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## 6 Who should pay?

### Key points

- Australian Government spending on aged care is projected by the 2010 Intergenerational Report to increase from 0.8 to 1.8 per cent of GDP over the period 2010 to 2050. This increase in spending could be paid for by increasing taxes and/or reducing government spending in other areas.
- But there is the question of whether there is a more efficient and equitable way to raise the necessary funds. There is already evidence of increasing strains on the aged care system under the current funding regime.
- Addressing inefficiencies in Australia's aged care system can reduce the rate of growth in government spending but is unlikely to be sufficient to prevent future tax increases. The public expenditure burden could also be lessened by requiring higher co-contributions from care recipients who can afford to pay.
- Funding arrangements could be improved by separating the costs of aged care (accommodation and living expenses, personal and health care) and applying funding principles consistently across care settings. This would allow prices to better reflect underlying costs, enable better targeting of subsidies to those most in need, and overcome inconsistencies and inequities between different forms of care.
- Accommodation costs and everyday living expenses are reasonably predictable and should be the responsibility of individuals, with a safety net for those of limited means.
- While the majority of older Australians will require some form of care, only a minority will require extended periods of intensive care. Individuals should contribute to the more predictable and manageable costs of their care, but not be exposed to excessive costs associated with extended periods of intensive care. A risk pooling mechanism would overcome this potential exposure.

With many more Australians living longer, there will be a sizeable increase in the *quantum* of people requiring care and support over the next 40 years. Australians also have increasing expectations about the type and quality of care they want to receive in their old age. Further, due largely to increased longevity, there will be a growing proportion of older people with complex care needs. Each of these factors translates into unavoidable increases in spending on aged care services. Without changes to the current funding arrangements, this will mean a much larger aged care

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outlay for governments (with the Australian Government being the largest contributor, chapter 2).

Going forward, the challenge is to come up with a system for funding that:

- achieves the objectives underlying the provision of support and care (chapter 4)
- is affordable for older Australians and taxpayers
- is fair between generations
- improves the basis on which individuals contribute to the cost of their own care.

The efficient use of resources will also be essential to optimise the cost-effectiveness of funds directed to aged care.

This chapter first looks at whether the funding arrangements are sustainable over the longer term (section 6.1) before unpacking the concept of ‘aged care’ and addressing the questions — who should pay and what should they pay for (section 6.2). Chapter 7 looks at applying the funding principles in practice, while chapter 8 examines alternative (or additional) ways of funding aged care and enabling individuals with the capacity to pay to contribute more to the cost of their care.

## **6.1 Are existing funding arrangements sustainable?**

Although there is some uncertainty about the future costs of aged care, projections in the *2010 Intergenerational Report* are that Australian Government spending on aged care is likely to increase from 0.8 to 1.8 per cent of gross domestic product (GDP) by 2050 on a no policy change basis (Australian Government 2010d). The significantly higher government spending projected for aged care could be paid for by diverting spending from other areas and/or by increasing the average tax burden.

This in itself would not be a problem provided the community considers that taxpayers’ money is well spent and that the distribution of funding responsibilities and tax burden between taxpayers and users and between generations is fair. But, there is the question of whether there is a more efficient and equitable way to fund aged care.

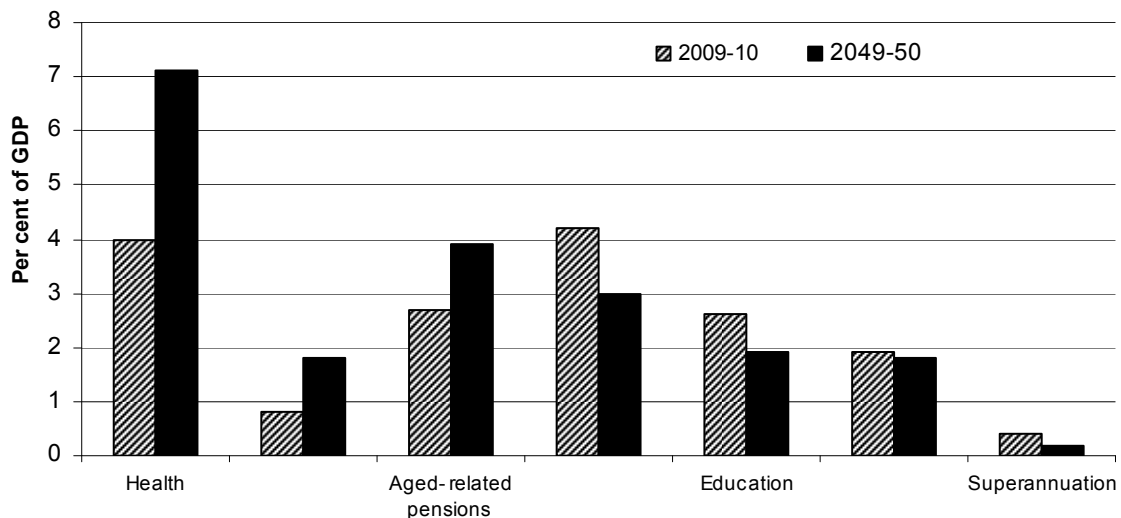
It is also true that if there is strong productivity improvement across the economy, growth in real GDP will mean a wealthier community with greater capacity to meet the additional costs associated with an ageing population. This points to the importance of continuing policy reforms which can lift Australia’s productivity performance and thereby more fully exploit the nation’s potential for improved

living standards (see, for example, PC 2010a). Stronger productivity growth will help to meet the fiscal demands of a pay-as-you-go financed system, although it is unlikely to fully obviate the need for tax increases and/or a reassessment of government expenditure priorities.

Population ageing, however, is not only expected to increase government spending on aged care, but also spending on health and aged-related pensions. Government spending on health is projected to increase from 4.0 to 7.1 per cent of GDP and age-related pensions from 2.7 to 3.9 per cent of GDP by 2050 (figure 6.1). However, the rate of growth in the proportion of GDP is projected to be highest for aged care expenditure (125 per cent compared to 78 per cent for health and 44 per cent for age-related pensions). In other areas, such as income support payments (excluding aged-related pensions), education, defence and public sector defined benefit superannuation, government spending is projected to decline as a share of GDP. Even so, overall increases in age-specific costs, combined with demographic change, mean that total government spending is expected to rise significantly as a share of GDP.

