
4 Equity, efficiency and sustainability

Key points

- Underpinning the aged care policy framework are notions of equity, efficiency and sustainability. The pressures associated with population ageing and growing diversity among older people are stimulating debate about how these concepts are interpreted and applied to the delivery of aged care services.
- The community has to decide how much weight should be given to equity, efficiency and sustainability including possible trade-offs between these objectives and those relating to quality and choice. Importantly, community expectations concerning the provision and funding of aged care services will continue to evolve.
- Notwithstanding recent initiatives to improve aged care services in Australia, some significant challenges remain, including:
 - tackling inequities arising from existing program design
 - achieving a more efficient regulatory regime
 - improving the responsiveness of services to changes in the care needs of older people
 - improving service interfaces
 - securing sustainable outcomes.

The previous chapter highlighted that over the next 40 years the community will need to provide aged care to a significantly larger number of Australians (both in absolute and relative terms). Moreover, among the aged, there is likely to be greater diversity in terms of their backgrounds, care needs, preferences and affluence. These developments pose a number of challenges for policymakers in seeking to ensure that the aged care system delivers outcomes that are broadly consistent with the community's expectations.

This chapter examines these challenges from the perspective of the equity, efficiency and sustainability objectives underpinning the aged care system. It begins by discussing these objectives and exploring the implications of population ageing and growing diversity among the aged for these objectives and associated trade-offs between them. It then provides a brief overview of recent initiatives to improve these dimensions of the aged care system. Finally, it outlines some of the emerging challenges recognising that, without ameliorative policy action, population ageing will accentuate these challenges.

4.1 The roles of equity, efficiency and sustainability

The overarching objectives of government involvement in aged care have been to ensure that frail older people have access to high quality and cost effective care and that their carers are supported (see outcome 4, DoHA 2007d). Reflecting this, the aged care policy framework is underpinned by concepts of equity, efficiency, sustainability, quality and choice (chapter 2). Such objectives are not peculiar to aged care. Indeed, they are common to other areas of social policy such as health care.

Reflecting their multifaceted nature, the community faces choices about how to interpret and apply notions of equity, efficiency and sustainability to aged care, including how much weight should be given to each, relative to the others. Importantly, what the community expects from the provision and funding of aged care services continues to evolve.

The quality and choice dimensions of aged care are dealt with in chapter 5.

Equity

Australia's aged care system gives considerable weight to achieving equity of access to appropriate care. In reporting on the operation of the *Aged Care Act 1997*, Department of Health and Aged Care (DHAC 1999, p. 7) observed:

A key objective of the Act is to ensure that access to aged care services is according to need and regardless of race, culture, language, gender, economic circumstance or geographic location. Underlying this objective is the need to ensure that services are targeted towards the people with the greatest need for those services, and to ensure that access to care is affordable by and appropriate to the needs of those who require it.

This commitment to equity of access is reflected in current policy settings in a number of ways:

- Equity is achieved through an objective assessment of a person's need for care. This recognises that there is a wide variation among older people in terms of their physical and mental wellbeing and, given the limited availability of resources, priority should be given to those with the greatest need for care.
- Subsidy and fee arrangements seek to ensure aged care is affordable for those who need it, having regard to their ability to pay. This does not imply that all clients of aged care services should be equally subsidised, but that public funds are targeted to those individuals needing care who are least able to pay. Income and asset tested care charges recognise this principle. Further, subsidies are

calibrated to reflect that the cost of providing aged care varies markedly depending on the complexity of a person's care needs.

- As a third dimension of equity, the quality assurance and accreditation system aims to ensure that all clients receive care which at least satisfies minimum standards of safety and quality (chapter 5).

However, increased recognition of the pressures associated with population ageing and growing diversity among older people (chapter 3) is drawing into sharper focus other dimensions of equity.

- Increased community awareness of Australia's changing demographics has prompted a wider discourse about the welfare of older people (for example, the *National Strategy for an Ageing Australia: An Older Australia, Challenges and Opportunities for all*, Andrews 2002a). Underpinning this discourse has been the view that age should not be a barrier to people participating in the community and economy. For aged care, this has focused attention on ensuring that these services promote equity of opportunity for older people to remain engaged in the community for as long as possible. This has been reflected in the decision by governments to expand the provision of community care, in order to enable more older people to exercise their preference to receive care in their own home.
- The pressures associated with population ageing have also focused attention on the long-term fiscal sustainability of aged care services and, hence, the intergenerational equity of current funding arrangements. Intergenerational equity requires that the overall funding mechanism encourages broadly even contributions between groups over time. In part, this will require striking an appropriate balance between public and private funding of aged care services.
- Concerns about fiscal sustainability have also encouraged more attention to be given to the cost effectiveness of providing different types of aged care services. Thus, the notion of equity of access underpinning aged care recognises it is appropriate for the types of services available at a particular location to reflect the level of demand for those services and the cost of delivering them at that location. That said, a choice needs to be made about trade-offs to, for example, determine how to accommodate the higher costs of service provision to rural and remote areas so as to reflect the collective preference of the community.
- Many commentators argue that in the future older people will demand more choice in the services they consume (chapter 5). In terms of equity, this is reflected in the view that a commitment to ensuring a minimum standard of service quality should not preclude people, who can afford to do so, paying for extra services. For example, the Hogan Review (2004, p. 10) argued 'the ability of some to purchase a higher standard or another form of care should not be denied'.

It is also important to recognise that equity has a dynamic dimension. As a community, we are not only concerned with equity when clients first enter the aged care system, but expect that it will continue to be taken into account as clients' circumstances and needs change over time. In practice, this means that policy makers must have regard for clients' access to changing amounts and types of services, the quality of these services and the outcomes of these services in terms of quality of life.

To some extent, what equity means in the context of aged care remains controversial, including what weight should be given to the various dimensions of equity. Policy makers also face the challenge of striking an appropriate balance between equity considerations and the other objectives of aged care (efficiency, sustainability, quality and choice), particularly in view of the emerging cost pressures identified in chapter 3.

Efficiency

Within the aged care policy framework, the current focus of efficiency appears to be largely on the integration and coordination of services, including the interface between aged care and related services (such as health care and public housing). The Hogan Review (2004, p. 11) exemplifies this view:

Aged care's regulatory and financing arrangements must promote and reward efficiency. This includes integration and coordination. The arrangements must also address service gaps, allowing a smooth transition between types of care and ensuring that funding methodologies are, where possible, consistent across sectors. They should also be simple, transparent and accountable for residents, providers or purchasers.

In broad terms, efficiency is concerned with the community's ability to maximise its overall welfare and living standards, given available resources. In looking for ways to improve efficiency in an area such as aged care, it is important to consider the incentives within the system to:

- provide services needed by clients having regard to the overall costs of their provision
- improve the per unit cost of producing services
- be innovative and flexible in the face of changing economic and social circumstances.

Reflecting this perspective, efficiency can be thought of as having a number of dimensions:

- *Allocative efficiency* — is concerned with ensuring that resources are allocated among different types of aged care, and between aged care and the wider

economy, so as to produce the combination of services that represents the best value for clients and the community. Allocative efficiency focuses attention on whether, due to market failures or regulatory and institutional settings, some aged care services may be over or under consumed from a community wide welfare perspective.

- *Productive efficiency* — involves the delivery of an appropriate level and quality of care services at the lowest possible cost, by using the least cost combination of inputs. Productive efficiency incorporates technical efficiency, which refers to the extent to which it is technically feasible to reduce any input without decreasing the output, and without increasing any other input. It should be emphasised that productive efficiency does not mean producing the lowest quality service or at the least cost to government. Put simply, productive efficiency is primarily concerned with avoiding waste in providing aged care services.
- *Dynamic efficiency* — refers to the capacity to improve efficiency over time. This can mean innovating to create 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 and social conditions. From a systems perspective, the quality of service integration, coordination and planning are clearly important as well. This is because service interfaces are often the points within systems that come under the most pressure as a result of changing conditions. Rigidities and inefficiency at these points can impose significant avoidable costs on clients, providers and the wider community.

In the Commission's view, given the cost pressures associated with population ageing, the welfare of the community as a whole would be best served by taking a broad view of efficiency, one that encompasses its allocative, productive and dynamic dimensions. In practice, this would include giving more consideration to whether current policy settings may be distorting the allocation of resources between different types of aged care services and weakening incentives for innovation.

Sustainability

In the context of aged care, sustainability has tended to be considered in terms of the long-term fiscal sustainability of government policy settings. As outlined in chapter 2, aged care subsidies are largely funded by the Australian Government on a 'pay as you go' basis (that is, from consolidated tax revenue). Population ageing has focused attention on the need to ensure that such subsidies remain affordable for the community in the medium to long term. Treasury (2002, p. 2) has defined fiscal sustainability as:

... the government's ability to manage its finances so it can meet its spending commitments, both now and in the future. It ensures future generations of taxpayers do not face an unmanageable bill for government services provided to the current generation.

One of the key requirements for sustainable government financial arrangements is a balanced budget over the medium to long term, given a reasonable degree of stability in the overall tax burden.

As in other areas of social policy, fiscal sustainability has drawn attention to the need to ensure there is an appropriate balance between public and private financial support for aged care services.

