential care and improve older people's choices about the environment in which they receive care. Placing residential care on a similar financial basis to community care could see a further shift towards more care being performed in the care recipients own home — although the increased burden on family and other carers would need to be recognised in practical ways.
- Greater certainty for individuals regarding their future liabilities, given that future accommodation and living costs would be subject to far less uncertainty than the possible future need for personal care.
- Better targeting, by not publicly funding accommodation and living costs for wealthier individuals in residential care.
- Potential for increased competition between providers in the areas of accommodation and living options — resulting in greater incentives for cost containment and greater response to users' needs by offering a greater range of accommodation and living options.
- A more sustainable system — public funding would be primarily for personal care costs (the largest component of costs, see box 7.3), but with a safety net for accommodation and living costs, where required.

Implementation issues

Under the proposed unbundling approach, funding for care would continue to be provided on the basis of eligibility according to a classification scale, such as the current RCS. The care classification would link the individual to a care package which provides access to a particular set of services (or a package worth a maximum dollar value — see discussion on entitlements below). Eligible individuals would then be able to access care in accordance with their preference for either community or residential care.

There are a number of practical hurdles which would need to be overcome if such an option were to be implemented successfully, such as:

- workable definitions for accommodation, living and personal care costs in order to determine the share of costs to be covered by the individual and the government;
- decisions about the appropriate pace of change — whether such a restructure should be introduced gradually or as a one-off change with a grandfathering clause covering existing users;
- the most appropriate forms of user payments and interactions with income and asset tests within the aged care sector; and
- the cost implications of having different funding streams with differing copayments and safety net arrangements.

While adoption of this proposal would require the resolution of these practical issues, the Commission considers that the concepts underlying the restructuring of costs to achieve greater equity across types of care, and better targeting of the public subsidy, are fundamentally sound and warrant further investigation by the Review.

What form should any public subsidy take?

Under the current arrangements, public subsidies for residential aged care are paid to service providers. An alternative would be an entitlement system. It would involve direct payments to users or the recipients of aged care services by way of, say, cash, a voucher or some combination of the two. As with the current system, payments would be subject to eligibility criteria based on the level of disability of the user. Eligible individuals, possibly in consultation with family members or other 'consumer representatives' or brokers, could choose the package of services that best fits their needs.

There are a number of advantages to an entitlement-based system:

- Individuals eligible for assistance can choose the types of care and provider that best suit their personal circumstances.
- Providers have a stronger incentive to be responsive to consumers' preferences, to provide choice in the types of services offered and to deliver services efficiently.
- Government intervention in planning the supply of aged services could be reduced — for example, by abolishing planning ratios and quantum controls — while still requiring accreditation and certification to ensure service and facility quality. Market mechanisms could come into play, with the incentives that they bring.

However, entitlement systems also have weaknesses:

- While they appeal to notions of consumer sovereignty, some aged care recipients — particularly those requiring high care — do not have the ability to make informed choices about the type of care that best suits their needs. In such instances, they rely on family members or care professionals to make decisions on their behalf (although, in reality, relatives and others often make such decisions under the current arrangements).
- Cost containment may be more difficult under an entitlement system. Under the current provider system, expenditure is not only limited by the control over those who are eligible users, but also by restrictions on the number of places available in the different types of care. Such limits may be less easy to implement within an entitlement system. That said, costs could continue to be controlled by changes to the eligibility criteria.
- Ensuring quality standards of care are met may be more difficult, particularly if entitlements cover community care and care provided by informal carers.

Internationally, entitlement systems for aged care are used in a number of European countries, including Austria, France, Germany, and the Netherlands, although they are a relatively recent phenomenon. The system in Germany, for example, recognises three levels of dependency and offers nursing home and community care options to eligible individuals. Individuals can choose between a cash benefit (for which there are no major restrictions on how it is spent), agency services at twice the monetary value of cash, or a combination of the two. Under this scheme, the majority of eligible individuals — in excess of 75 per cent — choose cash over care, however, the proportion opting for cash tends to decline with increases in disability levels (Stone 2001).

Implementation issues

Processes for determining eligibility are particularly important under entitlement systems. As Stone (2001, p. 104) puts it:

> Eligibility determination is a challenge in implementing the disability model because the potential for overuse is greater with cash than with an indemnity approach. The first hurdle is to establish the disability threshold for receipt of benefits and minimise the propensity for individuals to claim a higher level of disability than really exists.

A major concern relating to cash-based entitlements for aged care is that it may not be spent appropriately. One alternative is to offer cash dedicated to the purchase of particular aged care services (that is, a voucher). In the Netherlands, for example, personal care budgets have been introduced, whereby eligible individuals are given cash benefits with which to purchase particular services (Wittenberg, Sandhu and Knapp, 2002).

Monitoring the quality of services provided under an entitlement scheme may also be an issue, particularly if the entitlement covers community and informal care. However, it could also be argued that by empowering individuals to choose between providers, the incentive for providers to deliver high quality care is strengthened.

A better system?

Working within the current arrangements, it is questionable whether an entitlement system would bring about significantly greater choice and quality of service for users. Current controls on the number of residential places and community care packages available under the planning formula mean that providers can exercise discretion in choosing 'who' they care for. Hence, a number of those assessed as eligible for places face limited choices about the types of care and provider that best suit their circumstances, at times taking the 'first available bed they can find.' The Commission examined an entitlement option in its *Nursing Home Subsidies* report (PC 1999) and reaffirms its finding that subsidies paid to providers, but which follow the recipient (as occurs now), will, in effect, produce the same broad outcomes as direct payments to recipients.

If the current planning formula and quantum controls are removed (relying instead on eligibility criteria as the sole fiscal control), an entitlement scheme would then have the potential to expand choice for users and create an incentive for providers to be more responsive to their needs. For example, were the accommodation, living and personal care cost components of aged care to be unbundled, the care component could be provided as a maximum dollar value or as a voucher for a particular set of services. Individuals would then have a choice about whether to

receive the care at home, in a retirement village type environment or in residential care.

The Commission considers that the potential merits of an entitlement scheme should be considered as part of a broader unbundling of services initiative.

How might the risks of aged care be best managed?

The current funding arrangements are supported by two risk bearing mechanisms — a dominant taxpayer-financed mechanism and a relatively small user charges or copayments mechanism. Under the former, taxpayers meet the costs of the public subsidy and other government payments for residential care. This support is provided on a pay-as-you-go basis so that current taxpayers finance the cost of public support to current aged care residents. Taxpayers bear the full financial risk associated with the subsidy, including increases related to rises in unit costs and population ageing. With population ageing, a continuing strong reliance on public subsidies would involve a heavier burden on younger taxpayers in the future.

Contributions by users, financed by drawing on their income, savings and assets, currently account for about 30 per cent of residential aged care funding. However, since most user contributions are financed indirectly from age pension payments, the bulk of the cost of residential care is sourced from general revenue. The proposed changes to accommodation bonds and charges and the unbundling of costs, discussed earlier in this chapter, would require future users to bear more of the overall costs.

There are a number of additional funding mechanisms that would increase user contributions, including private savings and voluntary or compulsory insurance schemes. They are used in a number of OECD countries. Significantly, they can supplement, rather than replace, targeted public subsidies for residential aged care.

Prior to examining these forms of additional user charging, it is useful to consider the kinds of risk that individuals who require care face.

While most people expect to grow old, they generally do not expect to require residential aged care. Indeed, the majority of the population will never require such care. It is, for example, estimated that at birth, 24 per cent of men and 42 per cent of women will at some future time be admitted to residential aged care. At age 80, the proportions rise to 36 and 52 per cent respectively (Mason et. al. 2001). Based on current accommodation payments, government subsidies and an average period of stay, an episode of residential care is likely to entail a private cost in excess of $100 000, with a worst-case scenario of around $224 000 (Gray and Kendig 2002).

Private savings

One option available to individuals to fund higher user charges for residential care (such as to meet the accommodation component) could be to draw to a greater extent on their income and savings/assets. In terms of drawing on housing assets, equity release or reverse mortgage schemes may offer a solution for some.

While, in practice, many individuals may not have sufficient savings/assets to cover these costs, if all people were required to put away sufficient funds to cover, say, the average cost of residential care, the result would be oversaving. Even then, those who required high level care would not have saved enough. Those individuals who have saved for aged care, but did not require it, would have forgone the benefits of consumption or other forms of saving. The inefficiency of such an arrangement is set out clearly by Deeming and Keen (2001, p. 84), who argue:

> Saving for long-term care is not an efficient option for individuals. Not everyone will need long-term care, therefore it would be unrealistic and socially inefficient for everyone to save to meet the average cost of needing care, let alone the maximum cost.