The increase in government spending to support older Australians would be less of a concern if the working aged population was growing at a faster rate. But the demographic profile arising from increased longevity and the ageing of the baby boomers (chapter 3) means that, by 2050, it is projected that there will be 2.7 people of working age to support each Australian aged over 65 years, compared with 5 people today.

**Figure 6.1 Australian Government spending by category, 2009-10 and projections for 2049-50**



Data source: Treasury projections in Australian Government (2010a).

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## Intergenerational equity

Participants raised concerns about intergenerational inequities given a relative decline in the working age group and the fact that those requiring care in the future are expected to be the wealthiest older cohort yet (box 6.1).

### Box 6.1 Participants' concerns about intergenerational inequities

Aged Care Association Australia (ACAA) and Deloitte:

It is important to start by noting that current financing arrangements are not capable of supporting the expansion in supply that is needed. Currently aged care funding is financed from current tax payments. The changing demographics ... will result in a significantly lower percentage of current taxpayers to elderly requiring financing. It is also worth noting the substantial estimated intergenerational wealth transference generated from the sale of family homes and the question of whether this wealth should be applied to services for the elderly or simply continue to be a transfer from one generation to the next. (sub. 285, p. 5)

Aged and Community Services Australia:

We know that the numbers of older people requiring services and support is increasing and that the numbers of taxpayers to fund the care is shrinking. We know also that the system is under increased pressure and is facing a serious threat to its overall sustainability. The status quo is not an option. (sub. 181, p. 8)

Anglicare Australia:

It would appear that a call for people to accept a higher tax regime in order to ensure the wellbeing of older Australians, now or in the future, is unlikely to fall on fertile ground at present. On the other hand, there is no doubt that as time goes by many more older Australians will be able to pay for the care and services that they want themselves, and would be prepared to do so. (sub. 461, p. 20)

A number of participants maintained that some of the public expenditure burden could be shifted onto those individuals with greater capacity to pay. For example, Alzheimer's Australia said:

Currently, aged care in Australia is mostly publicly funded through subsidies or contributions financed indirectly from aged pension payments. In future, it may be necessary to increase the contribution of users who are able to pay. More older adults may have more capacity to pay than in the past due to increased retirement savings and wealth. (sub. 79, p. 15)

Others argued that concerns about intergenerational wealth transfers may be overstated given the current exclusion of the family home from the Age Pension asset tests. For example, Ergas and Cullen maintained:

The extent of the inter-generational wealth transfer ... should not be exaggerated. An effect of Commonwealth funding of aged care is to protect the bequests made by long term care recipients to their heirs. The exclusion of the family home from the assets

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tests used in determining eligibility for aged care subsidies is of central importance in this respect, as the family home is the primary asset most older Australians own and are in a position to pass on. As a result, the extent of the redistribution effected by the existing 'pay as you go' system depends on the degree to which the taxes used to cover current aged costs are correlated with the bequests that are being preserved. As that correlation seems likely to be quite high, the system may cause fewer intergenerational transfers than commonly thought. (2007, p. 13)

But, such intergenerational wealth transfers are only relevant for those who inherit assets.

To better understand the extent to which tax rates would need to increase to meet future public aged care costs, Hogan (2004a) estimated at that time that if the projected increase was to be funded by taxpayers via a Medicare-style levy, the existing levy would need to more than double by 2043. Based on Australian Government spending on aged care increasing to 1.8 per cent of GDP by 2050, the Medicare levy would need to increase to 3.1 per cent (from 1.5 per cent) to meet this cost.

Higher marginal rates of income tax risk creating disincentives for work. This would compound the effects of ageing on the supply of labour. Raising revenue through taxation also results in an inefficiency known as a deadweight loss (box 6.2). Hogan estimated that the higher rate of taxation implicit in doubling the Medicare levy would reduce GDP by around 0.4 per cent by 2042-43.

Importantly, population ageing will not happen over-night, with the baby boomers starting to retire but not entering their eighties for another two decades. This means that there is a limited opportunity to develop policies that increase people's capacity to pay for their own aged care and smooth out the costs of care associated with population ageing over time. The earlier that changes are made to funding arrangements, the more equitable they are likely to be from an intergenerational perspective. While there has been some 'rebalancing' of public and private funding of aged care in response to increasing cost pressures over the last decade or so (with users paying an increasing proportion of their care costs), this has largely been within a framework where taxpayers continue to meet most of the costs.

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## Box 6.2 The cost of funding government expenditure

While government expenditure can deliver considerable benefits to recipients and to the broader community, it comes at a cost. This cost includes the expense of collecting government revenue and any distortions ('deadweight' losses and administrative costs, etc) introduced by the taxes, fees or charges used to generate the revenue. These costs vary with the nature of the tax, as does the effect on equity.

Taxes drive a wedge between the price suppliers receive and the price a purchaser pays that leads to them buying less than they would have without the tax. This can improve wellbeing if the purchase gives rise to adverse outcomes for others (known as negative externalities) or where people experience addictive behaviour, such as with alcohol and tobacco. But, more generally, taxes that reduce consumption of preferred goods and services lower wellbeing, with loss of consumer surplus. The tax wedge can also distort firms' choices of inputs away from more efficient combinations. And over time the effects can be compounded as, for example, a tax on savings reduces the incentive to save, while a tax on wage income generally reduces the incentive to work.

The greatest deadweight losses, or marginal effective burdens (MEB), arise from taxes that create the largest price wedges and where demand and supply are highly price responsive and where the effects are long-lasting (taxes on investment or training). Taxes that are broad-based and levied at a low and common rate result in the lowest distortions and hence the lowest deadweight loss for any level of revenue.

Estimates made for the Henry Review found that taxes on tobacco imposed a negative MEB (-8 cents per dollar), while those on wages and profits result in a positive MEB (of 24 and 40 respectively). The GST imposes a MEB of 8 cents per dollar of revenue, while insurance taxes have a MEB of 67 cents per dollar. While some caution should be applied to the estimates as they are based on stylised models, they suggest that deadweight losses are significant, and must be taken into account in assessing the net benefits of public expenditure. As should the equity implications of any tax.

*Source:* KPMG Econtech (2010).

Part of the public expenditure burden could be shifted further onto individuals through increasing their share of the costs, rationing access and/or constraining service quality. Cutting or further rationing services that yield significant benefits to the community is clearly not a desirable option.