However, sustainability can be thought of more broadly as the ability over the long term to continue to provide services of an appropriate standard and in a way that meets community expectations in relation to their accessibility, affordability, quality and environmental impact. Accordingly, fiscal sustainability is only one dimension of sustainability. Other aspects include:

- Provider sustainability — is concerned with the financial viability of aged care providers in the long term. In the aged care sector, providers operate within a highly regulated environment and the design of regulatory and funding arrangements should not undermine the financial viability of providers or distort signals for new investment.
- Workforce sustainability — is concerned with the ability of the aged care industry to attract and retain people with the requisite skills needed to provide the level of safe, quality care expected by the community. This dimension of sustainability focuses attention on whether future models of care are able to be supported by the available workforce.
- Social sustainability — is the ability to maintain social harmony within the community concerning the distribution and use of available resources. Demographic change is reshaping family structures and values as well as the distribution of resources between generations (see, for example, Ozanne 2007). Social sustainability focuses attention on concerns that changing perceptions about intergenerational inequities may create tensions between generations. For example, the then Governor of the Reserve Bank of Australia, Ian Macfarlane (2003, p. 19) observed at the *2003 Economic and Social Outlook Conference* that:

If we are not careful, there is a potential for conflict between generations. The young may resent the tax burden imposed on them to pay for pension and health expenditure on the old. This will particularly be the case if they see the old as owning most of the community's assets. Housing is the most obvious example, where people of my generation have benefited from 30 years of asset price inflation, while new entrants to the workforce struggle to buy their first home.

All of these dimensions of sustainability are important to ensuring older Australians continue to have access to appropriate aged care services.

4.2 Recent initiatives to improve equity, efficiency and sustainability

In recent years, Australian Governments have taken a number of steps to improve the funding and provision of aged care services. This section provides some illustrative examples of recent policy changes that have sought to improve the equity, efficiency and sustainability of these services. A more detailed overview of these changes (along with those directed at improving the quality and choice dimensions of aged care) is provided in appendix A.

Increasing the number of aged care places and adjusting the service mix

Over the last decade Australian Governments have substantially increased the number of operational aged care places in order to better match supply with the growing demand for these services (chapter 2). In the eleven years to 30 June 2007, the number of operational aged care places increased from 141 282 to 214 250 (AIHW 2008d). At the same time, through adjustments to the aged care planning ratio, governments have sought to rebalance the mix of services provided. This has included expanding the number of community care places more rapidly than those for residential care to allow more older Australians to exercise their preference to receive care in their own homes; and within residential care, increasing the proportion of high care places.

Refining regulatory and financing arrangements

Australian Governments have also refined regulatory and financing arrangements. Some of these changes have sought to create a more integrated aged care system and improve interfaces between aged care and the broader health and community welfare systems. For example, the *Aged Care Act 1997* provided for the creation of a unified residential aged care system covering low and high care services, by restructuring the funding and administration of hostels and nursing homes under one system. Similarly, *A New Strategy for Community Care: The Way Forward* (DoHA 2004a) sought to strengthen the provision of community care by addressing gaps and overlaps in service delivery; providing easier access to services; enhancing service management; streamlining Australian government programs; and adopting a

partnership approach. Other joint initiatives between the Australian, State and Territory Governments have aimed to strengthen linkages between the aged care system and health and community services through, for example, the Transition Care and Multipurpose Services programs.

Other changes have sought to rebalance public and private financing of aged care services by requiring those people who can afford to make a contribution towards the cost of their care to do so to a greater extent.

While the overall regulatory burden on aged care providers has undoubtedly increased over the last decade, Australian Governments have streamlined some regulatory settings and administrative arrangements. This has included: simplifying and broadening the residential care income test; replacing the resident classification scale with a new simplified funding arrangement (the Aged Care Funding Instrument) for residential care; and introducing eBusiness to the aged care sector.

Other policy initiatives

Australian Governments have introduced a range of other measures, which can be broadly categorised as addressing service gaps, improving the financial viability of aged care providers and enhancing the ability of the aged care system to respond to emerging challenges. Examples of initiatives in the latter case include new measures to improve care for the growing number of older Australians suffering from dementia; changes directed at improving the effectiveness of funding arrangements for providers; and increased funding for nursing education and training places to enhance the aged care workforce.

4.3 Some emerging challenges

Notwithstanding the policy initiatives outlined above, there is broad agreement among key stakeholders including providers, consumer groups and various commentators that Australia's aged care system faces some significant challenges. It is also widely accepted that without ameliorative policy action these challenges are likely to be further accentuated in coming years by the pressures associated with an ageing population (chapter 3). However, there are a range of views on how these problems should be addressed as part of any future reform agenda.

This section concentrates on those issues that are most likely to challenge policymakers in seeking to ensure Australia's aged care system delivers equitable, efficient and sustainable outcomes in the future, namely:

- tackling inequities arising from existing program design

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- achieving a more efficient regulatory regime
 - improving the responsiveness of the aged care system to the changing needs of older people
 - improving service interfaces
 - securing sustainable outcomes.

Another important issue is the need to improve the productivity of the aged care sector. While this clearly has equity, efficiency and sustainability dimensions, it is dealt with separately in chapter 7.

Tackling inequities arising from program design

In recent years, commentators have identified a number of inequities arising from current program design, which also have important implications for the long-term sustainability of aged care services. These issues include service gaps in the provision of community care relative to residential care; some elements of residential care (notably accommodation and everyday living expenses) being more heavily subsidised than is the case for equivalent care received in the home; and accommodation bonds being able to be drawn upon by providers of low care and ‘extra service’ high care places but not ‘ordinary’ high care.

Service gaps in community care

The extent to which community care programs cover the spectrum of care needs of older Australians has improved over time, particularly with the addition of EACH and EACHD to the suite of government programs. Many community care programs ostensibly provide the equivalent of low and high residential aged care services to those wishing to receive care in their own home. An issue, however, is the extent to which community care packages are fully substitutable for residential care and the ease with which clients can make the transition to higher levels of care as their needs change.

For example, in a recent submission to the *Review of Subsidies and Services in Australian Government Funded Community Care Programs*, the Australian Institute of Health and Welfare (AIHW 2007g, pp. 23–24) argued that:

Changes in residential aged care have occurred to provide continuity of care with the desired outcome that many older people are now able to move from low to high care within the same facility. This ease of transition is more difficult to achieve in community care due to allocation and funding arrangements that distinguish CACP and EACH packages and which create a gap for those clients who need a level of assistance

somewhere between the two (i.e. clients new to community care who do not qualify for EACH but who are unattractive CACP clients).

A similar view is held by UnitingCare Ageing NSW.ACT (2007, p. 3), which in its submission to the same review observed:

The current gap in subsidy levels between CACPs and EACH is far too great to allow continuity of care and sufficient flexibility to respond to changing/increasing needs. It is proposed that a middle level of package be established. Eligibility for these packages could be determined by ACAT assessment.

The AIHW has suggested this problem could be addressed by adopting a single continuous community care program. It argues that a single program could deliver any type of assistance for any level of care within the scope of the entire program. Importantly, such a program would be able to provide access to nursing care to two groups of CACP clients who currently must go to another program for assistance:

- low care need clients who may require care on an episodic basis
- high and complex need clients where the availability of informal care means that while total hours required are low, skilled nursing assistance is nonetheless required (AIHW 2007g).

From a sustainability perspective, service gaps in the current suite of community care programs may result in more frequent hospital admissions (for those with episodic health care needs) and premature admission to residential aged care facilities (for those with high and complex care needs). To the extent this occurs, it results in unnecessary dislocation and stress for clients and their carers, as well as adding to cost pressures in both the residential care and hospital systems.

The subsidisation of residential care relative to community care

As a general principle, efficient decision making requires that government subsidies for aged care services should be neutral as to whether the personal and health care components of these services are provided in the home or in a residential care facility. Any financial bias that distorts the choice between residential care and community care may lead to a less than socially optimal allocation of resources across the aged care system.

There are concerns that under current arrangements, some older people in residential care may receive a higher level of public support than if they were receiving equivalent care in the community (see PC 2003 and Hogan Review 2004). Older people using community care receive subsidised personal and health care, but generally have to meet the cost of their accommodation and everyday living expenses from private means or out of income support payments. In contrast, some

users of residential care, in addition to receiving subsidised personal and health care, may also receive a subsidy for accommodation and everyday living expenses.

These inequities arise because the public financing principles generally applying in the health system have been applied to all components of residential care, even though some components are more akin to services that are typically provided through the welfare system. In relation to the accommodation component of residential care, Gray and Kendig (2002, p. 5) have observed that:

Residential care has evolved within a ‘health needs’ framework in which Australians generally expect the universal availability of good quality provision at public expense (as with hospitals). On the other hand, accommodation and income support have generally been conceived in a ‘welfare’ framework, for example, pensions and public housing available on the basis of both income and wealth means tests. Within this framework, the accommodation component of residential care remains problematic. Benefits to carers and community services do not fall so easily into one or another of these alternatives. Many of the specific debates in aged care hinge on prior ideological assumptions concerning the place of aged care in broader debates concerning public and private responsibilities and between health and welfare approaches.