Also, as Wittenberg, Sandhu and Knapp (2002, p. 239) observe, a private savings approach will not redistribute resources according to needs:

> … private savings approaches are not likely to provide equal resources for equal needs. They redistribute resources across the life cycle, but do not redistribute from those with lesser needs for long-term care to those with greater needs. They are relatively unfavourable to women; as women face a higher risk of needing care, they need more savings than men.

These considerations point to the desirability of assessing the feasibility of an arrangement to facilitate some degree of risk sharing amongst individuals, rather than requiring those who need such care to bear the full risks of the private costs themselves. Some form of insurance, if able to cost-effectively spread risk across a broad range of individuals, may be appropriate.

Voluntary private care insurance

Individuals generally use private insurance arrangements to protect themselves from the costs of potentially unpredictable and catastrophic events. For example, people take out insurance to protect themselves against the costs of loss or significant damage to homes, cars and other relatively expensive items, also disability, health and life insurance for cover against the costs of disease, accident or early death. As discussed earlier, some aged care costs (notably personal care costs) are inherently uncertain and have the potential to be equally catastrophic (a long stint in residential

care, if fully personally funded, would use up much of the assets of most elderly people).

The private insurance market for aged care operating in Australia is largely confined to disability insurance. Private health insurance funds are currently precluded from providing voluntary private care insurance (VPCI).

In principle, VPCI would be more efficient than private savings (that is, it would avoid a potential oversaving scenario) and would facilitate risk spreading (redistribution) from those with lesser care needs to those with greater care needs. Other potential benefits include:

- provide a mechanism whereby those with an aversion to being exposed to private aged care costs could take out insurance cover;
- ease pressure on taxpayers (that is, the working population) by allowing more of the costs of aged care to be met through private contributions;
- reduce the deadweight losses of taxation; and
- promote improved choice, by including cover against the cost of using higher quality aged care services.

Demand and supply-side characteristics of the market for VPCI are, however, likely to limit the extent and coverage of such insurance. Some key characteristics include:

- Unpredictability of total costs for insurers, making it difficult to calculate insurance premiums. From the insurer's point of view, it is extremely difficult to undertake an actuarial estimate of the future costs of aged care given the large time interval between the date of purchase and time of actual use, and the inherent difficulty of assessing likely changes in key variables such as rates of disability, forms of treatment, levels of public subsidy and the financial position and demand of those in need of care. As Wiener (1998, p. 4) states:

  > Selling to the non-elderly population raises difficult considerations of pricing and product design. An actuary pricing a private long-term care insurance product for a 45-year-old must predict what is going to happen forty years into the future, when the insured is age 85. To say the least, this is difficult. Ironically, although one of the advantages commonly claimed for private insurance is its flexibility to respond to the needs and wants of consumers, policyholders who buy insurance at younger ages could be locked into the existing model of service delivery decades before they use services. Who knows what the optimal delivery system will be half a century from now?

- Affordability problems for consumers. Cost is likely to be an important barrier to the take-up of VPCI. Because insurance bridges the gap between an individual's ability to meet the costs of care and the potentially high cost of that care (net of any public subsidies), those with high incomes need little cover and can easily

afford the premiums. In contrast, those with lower incomes who are not able to access care on a concessional basis, would have a bigger gap to bridge, need the most insurance cover and can least afford the premiums.

- Differential risk ratings for male and female consumers. The greater risks of requiring aged care in the future for females — related to their morbidity and mortality profiles — mean that they are likely to face higher premiums. In turn, this further reduces the probability of a large uptake of such policies by females, given the current inequalities apparent in female-to-male earnings.
- Consumer demand limited by myopia, ignorance, a genuine lack of interest caused by other spending priorities (such as mortgages and child raising expenses), and uncertainty about availability and types of future services in relation to need.
- Moral hazard problems, which occur if insured individuals utilise aged care services to a greater extent than would be the case if they were uninsured. For example, users could substitute care that would otherwise be provided by family and friends for services covered by insurance.
- Adverse selection problems, which occur where individuals with the worst health profiles and highest likely future aged care costs, are disproportionately represented amongst insurance policy holders. If insurers are unable to set differential premiums, the common rate premium will be correspondingly higher, thereby discouraging potential lower-risk purchasers. Identifying people more likely to claim aged care benefits, involves more than assessing their health and future probability of becoming disabled. For example, the preferences of individuals and their families towards using paid care, rather than family care, determines whether a claim will be made.

Insurers can counteract some of these problems. For example, the moral hazard problem could be reduced, to some extent, by requiring copayments or placing limits on what can be claimed. However, such measures tend to reduce the attractiveness of VPCI.

VPCI is currently available in a number of countries, including Belgium, France, Germany, Israel, Japan, the UK, and the USA (Fine and Chalmers 1998). Experience across these countries, however, points to its limited effectiveness, with low take-up levels being common. In the UK and Germany, for instance, VPCI provides coverage for small segments of the population (usually the most wealthy, and usually those who are ineligible for public assistance), but it has not emerged as a viable community-wide funding option. Early OECD figures (OECD 1996) suggest that, at the end of 1992, a total of 2.93 million policies had been sold by 135 insurers. Even so, the OECD noted that less than 1 per cent of nursing home expenditures were then being financed by VPCI (OECD 1996).

Recent experience in the USA has been somewhat more favourable. By the end of 1996, around five million policies had been sold (although far fewer were in force) and in large part to elderly individuals (Coronel and Kitchman 1997). However, between 1987 and 2001, the VPCI market in the USA grew at an average annual rate of 18 per cent (HIAA 2003). By the end of 2001, a total of 8.26 million VPCI policies had been sold. Significantly, estimates suggest that around seven out of ten of these policies remain in force at the present time. Despite this strong growth, which has been underwritten with incentives in a number of States, the proportion of the population covered remains small — probably less than 5 per cent (Wittenberg, Sandhu and Knapp 2002).

One option for encouraging the take-up of VPCI would be to link this insurance with life insurance. For example, such an insurance policy could pre-pay a death benefit for aged care costs or, in the event that the insured did not need residential care, funds within the insurance policy would continue to accumulate. The problem of moral hazard would be reduced because benefits not used for aged care would be available on death. The problem of adverse selection would also be reduced because such a product would be attractive to both the healthy and not-so-healthy. And, affordability would be less of an issue, as such a policy could have some appeal for younger individuals. Such a policy could also be designed to enable individuals to withdraw part of their contributed savings, if needed, for higher priority purposes, with a proportional adjustment to the aged care and death benefits.

The cost of insurance could be reduced if the government were to take on part of the risk. Partnership schemes introduced by some States in the USA have this effect. Under these schemes, individuals who purchase private insurance (offering benefits of a specified amount) are treated more favourably under the assets test should they exhaust their insurance benefits and require public funding for residential care.

Tax subsidies are another form of public support for VPCI. However, many question whether tax subsidies represent an equitable use of public resources, as they are more likely to reach those individuals already able to afford VPCI, rather than those who cannot afford it. Subsidies may also encourage excessive cover — insurance that would not otherwise be provided in the market because the costs exceed the benefits.

Given the demand and supply-side characteristics mentioned above, and the low uptake of such policies in those countries where such policies exist, VPCI is unlikely to attract widespread interest. Even so, the Commission considers that people should have the option of using VPCI as an alternative to precautionary savings and other forms of private insurance, as a tool for covering the possibility of incurring private residential care costs. Accordingly, the regulatory impediment to private health insurance funds offering such cover should be removed.

Compulsory care insurance

Compulsory care insurance (CCI) can be provided publicly or privately, although it is usually discussed in terms of public provision and referred to as social insurance or public long-term care insurance.

The rationale for considering CCI is that various demand and supply characteristics of the market for VPCI (discussed above) are likely to impair effective risk pooling, resulting in inadequate coverage of many elderly people and inequities between groups with different risk profiles. CCI is often advocated on the grounds that it can achieve better outcomes. As Rivlin and Wiener (1988, pp. 210–211) observe:

> The rationale for public long-term care insurance is that the use of long-term care is a normal, insurable risk of growing old, but that the private insurance market is unable to provide adequate coverage at a price affordable by most of the elderly. Covering long term care under a universal public program avoids two problems inherent in the current private insurance market: those people likely to need long-term care insurance may buy it disproportionately, and insurance companies tend to react by screening out disabled applicants. A universal public program also reduces the high marketing costs associated with private insurance and makes it easier to spread the costs of long term care over the working-age population as well as the elderly.