A significant hurdle to increasing co-contributions for aged care is the low incomes of many older people requiring care. Treasury projects that around 36 per cent of the pension age population will receive a full rate Age Pension in 2047 (down from 55 per cent in 2007), while around 40 per cent will receive a part rate Age Pension (Australian Government 2010d). The rate of self-funded retirement is expected to increase only slightly, from 20 per cent in 2007 to around 24 per cent in 2047. These estimates, however, apply to the pension age population as a whole and not those aged 85 or older, among whom the need for aged care is concentrated.

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Even so, as recognised by the Organisation for Economic Cooperation and Development (OECD), the issue of sustainability relates to private expenditure as much as it does to public expenditure:

... the issue of sustainability arises in relation to private as well as public expenditures. What may appear to be unsustainable in the future as a public contribution could drain the resources of middle-income families if similar costs had to be borne privately. (2005b, p. 80)

A large proportion of older Australians, however, have sizeable assets, mainly in owner-occupied housing. This was acknowledged by some participants. Anglicare Australia, for example, said:

Many of the people who will soon qualify as ageing will have significant assets and resources — property ownership in particular, superannuation, savings and investments — with which to purchase the care of their choice where it is available. (sub. 461, p. 6)

If older Australian home owners could draw on their housing wealth, they could contribute more to the cost of their care. Being able to convert housing wealth into an income stream without necessarily selling the home could also mean that they could afford to pay for additional services over and above the approved care. Alternatively, Australians could be encouraged to save for their care costs or to take out insurance. These options are discussed in chapter 8.

### **Scope for better outcomes with the same dollars?**

Many participants to this inquiry raised concerns about the current institutional arrangements (including quantity restrictions through planning ratios and price controls) adding significant avoidable costs. As discussed in chapter 5, many of the current arrangements do anything *but* encourage competition between providers or provide incentives for innovation.

The Department of Health and Ageing (DoHA) said that while the planning ratios help manage the Commonwealth's fiscal risk:

... they create an artificial scarcity that limits the scope for competition, blunts pressure for efficiency and innovation and deprives consumers of choice. ... The result is an industry structure which, while it does secure some important policy objectives (such as geographic equity of access), does not make the most efficient use of scarce resources. The consequence is persistent technical inefficiency. (sub. 482, p. 52)

Hogan (2004b) found that aged care providers could be around 17 per cent more efficient if they were to operate at the most efficient level (recognising that it is not possible to have all services operating at this level). This translated into providers being able to care for around 23 000 more people (at dependency levels in

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2002-03). Hogan also estimated that costs could be reduced by a further 7 per cent (or \$470 million in 2002-03 prices) by making structural adjustments that improved the scale efficiency of the sector.

DoHA said that ‘it appears that the level of inefficiency in the industry has not diminished since then’ (sub. 482, p. 52). An analysis of trends in the level of efficiency in the residential care sector provided by DoHA shows that the average rate of efficiency across the residential care industry was reasonably constant between 2001-02 and 2004-05 but fell after the introduction of the Conditional Adjustment Payment (from 64 per cent in 2004-05 to 60 per cent in 2006-07) and remained at that level in 2008-09 (sub. 482, p. 52, table 7).

Some participants, in response to the claim that older Australians would need to contribute more to the cost of their care if the aged care system was to be sustainable, argued that the inefficiencies within the system needed to be addressed as a priority. Juliette Maxwell, for example, said:

... the Australian government needs to get its act together and get the aged care sector running cost effectively and efficiently BEFORE they can start reaching into older Australians’ pockets to fund aged care (as noted in the draft report, older people are now expecting more e.g. better quality services etc). (sub. DR528, p. 3)

The Commission also heard many examples from individuals of their experience with the aged care system and providers that pointed to ‘inefficiencies’ and ‘waste’ within the system (chapter 5). Examples included multiple and inconsistent assessment processes and large compliance burdens associated with separate administrative and legislative obligations across multiple programs. DoHA acknowledged that there are ‘significant issues of allocative efficiency in the current arrangements’ (sub. 482, p. 50). In the context of continuity of care DoHA said:

... care funded under the Aged Care Act 1997 and care provided through low intensity interventions in the community, do not enable efficient and seamless transitions between care sectors or between services within a care sector, including enabling information and data to accompany the care recipient. This can result in repetition or omission. Similar issues arise at the interface of the aged care system with the acute, sub acute and primary care sectors. (sub. 482, p. 51)

Encouraging competition across providers, by providing care recipients with an entitlement to care rather than paying a direct subsidy to providers of services, has the potential to improve productivity and the quality of services for care recipients (chapters 9 and 10). Measures aimed at getting the different parts of the aged care system and the health care system to work together as more of a joined-up system are also discussed in chapter 9 and 10. Removing unnecessary regulatory constraints and redesigning regulations that currently increase the cost of providing

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services and/or impair competition also offer the potential for productivity improvements and enhanced efficiency (chapter 15).

A number of participants argued that aged care funding could be better spent on measures aimed at promoting independence, disease and fall prevention and early intervention. Alzheimer's Australia, for example, said:

It has been estimated that if the onset of Alzheimer's disease could be delayed by five years, it would reduce the numbers of those with Alzheimer's disease by half (between 2000 and 2040) with significant savings to the health and care system. In order to move towards the goal of prevention, we need adequate investment in research into the causes of dementia, and support for preventative health initiatives. (sub. 79, p. 6)

Others suggested savings from greater promotion of independence and channelling people to short term wellness/restorative approaches. Banksia Villages, for example, said:

One of the fundamentals that may assist to address the issue of the affordability of care for the ageing is to address the attractiveness of independency, primarily by promoting the benefits, facilitating the opportunities, and providing incentives to be independent. (sub. 467, pp. 17-18)

There is emerging evidence on the cost-effectiveness of preventative and early intervention measures and how they can improve the quality of life of individuals. For example, an evaluation of the Partnerships for Older People (POPP) project in the United Kingdom — a program of services for older people aimed at promoting their health, wellbeing and independence, and preventing or delaying their need for higher intensity or institutional care — found a:

- 12 per cent increase in health-related quality of life for those individuals receiving practical help
- 47 per cent reduction in overnight hospital stays and a 29 per cent drop in the use of Accident and Emergency departments. For every extra £1 spent on the POPP services, there was an additional £1.20 benefit in savings on emergency bed days (DOH 2010b).