‘Unbundling’ the service components that make up aged care provides a way of ensuring that appropriate and consistent public financing principles are applied to each of these components across different types of care. It is also a way of ensuring consistency between aged care services and equivalent services provided through the broader health and welfare systems.

From a public policy perspective two key issues arise in this context. First, deciding how to ‘unbundle’ the service components that make up aged care. Second, for each of these components, deciding on what public financing principles should be applied to determine the nature and extent of public as distinct from private contributions.

Aged care services can be unbundled in different ways (box 4.1). That said, equity requires that effective safety net provisions are in place to ensure all older people assessed as needing care have access to an appropriate level of care. The option of ‘topping up’ services (whether accommodation, everyday living services, personal care or health care) is also important to providing clients with greater choice in the services they consume (chapter 5).

There is a strong case that those receiving aged care in their home or in a residential facility should be required to meet the cost of their accommodation and every day living expenses from private means. These are fairly predictable expenses of everyday life and are not exclusively associated with increasing frailty or disability. While recognising the additional capital costs of providing residential aged care facilities (especially specialised facilities catering to more complex care needs), the conditions attaching to subsidies provided to residents should have regard for the income support and other safety net provisions applying more generally across the community.

More contentious are decisions about how to unbundle the ‘care’ component of aged care services and what public financing principles should apply. The care component of aged care is essentially the additional costs of being looked after because of frailty or disability (such as, assistance with eating and drinking, personal hygiene, managing urinary and bowel functions, managing problems with immobility, management of prescribed treatment, behaviour management and ensuring personal safety). To some extent, the costs associated with these services are unpredictable and may be overly burdensome.

As highlighted in box 4.1, these care services can be grouped as a single cost component ‘personal care’, or a distinction made between ‘personal care’ and ‘health care’. In principle, such a distinction should be possible since, in the context of aged care, health care largely consists of nursing and palliative care. However, in practice, the boundaries between personal care and health care are often blurred. For example, services such as podiatry, massage and swimming exercises could be grouped under either form of care. When provided in response to an existing medical condition they could be readily seen as a ‘health care’ item. However, if seen as discretionary, they could be classified as items of ‘personal care’ even though they contribute to good health and mobility.

It would need to be determined whether, from a community wide perspective, the benefits of unbundling ‘care’ in this way, and applying different financing principles to ‘personal care’ and ‘health care’ would outweigh the associated costs of greater regulatory complexity.

Box 4.1 **Different approaches to ‘unbundling’ aged care services**

There are different views about how aged care services could be unbundled and the public financing principles that should apply.

In the United Kingdom, a key recommendation of the Royal Commission on Long-Term Care (Sutherland Report 1999, Chapter 6) was that:

The costs of long-term care should be split between living costs, housing costs and personal care. Personal care should be available after assessment, according to need and paid for from general taxation; the rest should be subject to a co-payment according to means.

In the event, England, Wales and Northern Ireland chose not to follow the recommendation that personal care should be provided free to older people. In contrast, Scotland introduced free nursing and personal care in 2002 for those aged 65 years and over living in their own home or in a ‘care home’ (Bell and Bowes 2006).

The Productivity Commission (2003), in its submission to the Hogan Review, advocated the same approach to unbundling aged care services as the UK Royal Commission, but raised concerns about providing free personal care for those receiving residential care. It suggested one way of ensuring appropriate pricing of personal care for those in residential care would involve:

- 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 co-payments, up to a maximum (such that those needing expensive care are not faced with costs which are overly burdensome)
- providing a subsidy that is restricted to certain forms of care, for example, only the nursing component of personal care. (PC 2003, p. 101)

The Hogan Review (2004) distinguished between hotel and accommodation services (the equivalent of everyday living expenses and accommodation), personal care and health care. Thus, the Hogan Review identified ‘health care’ services as separate from ‘personal care’. Like the UK Royal Commission and the Productivity Commission, the Hogan Review argued that accommodation and everyday living expenses should be seen largely as a personal responsibility. With regards to personal care and health care it argued:

- Personal care services — these should be seen as primarily a personal responsibility, with a limited suite of basic necessary services available at Australian Government expense on a means-tested basis to those who are independently assessed as needing them. Individuals should be able to use their private resources to purchase additional personal care services.
- Health care services — basic necessary services should be provided free of charge to all those who are independently assessed as needing them. A specific co-payment is unnecessary as the bundling of services, together with the financing arrangements for hotel and accommodation and personal care services, means that the individual has already made a considerable private contribution. Individuals should be able to use their private resources to purchase additional health care services. (Hogan Review 2004, p. 126)

Sources: Sutherland Report (1999); PC (2003); Hogan Review (2004); Bell & Bowes (2006).

More generally, unbundling the cost of aged care services raises a number of broader implementation issues (see PC 2003; ACAA 2006b). These include:

- developing workable definitions of each of the service components in order to determine the financing principles and sharing of costs between 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 broader welfare system
- the cost implications of having different funding streams with differing copayments and safety net arrangements.

Nevertheless, the Commission remains of the view that the arguments in favour of unbundling the underlying cost components of aged care in order to achieve greater equity across different types of care, and better targeting of the public subsidy, are fundamentally sound and warrant detailed analysis. Moreover, as discussed below, unbundling is a key dimension of other potentially worthwhile reforms.

The availability of accommodation bonds

The introduction of new arrangements for accommodation payments for residential care was a key element of the Aged Care Structural Reform Package announced in the 1996 Budget. Accommodation payments encompass accommodation bonds (for ‘low care’ and ‘extra service’ high care places) and accommodation charges (for ‘ordinary’ high care places). The money raised through these capital contributions was intended to meet the cost of acquiring funds to upgrade and maintain residential aged care facilities. Earlier, the Gregory Report had found there were major deficiencies in the capital works of nursing homes and that funding arrangements were providing neither sufficient funding nor incentives for providers to maintain their buildings (DHAC 1999).

Over the last decade, accommodation bonds have provided an important source of funding for the expansion of aged care facilities. As Hogan (2007, p. 3) has observed:

Bonds have allowed access to funds for meeting the servicing costs of capital funding not otherwise effectively provided through government subsidies and payments, or approved charges on residents.

Anomalies arising from the current accommodation bond arrangements

A number of anomalies are created by accommodation bonds being available to providers of ‘low’ care and ‘extra service’ high care places but not ‘ordinary’ high care places (see PC 2003).

First, the accommodation bond arrangements increase the likelihood of providers having to use the capital made available through low care and extra service accommodation bonds to cross-subsidise the capital requirements of ordinary high care places. As the amount of low care bonds is effectively uncapped, there are concerns that cross subsidisation is putting upward pressure on the level of these bonds. Commentators have observed that the average level of low care accommodation bonds now appears to materially exceed the replacement cost of a residential place (Ergas 2006).

Cross subsidisation creates inequities and inefficiencies in meeting the capital requirements of ordinary high care places and is unlikely to be sustainable in the long term. As the Aged Care Association of Australia (ACAA 2007a, p. 17) recently argued:

Many aged care facilities have been cross subsidising their high care building costs from low care and extra service capital streams. However, as the percentage of vacant beds continue to rise across the industry continued cross subsidisation is becoming highly problematic.

Second, there are concerns that the arrangements might discriminate among elderly Australians requiring residential care. Hogan (2007, p. 2) has observed that:

The distinction drawn between extra-service high care, where bonds may be sought, and ordinary high care where they are not, brings a remarkable discrimination. Those with substantial assets may effectively buy their way into high care by offering substantial bonds. Those lacking substantial wealth — not only pensioner and part-pensioner residents but also those of relatively modest wealth — are not able to offer anything to support the provision of services for them. *Thus the discrimination is against the less well-off in Australian society.* [Author’s italics]

Another exception effectively applies to those residents initially in low care who elect to ‘age in place’; that is, they remain in the same location while receiving what amounts to high care. This measure ensured that residents of low-care facilities did not have to move to another location so long as they could receive effective care. A substantial proportion of residents in low care are ‘ageing in place’.

Third, as a result of these arrangements the capital funds available to providers of ordinary high care places are considerably more limited than those available for low care places (PC 2003). This reflects that the average income from accommodation bonds per low care client has substantially exceeded the average income derived from accommodation charges per high care client.

Fourth, the arrangements may create perverse incentives for providers to attempt to facilitate clients entering residential care through low care places, even though some of these people may require a higher level of care.

Finally, the current arrangements undermine the long-term viability of the aged care system by making investment in ordinary high care places less attractive to providers, despite those in need increasingly entering residential facilities at the higher end of the care spectrum (chapter 3). For example, Ergas (2006, p. 3) has observed:

... the current arrangements ... make the financing of 'high care' depend, at least in part, on the flow of admissions into (and hence bond payments for) 'low care'. However, demographic trends are likely to reduce demand for 'low care' relative to 'high care', compromising this source of funding just as the need for 'high care' places increases.

The equity, efficiency and sustainability of residential care would be improved by placing low care and high care on an equal footing in terms of meeting their capital requirements. This would involve all permanent clients of residential care, subject to a safety net, having the choice of paying either:

- a lump sum bond, or
- a daily or periodic rental charge (at a level equivalent to the stream of capital available to providers through the bond).