As with VPCI, CCI involves a pre-funded approach to financing the costs of residential aged care. By extending coverage, CCI seeks to provide individuals with the assurance that funds for care will be available when needed. Further, in an environment characterised by an expected sizeable increase in the number of aged Australians, a pre-funded approach would lessen fluctuations in the demand for general tax revenue to finance aged care. This would lessen the intergenerational redistributions that arise under Australia's current pay-as-you-go approach.

CCI could be organised by way of a levy or hypothecated tax, or some form of earnings-linked contributory scheme.

A well-designed and carefully implemented CCI scheme would have several advantages.

- It would provide a compulsory vehicle through which individuals would be required to make some financial contribution to the future costs of aged care, thereby addressing the intergenerational inequity created by a pay-as-you-go approach.
- By spreading the cost of aged care across a wide range of individuals, it would avoid the significant adverse selection problems likely to be experienced with VPCI.
- If contributions to the scheme are means tested and proportional to income (as with the Medicare levy), a broad cross-section of individuals would gain access

to coverage under the scheme, with contributions from those on higher incomes effectively extending the benefits available to low income participants.

- In terms of technical efficiency, the establishment of a single insurer is likely to reduce administrative and marketing costs compared to a system of multiple insurers. (That said, the allocative and dynamic efficiency implications of a single versus multiple insurer arrangement would need to be taken into account in judging whether a single insurer arrangement would be preferable.)

However, there are a number of problems with the use of CCI. Key ones centre on problems of hypothecation, the implications of uncertainty about the future costs of care for setting the tax or contribution rate, moral hazard problems and the possibility of creating a two-tiered system of care.

Hypothecation can provide some level of guarantee that a specified level of resources will be available for a specific purpose. This is arguably an advantage for future users, who may be concerned about the adequacy of future funding. However, hypothecation may limit a government's flexibility in using public funds. Hypothecation may also be unpopular with an electorate who could view it as simply another tax, albeit for a specific purpose, and with sectional interests who are competing for access to the tax dollar.

Uncertainty about the future costs of aged care makes it difficult to calculate an appropriate tax or contribution rate in the same way as applies to the calculation of premiums for VPCI schemes. A rate that is set too high would lock in excessive future forced saving relative to the future costs of aged care services. If set too low, supplementation from general tax revenue would be required.

The moral hazard of insurance coverage encouraging people to claim, is likely to be a greater problem under CCI than under VPCI. This is particularly the case if the degree of cost-sharing is low under CCI.

CCI schemes are often criticised on the grounds that they may lead to the creation of a two-tiered system of aged care provision, if there is any relationship between the level of contribution and the level of benefits. A number of commentators (Richards, Wilsdon and Lyons 1996; Kendig and Duckett 2001; Gibson 2002) have suggested that the quality of aged care services provided under a CCI scheme (with employment-related contributions) is likely to vary, with those having a poor or interrupted employment history having access to fewer services of lesser quality.

Implementation of an effective CCI scheme in Australia — as an adjunct to the current system — would also face a number of significant design questions. Some examples include:

- What costs should be covered under such a scheme — only the personal care costs of aged care or should there also be coverage for accommodation and living expenses?
- Whether the scheme should be based on a flat rate tax levy, or progressive income-related levy.
- Whether the scheme should be linked to an employment-related contributions system.
- What arrangements need to be made to handle non-tax paying individuals, or individuals that are unemployed or not in the workforce?
- Whether the tax or contribution rate should be levied on all adult Australians, or only on a sub-section of the population, such as those over 40 years of age.
- Whether the scheme should be managed by a private or public insurer, or by multiple insurers.
- What arrangements, if any, need to be made to handle the effective double taxation of those who have contributed past taxes, but not yet had cause to use age care services?

On balance, the Commission considers that it is unclear whether a CCI scheme would represent a significant improvement over the existing pay-as-you-go tax-financed and user copayment system. The pay-as-you-go tax-financed element of this system pools risk across the community and redistributes funds according to need although, with population ageing, it gives rise to uneven contributions by generations, over time. Further analysis may be warranted to more fully assess the advantages and disadvantages of a CCI scheme.

Concluding comments

Short term changes to the current funding and delivery arrangements for aged care services, particularly residential aged care, could yield worthwhile improvements in such areas as pricing arrangements, mechanisms for adjusting subsidies, coordination and planning across programs and wider choice.

Current problems with the pricing arrangements for residential care services, and between residential and other aged care services, would be lessened through:

- extending the period for which bond retentions and accommodation charges can be charged; and
- placing accommodation payments for low and high care residential places on an equal footing.

Mechanisms for adjusting public subsidies for residential aged care could be improved by revising the indexation arrangements for adjusting the basic subsidy and supplements, and for improving procedures for handling special needs funding applying to places provided in rural and remote areas.

The coordination and planning of aged care services could be enhanced through the further development of existing consultation and management arrangements between the Commonwealth and State governments, directed at fuller integration of the planning and funding framework with a clearer specification of responsibilities between jurisdictions. Beyond this, the merits of a regional fund pooling arrangement warrant closer analysis.

Changes to existing regulations covering the provision of extra service places could provide older Australians with wider choices in relation to residential care services. Beyond this, the further development of flexible care initiatives and innovations in program development could provide wider choices for residential and community care services alike.

In the Commission's assessment, such changes, while beneficial, remain limited and would leave unaddressed some systemic problems with the existing system. Nor would they substantially address constraints on the ability of the system to cope with increasing unit costs of delivery and an ageing population. Accordingly, there is a case for examining broader, medium to long-term reform options.

The current subsidy for residential aged care services applies to the full gamut of residential aged care costs — accommodation, living and personal care costs. There is a strong case for unbundling these costs and applying different funding principles to them. Specifically, those receiving residential care services should be responsible for covering accommodation and living costs (subject to appropriate safety net provisions), as currently applies to those receiving community care. In contrast, many of the costs of personal care are essentially unpredictable and may be overly burdensome. Consequently, some argue for universal access to such care based on need. However, concerns about the long-term sustainability of the aged care system provide a case for targeted public assistance. Targeting subsidies to those most in need improves the cost effectiveness of such assistance. Overall, the Commission considers that the concepts underlying the restructuring of costs to promote equity across different types of care and better targeting of the public subsidy, are fundamentally sound and warrant further investigation by the Review.

Working within the current arrangements it is debatable whether changing from a provider-based funding model to a user-based entitlement model would improve choice and promote improved quality of service. However, if costs were unbundled and quantum (but not quality) controls over the number of places abolished, a personal care entitlement system would be likely to enhance choice and provide stronger incentives for providers to meet users needs.

Finally, the Commission considers that there is scope to more effectively manage the risks associated with the use and cost of residential aged care. The unbundling of the cost base for residential care services and the associated proposal to shift the focus of the subsidy to personal care costs, would increase the proportion of care costs met by individuals. The further development of housing equity release schemes could assist some elderly Australians to meet these costs.

VCPI offers another option for handling the financial risks associated with having to incur private aged care costs. Although demand and supply-side features of the insurance market are likely to limit the extent of coverage available and the attractiveness of such insurance, regulations currently preclude health insurance funds from offering this option to elderly Australians. In the Commission's view, this regulatory impediment should be removed.

A number of commentators have advocated the introduction of CCI for aged care services and further analysis may be warranted. However, it is not clear that such insurance would represent a significant improvement over the existing pay-as-you-go tax-financed and user copayment mechanisms.

A Demand for residential aged care

This appendix consists of two sections which supplement the analysis presented in chapter 6.

- The first provides further information covering some of the factors likely to influence the future demand for residential aged care.
- The second considers the nature of the links between demand and the future use of residential care.

A.1 Possible demand offsets to an ageing population

The ageing of the population by itself, is expected to place pressure on the future demand for residential aged care — particularly in the third and fourth decades of this century. This reflects the fact that the bulge of the 'baby boomers' aged 75 years and over will peak during this period.

This section looks in more detail at some of the factors that may, at least partially, offset the effects of ageing on future demand, namely:

- changes in disability rates;
- changes in the availability of family carers; and
- changes in income and wealth.

While there is some debate whether these factors will necessarily reduce the demand for residential aged care in all future time periods, they have the potential to do so under some circumstances.

