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## 7 Paying in practice

### Key points

- For accommodation charges to reflect the market value of the service, regulatory restrictions on the number of community and residential care places and price controls need to be phased out over time.
- Under current arrangements, the interaction of the Age Pension means test with the accommodation bond instrument means that care recipients and providers are *not* indifferent between bonds and periodic payments. There is a strong bias towards bonds, and bonds that exceed the value of the accommodation provided.
- To avoid distorting choices between accommodation payment options, providers should offer a periodic charge and accommodation bonds that are equivalent (or lower) to that charge. All accommodation charges and bonds should be published.
- Some age pensioners faced with the choice of selling their homes to go into residential care, or a retirement village, could find themselves with surplus funds that would not be exempt from the Age Pension assets test. This is a disincentive to move to more 'appropriate' accommodation. A government age pensioners savings account scheme could be made available to age pensioners for investing any surplus funds from the sale of the principal residence and for those funds to be exempt from the Age Pension assets and income tests. The funds could be drawn upon to fund living costs, aged care and other expenses.
- To ensure adequate provision of an approved basic standard of accommodation for those with limited financial means, providers should continue to be obliged (but compensated) to make available a proportion of their accommodation (set on a regional basis) to supported residents. To improve flexibility, the obligation could be made tradeable between providers.
- While those with the capacity to pay should contribute to the cost of their care, a lifetime stop-loss mechanism could protect individuals against very high out-of-pocket expenses for aged care (recognising that voluntary insurance arrangements to do this are not available or likely to be feasible).

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This chapter looks at applying the funding principles established in the previous chapter to the various cost components of aged care. The funding principles are that:

- accommodation and everyday living expenses are reasonably predictable and should be the responsibility of individuals, with a safety net for those of limited means
- 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.

The first section of this chapter (section 7.1) looks at applying the funding principles to accommodation expenses and what this means for changes to the existing arrangements for paying for accommodation. It also examines the issue of those who do not have the capacity to pay for their own accommodation expenses. Section 7.2 looks at applying the principles to everyday living expenses, while section 7.3 examines the application of the funding principles to the costs of care and how, in practice, individuals might be protected from excessive costs associated with intensive care for long periods of time.

## **7.1 Accommodation costs — applying the principles**

### **What are the current arrangements for paying for accommodation?**

Accommodation costs in community care are generally fully funded by care recipients. Rental assistance and social housing are available for those with limited means.

Currently the type of accommodation payment that older Australians pay for their entry to residential care depends on the resident's assessed care need at the time of entry. They can be charged either an:

- accommodation charge (for entrants to high care) or
- accommodation bond (for those entering low level care or those receiving extra services in high level care).

The level of the accommodation payment is determined according to a resident's assets. Accommodation supplements are paid to providers for residents in their care who have few assets. Such supplements are appropriate in this context, because if the care recipients were in the community they would most likely be eligible for rental assistance (in addition to their pension).

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### *Accommodation charges — non-extra service high care*

Residents of high level residential care (not on an extra service basis) can be asked to pay an accommodation charge if they have assets above the minimum asset level of 2.25 times the maximum amount of the annual single basic age pension (\$39 000 at March 2011). The upper limit for any accommodation charge is regulated (currently the maximum amount is \$30.55 per day at an asset level above \$102 544). Accommodation charges are payable by high care residents for the entire period of their admission (with some exceptions), but cannot be charged for more than one-month in advance. In 2009-10, the average accommodation charge for new high care residents was \$22.51 per day (DoHA 2010n).

Residents can agree with their aged care provider to defer payment or pay it from their estate. The aged care provider can charge interest on the unpaid amount but at no more than double the lowest pension deeming rate applicable at the time of entering the facility. Residents who pay an accommodation charge can rent out their former home without the value of the home or the rental income affecting their aged care fees and, if applicable, their pension. The former home is exempted from the pension assets test for two years for all people entering residential care, and longer if the person's partner remains living in the home (DoHA 2011h).

### *Accommodation bonds — low care and extra service places*

An accommodation bond is an amount residents can be asked to pay when requiring low care or an extra service place. Bond amounts are agreed on between a resident and the aged care provider. A resident, however, cannot be charged a bond that leaves them with less than \$39 000 in assets.

Bonds are effectively interest-free loans to providers. Providers can also deduct an annual (capped) retention amount for the first five years of residence. The maximum retention amount is set by the Government — for residents entering care during the 12 months from 1 July 2010 the maximum amount is \$307.50 per month (\$3690 for the 12 months). The retention amount does not vary while the resident lives at the residential care facility (for a maximum of five years). As for other residential care fees, the retention amount is negotiable below the maximum (with evidence presented to the Commission that some providers are willing to accept significantly lower or zero retention amounts in the case of a sufficiently large accommodation bond).