Other international studies also show a positive relationship between receiving low-level community services and delayed or avoided entry into residential care. A systematic review and meta-analysis of 15 studies of home based support for older people found home visits reduce mortality and admission to long term institutional care (Elkan et al. 2001). Other studies show that the earlier older people receive community care services the longer the delay before residential care is required (Gaugler et al. 2005, Long et al. 2005, Stuck et al. 2002).

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There is also emerging evidence that reablement or restorative home support programs — programs designed to help people ‘do things for themselves’ rather than ‘having things done for them’ — can delay or reduce the need for home care and other aged care services. A number of trials have found significant improvement in the independence of individuals who received reablement services when compared with individuals who had followed a ‘conventional’ home care package. For example, a comparison of outcomes for a restorative home support service conducted in Western Australia — the Home Independence Program (HIP) — and the Home and Community Care (HACC) program found that older people referred for home care who received assistance under the HIP achieved better personal and service outcomes than those referred to standard HACC services (Lewin and Vandermeulen 2009). Similar outcomes for reablement home care programs have been found internationally (box 6.3).

**Box 6.3 Evidence on the effectiveness of reablement or restorative home support services**

A United Kingdom study found that in three reablement schemes, 53 to 68 per cent of people left the schemes requiring no immediate home care package, and 36 to 48 per cent continued to require no home care package two years after reablement.

A more recent UK report found that during the initial eight week period the cost of reablement (mean £1 640) exceeded that of conventional home care (mean £570). However, over the course of the follow up period, this was more than offset by higher costs of conventional care (mean £2 240) compared with post reablement (mean £790).

A United States study found that individuals’ restorative home care episodes were shorter than usual care episodes and concluded that reorganising the structure and goals of home care can enhance the outcomes for clients without increasing health care utilisation.

*Sources:* DOH (2010b); Tinetti et al. (2002).

Further evidence, however, is needed to answer questions such as what are the most effective types of restorative or reablement programs, who benefits most from the programs and what is the most effective duration and timing of interventions. DoHA, commenting on the allocation of resources between preventative and early intervention measures and care, said:

... the distribution of emphasis between ... treatment and prevention, and between early intervention and ongoing care are currently determined largely by the history of program development rather than on the basis of evidence. There is a general consensus that prevention involves low levels of investment for significant impacts. (sub. 482, p. 51)

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The allocation of aged care funds should be evidence based. Better monitoring and evaluation of programs will ensure that funds for government services are appropriately allocated between preventative and early intervention and care, as well as providing a basis for future policy direction. But the evidence base about what works best needs building further. The OECD recently made a similar assessment and suggested that there may be value in international research and collaboration:

Evidence on what works best remains scarce. There is therefore a strong need for focusing policy attention on the efficiency gaps in the sector. International research and collaboration on value for money and the development of measures or indicators of efficiency in LTC [long-term care] deserve much priority. (Colombo et al. 2011, p. 32)

Options for building a better evidence base are discussed in chapter 16.

Reforming the aged care system has the potential to get better outcomes from the same dollars. This would help contain upward pressure on aged care costs. But, this is unlikely to be sufficient to prevent significant pressure on the total aged care bill and avoid future increases in tax rates. Ergas and Cullen made a similar assessment:

While reform can help ensure aged care provides ‘good value’ to consumers, the reality is that younger Australians face a future in which they will have to provide a potentially rising share of aged care costs. If it is a goal of policy to prevent future tax rates on income earners from having to rise substantially, some savings would need to be set aside now to fund aged care costs. (2007, p. 23)

Also, if subsidies for care and some accommodation charges are currently under-funded (as discussed in chapter 5 and 7), then ensuring subsidies accurately reflect the cost of supplying the care and accommodation would mean a larger aged care bill. This again points to the need to consider ways in which each generation can better contribute to the costs of their own care in old age (chapter 8).

## **6.2 Who should pay and what should they pay for?**

Allocating resources in a way that is ‘efficient’ and considered ‘fair’ are important design principles for funding aged care going forward (chapter 4). Participants spoke about the current ‘ad hoc’ and ‘inconsistent’ arrangements for aged care subsidies and user contributions, and the need to better align them across care settings. An important starting point for examining options for improving funding arrangements is to answer the two questions:

- who should pay
- what should they pay for?

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To answer these questions, the components of what we know as ‘aged care’ need to be unpacked. Only then is it possible to consider the funding principles that should be applied to the separate components of aged care and the issue of who should bear the risks associated with aged care costs.

Although the distinctions are not always clear, there are, broadly speaking, four components to aged care:

- accommodation services (the equivalent of rent, mortgage payments and related expenses such as gardening and home maintenance)
- everyday living expenses (such as food, clothing, laundry, heating and cooling and social activities)
- health care (such as nursing, allied therapies and palliative care)
- personal care (the additional costs of being looked after because of frailty or disability).

There was wide support from participants for ‘unbundling’ or separating out the costs of aged care so as to support a more effective funding framework for the aged care system (box 6.4). For example, Catholic Health Australia said:

... the separation of aged care costs between care and support, accommodation and living expenses is an important enabler for policies designed to give older people and their carers greater choice as to where they receive their care. Such a categorization of costs is also useful for developing policies on personal contributions towards the costs of aged care. (sub. 1, pp. 12–13)

The Henry Review also recently concluded that:

For each of the different services available through the aged care system, the provision of assistance and the assignment of funding responsibilities are best considered separately, as these services can be provided both inside and outside the system. By ‘unbundling’ services and responsibilities in each component, assistance for aged care can be targeted most effectively. In particular, unbundling funding for care (both personal and health care) reduces the potential for cross-subsidies across different care types or between different users. (2010, p. 631)

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## **Box 6.4 Support for separating out the costs of aged care**

Council on the Ageing (COTA) Australia:

... separation assists with removing the distinction between community and residential support and care and would allow for a dollar value to be put on people's needs regardless of their setting of support or care. This in turn would give individuals more real choice on where they receive their support and care. (sub. 337, p. 19)

National Seniors Australia (NSA):

NSA notes that there are suggestions for a distinct separation between the funding processes for care services and funding processes for accommodation/amenity in aged care. It is argued this provides greater opportunity to identify where the funding is going so that it can be better assessed and evaluated and would provide opportunity to remove the anomalies that currently exist between the allocation of funds to care and the allocation of funds to accommodation. NSA considers this has merit and should be seriously considered, particularly given that 'unbundling' provides scope for more targeted delivery of the funding; enables increased scrutiny of where funding is directed; and reduces the risk of cross subsidisation. (sub. 411, p. 15)