Changes in disability rates

Disability is a concept that does not lend itself to a simple definition. In Australia, the ABS conducts a five-yearly survey on disability with the latest survey defining a disability as the presence of one or more limitations, restrictions or impairments that have lasted, or are likely to last, for at least six months (ABS 1999a). The ABS classifies such core activity restrictions into mild, moderate, severe or profound, to signify the severity of disability.

In terms of the demand for residential care, the different restrictions imply varying degrees of dependency, which, in turn, set the broad requirements for high or low level care. Aged Care Assessment Teams use the Residential Classification Scale criteria to assess (and rank) clients according to their care needs. The elderly with severe or profound disabilities are more likely to require high level support while those with mild or moderate disabilities are more likely to require low level support.

The incidence of severe/profound disability for the Australian population aged 65 years and over increased from 16.2 per to 19.6 per cent between 1981 and 1998, while the incidence of mild/moderate disability almost doubled between 1981 and 1988 (from 15.4 per cent to 27.5 per cent), but has remained stable since (see table 6.3).

Some of the apparent changes may reflect factors other than underlying structural changes in disability rates — for example, subtle differences in survey design over time may affect the comparability of data. While the Australian data have been adjusted to standardise across the surveys, some methodological differences remain.[1] Davis et al. (2001) undertook an analysis of the factors accounting for the changes in severe or profound disability between 1981 and 1998. They found that around half the increase was due to changes in prevalence in the 'older' old (aged 85 years and over) and men aged 75–79, but the other half was due to changes in survey design.

Looking to the future, the broad consensus of various research findings relating to Australia, including AIHW (1999), Madge (2000) and the OECD (Jacobzone et al. 1998), is one of little change in severe/profound disability rates. There remains the possibility, though, of health improvements through better illness prevention and disease management (Byles and Flicker 2002). In addition, unexpected but dramatic medical advances such as have occurred in the past (for example, organ transplants, hip replacements and drugs that lower cholesterol) seem likely to impact on future disability rates (Gibson and Goss 1999).

Madge (2000) examines the links between the disability-free years of the aged and average life expectancy — the 'compression of morbidity' issue (box A.1) — as an aid to analysing future changes in age specific disability rates. (For a detailed discussion of compression of morbidity, see DHA 1999.)

[1] The disability rates for each year are age-standardised to the estimated resident population for March 1998. This means that the figures provide a perspective of what has happened to the weighted average of age-specific disability rates, using a *fixed* set of population weights.

Box A.1 **Compression of morbidity**

The impact of increased life expectancy on age-specific disability rates depends on whether those gaining extra years of life have higher, lower or the same age-specific disability rates as those who would have lived longer anyway. Fries (1980) has hypothesised 'compression of morbidity' associated with increased longevity. In this case, as people live longer it is supposed that the number of disability-affected years remains constant — and is shifted to more advanced years of age. Assuming such compression, Manton (1999) argues that it is inconsistent to project increased life expectancy, while simultaneously supposing that *age-specific* disability rates do not fall over time. On the other hand, if there are significant increases in substitute morbidity with high associated disability, then those experiencing prolonged life may also experienced prolonged disability.

Source: Madge (2000).

Given the degree of uncertainty about the future, three different possibilities for changes in disability rates in the period to 2041 were considered by the Commission — no reductions in disability rates, moderate reductions and high reductions.

The broad picture that emerges under all these scenarios is that the robust increases in population projected for the 'older' old will offset any likely reductions in disability amongst their numbers. This is demonstrated more clearly in table A.1, which decomposes the changes into the contributions caused by the ageing population and the assumed disability rate reductions under the high disability reductions scenario.

Table A.1 **Contributions of ageing and disability reductions to the changes in the number of elderly persons with severe or profound disability between 2001 and 2041**[a]

Age group	*Change in disabled persons due to ageing*	*Change in disabled persons due to changes in disability rate*	*Change in overall number of disabled persons*[b]
	'000	'000	'000
65–74	177.2	-176.7	0.6
75–84	370.5	-206.4	164.1
85+	503.1	-234.8	268.4
65+	835.1	-402.1	433.0

[a] High disability rate reductions scenario — that is, based on the annual rate of decline in the disability rate experienced by the United States in the last decade (0.4 per cent per annum).

Source: Productivity Commission estimates based on Series II projections in ABS (2000b).

Only in the case of the youngest age group (65–74 years) does the decline in the number of disabled people attributable to high reductions in disability rates match the increase in disabled people due to ageing. In all other age groups, the effects of ageing significantly outweigh the impacts of disability reductions. Given the weight of numbers in the older age groups, this results in a significant projected increase in the overall number of disabled persons aged 65 years or over.

Even under the most favourable assumptions regarding future disability rates (the high disability reductions scenario), increased morbidity will continue to be observed over time for the aged.

Changes in the availability of family carers

Any increase in the availability of informal carers in Australia will be a major source of assistance for the elderly and would reduce their likelihood of using residential aged care services. Three forms of family support for the disabled in the future are discussed below:

- living alone or with others;
- support for the elderly from other family members (usually children); and
- impacts of ethnicity on family care.[2]

Living alone or with others

Research indicates that older persons living alone are more likely to require residential care than those living in other types of households (Breeze, Sloggett and Fletcher 1999; Evandrou et al. 2001; Pendry, Barrett and Victor 1999).

AIHW (2002b) data on the living arrangements of the elderly before being admitted to residential care show that almost half (45 per cent) of the women lived alone, while around 15 per cent lived with their spouse and around 18 per cent lived with other family members. The inferior life expectancy of men is reflected by the fact that around two-fifths (38 per cent) of men lived with their spouse prior to residential care and only around one-third (32 per cent) lived alone. A further 14 per cent of men lived with other family members.

Household and family projections to 2021 (ABS 1999b) show that the proportion of persons aged 65 and over living alone is expected to decline slightly between 2001

[2] A fourth, and particularly important, form is discussed in chapter 6 — that is, the availability of a spouse or partner as carer. However, all relevant information relating to this dimension is contained in chapter 6 and, accordingly, no additional analysis is presented here.

and 2021 (table A.2).[3] And, for those aged 85 and over, the picture is one of a small increase in the share living alone to 2011, but then returning to current levels by 2021. As such, this is not likely to generate additional demand for subsequent residential care (although the absolute number of elderly persons living alone will of course increase due to the ageing population).

Table A.2 **Proportion of elderly persons by household type, 2001 to 2021**

	2001	*2011*	*2021*
Persons 65 and over			
Living alone	28.8	28.6	27.7
Living only with spouse	47.2	46.5	46.5
Other family	14.3	13.7	13.6
Non-private dwelling	7.6	7.7	6.9
Other	2.1	3.5	5.3
Persons 85 and over			
Living alone	34.8	35.9	35.0
Living only with spouse	18.9	19.0	18.5
Other family	9.2	7.8	8.2
Non-private dwelling	32.8	31.0	30.3
Other	4.3	6.3	8.0

Source: ABS (1999b).

Availability of care from children

If children (and other family) provide assistance to the elderly in their homes, this may be sufficient to allow the elderly to delay entry into or even avoid residential care.

The data on living arrangements in table A.2 may not be a particularly robust indicator of future care from family members (or indeed the likelihood of the elderly requiring residential care). Most adult children providing assistance to their elderly parents, often in conjunction with community care services, do not share the same house. Looking to the future, there are other indicators that can be used with respect to possible care from family members.

The future availability of informal care from family members is sometimes estimated by changes in the ratio of the elderly population to potential female carers. Madge (2000), following an approach adopted by Saunders (1990), defined potential female carers as those aged between 35 and 59. The AIHW (1999), however, defines potential carers as females between 20 and 69 — basing this on

[3] The household and family projections are an assessment of what will happen if recent trends were to continue. They are not predictions or forecasts.

ABS Disability Survey data which shows this age group represents the majority of those caring for the aged or people with a disability.

Using the AIHW definition, the ratio of the broad elderly population (aged 65 and over) to female carers is projected to more than double between 2001 and 2041, with the largest increases occurring in the 2011–2031 period.