Addressing community concerns

Community concerns about extending accommodation bonds to ordinary high care places have been a significant stumbling block to reform in this area. Bruen (2006, p. 15) has noted that these objections include:

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

These concerns may be assuaged to some extent if the accommodation component of residential care was clearly 'unbundled' from the everyday living, personal care and health care components of aged care and further, if the principle that accommodation is largely a private responsibility (subject to a safety net) was consistently applied across residential and community care settings. One

implication of this, is that those receiving residential care who can afford to do so, should be required to make a contribution towards the cost of their accommodation for the full length of their stay (subject to the current exemption for those people entering residential facilities for respite care).

There are valid concerns about requiring clients, who are expected to need high level care for only a matter of weeks or months (for example, the very frail or those entering residential care for palliative care), having to pay large up-front accommodation bonds. However, these clients could have the option of paying the daily or periodic rental charge and therefore should not be disadvantaged. That said, this is predicated on providers being required to genuinely offer clients this choice.

In this regard, it is worth noting that clients currently entering low care residential places have the option of paying a lump sum bond, an equivalent periodic payment or a combination of both. Historically, clients' take-up of the periodic payment option has been surprisingly low (PC 2003; Hogan Review 2004). This could reflect that clients are not well informed about these options. However, there are concerns it may also reflect constraints on competition in the aged care industry, with high occupancy rates enabling providers to enter into only limited negotiation with clients around their preferred method of payment (see Hogan Review 2004). This underscores the importance of broader reforms in aged care, including measures to strengthen competition and consumer choice (chapter 5).

Finally, there is likely to be stronger community acceptance of this change if capital contributions accurately reflect variations in the cost of supplying accommodation, such as those arising from differences in location (and hence land values) and building costs. The Commission has previously raised concerns that under current institutional arrangements, accommodation bonds may include a quasi-rent reflecting the scarcity premium created by government controls on the supply of places (PC 2003). In commenting on clients facing more responsibility for meeting the cost of their accommodation, Sullivan (2005b, p. 3) has contended:

This seems sensible as long as consumers get more if they pay more.

That is not the case at present. Some consumers are paying higher bonds than others even though they reside in homes that are not as recently built as others.

Achieving a more efficient regulatory regime

Over the last two decades aged care, like many other areas of economic activity, has seen a significant increase in government regulation (see, for example, Banks Review 2006). In large part, this has been in response to changing community expectations about consumer rights and the quality of aged care services. However,

groups representing both aged care providers and their staff argue that, in some areas, the level of government regulation has become burdensome and imposes avoidable costs on providers, clients and the wider community.

It needs to be stressed that arguments favouring a reduction in the burden of government regulation are not about imposing a lower level of service quality on older Australians. There is a strong rationale for government intervention to ensure that aged care services at least meet an acceptable standard of care and the consumer rights of the frail aged and others are adequately protected. At issue is whether there is scope to achieve these objectives at a lower overall cost to the community through more efficient regulatory design.

The Banks Review (2006, p. i) considered aged care regulation as part of its much broader remit to identify opportunities to address areas of Australian Government regulation that are ‘unnecessarily burdensome, complex, redundant, or duplicate regulations of other jurisdictions’. The aspect of aged care regulation that particularly attracted the attention of the review was the quality assurance and accreditation regulatory framework existing on top of, and in many respects duplicating, other Australian, state, territory and local government regulations and administering agencies. The Banks Review (2006, p. 33) noted that:

There is, however, an increasing level of concern by industry that this additional and separate level of regulation is not well matched to desired policy goals. The duplication appears unnecessarily costly for both providers and government. It may also restrict the development of a mature industry able to take responsibility for its own actions.

The Review made three recommendations to improve the regulation of aged care services. First, it recommended rationalising the certification process in order avoid duplicating the Building Code of Australia, and related state, territory and local government laws and monitoring arrangements. The Review argued that requirements not currently addressed by the code and state, territory and local government mechanisms could be mandated separately. Second, the review recommended introducing competition into aged care accreditation by allowing providers to select from a range of approved quality improvement and quality management agencies. Among other things, this change was seen as a way of ensuring that providers did not have to deal with multiple accreditation systems to cover all of their activities. Finally, the review recommended that the DoHA should expedite its review of Resident Classification Scale documentation to implement improvements as soon as possible.

The first two of these recommendations were not accepted by government (Australian Government 2006).

The Commission notes that the Australian National Audit Office (ANAO) recently released a performance audit of building certification of residential aged care homes by DoHA. The ANAO (2008, p. 15) contended that:

The focus on building certification has created a specialised and professional industry for the design, building and management of aged care facilities that did not exist prior to the program. The certification program was developed and implemented by DoHA with wide ranging and active involvement of all sectors of the aged care industry. Overall, these industry stakeholders supported the certification program and considered that it had been both needed and successful in achieving improvements to the building stock of aged care facilities.

The ANAO (2008, p. 14) also noted that the building certification program is expected to be reviewed in 2008 and suggested two areas that could be strengthened:

- a more effective performance information framework to assist internal decision making and provide more comprehensive information on program outcomes
- a more formal, structured communication strategy that better allows DoHA to engage with key industry stakeholders to identify emerging certification issues.

DoHA has agreed with ANAO's recommendations in these areas.

While the Commission welcomes improvements to the building certification program, it considers that the Banks Review (2006) concerns about the potential duplication of the Building Code of Australia remain unanswered (chapter 7).

More generally, Aged and Community Services Australia, a national peak body for aged and community care providers, has argued that further consideration needs to be given to reducing red tape in the industry (ACSA 2008). Notably, ACSA has reiterated the case for addressing industry concerns about building certification and the accreditation process. In addition, ACSA (2008) has argued for:

- ceasing or redesigning the unannounced spot check program using a risk management approach
- ending regulation of extra service places
- streamlining the community care reporting burden.

It is beyond the scope of this informational study of aged care trends to consider the merits of these or other proposals to streamline government regulation in the industry. That said, in view of the need to improve efficiency (chapter 3), it is clear the community can ill-afford regulatory arrangements that impose excessive and unnecessary costs on aged care providers or that stifle the efficiency benefits arising from greater competition. This underscores the importance of rigorously assessing

the merits of proposals to reduce red tape in the industry as part of any future reform agenda.

Further, regulation can have significant implications for the aged care workforce. This issue is explored in more detail in chapter 6. However, it is worth noting here that regulation can affect the ability of the aged care industry to attract and retain staff and adapt work practices in response to changing labour market conditions. For example, some argue that excessive government regulation is resulting in registered nurses having to spend more time on administration and less time on providing care, which is undermining job satisfaction in the industry (see, for example, Venturato, Kellett and Windsor 2007).

Given the high level of community concern at any suggestion of poor treatment of our elderly, the industry is particularly vulnerable to regulatory creep in response to high profile incidents. Recognising this, it is especially important that governments adhere to the principles of good regulatory process (Banks Review 2006). These principles include clearly establishing the need for regulation; considering all feasible policy options (including self-regulatory and co-regulatory approaches) and consulting widely. In addition, these principles require policy options to be assessed within a cost-benefit framework, with only the option that generates the greatest net benefit for the community (taking into account all impacts) being adopted.

Improving the responsiveness of the aged care system

There is evidence of unmet need for aged care services in the Australian community. In this context, a key issue is the extent to which the aged care system can provide the level and mix of services that best meets the needs of clients and is sustainable in the long term. As outlined in chapter 3, all the indications are that Australia's aged care system will need to be more flexible and responsive if it is to efficiently and equitably meet the needs of a growing and increasingly diverse cohort of older Australians in a sustainable manner.

This section begins by briefly considering the evidence of unmet need for aged care services. It then discusses the scope to improve the flexibility and responsiveness of the aged care system.

Evidence of unmet need

The issue of unmet need is distinct from the extent to which there may be unsatisfied demand among older Australians for greater choice in consuming aged care services. The former is essentially concerned with the ability of older people to access an appropriate level of care that meets their individual care needs, while the

latter focuses on the extent to which they are able to choose from a range of differentiated service offerings (chapter 5).

In terms of community care services, a report by the Allen Consulting Group (2007) for the Community Care Coalition estimated that in 2003, 433 000 older Australians living at home had unmet needs. This estimate was based on data from the ABS survey *Disability, Ageing and Carers: Summary of Findings* (ABS 2004b). The data revealed that in 2003, 1.2 million people aged 60 years and over living at home reported needing assistance with 10 broad areas of activity: self-care, mobility, oral communication, cognitive or emotional tasks, health care, household chores, meals preparation, property maintenance, private transport and paperwork. Taking into account the availability of both formal and informal care:

- 788 000 people (64 per cent) said their needs were being fully met
- 363 000 people (30 per cent) said their needs were being partly met
- 70 000 people (6 per cent) said their needs were not being met at all (Allen Consulting 2007).