The balance of the bond is returned to a resident, or their estate, when they leave the residential care facility. The income from invested returns on accommodation bonds and retention amounts can be used by providers to meet capital costs or retire debt

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related to residential care, or to improve the quality and range of aged care services. The Government recently introduced legislation that widens the range of activities from which the income from accommodation bonds can be used (chapter 15).

Residents can choose to pay an accommodation bond as a lump sum, a regular periodic payment (fortnightly or monthly) or a combination of both. Residents who have paid an accommodation bond and who are moving to high care can elect to roll over their accommodation bond.

### **Accommodation charges in high care do not reflect costs**

The price charged for accommodation in residential facilities should reflect the value of the accommodation so that care recipients take into account the costs of provision in their decision-making (which in turn results in resources being allocated to the forms of accommodation that people value most). Regulatory restrictions under the current arrangements (price caps, maximum retention amounts, supply constraints on the number of allocated places) mean that, in practice, the contribution that older Australians make towards the cost of their accommodation in residential care does not reflect the value of the accommodation.

In ordinary high care, the only payment option is an accommodation charge and the maximum charge is the same regardless of the room size, number of occupants, location, quality of fittings and amenity. This is a bit like charging the same rate for all hotel rooms across the country irrespective of where they are located and their star rating. A number of participants pointed to the lack of relationship between the accommodation charge and the cost of supply (and what that meant for choice of accommodation). Little Company of Mary Health Care said:

It is illogical that the same (single) price applies to residential aged care in a fifty year old facility, with four bedded wards and multi-resident bathrooms as it does in a new, single-room with ensuite facility, and water views. (sub. 289, p. 22)

Ageis Aged Care Group also said:

It is inconceivable that for 12 years we have had a system in place where residents and their families cannot pay for the standard of high care accommodation they want and deserve. (sub. 206, p. 3)

Having the same charge for vastly different accommodation is inequitable, limits care recipients' choice, provides little incentive for providers to compete on quality, and fails to provide an incentive for care recipients to take into account the cost of provision in their decision-making. Providers are handing back allocated places, beds that have been approved have not been made operational, and interest in aged care allocation rounds (ACAR) has diminished. A number of industry surveys also

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indicate that the financial returns on high care places (not extra service places) are inadequate to justify future investment (box 7.1).

**Box 7.1 Participants point to evidence of insufficient returns on capital outlays in high care (non-extra service) places**

Toohey and Ansell identified some concerning trends:

1. An estimated 25 000 'phantom' beds i.e. places issued under ACAR over the last decade which have not converted to operational beds on the ground because of a lack of viable financing options.
2. Rapidly diminished interest by existing providers and new entrants in competition for new places in annual ACAR rounds. ... most regions and states have been undersubscribed in recent years.
3. An unprecedented situation where existing, well established and highly respected providers have surrendered places to the Commonwealth because they are unable to viably construct and operate them. (sub. 464, p. 3)

Regis Group:

...'extra services' places remain the only viable solution to obtaining capital. (sub. 237, p. 2)

Government of Western Australia:

... the industry is currently funded by the Commonwealth Government at \$109 000 per bed, whilst the average cost of construction ranges from \$200 000-\$240 000. ... Following the outcome of the 2007 Aged Care Approvals Rounds (ACAR) the Western Australian residential aged care sector was allocated only 644 out of a total 1006 places due to a lack of suitable applications from existing and new residential aged care providers. This represented 362 (36%) residential places available but not allocated. (sub. 412, pp. 1-2)

Deloitte's annual survey into the Australian Aged Care Industry found that three-quarters of the 137 respondents (managing around 700 facilities) had no intention of expanding their operations by acquiring pre-existing facilities and 61 per cent had no intention to undertake any new construction activity on existing facilities or build new facilities over the next five years (Deloitte 2010).

Bentley's 2009 survey of performance of more than 100 service providers operating approximately 350 residential aged care services found that more than 40 per cent of providers were operating at a loss.

Grant Thornton's Aged Care Survey of almost 700 residential care services reported that providers' average earnings before interest, taxation, depreciation and amortisation (EBITDA) in 2008 was \$2 934 per bed per annum. The average return on investment for modern high care facilities with single bedrooms was around 1 per cent.

Stewart Brown's December 2010 survey of residential facilities found that 38 per cent of high care facilities (22 per cent in June 2009) and 44 per cent of low care facilities (39 per cent in June 2009) achieved an operating profit (sub. DR842, p. 12).