The potential shortage of female carers would be exacerbated if the trend to increasing labour force participation by women continues.[4] For example, between 1983 and 2001, female participation (15–64 year olds) in the labour force increased from 45 per cent to 55 per cent (ABS 2003), with most of this increase being attributable to growth in part-time employment. The predominance of part-time work may still allow many women to combine their work with carer activities.[5]

It does not necessarily follow, of course, that a decreased availability of females (or males) will result in less provision of care for their elderly parents — it only indicates the numbers available for potential care. On the qualitative side, there is some encouraging evidence available on Australian attitudes to future care. A survey of community attitudes toward ageing undertaken in 2001 by the Office for Seniors Interests, for example, found that a majority of respondents (two-thirds) felt positive about providing care to elderly family members, with over half of these feeling 'very positive'. Similarly, around two-thirds believed they would have at least a reasonable obligation to care for an elderly member at some stage (OSI 2001).[6]

Ethnicity and family care

The proportion of the elderly from non-English speaking countries is forecast to increase in the next 20 years or so — from 17.8 per cent in 1996 to 21.2 per cent in 2026 (Gibson et al. 2001). In 2001, 34.5 per cent of persons in residential aged care were born overseas, compared with 37.3 per for all persons aged 65 and over

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[4] In responses to a survey by the Office for Seniors Interests undertaken in 2001, 'having to work' was one of the main reasons why respondents felt negative about caring for elderly family members (OSI 2001).

[5] It is worth noting though that this may not necessarily result in an optimal/cost-effective outcome for society. Carers, especially those who also work, may suffer from increased stress and other problems. Mooney, Stratham and Simon (2002), for example, found that people combining work and care often did so at personal cost such as tiredness, ill-health and lack of leisure. These consequences may result in additional health costs and lower productivity, factors that need to be balanced against possible residential care expenditure savings flowing from any increased availability of carers.

[6] The survey sample consisted of an even number of respondents in four age groups: 16–39, 40–59, 60–69 and 70 plus.

(DHA 2003b). In addition, 0.5 per cent of persons in residential aged care in 2001 were of Indigenous descent.

These figures raise the issue of whether there are any observable differences between the overseas-born elderly and the general aged population that affects their likelihood of entering an aged care home. In fact, the rate of use of residential aged care appears to be clearly related to the differing origins of residents (table A.3).

Table A.3 **Residential aged care use by age group, by people from culturally and linguistically diverse backgrounds, 2000**
Age group

English Proficiency (EP) Group[a]	*Residential aged care clients per 1000 population*			
	65–74	*75–84*	*85+*	*65+*
Australian born	12	63	279	60
EP1 – Born in English speaking countries	7	46	235	49
EP2 – Majority speak only English, or other language and good English	9	53	224	38
EP3 – At least half speak only English, or other language and good English	6	37	153	27
EP4 – Less than half speak only English, or other language and good English	5	29	106	20
Total persons	*10*	*57*	*257*	*53*

[a] EP2 examples include persons born in Austria, Germany and Malta; EP3 examples include persons born in Greece, Italy and Poland; EP4 examples include persons born in China, Turkey and Vietnam.

Source: AIHW (2001).

For example, Australian-born persons aged 65 and over are three times more likely to enter aged care homes than immigrants from such countries as China, Turkey and Vietnam (EP4 persons). They are also twice as likely to use residential care as persons from European countries such as Greece, Italy and Poland (EP3 persons).

Recent research supports these findings and suggests that the differences in the usage of residential aged care between ethnic groups stem largely from attitudes to care for the elderly. See, for example, De Vaus and Wolcott (1997) and Walker (1999).

Looking to the future, these findings suggest that potential family support for the elderly may be heightened by the expected increasing share of overseas-born in the elderly population. By 2026, persons born in Italy will be the largest overseas-born group, followed by persons born in Greece, Vietnam and China.

Changes in income and wealth

Estimates of the wealth of the elderly population in Australia (past and future) have been prepared by researchers at the National Centre for Economic and Social Modelling (NATSEM). The NATSEM publications used in this section are Harding, King and Kelly (2002), Kelly (2002) and Kelly (2003).

The distribution of wealth has shifted markedly towards older Australians since the mid-1980s (Harding, King and Kelly 2002). The share held by those aged 65 or over increased from around 17 per cent in 1986 to around 27 per cent in 1997. While some of this increase simply reflects higher population numbers in the older age groups, the estimated real *average* wealth of Australians aged 65 years and over still increased by about 90 per cent. Amongst the elderly, the share of wealth held by the wealthiest 25 per cent rose from about 67 per cent to 71 per cent.

These trends are expected to continue over the next 30 years (Kelly 2002). The real average family wealth of older Australians is projected to grow at a significantly faster rate than that of younger Australians between 2000 and 2030 (figure A.1).

The variation in the rates of growth of wealth by age, combined with the ageing population, will also result in significant changes in the distribution of wealth by age (figure A.2).

Interestingly though, despite these wealth changes the 'baby boomers' may not have access to a retirement income 'that allows them to prosper', at least in Sydney (see Kelly 2003).[7]

In addition, Madge (2000) argues that while future generations are likely to be wealthier than their forbears, the net increases in wealth may not be as great as they appear:

- increased compulsory superannuation will, to some extent, be offset by reduced voluntary savings and reduced access to the aged pension; and
- while the amount of assets bequeathed to individuals is likely to increase, the expectation of a bequest may reduce saving out of current income by the next generation.

Nevertheless, there is little doubt that the future aged will be wealthier and have higher incomes than the current aged. What are the likely impacts of increased income and wealth on the demand for residential aged care?

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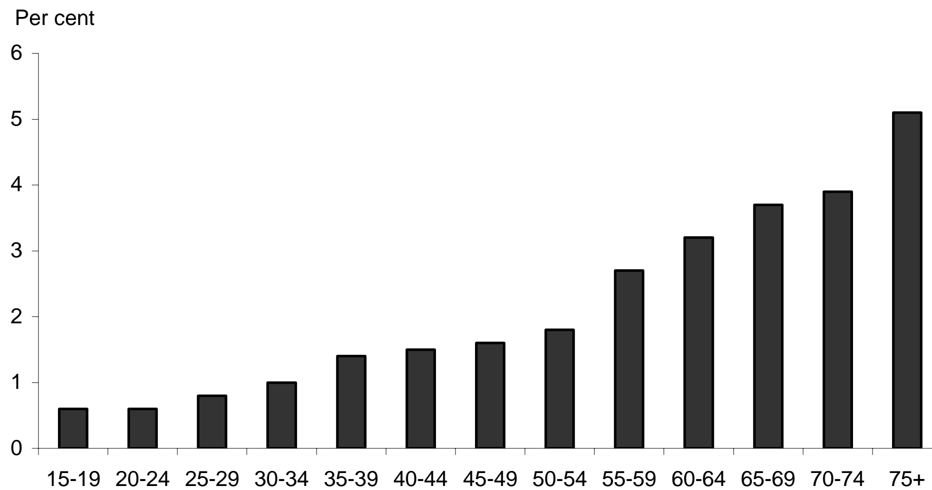
[7] Kelly assumes that Sydney retirees will require a higher income than retirees in other parts of NSW on the basis that people need a retirement income equivalent to a set proportion of their annual pre-retirement income to be financially comfortable.

Figure A.1 **Change in real average family wealth by age group, 2000–2030**



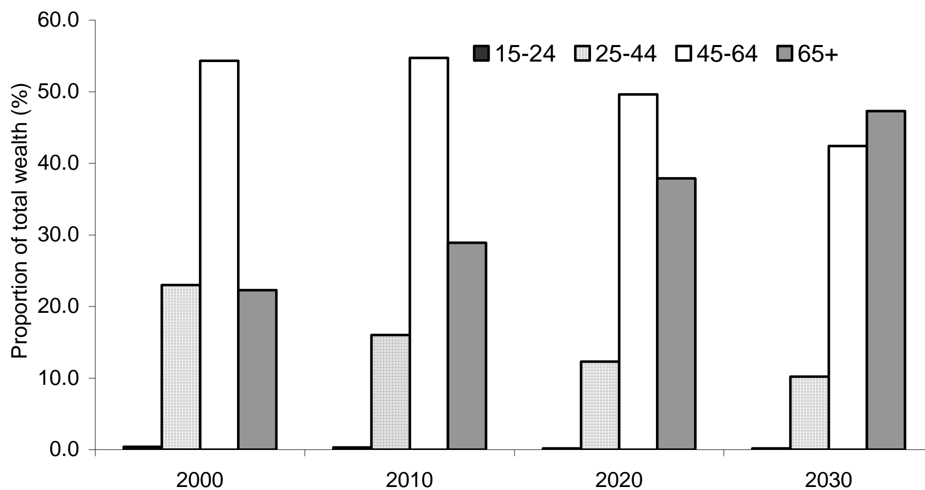
Data source: Kelly (2002).