The AIHW (2007b) included an analysis of unmet need among older Australians for assistance in *Australia's Welfare 2007*. The analysis focused on the need of persons aged 65 years or over with a disability (including those older people without disability but who have a long-term health condition), living at home, for formal or informal assistance with the 10 broad areas of activity listed above. Among other things, it found:

- Older people who report unmet need for assistance can be divided into two broad groups according to type of unmet need. Nearly all of those who report unmet need for assistance in core activities (mobility, self-care and oral communications) are people with profound or severe limitations. On the other hand, those who report unmet need in other activities, such as transport, household chores or home maintenance, are a mix of people with core activity limitations and others who have a disability without core activity limitations.
- Key areas of unmet need for assistance (both formal and informal) in 2003 included property maintenance (27.3 per cent of people with a need for assistance in this activity), cognitive or emotional tasks (23.6 per cent), household chores (20 per cent), mobility (17.4 per cent) and private transport (16.4 per cent).

These studies lend support to the Senate Community Affairs References Committee report *Quality and equity in aged care* (SCARC 2005), which found evidence of considerable unmet need for community care. The report also noted there were waiting lists for many community care services.

There is also evidence of unmet need for residential care. Under current institutional arrangements, waiting lists are an indicator of the unmet demand for residential care. With both the number of subsidised aged care places and the price of these places effectively determined by government, changes in the demographic and economic determinants of demand only impact on the private non-financial price of these services (that is, they affect waiting times) (Hogan Review 2004). The Hogan Review found the average wait for residential care was around 50 days, but it could be as long as a year in some rural areas. In an environment of high occupancy rates, the report accepted that waiting lists were evidence of unmet demand for residential care in Australia.

More recently, in relation to the waiting times for residential and community care, Ergas (2008, p. 3) has observed that:

Although many difficulties are involved in measuring waiting times, they appear to be reasonably substantial. In 2007, some 40 per cent of people assessed as needing high level residential care had to wait more than a month before they could access the care they need and around 17 per cent had to wait more than three months. Moreover, waiting times for care recipients in the lowest income and asset brackets are greater than average, suggesting that providers 'cherry pick' the residents with the greatest capacity to pay. Waiting times for community care packages have also been high, with the mean waiting time being some 15 per cent greater than for low level residential care.

Implicit in recent changes to the aged care planning ratio is the view that the supply of certain forms of aged care have been falling short of the underlying need for these services (appendix A).

Further, the accessibility of community and residential care services can be gauged from the extent to which the incidence of unmet need varies across different groups in the Australian community. In particular, commentators generally emphasise the higher incidence among special needs groups, including: people from culturally and linguistically diverse backgrounds; Aboriginal and Torres Strait Islander people; people with dementia; financially disadvantaged people (including the homeless); and people living in remote and isolated areas. For example, the SCARC (2005) found evidence that these groups find it more difficult to access HACC services. Among other things, the Committee observed:

While many people in these [remote and very remote] areas are eligible for HACC and other community care programs there are often long waiting lists. For those receiving services there is often difficulty moving through the various levels of care as their needs change. In rural and remote areas, with relatively more limited access to residential aged care, it is important to ensure people can access community care services. (SCARC 2005, p. 158)

There is a need for better data with which to assess the extent of unmet need for aged care services among older Australians, including how its incidence varies across different groups in the community. In a recent submission to the *Review of Subsidies and Services in Australian Government Funded Community Care Programs*, the AIHW (2007g) strongly recommended a comprehensive study of unmet need for formal and informal assistance among older Australians, by type of assistance, in order to investigate the adequacy of existing community aged care programs and services. Such a study would be a useful first step in improving the type and quality of evidence available to help guide policy development.

Some observations on unmet need

Unmet need for aged care services can potentially have serious consequences for the physical, mental and emotional wellbeing of older Australians, and the aged care and broader health and community welfare systems. For example, the effect on those needing but not receiving community care could include functional loss, depression, impaired access to everyday services and greater social isolation. It could also lead to more frequent hospital admissions and premature admission to residential aged care. Similarly, unmet need for residential care can put considerable pressure on those requiring this type of care, their carers and families, and the hospital system.

Conceptually, unmet need for aged care services could arise as a result of:

- existing programs not being adequately funded (either publicly or privately)
- service gaps (in the sense that some services for which there is a need in the community are not being provided)
- potential clients of aged care services finding it difficult to access existing services because, for example, of geographic isolation, a lack of information or cultural barriers
- aspects of regulatory and financing arrangements that distort decision making and make the aged care system less responsive to the changing needs of older people.

Based on the available literature, this study has found evidence of unmet need for aged care services. The extent of the shortfall and its underlying causes, while beyond the scope of this study, deserves detailed policy analysis.

Reforms to improve the responsiveness of the aged care system

Currently, adjustments to the provision of aged care services occur largely through periodic changes to planning and funding parameters, and regulatory settings. Governments largely determine how many aged care places should be supplied, where these places are located, the appropriate mix of services, the price of these services and how to respond to changing community expectations with regards to quality and choice. Separately, ACATs independently assess eligibility for these services — that is, the level of demand.

Competition and price play little role in signalling to providers changing patterns of demand and the need to adjust decision making accordingly (including the need for new investment). In effect, client needs and preferences are revealed only indirectly to providers through government planning and regulatory processes, rather than directly.

In recent years, an emerging theme in the literature has been the scope for reforms to make the aged care system more responsive to the changing needs of clients (see, for example, PC 2003 and Hogan Review 2004). This is generally considered important to improving the quality of investment decision making in the industry and sharpening incentives for innovation in service design and delivery. For example, Ergas (2006, p. 11) argues that:

... population ageing will place the aged care system under great stress, though it also creates significant opportunities for innovation in service design and delivery. A more market-oriented approach to aged care would provide a framework that allowed and encouraged that innovation, and more generally help ensure that older Australians can continue to obtain high quality aged care services into the future.

Any proposal to strengthen the influence of clients through reforms to existing arrangements needs to ensure that it would not undermine the accessibility, safety and quality of aged care services. For example, there are concerns about the provision of adequate aged care services in rural and remote areas, where the markets for these services are thin and the scope for effective competition is limited. As Sullivan (2005b, p. 1) has observed:

There are always downsides to market approaches if the market created is not consumer friendly. But moving a highly regulated program into a more sophisticated competitive environment requires a market structure.

If market forces produce better more affordable services then they should be encouraged. If particular people become priced out of the market or are less commercially attractive to providers, then safety nets are vital.

Improvements in the responsiveness and flexibility of aged care services are likely to require the re-design of current regulatory and funding arrangements. A menu of reform options *might* encompass:

- relaxing restrictions on the number of aged care places and the prices that are charged
- more clearly signalling to clients the underlying cost and quality of alternative types of aged care services
- empowering clients to exercise greater choice in consuming aged care services.

The last option is explored in chapter 5 in the context of providing clients with enhanced choice.

Easing quantity and price restrictions

One of the ways the government manages the fiscal risk associated with the provision of aged care services is to limit the number of subsidised aged care places. Two mechanisms — the aged care planning and allocation system and ACATs — are used for this purpose. Through the aged care planning and allocation system the government determines the notional number of aged care places it is prepared to fund based on a judgement about the number of people aged 70 years and over likely to require these services. These places are then allocated at a regional level. At the same time, ACATs perform a gate-keeper role, as an ACAT assessment and approval is required before people can access subsidised residential aged care, CACPs, EACH and EACHD packages. In effect, a positive ACAT assessment represents an entitlement to access care and, if eligible, a subsidy for that care.

Restricting the number of aged care places requires price controls to ensure that providers do not abuse the localised market power that this creates. This effectively mutes the role of prices in signalling changing market conditions and in inducing appropriate responses from clients and providers. In such an environment, there is a risk that prices will not be allowed to cover efficient costs, thereby compromising incentives to invest in aged care (Ergas 2006).

It is increasingly recognised that these restrictions combine to limit the scope for effective competition between providers, weaken incentives for innovation in service design and delivery, distort investment decision making, and risk the long-term sustainability of aged care services (see, for example, PC 2003 and Hogan Review 2004).

As recognised in the Intergenerational Reports (Treasury 2002, 2007), the Australian Government faces a significant challenge in attempting to manage the

fiscal risk associated with providing subsidised aged care services in the context of an ageing population. However, a key issue going forward is whether there are other ways of managing this risk that allow greater flexibility within the aged care sector to respond to the changing needs of clients.

One possibility, which warrants further analysis, would be to dispense with having dual regulatory controls over the number of aged care places. This would involve abolishing the aged care planning and allocation system (while retaining accreditation) and relying on the gate-keeping role performed by ACATs and on complementary regulation to ensure sufficient places for those needing concessional access. This would require strengthening the current assessment process, which is oriented towards helping match people with available services. As Bruen (2006, p. 19) argues:

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

Consideration would also be need to be given to the need for transitional arrangements to accommodate this change to the current gate-keeping mechanisms to avoid the possibility of significant policy induced disruption to the market. Beyond this, such a change could be supported by other complementary reforms designed to help lessen the fiscal risk associated with subsidised aged care services. For example, measures intended to more clearly signal to clients the underlying cost and quality of different types of care; and encourage, where possible, people to make better financial provision for meeting the costs of their care in later life. These issues are discussed further below.

At the same time there may be scope to relax price controls. However, some form of price control is likely to remain necessary to help manage the fiscal risk associated with the large number of older people seeking access to aged care services on a concessional basis and to lessen the potential for providers to ‘cherry pick’ clients with the greatest capacity to pay.