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In this context, Access Economics said:

The ultimate consequence of a lack of industry sustainability is exit from taking up high care places or lack of commissioning of places taken up (ie, retaining them as provisional). This leads to overall service gaps and under-provision of care. Care needs are not met and the thinning in competition in the sector compromises the goal of efficiency also for remaining providers. (2009a, p. 35)

Australian Unity spoke about the ‘bleeding of capacity from the system’, arguing that without action to support capacity building, residents will be unable to access appropriate care and ‘a surge in hospital demand will be inevitable and with that higher per day care costs’ (sub. 424, attachment 1, p. 7). Hogan also said the prohibition of bonds in high care:

... impedes investment in that branch of the industry. Until this handicap is removed, the scope for making fully effective progress in efficiency and productivity will be marred at the expense of those who cannot secure or afford entry to extra service high care. (2004b, pp. 16–17)

The market is also responding to these pressures with strong growth in extra service places where bonds can be charged.

### **Bonds in low care and extra service places also do not reflect costs**

Accommodation bonds, because they are only limited by an individual’s capacity to pay (the only limit on the size of the bond is that it must leave the care recipient with a minimum of \$39 000 in assets), and they are the only avenue of the market where providers have flexibility on price, have increased significantly in recent years. Bonds from new residents increased on average from around \$58 000 in 1997-98 to more than \$230 000 in 2009-10. Since 2004-05, the total value of accommodation bonds held by approved providers has doubled from \$4.3 to \$10.6 billion in 2009-10 — an increase of 20 per cent per annum. Since accommodation bonds are typically financed by the sale of the home, the growth in house prices is likely to be the major factor behind the growth in the size of bonds. To provide protection to the resident, the Government guarantees the bonds, for which providers are not charged (chapter 15).

The Commission heard evidence of very large bonds being paid (some well in excess of \$1 million). Fortus (sub. 463, p. 6) cited the example of a Melbourne couple who were asked to pay bonds of \$750 000 each, based on their home being valued at around \$2.3 million. The Australian Guardianship and Administration Committee also presented evidence of high bonds being paid in recent years:

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All State and Territory members of AGAC have commented on the rapid acceleration, over the past 2 years in particular, in the amounts now being requested for accommodation bonds with sums of \$550K to \$750K and sometimes \$1M+ now becoming somewhat of the norm rather than the exception. In NSW one approved provider has set its bond levels at between \$500K to \$2.6 million depending on the floor level and the particular rooms. (sub. 478, p. 1)

The average value of new bonds paid in recent years appears to exceed the estimated replacement cost of residential care places. Industry estimates of the average cost of construction for residential care beds ranged between \$200 000 to \$250 000. DoHA presented evidence to the Senate inquiry into residential and community aged care in Australia that the average construction costs for new or rebuilt aged care beds was \$150 000 in 2009 (DoHA 2009h).

The Henry Review described the bond as a ‘tax’ (levied by the private sector) rather than a user charge:

The design of a bond is more like a tax, limited by people’s capacity to pay, rather than a user charge, which would be limited by the costs of their accommodation. (2010, p. 636)

In 2008-09, anyone paying a bond of more than around \$80 000 was paying more for their accommodation than those paying an accommodation charge in ordinary high care. For the accommodation charge to be equivalent to the average bond in 2008-09 it would need to have been more than \$61 per day.<sup>1</sup>

For providers who offer both low care (or extra service high care) and high care, people who pay large bonds are cross subsidising those who pay the capped high care charge. Cross-subsidisation creates inefficiencies in meeting the capital requirements of ordinary high care places as the financing of high care places depends in part on admissions into low care or extra service high care places. It also increases risk to providers by forcing them to rely on a subset of consumers from which they can earn a return. This situation is unlikely to be sustainable in coming years as demographic trends suggest that demand for low care places will continue to decline. The weakening incentives for investing in high level residential aged care services must be addressed if there is to be adequate investment.

The different accommodation payments are also inequitable because they are based on the level of assessed care need (high or low) and capacity to pay, not the cost of supply. As Sundale Garden Village said:

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<sup>1</sup> Assuming forfeited interest of one year at 8.74 per cent (\$18 612) and the maximum retention in 2008-09 of \$292.12 per month, the annual (pre-tax) cost to the individual providing a bond of \$212 958 was \$22 118 or \$61 per day.