Madge (2000) noted that increases in the income and wealth of the aged would have complex and ambiguous effects on the demand for aged care services. While acknowledging that greater affluence would reduce the likelihood of disability, he suggested that it might also increase underlying future demand — with the net effect of these opposing factors being uncertain. At the same time, he said it was likely that the effects of income on usage would be principally felt in the 'non-regulated segments of long-term aged care services' (such as informal care and home services) and that the share of the formal sector (residential care) may actually be reduced.

On balance, the Commission expects that the impacts of a more affluent elderly population would be a fall in demand for residential aged care. This is due to a combination of a reduced likelihood of disability, an increased likelihood of alternative living arrangements and an increased likelihood of staying at home (with support) or with family carers.

Another impact of increased wealth on residential aged care may be a growing demand for higher quality services. However, while raising the quality standards of residential care facilities will add to costs, the impacts on future demand and use are unclear.

Figure A.2 **Proportion of total estimated family wealth by age group, 2000 to 2030**



Data source: Kelly (2002).

A.2 Demand and utilisation

An underlying demand for residential care services is not automatically translated into an equivalent number of residential care places being utilised. Utilisation is likely to differ from underlying demand for a number of reasons:

- the impact of institutional factors;
- the relationship between ageing, disability rates and institutionalisation rates;
- changes in length of stay; and
- the availability of other forms of care and living arrangements.

These issues need to be kept in mind when the impact of demand on future utilisation is discussed.[8]

The impact of institutional factors

The residential aged care sector is subject to substantial government regulation and control, mainly stemming from the Commonwealth Government (chapter 3). The key elements of the regulatory regime include a subsidy to residential care providers, control over the supply of available places, restrictions on eligibility for

[8] Another reason relates to any unmet demand in the system. This issue is analysed as part of the discussion of access to aged care services in chapter 5.

residential aged care, controls over the contributions (both recurrent and capital) from residents, and regulated care and accommodation standards.

The existence of these controls strongly influences the supply of, and the demand for, residential aged care services.

- On the supply side, the Commonwealth's funding regime dictates the number of places available, while Commonwealth and state regulations influence the nature of care services provided.
- On the demand side, government policies have a direct influence on the 'price' charged for residential care (as well as its substitutes). They also influence demand by controlling eligibility to residential care through ACATs, by influencing charges for accommodation services and by applying income and assets means tests.

The extent of government regulation and control means that the number of persons in residential care will never truly reflect the underlying demand for places. Rather, it will provide an indication of demand under the prevailing conditions. For example, any tendency for excess demand because of subsidised prices is controlled by regulating the quantity of places available and by controlling entry to aged care homes.

Looking to the future, one of the demand factors that may influence the institutional framework — rather than the reverse — is the increasing wealth of the elderly. The projected increases in wealth over the coming decades (see section A.1) suggest that the future elderly will have a greater capacity to pay for residential care than their current cohort. Governments of the future may react to this by, for example, reducing residential care subsidies, more tightly targeting potential clients, or allowing for more 'extra service' places.

Beyond the institutional framework of the residential aged care sector, other government policies may influence demand and usage. One example is any move towards the imposition of a later retirement age. The consequences for future aged care of people staying in the workforce for a longer period could be quite significant, as it would have implications for their personal health and wealth as well as the availability of carers.

Ageing, disability rates and institutionalisation rates

There is no defined relationship between ageing, disability and entry to residential care. This applies to both the links between ageing and disability, and disability and institutionalisation rates.

Demand will depend upon the severity of the disability, its impacts on individuals, its amenability to management and the extent to which the aged are aware of the services they can use (Madge 2000).

In addition, allowing for the fact that changing disability rates will have *some* impact on the demand for residential care, there is still a considerable amount of uncertainty (and debate) over how such demand changes will affect the likelihood of institutionalisation. The link between disability rates and institutionalisation rates is not straightforward. Indeed, the ratio of those with profound/severe disabilities in the aged population substantially exceeds those cared for in residential care homes. By way of example, if the latest (1998) disability rate for profound/severe persons of 19.6 per cent is applied to the population aged 65 and over in 2001, the 'notional demand' for (high level) residential care is 471 000 persons. However, the total number of residential high care places occupied in 2001 was around 83 000 — a difference of 388 000 persons.[9] This, of course, represents only a crude estimate but it emphasises the point that the relationship between disability rates and institutionalisation is clearly a complex one.

Length of stay

The overall utilisation of residential aged care services depends not only on the likelihood of admission — and the demand factors shaping this — but also, critically, on the duration of service use, or length of stay.

The major implication of any tendency for clients to stay for longer periods in residential care is that there will be fewer places available than in previous years to meet ongoing demand, in the absence of extensions to existing places.

There is evidence that lengths of stay are increasing. Between June 1999 and June 2002, the average length of completed stay for permanent residents increased by an average of 1.6 per cent per annum to almost 27 months (DHA 2003b). In addition, fewer residents are staying for very short periods (less than one month) and more residents are staying for long periods (more than two years).

Increased lengths of stay may partially reflect an increased number of dementia and rural community care type patients, but, more importantly, the 'ageing in place' policies of recent years. Residents who are now allowed to age in place would in the past have been discharged from low care and admitted to high care. A different length of stay picture emerges, in fact, for high level care. Length of stay has always

[9] Of course, most of the disabled who are not in residential care are probably quite happy being cared for at home (or in hospital in some cases).

tended to be less for high care residents than for low care residents, reflecting the fact that high level care is designated for the frail aged who tend to die after a relatively short stay. According to industry sources, the current trend is for people to enter high care at a later age and to stay for shorter periods than previously.

Availability of other forms of care and living arrangements

The demand for, and consumption of, most goods and services is influenced by the availability and price of any substitutes. In the case of residential aged care services, these take the form of alternative care and living arrangements.

Alternative care may consist of informal care from relatives or friends, and/or the provision of home-based services by either government or private operators. Alternative living arrangements to residential care comprise any arrangement whereby elderly persons in need of assistance can reside — for example, with family members, in assisted living apartments, or in retirement villages.

The presence of these alternatives may contribute to 'driving a wedge' between the underlying demand for residential care and the utilisation of aged care homes. For example, some seriously disabled people who would be eligible for formal residential care, may manage at home with family support and/or the support of government programs (such as HACC and EACH). Or, alternatively, they may live in the same house as their child or in a retirement village. Evidence of retirement village operators introducing measures to retain their ageing residents — such as providing a range of additional support mechanisms to residents — and so reducing the demand for residential care, has recently been provided by the Australian Nursing Homes and Extended Care Association (ANHECA 2002).

The reasons why the infirm use — and in many instances prefer — these various alternatives to residential care are many and some of the issues involved have been discussed in other parts of this submission. The point to be made here though is that the continuing availability of a wide range of informal or government-sponsored care options — in conjunction with underlying preferences for non-residential forms of care — are likely to offset somewhat the impact of population ageing on the usage of residential care homes.

B Residential aged care projections

The analysis in chapter 6 included projections of key residential care demand factors as well as projections of residential care use. This appendix augments these projections and is divided into three sections:

- the population projections underpinning the residential care projections;
- assumptions regarding key variables used in the residential care projections;
- projections of residential aged care use under different scenarios for disability reductions, institutionalisation rates and the high/low level care resident mix.

B.1 Population projections

The ABS (2000b) produces three series of population projections using different assumptions about future levels of births, deaths and migration. In chapter 6, the population estimates are based on ABS Series II (medium) projections. These projections assume:

- a total fertility rate of 1.6 births per woman;
- an annual net overseas migration gain of 90 000; and
- life expectancy at birth increases from the 1996–1998 levels of 75.9 years for males and 81.5 years for females to 83.3 years for males and 86.6 years for females by 2051.

The following tables present population estimates based on the alternative ABS Series I (high) and Series III (low) population projections. These projections assume different fertility rates and migration gains, but make the same assumption about life expectancy as the Series II projections.