To protect vulnerable members of the community, it would be desirable to delay easing price restrictions until effective competition and appropriate safety net provisions were in place.

More generally, policymakers could usefully consider the scope for the design and implementation of reforms directed at improving the responsiveness and flexibility

of services across the aged care sector to be informed by the reform experience of other social policy areas, such as health care and childcare.

More clearly signalling the underlying cost and quality of aged care services

Over the next 40 years it is likely that clients will demand greater choice in the types of aged care services available to them (chapter 5). At the same time, a substantial proportion of these clients will continue, to varying degrees, access aged care services on a concessional basis (chapter 3). From a community wide perspective, it is important that the individual decisions of clients reflect variations in the underlying social costs and benefits of these services. This would help ensure there is an efficient allocation of resources across the aged care system, improve choice of services and lessen the risk of the community either over or under consuming particular services.

While easing quantity and price restrictions would be a useful step towards better communicating to clients the underlying cost and quality of aged care services, of themselves, these measures are unlikely to be sufficient. This is because on equity grounds, a substantial number of older people will continue to access aged care on a concessional basis and thus, to some degree, be shielded from the full cost of providing these services. In these circumstances, there is a need to explore other ways institutional arrangements could be refined to more clearly signal to clients the underlying cost and quality of different types of care.

Conceptually, unbundling the components of aged care services could assist in this regard, in that it would:

- more accurately price the components of aged care services
- apply consistent public financing principles across different types of care (discussed earlier in this chapter)
- better target government subsidies to those most in need
- strengthen the role of competition in the provision of those elements of aged care services where this is feasible.

Such suggestions are not unique to the Australian aged care debate. As noted earlier, in the United Kingdom, a key recommendation of the Royal Commission on Long-Term Care (the Sutherland Report 1999) was that the costs of long-term care should be split between accommodation, everyday living expenses and personal care.

In addition, there may also be scope to strengthen the ACAT assessment process. Access to appropriate care should be based on an objective assessment of need through that process, with clients nominating to assessors their preferred mix of services and assessors having regard to the cost effectiveness of different service mixes in establishing the appropriate service entitlement. In cases where a client's preferred method of receiving care is less cost effective from a community wide perspective (that is, exceeds the benchmark minimum standard of care) they should be required to contribute more to the cost of their care.

This would be similar to some other areas of social policy, where there have been attempts to develop institutional arrangements to encourage clients and providers to take into account the underlying cost-effectiveness of providing goods and services involving significant public funding. For example, applications for new listings under the Pharmaceutical Benefits Scheme are assessed in terms of their clinical efficacy and cost effectiveness relative to listed products. In effect, the costs of securing particular health outcomes are compared with the benefits, to assess the relative merits of different drug treatments. Australia is seen as a leader in using such assessment processes to inform listing and funding decisions.

Accurately assessing the underlying cost effectiveness of different types of aged care services would require much better data than is currently available. For example, little is known about how variations in economies of scale impact on the cost effectiveness of providing care in different settings; and the extent to which different types of care may affect clients' quality of life (encompassing, for example, indicators of mortality, morbidity, the frequency of hospitalisation, the incidence of depression, the quality of social engagement, perceptions of happiness, and carer wellbeing).

Despite the inherent difficulty, there is a need for further research in this area, particularly in view of the demand pressures outlined in chapter 3. To illustrate one of the issues; there is a perception that in terms of public expenditure, delivering aged care through community care programs is less expensive than through residential care. However, from a community wide perspective, there is some uncertainty. For example, Gray and Kendig (2002, p. 3) have observed:

It is frequently asserted that community care is less costly than residential care. However, the cost of community care may be similar to residential care but the government contribution less. In community care, the capital costs of accommodation are provided by the user. The hotel services (cleaning, meals, heating etc) generally are provided by informal carers or paid for by the older person, or not provided at all. A large proportion of the personal care is provided by informal carers.

Improving service interfaces

In terms of public debate and policy development, ‘care’ is often viewed narrowly, for example through an ‘aged care’, ‘health care’, ‘social welfare’, ‘veterans affairs’ or ‘disability services’ lens. Moreover, even within areas such as aged care, there has been a tendency to base policy development on a largely static and siloed view of the care needs of older people at particular points in the system, for example; ‘nursing homes’ versus ‘hostels’, ‘residential care’ versus ‘community care’, and ‘high care’ versus ‘low care’.

While such an approach can be useful in helping identify and address particular problems within complex systems, there is growing recognition of the need to view ‘care’ more holistically. This recognises that older people potentially need access to different forms of care during their later years in order to maintain what the community would consider to be an acceptable quality of life. For example, older people managing one (or more) chronic illnesses may move back and forth between general practitioners, acute health care, respite care, residential care and their own homes. In view of the demand and cost pressures outlined in chapter 3, from a community wide perspective, a key issue is how efficiently and effectively aged care services can be supplied in concert with other health and welfare services to meet these individual care needs.

In this context, service interfaces are clearly important. They are essentially points where there are significant crossovers between different bundles of aged care or between the aged care system as a whole and other systems. These crossovers work in both directions, for example, how community care is configured and resourced can have implications for residential care and vice versa.

Within the aged care system there are interfaces between residential care, community care, respite care and transitional care. There are also interfaces with various elements of the health system (encompassing acute care, general practitioners, allied health services, health promotion and disease prevention); mental health; disability services; income support; public housing; community residential and supported care (including services to the homeless); public transport; and urban planning and design. This complex web of interfaces presents a significant challenge to policy makers in trying to adequately meet the care needs of older people.

Poor service interfaces are particularly seen as a problem for those older people needing to access multiple services in order to continue to live independently in the community, and those needing to make the transition from one environment to another (for example, from hospital back home or to a residential care facility).

These types of problems are not unique to aged care. For example, Bird et al. (2007, p. 451) note in relation to the health system that:

It is widely acknowledged that many countries face serious challenges in caring for a growing population of older people with multiple health problems. Part of this problem is that many health care systems have fragmented geriatric services, discontinuities within the system of geriatric care, system inefficiencies and a community/hospital split. In these systems, elderly patients may fail to receive all the services they require and, as a consequence, suffer detrimental impacts upon their health status and quality of life.

Typical of stakeholder concerns about service interfaces are those presented in box 4.2.

In recent years, there have been a number of initiatives to try and improve service interfaces, including:

- a national action plan for improving the care of older people across the acute-aged care continuum (2004–2008), which was endorsed by Australian Health Ministers in July 2004 (AHMAC 2004)
- the introduction of the Innovative Pool of flexible care places, which has trialled services linked to the acute-aged care interface, the disability-aged care interface and dementia care
- the establishment of the Transition Care Program to provide older people with low level rehabilitation and support to improve their independence and confidence after a hospital stay
- the pathways home program funded under the 2003–2008 Australian Health Care Agreements, which provides one-off capital and infrastructure funding to assist states and territories to expand their provision of step down and rehabilitation care.

While these are welcome initiatives, as the selection of views presented in box 4.2 illustrates, there appears broad agreement that there is still considerable scope to do better.

In the first instance, further research and analysis is required. This needs to be underpinned by better data than is currently available, if we are to move away from a largely static ‘stock’ view of aged care and develop a much better understanding of ‘flows’. For example, to investigate how the care needs of older people change over time; how these changes trigger interactions between different parts of the aged care system (and between the aged care system and the broader health and community welfare system); and how efficiently and effectively the care needs of older people are being met.

Box 4.2 Some views on service interfaces

National Aged Care Alliance on the aged care — health care interface:

Progress toward a continuum of care for older people requires policies and strategies across the acute, community and residential aged care settings. Health and aged care services need to be integrally linked to achieve a system of services where access is determined by the needs of people, rather than the particular point of contact or service setting, taking into account culture, geography and means. (NACA 2007b, p. 2)

... on transport and access to health care services for older Australians:

The quality of older people's health is inextricably linked to their capacity to get transport to health services. The present lack of transport to take older people to health care is a barrier to good health. (NACA 2007c, p. 3)

Aged and Community Services SA and NT:

People with a disability who are ageing are presenting to community services in a new manner. Providers will need to have assistance to adapt their service offering to this new client group, who has not previously sought extensive aged community support. Agencies and staff will need to acquire new skills and capacities to deliver responsive services to people with a disability and new partnerships formed. The ambiguity around program boundaries will need to be addressed to support service provision. (ACS SA & NT 2007, p. 8)

Australian Medical Association:

Thousands of Australians are trapped in the wrong environment for the type of care they need. There are many people in hospital who no longer need acute care, but are unable to care for themselves at home and cannot access appropriate residential or community care. Similarly, there are people in nursing homes who should be in hospital, and people in the community who ought to be in either hospital to treat particular conditions, or in aged care homes. (AMA 2004, p. 8)

Australian Institute of Health and Welfare:

... our understanding of how older people use services is still too heavily reliant on data about the 'stock' of people within a program (e.g. residential aged care), despite the acknowledged importance of interfaces between different service components (e.g. acute care hospitals and nursing homes) and the importance of understanding flows of people into and through the service system (e.g. the changing needs of older people receiving home based care over a period of say a decade). Some limited work has been done in this area, particularly at the interface between hospital care and residential aged care, but this remains an area where further research and statistical analysis is needed. (AIHW 2007e, pp. viii–ix)

Senate Community Affairs References Committee report *Quality and equity in aged care*:

A number of initiatives have been taken at the Commonwealth and State levels towards improving the effectiveness of current arrangements for the transition of older people from hospital settings to aged care settings or back to the community. While these initiatives are welcome, evidence suggests that a more co-ordinated approach needs to be adopted between different levels of government to address a system that remains fragmented and ill-equipped to meet the transitional care needs of the elderly now and into the future. (SCARC 2005, p. 182)

Hal Kendig and Catherine Bridge in a contribution to *Longevity and social change in Australia* :

The future of community care will depend heavily on government's capacities to resource an adequate accommodation base for frail older people who do not have housing or other assets. (Kendig and Bridge 2007, p. 232)

In this respect, the AIHW has been developing an event-based data linkage method to link national hospital morbidity data and residential aged care data, in order to help understand the movement of people between these sectors (Karmel et al. 2008).