Anglicare Australia:

By separating accommodation and care costs individuals can contribute to the overall costs in a more equitable way, with those with the financial means making a more meaningful contribution. This reform would also streamline the delivery of services and make the whole aged care system much easier to navigate for clients, residents and their families. (sub. 461, p. 26)

Australian Nursing Federation:

... the separation of care and non care costs is highly desirable and indeed a viable option using the current funding model as the calculation basis, without any significant modification of the current system. (sub. 341, p. 93)

Australian Unity:

Separation of the cost of accommodation from the cost of care service provision is already established in the delivery of community care into residential homes and retirement units and to some extent in low care residential services... extending this established principle to all aged care services will stimulate competition between providers and allow the varying preferences and wealth of clients to be better matched with service delivery. (sub. 265, pp. 6–7)

Benevolent Society:

Separating the cost of the accommodation component from the care component may be difficult, but it is a vital move which will bring greater equity and choice to the system. (sub. DR805, p. 2)

## **Accommodation and everyday living costs**

Accommodation costs and everyday living expenses are reasonably predictable expenses of everyday life and are not especially associated with increasing frailty or

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disability. Older Australians living in the community (and Australians at other stages in life) are in general expected to meet these costs themselves and, as such, grounds for government subsidising these costs are weak, except for those of limited means. Indeed, the Australian Government makes provision to cover the costs of these services for those unable to pay for their own accommodation via the welfare system (providing public housing/rental assistance and income support). Subsidy design for aged care accommodation should take into account any additional costs of providing accommodation in residential care facilities and income support and other safety net provisions that may be in place.

Across the OECD countries ‘board and lodging’ costs are generally viewed as a social/housing risk and typically not included in public long term care coverage. Assistance is generally targeted to low-income people as part of existing social assistance or housing subsidy programs. The exception is countries with comprehensive long term care (LTC) systems (for example, Japan and some Nordic countries) but cost-sharing arrangements under these systems see board and lodgings accounting for a high share of residents’ income. As a recent OECD paper said:

It can be argued that all individuals should be required to pay at least for a minimum of their food and shelter-related expenses, regardless of the dwelling where they are living. It is also reasonable to expect that accumulated savings will meet some of the basic expenses related to food and shelter, including when a person moves to a nursing home. The policy debate with respect to the B&L [board and lodging] costs of a nursing home, then, is not on whether residents should pay for it, but *how much* and *what type* of expenses. (Colombo et al. 2011, p. 30)

There was widespread support among inquiry participants for older Australians requiring care to pay for their own accommodation costs and everyday living expenses, with a safety net for those of limited means. For example, National Presbyterian Aged Care Network said:

... older people should be responsible for their housing and living costs, with government support made available predominantly through the pension and rent assistance systems. (sub. 110, pp 3–4).

Aged and Community Services Australia:

Paying for our own accommodation is a given at each stage of our lives. (sub. 181, p. 4)

Sundale Garden Village:

The Government should remove itself from consideration of accommodation for anyone other than those who need a safety net. This reflects the reality of those in receipt of community care services, and would bring equity and social justice to all consumers seeking to access aged care services. It would also introduce a competitive

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structure to aged care services based upon consumer choice that does not exist under current legislation. (sub. 269, p. 32)

A number of participants argued that separating out accommodation costs would provide an incentive for the development of innovative housing options and promote increased choice for people requiring care. Helping Hand Aged Care, for example, said:

Provision of accommodation and provision of care should be separated, so that residential facilities become an accommodation choice, rather than a ‘compulsory extra’ provided in tandem with particular types of care.

The starting point should be that older people are able to provide/look after their own accommodation, regardless of the level of care they need. Residential care then becomes one of the choices they can make ... This approach could then lead to the emergence of different types of accommodation options (eg as in Sweden; smart house units) and/or changes in the way existing accommodation options are accessed/used. (sub. 196, p. 5)

Hal Kendig argued that separating accommodation from care was a priority as it would improve choice and independence for care recipients and reduce costs to taxpayers:

A priority for the Commonwealth government is to ‘unbundle’ the residential care program into separate funding for accommodation and care. ... This separation would provide more choice and independence for older people as they would not have to move into residential care in order to receive high levels of care. The Commonwealth would benefit because it would not have to pay for accommodation components of aged care for those individuals who can afford to meet their own accommodation costs.

... New supportive accommodation models offer the advantages of age-concentrated, purpose-built accommodation to which care could be delivered flexibly and economically as needed by residents. (sub. 431, pp. 5–6)

## **Care**

The ‘care’ component of aged care is a mix of health (or medical care) and personal care services.

### *Health care costs*

Aged care can include health services similar to those provided through the health care system. For example, the health component of care could involve a nurse administering injections or managing a care recipient’s pain and complex skin conditions. It could also include access to allied health professionals, such as physiotherapists and occupational therapists.

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The principles underlying the funding arrangements for aged care health services should be the same as those applying to other health care services. The Henry Review made the same assessment:

Governments need to finance the health care-related elements of aged care. Health care provided through aged care should be subject to similar charging arrangements as occurs in the health care system. This means that the health care component should generally be free or accompanied by modest co-payments. (2010, p. 632)

In the context of health care, however, the principles underlying the funding arrangements are not straightforward because a range of approaches apply. As a general rule, the government underwrites a significant proportion of the costs of essential health care for everyone requiring care (irrespective of their ability to pay), but a range of co-contributions apply. For example, there is no co-contribution attached to basic public hospital acute care and emergency department services. On the other hand, for general practitioner services, while all Australians are entitled to a non-means-tested subsidy, because of limited access to bulk-billing, many Australians make a co-contribution.

A further complication is that the distinction between aged care health services and personal care is not always clear, so a practical approach needs to be applied to this principle.

As with health services provided through the health care system, individuals should be able to use their private resources to purchase aged care health care services that are additional to the basic services that attract the universal subsidy.

### *Personal care costs*

The personal care component of aged care services is essentially about the costs of being looked after because of frailty or disability and includes both assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs):

- ADLs are a core set of self-care or personal care activities that include bathing and washing, dressing, feeding, getting in and out of bed, getting to and from the toilet and continence management
- IADLs relate to domestic tasks such as shopping, laundry, vacuuming, cooking a main meal and handling personal affairs (OECD 2008).