Table B.1 Australia's aged population, 2001 to 2041 — Series I (high) projections[a]

Age gropup	2001	2011	2021	2031	2041
Number	'000	'000	'000	'000	'000
65–74	1 305.6	1 673.1	2 442.6	2 818.1	2 993.0
75–84	837.5	981.7	1 320.7	1 959.4	2 293.3
85+	260.4	389.4	479.8	680.2	1 042.2
65+	2 403.4	3 044.2	4 243.2	5 457.7	6 328.5
	2001–2011	*2011–2021*	*2021–2031*	*2031–2041*	*2001–2041*
Change	%	%	%	%	%
65–74	28	46	15	6	129
75–84	17	35	48	17	174
85+	50	23	42	53	300
65+	27	39	29	16	163

[a] The Series I (high) projections assume an annual net overseas migration gain of 110 000, a total fertility rate of 1.75 births per woman and that life expectancy at birth increases from the 1996–1998 levels of 75.9 years for males and 81.5 years for females to 83.3 years for males and 86.6 years for females by 2051.

Source: ABS (2000b).

Table B.2 Share of aged population and dependency ratio, 2001 to 2041 — Series I (high) projections[a]

	2001	2011	2021	2031	2041
	%	%	%	%	%
Share of population aged 65 and over to total population	12	14	18	21	23
Aged dependency ratio [b]	18	21	27	34	39

[a] The Series I (high) projections assume an annual net overseas migration gain of 110 000, a total fertility rate of 1.75 births per woman and that life expectancy at birth increases from the 1996–1998 levels of 75.9 years for males and 81.5 years for females to 83.3 years for males and 86.6 years for females by 2051. [b] The aged dependency ratio is the number of persons aged 65 and over as a proportion of the working population aged 15–64 years.

Source: ABS (2000b).

Table B.3 **Australia's aged population, 2001 to 2041 — Series III (low) projections[a]**

Age group	*2001*	*2011*	*2021*	*2031*	*2041*
Number	'000	'000	'000	'000	'000
65–74	1 305.1	1 661.4	2 412.9	2 748.4	2 840.5
75–84	837.4	977.6	1 307.6	1 931.5	2 232.0
85+	260.3	388.8	477.3	672.9	1 026.5
65+	2 402.8	3 027.8	4 197.8	5 352.8	6 099.0
	2001–2011	*2011–2021*	*2021–2031*	*2031–2041*	*2001–2041*
Change	%	%	%	%	%
65-74	27	45	14	3	118
75-84	17	34	48	16	167
85+	49	23	41	53	294
65+	26	39	28	14	154

[a] The Series III (low) projections assume an annual net overseas migration gain of 70 000, a total fertility rate of 1.6 births per woman and that life expectancy at birth increases from the 1996–1998 levels of 75.9 years for males and 81.5 years for females to 83.3 years for males and 86.6 years for females by 2051.

Source: ABS (2000b).

Table B.4 **Share of aged population and dependency ratio, 2001 to 2041 — Series III (low) projections[a]**

	2001	*2011*	*2021*	*2031*	*2041*
	%	%	%	%	%
Share of population aged 65 and over to total population	12	14	19	23	25
Aged dependency ratio[b]	18	21	29	37	42

[a] The Series III (low) projections assume an annual net overseas migration gain of 70 000, a total fertility rate of 1.6 births per woman and that life expectancy at birth increases from the 1996–1998 levels of 75.9 years for males and 81.5 years for females to 83.3 years for males and 86.6 years for females by 2051. [b] The aged dependency ratio is the number of persons aged 65 and over as a proportion of the working population aged 15-64 years.

Source: ABS (2000b).

B.2 Residential aged care use — assumed rates for key variables

Three key variables affect the Commission's residential aged care estimates between 2001 and 2041:

- possible changes in disability rates;

- the proportion of aged care residents likely to require high and low level care; and
- the proportion of the aged population likely to be institutionalised.

The Commission has developed three scenarios for each of these parameters, which were outlined in chapter 6. The tables below show the impact of these scenarios on disability rates, the resident mix and institutionalisation rates.

Table B.5 **Disability rates for residential use projections — assumed rates under moderate and high scenarios for reductions in disability rates, by age group, 2001 to 2041[a]**

Age group	*2001*	*2011*	*2021*	*2031*	*2041*
	%	%	%	%	%
Medium reductions in disability rates[b]					
65–74	10.9	10.3	10.1	10.1	9.7
75–84	25.8	24.4	23.8	23.9	23.0
85+	64.9	61.5	60.0	60.0	58.0
65+	21.9	21.4	20.0	21.3	22.6
High reductions in disability rates[c]					
65–74	10.9	9.5	8.3	7.3	6.4
75–84	25.8	24.0	22.3	20.8	19.4
85+	64.9	60.4	56.3	52.4	48.8
65+	21.9	20.7	18.1	17.8	18.2

a Estimates are for severe/profound disability. **b** Based on AIHW (1999) projections which assume a decline of 0.25 per cent per annum. **c** Based on the annual rate of decline in the disability rate experienced by the United States in the last decade (0.47 per cent per annum).

Sources: AIHW (1999); Productivity Commission estimates.

Table B.6 **Resident mix for residential use projections — assumed ratios of high level care to low level care residents, 2001 to 2041[a,b]**

Scenarios	*2001*	*2011*	*2021*	*2031*	*2041*
	%	%	%	%	%
Low increase in high care/low care mix[c]	60.8	62.9	64.8	66.7	68.8
Medium increase in high care/low care mix[d]	60.8	63.5	66.1	68.8	71.6
High increase in high care/low care mix[e]	60.8	64.1	67.4	70.9	74.5

a Reported as the proportion of residents in high level care. **b** The high care/low care mix in 2001 is a weighted average of the high care/low care mix for the 65-74 year age group (64.4 per cent), the 75–84 year age group (61.5 per cent) and the 85 years and over age group (59.6 per cent) **c** Assumes 75 per cent of trend growth in the high care/low care mix between 1991 and 2001 continues over the projection period. **d** Assumes trend growth (0.4 per cent per annum) in the high care/low care mix between 1991 and 2001 continues over the projection period. **e** Assumes 125 per cent of trend growth in the high care/low care mix between 1991 and 2001 continues over the projection period.

Source: Productivity Commission estimates.

Table B.7 **Institutionalisation rates for residential use projections — assumed rates under low, medium and high scenarios, by age group, 2001 to 2041[a]**

Age groups	*2001*	*2011*	*2021*	*2031*	*2041*
	%	%	%	%	%
Low reduction in institutionalisation rate[b]					
65–74	1.0	1.0	1.0	1.0	1.0
75–84	5.6	5.0	4.4	3.9	3.4
85+	26.0	25.0	24.1	23.2	22.3
65+	5.3	5.4	4.7	4.8	5.4
Medium reduction in institutionalisation rate[c]					
65–74	1.0	1.0	1.0	1.0	1.0
75–84	5.6	4.8	4.0	3.4	2.9
85+	26.0	25.0	24.1	23.2	22.3
65+	5.3	5.3	4.6	4.6	5.2
High reduction in institutionalisation rate[d]					
65–74	1.0	1.0	1.0	1.0	1.0
75–84	5.6	4.6	3.7	3.0	2.4
85+	26.0	25.0	24.1	23.2	22.3
65+	5.3	5.2	4.5	4.5	5.0

[a] Broad measure of institutionalisation rate (the number of people in residential aged care institutions as a proportion of the total aged population) which does not account for the impact of disability reductions. Accounting for high disability reductions would result in further average annual declines of 1.3 per cent for the 65–74 year age group and 0.7 per cent for each of the 75–84 year and 85 years and over age groups. [b] Assumes 75 per cent of trend growth in the institutionalisation rate, by age group, between 1991 and 2001 continues over the projection period. [c] Assumes trend growth in the institutionalisation rate, by age group, between 1991 and 2001 — that is, 1.5 per cent per annum for the 65–74 year age group, 2.4 per cent per annum for the 75-84 year age group and 2.2 per cent per annum for the 85 years and over age group — continues over the projection period. However, the 85+ age group is assumed to have an institutionalisation rate which is 25 per cent of trend growth in institutionalisation rate between 1991 and 2001, for all the scenarios. [d] Assumes 125 per cent of trend growth in the institutionalisation rate, by age group, between 1991 and 2001 continues over the projection period.

Source: Productivity Commission estimates.

B.3 Residential aged care use projections

The following tables supplement the summarised residential care projections in chapter 6:

- Tables B.8 and B.9 show projections of residential aged care use between 2001 and 2041, under the three scenarios for disability rate reductions and for the high and low institutionalisation rate scenarios (the projections for a medium institutionalisation rate scenario are reported in chapter 6).
- Tables B.10 to B.12 show projections of high level and low level care residents between 2001 and 2041, under different scenarios for the high care/low care mix, disability rate reductions and institutionalisation rates.