The Commission also notes that a team of researchers lead by Len Gray has developed a computer simulation model of the interface between aged care and acute health care. The model is intended to assess a variety of different policy scenarios. Gray et. al. (2006, p. 456) has noted that:

Dynamic systems simulation provides a method of conducting policy experiments at low risk and cost with instant results. While the outcomes will not necessarily be precise, the development process and interactions with stakeholders, with the opportunity for users to conduct their own experiments, are likely to raise the quality of the debate around futures for the acute-aged care system.

Notwithstanding these developments, further research and analysis is necessary to identify those service interfaces where reforms could potentially yield significant benefits to the community as a whole. Depending on the circumstances, there is, in the Commission's view, potentially a wide range of barriers that might need to be addressed (box 4.3).

The mechanisms for diffusing examples of best practice and innovation in service design and delivery also need improvement to help inform policy development in other parts of the system.

Given the involvement of multiple government departments and agencies across multiple levels of government, making progress to improve any of the service interfaces affecting the quality of life of older people will require a whole-of-government response.

Box 4.3 Potential barriers to improving service interfaces

- Existing programs not being adequately funded.
- An excessively fragmented policy and program environment.
- Poor program specification and design, including overly rigid program boundaries.
- Poor program evaluation leading to the perpetuation of existing problems.
- Unnecessary variations across programs in terms of eligibility criteria and financing arrangements.
- Regulatory and financing arrangements that fail to provide sufficient incentives to encourage innovation in service design and delivery.
- A lack of clarity about roles and responsibilities leading to service gaps and/or unnecessary duplication of effort and waste. In areas such as aged care, this is complicated by the confluence of interfaces with the involvement of multiple levels of government.
- Inadequate mechanisms for holistically assessing the needs of older people and keeping track of how these change over time. Particularly important here are likely to be barriers to appropriately sharing information across professional boundaries.
- Rigidities in professional scopes of practice and models of care (chapter 6).
- Professionals working at an interface having a poor understanding or inadequate information about the full range of services available to older people at these points.

Securing more sustainable outcomes

As outlined in section 4.1, there is a strong case for taking a broad view of sustainability in the context of aged care. Two issues that are inextricably linked to the sustainability of aged care services, namely the workforce and the need to improve productivity, are discussed in chapters 6 and 7 respectively. The remainder of this section focuses on two broad issues that are not elsewhere covered in this study, namely the potential to:

- encourage greater self-provision for meeting the costs associated with aged care
- improve the financial viability of aged care providers.

Encouraging greater self-provision in meeting the costs associated with aged care

Currently, aged care subsidies are funded by the Australian Government on a ‘pay as you go’ basis (that is, from consolidated revenue), supplemented by user co-payments (chapter 2). As a consequence, working age taxpayers bear a large part of the cost of providing aged care services. In the context of an ageing population,

this represents a significant and growing burden for future taxpayers. While few people would advocate totally moving away from the existing arrangements, there is an argument for some degree of re-balancing of public and private financial support for aged care services to ensure their long-term fiscal sustainability.

The trend towards seeking a higher level of co-payments from clients is already evident, with Ergas (2008, pp. 4–5) noting that:

A trend for the effective copayment rate in the Australian aged care system to increase has already been evident for some time. Thus, new entrants to low level residential care paid approximately 40 per cent of their residential care costs in 1995-96 and that proportion had risen to 57 per cent in 2005-06. Equally, while new entrants to high level residential care paid approximately 21 per cent of their residential care costs in 1995-96 (the remainder being covered by payments from the Commonwealth), that proportion had risen to 29 per cent in 2005-06. The growth in the role of ‘extra service’ places makes the increase in copayments all the greater.

Those trends notwithstanding, it is likely that the Australian arrangements are still at the relatively redistributive end of the international spectrum, and that longer-term pressures for a rising element of ‘user pays’ will persist, regardless of which Government is in office.

This raises the question of what additional policy measures may be desirable to encourage those members of the community who can afford to make financial provision for the possibility of requiring aged care services to do so. The government would continue to fund a minimum acceptable level of aged care services for a targeted group of those not well placed to make such contributions.

As Kendig and Duckett (2001, p. 63) have observed:

While there is little reason to fear a financial doomsday ahead, it is clear that both older and younger people could be advantaged by having better financial mechanisms to enable older people to pay in advance for their aged care should they require it.

As canvassed by the Commission in 2003, there are three broad mechanisms for allowing people to effectively ‘pre-pay’ some of the costs associated with their care later in life:

- voluntary savings schemes
- voluntary private aged care insurance
- compulsory private aged care insurance (PC 2003).

Voluntary savings schemes

Voluntary savings schemes include dedicated ‘aged care’ savings accounts and the ability for people to draw on their housing assets, through equity release or reverse mortgage schemes.

Generally, voluntary savings schemes are unlikely to be a very effective or efficient way of helping fund the future cost of providing aged care services. In part, this reflects the considerable unevenness in the incidence of needing high cost aged care services across the elderly population. As Allen Consulting (2002, p. 16) has observed, this tends to reduce people’s willingness to voluntarily save to meet these costs:

The risk of needing expensive, high-intensity aged care is not high relative to the probability of using other government services (such as health care). For some people, though, the costs can be high. People generally do not expect to need such care and so are not inclined to save for that eventuality [Author’s italics].

Given these characteristics, there is a risk of people either not saving enough or over saving. From a community wide perspective, such outcomes would not represent an efficient use of available resources.

A second option would be to enable people to draw on their housing assets, through equity release and reverse mortgage schemes. These schemes provide a mechanism for older people to take a non-recourse loan, which is repaid with interest when their home is surrendered (for example, at the death of the final equity holder). In the case of residential care, this loan can be used to pay a lump sum accommodation bond or be periodically drawn down if the periodic payment option for paying an accommodation bond is preferred. The income stream that reverse mortgages can provide is limited by the need to avoid negative equity.

The evidence suggests that there is a growing market for reverse mortgage products in Australia. Indeed, the size of Australia’s reverse mortgage market more than doubled in the two years to December 2007 (SEQUAL and Deloitte Touche Tohmatsu Australia 2008). This was not withstanding some slowing in the sales of these products in the second half of 2007 reflecting tighter credit market conditions, rising interest rates and growing economic uncertainty. However, the extent to which these products are currently being used to fund aged care, or to fund consumption, or to effect inter-generational wealth transfers within families is not clear. That said, for some people, these products are likely to be an attractive option for meeting the private costs of higher quality aged care. One significant consideration is to ensure that the needs of the surviving member of a married or other joint-owning couple are adequately protected.

As highlighted in chapter 3, the wealth of many older people is predominantly in the form of home ownership. Recent research suggests that while around a third of retirees expect to rely on their home as a source of retirement funding, most thought they would be forced to downsize to release equity and did not have a good understanding of other financial options (SEQUAL 2008). This suggests there may be scope to improve the information available to older people about these products. More generally, ASIC's (2007) work on reverse mortgages suggests that several factors can inhibit good consumer decision making including difficulties estimating how much equity might be available at any future point in time, a reluctance by consumers to consider the risk of declining health in future years and the impact this may have on their financial needs.

Voluntary private aged care insurance

Voluntary private aged care insurance would allow people to insure against the risk of requiring high cost aged care services in the future. This would be somewhat akin to the insurance that many people already take out to cover unpredictable and catastrophic events such as damage to or destruction of their homes, early death or injury, and loss of income.

There are likely to be many practical difficulties in the development of private insurance markets for aged care. Ergas (2008, p. 5) argues that:

International experience suggests it is not easy for voluntary insurance markets to efficiently underwrite this added risk [the longevity risk associated with requiring aged care], for reasons that include adverse selection, the very long-tail nature of the risk and the associated policies (which need to be entered into long before the risk eventuates), and the likelihood that the underlying risks are correlated. Moreover, individual incentives to insure may be low if entry into aged care signals a reduction in life-time income needs (so that those individuals who do not enter into aged care could rationally choose to run down their assets). This would further narrow the insurance pool, and limit its ability to achieve economies of scale. Additionally, and importantly, for so long as Commonwealth support is reasonably widely accessible, the take-up of voluntary insurance is likely to be low.