What is included in the ‘personal care’ component of aged care services, however, is contentious as the boundaries between living costs, personal care and health care are often blurred. For example, while food is a cost of everyday living, having someone assist with shopping and food preparation could be classified as ‘care’ (as

the person is unable to undertake these tasks because of frailty or disability), or as an everyday living expense.

Care costs (personal and health aged care costs) vary depending on the needs of the individual. They can range from less than \$1000 per annum for basic home support to around \$50 000 for some people with dementia on an intensive package in the community, and to around \$65 000 per annum for the highest cost of care services in a residential facility.

While aged care costs are reasonably predictable at a population level, they are less so at the individual level. For example, it is difficult for anyone to anticipate whether they will need care and support in old age and, if they do, how intensive and long-lasting those needs will be. It is also difficult to know what kind of unpaid care will be available from family and friends if care and support is needed.

That said, it is reasonable to expect that, if you live long enough, you will need some form of care and support because of frailty. Lifetime risk estimates show that retiring Australians face a reasonably high probability of requiring care in older age. For example, 68 per cent of women and 48 per cent of men at 65 years of age will require some aged care services (CACP, EACH, EACH-D, Transition Care and permanent and respite residential care) at some time in their remaining life (table 6.1). The likelihood of needing these services increases with age up to 95 years.

**Table 6.1 Lifetime risk of requiring aged care<sup>a</sup>, 2006-08**

<i>Remaining lifetime risk of requiring care (%)</i>	<i>At birth</i>	<i>At age 65</i>	<i>At age 75</i>	<i>At age 85</i>	<i>At age 95</i>	<i>At age 100 or over</i>
Females	62	68	72	80	83	65
Males	42	48	53	62	67	41

<sup>a</sup> Probability of ever using at least one of the following — residential aged care, community aged care packages (CACP) or extended age care at home packages (EACH or EACH-D).

Source: Data supplied by DoHA.

For females aged 65 years, the likelihood of entering residential care in their remaining lifetime was 54 per cent and for males aged 65 years it was 37 per cent. The likelihood of entering residential care increases with age, although the risk declines again for the very old — in 2007-08 for females the likelihood of entering residential aged care was highest during their early to mid eighties (likelihood of around 60 per cent) while for males the likelihood peaked during their mid to late eighties (around 48 per cent) (DoHA 2011i).

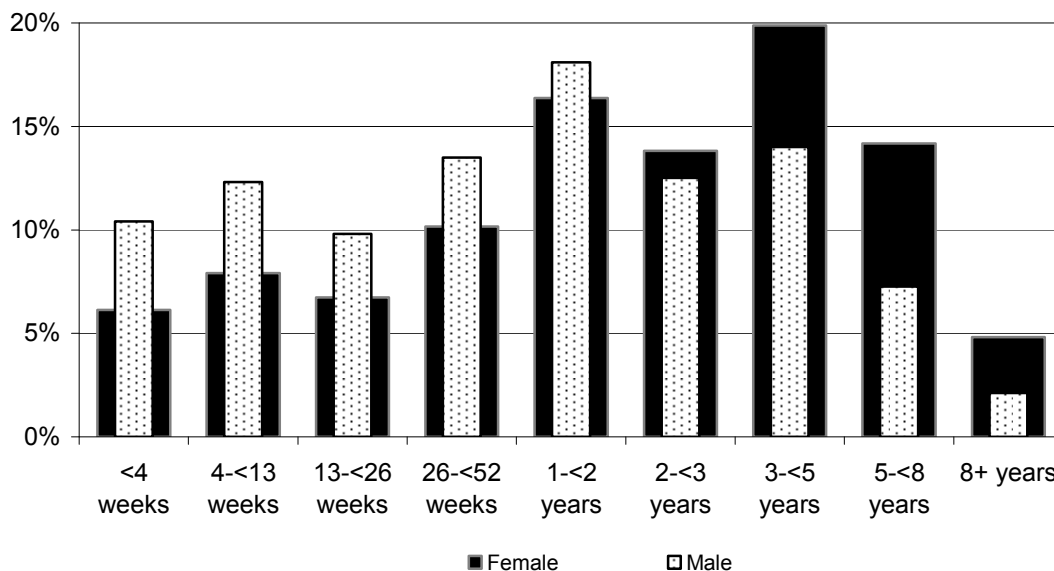
This suggests that some care costs should be considered a normal risk of growing old. And, because they are the more predictable and manageable costs of care associated with ageing, people should anticipate that they will contribute to those costs, except when they do not have the capacity to pay for care themselves.

Less predictable, however, is whether an older person will develop a chronic condition (such as dementia) or disability that requires intensive care for an extended period of time. As Wanless (The ‘Wanless Report’ on Securing Good Social Care for Older people in England) stated:

The risks attendant with social care need are complex and difficult to measure. There is the risk of developing conditions or disabilities that in turn imply a need for social care. There is also the risk associated with how long people remain in poor condition, principally but not only in the cost of services. (2006, p. 223)

Only a minority of older Australians are likely to face extended periods of intensive care, and therefore could find themselves liable for very expensive — or catastrophic — costs of care. Around 14 per cent of women and 7 per cent of men entering residential care stay for between 5 and less than 8 years. Around 5 per cent of women and 2 per cent of men entering residential care stay for eight years or more (figure 6.2).

**Figure 6.2 Duration of stay in residential care<sup>a</sup>**



<sup>a</sup> Per cent of people who were in residential care for at least some of the period July 1997 to December 2009. Sources: DoHA Aged Care Data Warehouse, supplied by DoHA on 24 September 2010; DoHA (2011i).

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The lifetime risks of requiring aged care services are not well understood. To make Australians more aware of these risks and the potential costs of such care (so they can be better prepared financially), there would appear to be a role for a public education campaign. This is discussed further in chapters 7 and 16.