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The existing capital funding system is structured in such a way as to have part pensioners in low care facilities (hostels) potentially cross subsidising millionaires in high care. (sub. 269, p. 32)

Other participants pointed out that the different accommodation payments discriminate against older Australians who are least well off but who require residential care. As high-wealth care recipients paying bonds are more financially rewarding to providers than lower-wealth care recipients, this provides an incentive for providers to ‘cherry pick’ (with some providers readily acknowledging that they do, chapter 5). One participant, relaying his experience on seeking a residential care place for a parent, said:

I was told that there was no maximum fee and that it depended on the assets.

I asked if she had a house worth \$1 000 000 would they take all of that. I was told that would be very unusual but yes they would take that into the equation. They would not give me a ‘retail’ price for the room. ... I don’t feel it is fair for villages to charge people on the basis of their assets with no limit as to what they can charge. It is contrary to the usual way in which our society operates. (sub. 58, name withheld, pp. 1–2)

Hogan also observed that the distinction between extra service high care (where bonds can be sought) and ordinary high care:

... 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] (2007, p. 2)

## **Higher charges or bonds for high level care — what is the solution?**

The equity, efficiency and sustainability of residential care could be improved by placing low care and high care on an equal footing in terms of access to charging arrangements to meet capital requirements.

### *Increase the regulated daily accommodation charge?*

One option is to increase the daily accommodation charge for all high care so that the charge is adequate to cover average capital costs. But, with any new cap there is the risk of getting the price ‘wrong’ and it would need to be appropriately reviewed and/or indexed over time. And an average capped charge cannot accurately reflect the actual building costs of residential care in different regions nor would it allow older Australians to pay different accommodation charges for accommodation of

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different quality/with different features (a refurbished room with a view would have the same charge as an older room without a view). Some participants identified problems with this option. Aegis Aged Care Group, for example, said:

To increase the cap is not appropriate because it restricts what can be built and takes away resident choice. (sub. 206, p. 4)

Uncapping the daily accommodation charge so that it can reflect the building costs across different regions and allow variation based on varying quality and features would be more in line with a user-pay approach. Anglicare Sydney supported such an approach:

The accommodation charge should not be regulated by Government. It should be set by the market so that people willing and prepared to pay for a higher standard of accommodation may choose to do so, whereas others may be content to pay for more modest accommodation. However, those with limited or no capacity to pay should have their accommodation costs subsidised at a fair and reasonable level. (sub. 272, p. 9)

Under this market price option, accommodation costs to high care recipients and taxpayers (the accommodation subsidy for supported residents) are likely to be higher, but consumer choice and industry sustainability would be enhanced. Care recipients, however, would continue to be charged differently according to the level of assessed care need (high or low care) not the standard of accommodation they have chosen. There is also a concern that, as providers could charge what the market would bear, care recipients could be exploited and those with a lower capacity to pay would miss out. This is a greater concern in the short term, particularly in areas where there is limited competition. But in the longer term, provided that the accommodation subsidy is adequate to cover the cost of supply, there should be improved access as providers are more likely to build new places with higher returns on accommodation. Transitional issues are discussed in chapter 17.

### *Bonds for high care?*

The majority of participants saw the extension of bonds to high care as the ‘solution’ to under-investment in high level residential aged care services, and for removing the artificial distinction between high and low care (box 7.2).

A survey of providers undertaken by Hynes Lawyers reported that 88 per cent of respondents said that approved providers should be able to ask any resident who can afford to pay an accommodation bond to do so.

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## **Box 7.2 Support for removing restrictions on bonds**

### **Australian Unity:**

Abolish the restrictions on high care bonds (and abolish 'low care' and 'high care' categories in residential and community aged care, as outlined below) to encourage investment in residential aged care by investors and operators. (sub. 265, p. 7)

### **ECH joint submission:**

On the question of accommodation payments, the government has offered no justification for its refusal to allow accommodation bonds to be charged for all residential care. By contrast, virtually every other review and inquiry into aged care in recent years has supported the lifting of regulatory restrictions in this area. (sub. 453, p. 12)

### **Clubs Australia:**

There is a need for providers of both high care and low care to be able to utilise and benefit from accommodation bonds, and the current restrictions on charging an accommodation bond for high care should be removed. (sub. 197, p. 28)

### **Older People's Reference Group:**

The disparity between an average bond of more than \$200 000 for low care, while none applies for high care unless 'extra services' is provided, cannot be justified in the long run. (sub. 25, p. 10)

### **Aged Care Association Australia — South Australia:**

We propose that, subject to an indexed asset value which would be excluded from any payment, all people entering residential aged care, whether as high or low care recipients, would have the option of paying a refundable deposit for their accommodation, a payment which equates to an agreed deposit, or a combination of these. (sub. 309, p. 6)

### **Blue Care:**

Remove restrictions on high care bonds, including retentions, and deregulation of bed supply should follow in the longer term. (sub. 254, p. 4)

Some participants, including National Seniors Australia (NSA), raised concerns about the extension of bonds to high care:

Government and industry have raised the possibility of requiring bonds from high care residents. NSA believes this is a short-sighted approach to a bigger issue which requires planning ahead to meet increasing costs in aged care generally. NSA believes that accommodation bonds may be part of a suite of funding choices for consumers, but are not the only option. In fact, such bonds can be disadvantageous to some consumers, particularly those entering residential aged care for very short periods of time. (sub. 411, pp. 15-16).