In its submission to the Hogan Review, the Commission outlined the demand and supply-side characteristics of the market for voluntary private aged care insurance, which are likely to limit its extent and coverage. The Commission also noted that there appears to have been a relatively low uptake of this form of insurance in those countries where such policies are available. Nevertheless, the Commission argued that people should have the option of using voluntary aged care insurance 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,

it argued that private health insurance funds should no longer be precluded by regulation from offering such cover (PC 2003).

Compulsory aged care insurance

A final broad option for encouraging greater self-provision for the costs of aged care is some form of compulsory aged care insurance. In the context of the Australian aged care debate, this has usually been advanced as a social insurance or public long term insurance scheme.

Anna Howe (2003b, p. 8), who advocates the introduction of a social insurance scheme, has observed:

Current aged care funding relies on only two ‘pillars’ — taxation revenue and user charges. Adding a pillar of social insurance would add a third pillar and so strengthen the whole of the funding arrangements. In particular, by providing a source of forward funded capital, social insurance would serve as a buffer against downturns in the wider business cycle for aged care investment, and in turn, marginally moderate the business cycle.

A social insurance approach to aged care funding in Australia is highly consistent with and would complement both the Medicare Levy and the Superannuation Guarantee that are already in place. Both have proved ‘painless and popular’ taxes with the community, and a social insurance scheme for aged care could be expected to gain similar acceptance.

The Commission considered the case for some form of compulsory aged care insurance scheme in its submission to the Hogan Review. It noted that although there were potentially some advantages of such an approach, there were also a number of significant design issues (PC 2003). It argued that it was unclear whether this type of insurance would represent a substantial improvement over existing arrangements, and suggested that further work may be warranted to more fully assess the advantages and disadvantages of a compulsory aged care insurance scheme.

Summing up the self provision options

Options for encouraging greater self-provision in meeting the costs associated with aged care are best considered as part of a broader reform agenda rather than in isolation. Aged care services are heavily subsidised in Australia and various regulations constrain the extent of client choice. Arguably, this considerably weakens the incentives for people to voluntarily make financial provision for the possibility of needing these services. Changing this perception would require signalling to younger generations the extent to which they are likely to have to meet

more of the costs associated with consuming aged care, and the benefits that would arise from being able to access higher quality services. In this context, some of the reforms discussed earlier in this chapter are likely to be important, such as:

- tackling inequities arising from existing program design
- easing quantity and price restrictions
- improved signalling of the underlying cost and quality of alternative types of aged care.

Such changes are only likely to be acceptable to the community if there are appropriate safety net provisions to protect those who cannot provide for themselves, and clients of aged care services having more choice in the services they consume (recognising a preparedness of a number of them to pay for higher quality services) (chapter 5).

Any appreciable re-balancing of public and private financial support for aged care will raise inevitable transitional issues. As in relation to superannuation, current taxpayers face both a tax burden (reflecting current ‘pay as you go’ arrangements for meeting the costs of those already receiving a pension) and a requirement to pre-pay for their own future retirement.

Finally, it is important to recognise that given the demographic and other trends outlined in chapter 3, any new policy measures in this area are unlikely to result in a dramatic shift in the balance between public and private financial support for aged care services in the short to medium-term. Future taxpayers will almost certainly be faced with having to fund a significant proportion of the growing cost of providing aged care to the baby boomer generation. Indeed, recognising the importance of the timing of any future policy measures, Howe (2003b, pp. 9–10) has argued that:

If the baby boomers are to contribute to their own future aged care, they need to be provided with a vehicle for doing so in the near future. A fund established by 2005 would have matured and be generating substantial funds precisely at the time when demands on public funds for health care for the ageing population will be growing most rapidly.

Improving the financial viability of aged care providers

As noted in section 4.1, provider sustainability is an important issue. There are aspects of current regulatory and financing arrangements that potentially impinge on the financial viability of providers and, hence, may jeopardise the future provision of these services. They include:

- indexation of government subsidies paid to aged care providers

-
- retention value of accommodation bonds
 - phasing-in of the Aged Care Funding Instrument (ACFI).

Indexation of basic subsidies

A longstanding concern of the aged care industry has been that the indexation of basic subsidy rates is not based on movements in industry-specific costs. Rather, subsidies are indexed using the Commonwealth Own Purpose Outlays (COPO) index, which is weighted 75 per cent for wage costs and 25 per cent for non-wage costs. The COPO is premised on the view that virtually all wage increases are productivity based. Hence, it only makes provision for safety net increases in wages and for economy-wide movements in non-wage costs. Thus, if productivity gains within the aged care sector do not keep pace with other sectors, the subsidy, as indexed, will be increasingly inadequate.

In addition, eligible residential aged care providers receive the Conditional Adjustment Payment (CAP). This was introduced following a recommendation of the Hogan Review (2004) and is intended to provide an incentive to residential aged care providers to improve their efficiency and productivity. In line with the recommendation of the review, the Commonwealth initially only committed to paying the CAP for four years (2004–2008). However, the Australian Government announced in the 2008-09 Budget that it would be increasing the level of the CAP, in order to provide additional funding for investment in the aged care sector. It also announced a review of the ongoing need for and level of the CAP (Elliot 2008a).

In this context, it is worth noting that the Hogan Review saw the CAP as an interim measure, while a broader re-structuring and re-ordering of policy arrangements occurred (Hogan 2007, p. 8). Arguably, this restructuring has not occurred to the extent envisaged by the review.

ACSA (2008, p. 13) is one who has raised a number of concerns:

Even with the CAP, costs are outstripping funding. Costs have been rising in all areas including wages (which represent approximately 75% of a provider's expenditure); insurance premiums; compliance costs with workers' compensation regulations and Government administrative requirements; costs of refurbishing or replacing older buildings and/or constructing new ones; fees and other costs associated with accreditation for residential care; and accountability costs for community care.

... It is clear that either the COPO indexation method must be changed or that the CAP must be maintained for residential care providers and extended to cover community care services. If this does not occur service providers will inevitably become unviable. Given the increasing demand and need for aged and community services this must not be allowed to happen.

Reflecting these concerns there have been calls for the current indexation arrangements to be reviewed, with the continuation of CAP until new arrangements can be put in place (see, for example, Hogan 2007). However, the Commission notes that the recently announced review of the CAP does not encompass the broader issue of the effectiveness of current indexation arrangements.

The Commission considered COPO indexation procedures as part of its inquiry into nursing home subsidies (PC 1999). At the time, it noted that with other sources of income for providers largely tied, inadequate increases in subsidies after allowing for efficiency improvements would, in one way or another, compromise the delivery of quality care (PC 1999). The Commission did not endeavour to come to a final view on the most appropriate indexation methodology, as it was not in a position to assess all the benefits and costs of the various alternatives within the limits of that inquiry. Nevertheless, it recommended:

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. Revised indexation arrangements should be introduced as soon as possible. (PC 1999, p. 97)

This approach recognises the importance of both ensuring subsidies accurately reflect the cost pressures faced by the aged care industry and providing an incentive for providers to look for ways of improving their efficiency and productivity.

Other issues potentially impinging on the financial viability of aged care providers

Stakeholders have identified a number of other issues relating to current regulatory and financial arrangements that potentially impinge on the financial viability of aged care providers.

Although the value of accommodation bonds has risen sharply over the last decade the amount that aged care providers can retain in order to fund capital servicing has remained largely unchanged. Hogan (2007, pp. 9–10) argues that this should be re-visited in order to provide an increment to the funding of productive capacity:

Retention sums have remained much as they were a decade or so ago. Any reasoned reflection would suggest that the present retention limit, now around \$3,000 per year and arrived at long ago, is trivial in relation to present values, whether measured in asset or cost terms.

The time is opportune for this aspect of funding to be revisited, so as to offer an increment to the funding of productive capacity. Rather than rest on some fixed sum as at present, the maximum retention might be set as a specified percentage of the value of the accommodation bond, say 5%.

Some in the aged care industry are concerned about the phasing in of financial arrangements for the new ACFI. In part, the ACFI is intended to recognise the higher costs associated with meeting the increasingly complex care needs of older people entering residential care. However, it was decided to phase-in the new arrangements over four years. The ACAA (2007b, p. 3) argues that:

... the former Government decided to defer to fully implement the scheme and it will now take four years for the top end subsidy to be gradually introduced in \$10.00 tranches over the four year period.

The high care subsidy rates struck by the Government's contracted consultant was an attempt to make a realistic assessment within the bounds of the existing budget of the real cost of providing care to high care residents. Deferral of this payment ignores the service the industry already delivers and is a major factor in the declining financial performance of the industry.

As discussed in chapter 7, there are a number of other aspects of the ACFI that have caused concern in the aged care industry. The Australian Government has scheduled a review of the instrument for 18 months after its implementation (Elliot 2008b).

It is beyond the scope of this study of trends in aged care to assess these or other policy issues relating to current regulatory and financial arrangements that stakeholders have identified as potentially impinging on the financial viability of aged care providers, but clearly there may still be some important areas of 'unfinished business'.