The fact that ‘unpredictable’ and potentially very high, or ‘catastrophic’ personal care costs are faced by a minority, points to the need for a risk/cost pooling or sharing mechanism. Options for spreading this risk across the population include some form of insurance (be it private or public), or a collective publicly funded system. As a recent OECD paper recognised:

Uncertainty about whether, when, and for how long an individual might need long-term care services suggests that pooling the financial risk associated with long-term care is a more efficient solution than relying solely on private out-of-pocket payments. Otherwise, the cost of long-term care services and support can rapidly become unaffordable, and not only for low-income seniors. Average LTC expenditure can represent as much as 60 per cent of disposable income for all but those in the upper quintile of the income distribution. The oldest old and those with severest care needs are especially at risk. (Colombo et al., 2011, p. 28)

Such risks create a typical insurance problem, but currently the limited scope for risk-averse individuals to insure against the possibility of catastrophic costs (as they can for other potentially catastrophic costs, such as the loss of, or significant damage to, their house or car) results in a large welfare loss. And, as noted by Ergas, as the prevalence of dementia rises and the distribution of care costs becomes more skewed, the welfare losses become more acute. Barr observed that:

There are potentially large welfare gains if people can buy insurance that covers the cost of long-term care. (2010, p. 359)

To illustrate the potential welfare gains from insurance, if aged care costs were \$30 000 a year and one in six people needed care for an average of two years, the typical person would need care for one-third of a year, at a cost of \$10 000. There are two ways a person could seek to finance the costs:

1. through buying insurance at an actuarially fair price. This would require a person to save enough to cover the premium for the average duration (\$10 000)
2. by self-insuring where no insurance scheme is available, a person would need to save enough to cover the maximum potential duration of long term care, say 10 years at \$30 000 = \$300 000 (based on an example provided in Barr 2010).

Voluntary insurance, however, is unlikely to work or be equitable or efficient because of problems on both the supply and demand side of the insurance market (chapter 8). The other options are compulsory insurance (which is examined in

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chapter 8), or the government acting as the ‘insurer’ by offering a stop-loss mechanism (see below).

A lifetime stop-loss limit as part of a publicly funded system could protect individuals from very high costs of care. Such a limit could cut in either after a certain period of time of paying care costs (say after three years of intensive care) or after an individual had reached a cumulative level of ‘out-of-pocket’ payments. A key advantage of capping care costs to the individual would be to provide greater certainty for planning throughout life for aged care costs. As NSA said:

Older Australians want to know that they will be able to have affordable quality care in later life. (sub. 411, p. 13)

This issue is explored in more detail in chapter 7.

#### *How much should individuals contribute to care costs?*

As stated above, some care costs are reasonably predictable and manageable (the high probability costs) and others less so (low probability, catastrophic cost events). The more predictable personal care costs should be largely the responsibility of the individual, but there should be some mechanism in place for pooling the risk of the more unpredictable, and potentially catastrophic, costs of care.

In the Commission’s assessment, there is a clear case for subsidising care for those unable to pay for care themselves (the safety net), and a case for protecting individuals from very high out-of-pocket costs of care (pooling of the ‘tail’ of the financial risk). What is less clear is how much individuals should contribute to the cost of the more predictable elements of their care.

A number of participants argued for universal access to subsidised care noting the parallels between personal care in old age and health care. For example, Catholic Health Australia said:

... Medicare provides a precedent for the community meeting all or most of care costs, noting that an individual’s aged care needs are unpredictable. (sub. 1, p. 13)

Others, however, were of the view that those who have the capacity to pay should pay for their own care costs. For example, an NSA survey of more than 3200 seniors found that:

... many people would be prepared to pay for high quality aged care, while wanting a safety net for those who cannot afford to pay. (sub. 411, p. 20)

Anglicare Australia said that a strong argument could be made that aged care is a ‘public good’, but supported the principle that:

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... people with considerable wealth or income make an appropriate contribution to their care. (sub. 461, p. 4)

ACAA and Deloitte also said:

In principle, the primary financial role of the Commonwealth should be to finance care for those elderly Australians who are not in a position to themselves cover its costs. In that sense, the Commonwealth has, and must retain, a primary responsibility to ensure an adequate social safety net is in place. Conversely, those consumers who are in a position to cover their own care costs should do so, thus minimising the call on public expenditure and hence also minimising the need to impose distorting taxes so as to fund that expenditure. (sub. 285, p. 6)

The fact that it can be difficult to separate out health care services from personal care suggests that there is a case for providing an entitlement for some services to everyone who has those needs. However, as discussed earlier, within Australia's health care system there are a range of co-payment arrangements (public hospital acute care and emergency department services do not incur a co-payment while there are co-contributions subject to means-testing and a capped safety net for primary care services and pharmaceuticals). Ergas and Cullen noted that this reflects funding features inherited from both the pension and health care systems:

Commonwealth involvement in the funding of aged care arose at the intersection of the pension (and more generally, income support) and health care systems. From the former, it inherited an emphasis on means testing. From the latter came an emphasis on universality of access, tempered by quantity rationing (enforced through the restrictions on the number of places) and by reliance on significant co-payments. (2007, p. 10)

It may, therefore, be appropriate for the government to underwrite a significant proportion of the costs of some aged care services (for example, those services closer to health care, such as palliative care), while others would be subject to means testing or specified co-contributions (for example, low level assistance measures such as domestic help). A recent OECD paper noted that:

Determining the basket of domestic-care services generally involves a greater element of subjectivity (e.g. over the frequency of shopping trips, where to and for how long). Support for IADL can also be more readily provided by family, friends or the community, since there is generally more flexibility with their provision. There is therefore a rationale for targeting support on nursing care and basic personal-care needs, since their assessment is less subjective and there are also cost-control considerations. (Colombo et al. 2011, p. 269)

But too great a focus of subsidies on those services closest to health care could ignore opportunities to help older people earlier, which in turn could lessen the risk of rising levels of need and higher costs to the taxpayer at a later stage. For example, early intervention measures such as installing hand railings could avoid an older person having a fall, requiring hospitalisation, and experiencing a further

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decline in functionality. Also, as recently noted by the OECD, for the increasing number of dependent individuals with cognitive impairments, limiting support to personal care may not enable these people to live independently (Colombo et al. 2011).

However, providing a broad basket of care services free or with a high subsidy has significant fiscal implications for government and can reduce efficiency — which in turn would mean higher costs of providing the services (and this approach itself imposes a large burden on the public purse). And, it could see informal carers being replaced by more formal care.

Co-contributions can provide a test of how much individuals value particular services (provided they are not set too low), empower users to consider the value they place on services and encourage them to demand higher quality. Co-contributions can also be designed in a way which makes the system progressive and encourages individuals to save for their aged care costs. The impact of any co-contributions on demand will depend on how responsive or sensitive care recipient decisions are to the effective service price — that is the out-of-pocket cost to the care recipient.