Table B.8 **Projections of aged care residents, by age group, assuming low reductions in the institutionalisation rate and different scenarios for disability rate reductions, 2001 to 2041**

Age groups	*2001*	*2011*	*2021*	*2031*	*2041*
	'000	'000	'000	'000	'000
No disability rate reductions					
65–74	13.7	17.3	24.9	28.2	29.2
75–84	47.3	48.7	57.5	75.0	76.8
85+	67.6	97.3	115.2	156.8	230.9
65+	128.5	163.3	197.6	260.0	336.9
Medium disability rate reductions					
65–74	13.7	15.7	20.4	21.0	19.7
75–84	47.3	46.2	51.7	63.9	62.1
85+	67.6	92.3	103.7	133.8	186.9
65+	128.5	154.1	175.8	218.7	268.7
High disability rate reductions					
65–74	13.7	15.2	19.1	19.0	17.3
75–84	47.3	45.3	49.9	60.6	57.8
85+	67.6	90.7	100.1	126.9	174.1
65+	128.5	151.2	169.1	206.5	249.2

Source: Productivity Commission estimates.

Table B.9 **Projections of aged care residents, by age group, assuming high reductions in the institutionalisation rate and different scenarios for disability rate reductions, 2001 to 2041**

Age group	*2001*	*2011*	*2021*	*2031*	*2041*
	'000	'000	'000	'000	'000
No disability rate reductions					
65–74	13.7	17.1	24.5	27.5	28.3
75–84	47.3	44.7	48.5	58.0	54.6
85+	67.6	97.3	115.2	156.8	230.9
65+	128.5	159.1	188.2	242.4	313.7
Medium disability rate reductions					
65–74	13.7	15.5	20.1	20.5	19.1
75–84	47.3	42.4	43.5	49.4	44.0
85+	67.6	92.3	103.7	133.8	186.9
65+	128.5	150.2	167.3	203.7	250.0
High disability rate reductions					
65–74	13.7	15.0	18.8	18.6	16.7
75–84	47.3	41.6	42.0	46.8	41.0
85+	67.6	90.7	100.1	126.9	174.1
65+	128.5	147.3	160.9	192.3	231.8

Source: Productivity Commission estimates.

Table B.10 **Projections of resident mix, assuming a low increase in the high care/low care ratio and different scenarios for the institutionalisation rate and disability rate reductions, 2001 to 2041[a]**

Scenarios	*2001*	*2011*	*2021*	*2031*	*2041*
	'000	'000	'000	'000	'000
Low reduction in institutionalisation rate					
No disability rate reductions					
High care residents	78.2	102.7	128.0	173.4	231.8
Low care residents	50.4	60.6	69.6	86.6	105.1
Medium disability rate reductions					
High care residents	78.2	96.9	113.9	145.9	184.8
Low care residents	50.4	57.2	61.9	72.8	83.8
High disability rate reductions					
High care residents	78.2	95.1	109.6	137.8	171.4
Low care residents	50.4	56.1	59.5	68.8	77.8
Medium reduction in institutionalisation rate					
No disability rate reductions					
High care residents	78.2	101.4	124.9	167.2	223.2
Low care residents	50.4	59.8	67.8	83.5	101.2
Medium disability rate reductions					
High care residents	78.2	95.7	111.1	140.6	177.9
Low care residents	50.4	56.4	60.3	70.2	80.7
High disability rate reductions					
High care residents	78.2	93.9	106.8	132.7	165.0
Low care residents	50.4	55.4	58.0	66.3	74.8
High reduction in institutionalisation rate					
No disability rate reductions					
High care residents	78.2	100.1	121.9	161.7	215.8
Low care residents	50.4	59.0	66.2	80.7	97.9
Medium disability rate reductions					
High care residents	78.2	94.5	108.4	135.9	172.0
Low care residents	50.4	55.7	58.9	67.8	78.0
High disability rate reductions					
High care residents	78.2	92.7	104.3	128.3	159.5
Low care residents	50.4	54.7	56.6	64.0	72.3

a A low increase in the high level care/low level care scenario is based on the assumption that the trend growth in this ratio, by age group, between 1991 and 2001 will taper off over the period 2001 to 2041, with annual growth arbitrarily selected as being 75 per cent of the historical trend.

Source: Productivity Commission estimates.

Table B.11 **Projections of resident mix, assuming a moderate increase in the high care/low care ratio and different scenarios for the institutionalisation rate and disability rate reductions, 2001 to 2041[a]**

Scenarios	*2001*	*2011*	*2021*	*2031*	*2041*
	'000	'000	'000	'000	'000
Low reduction in institutionalisation rate					
No disability rate reductions					
High care residents	78.2	103.7	130.6	178.9	241.2
Low care residents	50.4	59.6	67.0	81.1	95.7
Medium disability rate reductions					
High care residents	78.2	97.9	116.2	150.5	192.4
Low care residents	50.4	56.3	59.6	68.3	76.3
High disability rate reductions					
High care residents	78.2	96.0	111.8	142.1	178.4
Low care residents	50.4	55.2	57.3	64.4	70.8
Medium reduction in institutionalisation rate					
No disability rate reductions					
High care residents	78.2	102.3	127.4	172.5	232.2
Low care residents	50.4	58.8	65.3	78.2	92.1
Medium disability rate reductions					
High care residents	78.2	96.6	113.3	145.0	185.1
Low care residents	50.4	55.5	58.1	65.8	73.4
High disability rate reductions					
High care residents	78.2	94.7	109.0	136.9	171.7
Low care residents	50.4	54.5	55.9	62.1	68.1
High reduction in institutionalisation rate					
No disability rate reductions					
High care residents	78.2	101.1	124.4	166.7	224.6
Low care residents	50.4	58.1	63.8	75.6	89.1
Medium disability rate reductions					
High care residents	78.2	95.4	110.6	140.2	179.0
Low care residents	50.4	54.8	56.7	63.6	71.0
High disability rate reductions					
High care residents	78.2	93.5	106.4	132.3	166.0
Low care residents	50.4	53.8	54.5	60.0	65.8

a A low increase in the high level care/low level care scenario is based on the assumption that the trend growth in this ratio, by age group, between 1991 and 2001 will taper off over the period 2001 to 2041, with annual growth arbitrarily selected as being 75 per cent of the historical trend.

Source: Productivity Commission estimates.

Table B.12 **Projections of resident mix, assuming a high increase in the high care/low care ratio and different scenarios for the institutionalisation rate and disability rate reductions, 2001 to 2041**[a]

Scenarios	*2001*	*2011*	*2021*	*2031*	*2041*
Scenarios	'000	'000	'000	'000	'000
Low reduction in institutionalisation rate					
No disability rate reductions					
High care residents	78.2	104.7	133.2	184.3	251.0
Low care residents	50.4	58.6	64.4	75.7	85.9
Medium disability rate reductions					
High care residents	78.2	98.8	118.5	155.1	200.1
Low care residents	50.4	55.3	57.3	63.7	68.5
High disability rate reductions					
High care residents	78.2	96.9	114.0	146.4	185.7
Low care residents	50.4	54.3	55.1	60.1	63.5
Medium reduction in institutionalisation rate					
No disability rate reductions					
High care residents	78.2	103.3	129.9	177.7	241.6
Low care residents	50.4	57.9	62.8	72.9	82.7
Medium disability rate reductions					
High care residents	78.2	97.5	115.5	149.4	192.6
Low care residents	50.4	54.6	55.9	61.3	65.9
High disability rate reductions					
High care residents	78.2	95.6	111.1	141.1	178.6
Low care residents	50.4	53.6	53.7	57.9	61.2
High reduction in institutionalisation rate					
No disability rate reductions					
High care residents	78.2	102.0	126.8	171.8	233.7
Low care residents	50.4	57.1	61.3	70.5	80.0
Medium disability rate reductions					
High care residents	78.2	96.3	112.8	144.4	186.2
Low care residents	50.4	53.9	54.5	59.3	63.7
High disability rate reductions					
High care residents	78.2	94.4	108.4	136.3	172.7
Low care residents	50.4	52.9	52.5	56.0	59.1

a A low increase in the high level care/low level care scenario is based on the assumption that the trend growth in this ratio, by age group, between 1991 and 2001 will taper off over the period 2001 to 2041, with annual growth arbitrarily selected as being 75 per cent of the historical trend.

Source: Productivity Commission estimates.

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