Means-testing seeks to ensure that those people with the capacity to contribute to their care costs do so. A feature of means-testing is that public funds are used as a safety net for those unable to pay for care themselves. Means-testing, however, can create perverse incentives including asset stripping by families prior to the individual requiring care. Administrative design can reduce the incidence of such behaviour.

### *International approaches*

Internationally, very different decisions have been made about where to draw the line between public and private responsibility for funding (figure 6.3). The OECD identified three broad types of arrangements for long term care:

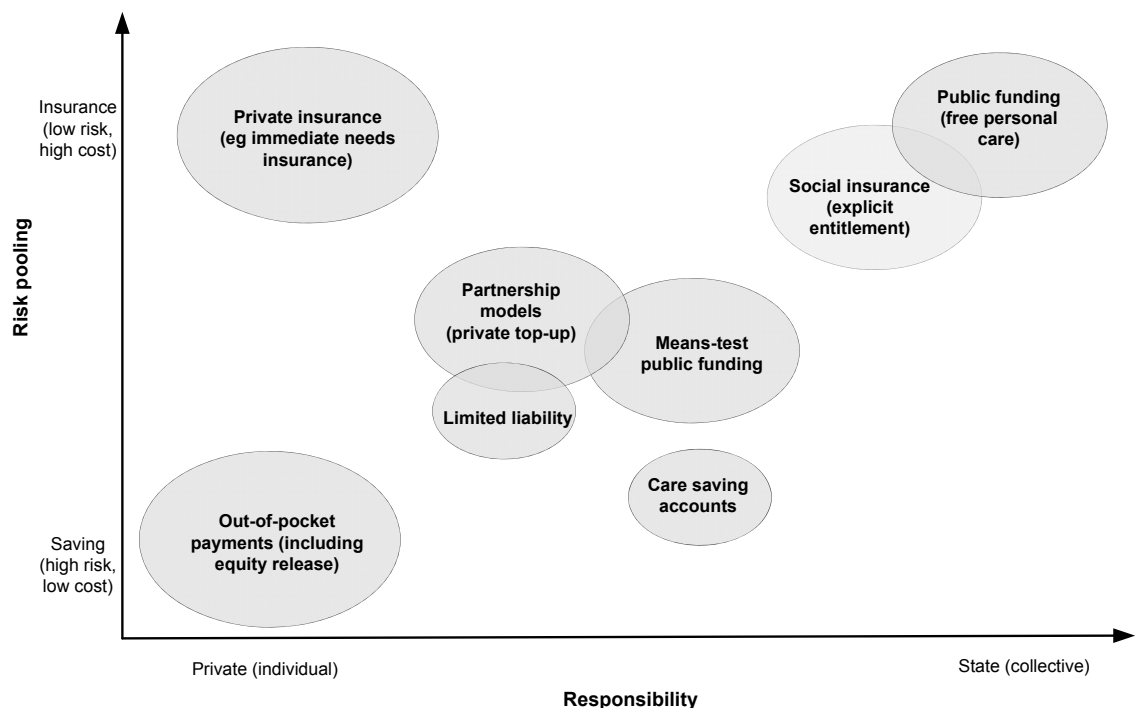
- *universal systems* where the majority of the population is entitled to publically funded care, with little need for private contribution. These include tax-based (such as Denmark, Sweden and Scotland) and insurance models (notably Germany, Japan and the Netherlands).
- *mixed or progressive systems* where there is some degree of universality, but also means-tested/income-related benefits. Under such systems a significant share of costs can be imposed on the individual. Countries with these systems include Austria, France and Australia.

- *means-tested or safety net systems* where there is minimal state intervention with support directed to those who lack the financial resources to pay for services. The United Kingdom and the United States are included in this category (OECD, 2011).

Long term care systems across the OECD seem to be evolving in some common directions:

At one end of the spectrum, some means-tested, safety-net approaches have been called into question, mostly on grounds of fairness and growing need ... At the opposite end of the spectrum, in comprehensive universal coverage countries, the range of services eligible for coverage has been subject to scrutiny and increased targeting to those on most severe needs. (Colombo et al. 2011, pp. 240–41)

**Figure 6.3 Archetypal funding arrangements**



Source: Wanless (2006, p. 253).

All public coverage schemes across the OECD countries require users to share part of the cost of the personal care support they are entitled to, but countries differ in the method and level of subsidy relative to total costs of care. The three main approaches are:

- setting public subsidies and leaving individuals responsible for the difference between the subsidy and the cost of the service (Germany, France, Italy and Austria)

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- flat cost-sharing — where cost sharing is a given percentage of care costs (for example, in Korea individuals pay 20 per cent of institutional care and 15 per cent of home based care; in Japan co-payments are 10 per cent of the cost of care)
  - cost-sharing set according to income and sometimes assets of the care recipient.

A more detailed discussion of the different funding systems is provided in appendix D.

The bottom line is that there is no ‘single’ or ‘right’ answer to the question of how much individuals should contribute to the cost of their aged care (although they should not be exposed to very high, or catastrophic costs of care). In the Commission’s view, where the balance between private and public responsibilities lies should be based on what is sustainable, considered equitable and ‘fair’ by older people and the community more generally, as well as what represents value for taxpayers’ money.

#### *Where does that leave us?*

Drawing on the preceding discussion, the Commission considers that the following principles should guide the funding of aged care:

- accommodation and everyday living expenses should be the responsibility of individuals, with a safety net for those of limited means
- health care services provided through aged care (such as nursing and allied health care), should be subject to charging arrangements consistent with those in the health care system
- individuals should contribute to the cost of their personal care according to their capacity to pay, but should not be exposed to catastrophic costs of care.

Unpacking the different cost components of aged care makes it easier in practice to consistently apply the funding principles to the different types of care (community, respite, residential), to improve pricing signals to users and providers, and to better target subsidies to those in most need. Aligning care subsidies and charges between community care and residential care would facilitate more equitable choice and provide an incentive for providers and the government to drive service responsiveness and dynamic efficiency improvements.

***The Australian Government should adopt separate policy settings (including for subsidies and co-contributions) for the major cost components of aged care, namely care (including personal and nursing care), everyday living expenses and accommodation.***

The next chapter looks at what unpacking the different cost components and applying the above principles mean in terms of changes to the current regulatory arrangements and examines options for improving funding arrangements.