Community concerns about extending accommodation bonds to ordinary high care places have in the past been a major stumbling block to reform in this area. In 1997, the Government proposed accommodation bonds for high level care but the proposal was quickly retracted as a number of baby boomers (supported by various stakeholder groups) strongly objected to the prospect of losing control over their

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inheritances. A more substantial concern relates to care recipients having to pay large up-front bonds when they are expected to only need high care for a short period of time (for example, the very frail or those entering residential care for end-of-life care).

### *Choice in payment options for accommodation*

A system that provides flexibility and choice in terms of the form of accommodation payment acknowledges that one size does not fit all — someone entering high level care with dementia may (or may not) have the prospect of an extended period of time in care, while someone else entering care may require palliative care and not expect an extended stay.

Many participants called for choice in accommodation payment options:

... because the life time savings of many Australians is in the form of home ownership, flexible payment arrangements will be necessary to cater for individual circumstances. (Catholic Health Australia, sub. 1, p. 13)

Residents need to have a means to be able to choose how they contribute towards their accommodation costs. We need flexible high care accommodation payment arrangements. There will be further pressure on the Aged Care Sector with current and future generations having higher expectations of choice, flexibility and responsiveness in how they use and access aged care services. (Anglican Care, sub. 49, p. 2)

... people should have options for how they pay for accommodation in a residential aged care facility. Options could include paying rent, deferred contributions from estates, a refundable lump sum which in effect is a loan, or other negotiated arrangements. (Aged and Community Services Australia, sub. 181, p. 4)

Residential aged care accommodation could be funded by a periodic charge (for example, daily, weekly or monthly rental payments), a lump sum, a deferred payment, or some combination of these options. Such an approach would be consistent with an aged care system that offers flexibility and choice. But, the payment options need to operate such that they represent equivalent amounts which cover the value of accommodation.

Providers require a reasonable rate of return on the capital cost of providing residential care facilities. So long as the returns are the same for the different payment options (after allowing for differences in transaction costs, risks of non-payments, etc.) providers should be indifferent between how care recipients pay for accommodation (and care recipients would have a range of payment options available to them).

As discussed earlier, older Australians entering low care and extra service high care already have the option of paying a lump sum bond or an equivalent periodic

payment or a combination of the two, but care recipients' take-up of the periodic payment option has been low (table 7.1).

**Table 7.1 Method of payment of bonds**  
Percentage of all bond-paying new residents

<i>Method of payment</i>	<i>2004-05</i>	<i>2005-06</i>	<i>2006-07</i>	<i>2007-08</i>	<i>2008-09</i>	<i>2009-10</i>
Lump-sum	91.8	91.2	91.1	91.0	89.3	89.6
Periodic payments	4.5	3.8	3.6	3.1	3.5	4.1
Lump-sum and periodic payment	3.7	5.0	5.3	5.9	7.4	6.3

Sources: DoHA (2009e, 2010n).

Low take-up of alternative accommodation payments can be explained by:

- providers' strong preference for bonds combined with constrained competition (arising from supply restrictions) which has allowed providers to offer care recipients little choice about the method of payment
- income and asset tests within the broader welfare system (the Age Pension in particular) which create incentives for residents to pay lump sum bonds
- evidence that clients are not well informed about their payment options (box 7.3).

Bonds are particularly attractive to providers as a form of accommodation payment because they allow providers to offset bank debt with zero interest debt. The benefits to providers from negotiating large bonds can be significant. As shown in table 7.3, the interest that can be saved on \$200 000 is around \$17 000 a year. As Hogan put it:

The use of accommodation bonds is attractive to boards and management compared with charges because of their contribution to the capital needs of the aged care entity; whereas accommodation charges simply meet the costs of servicing the capital which still must be raised and, most importantly with debt, repaid. Accommodation bonds offer a self-replenishing means of funding. (2004b, p. 1)

Bonds also allow providers to leverage their equity — magnifying profits over a relatively small pool of equity and similarly magnifying losses. Thus bonds can systematically increase leverage and providers' risk and return.

### Box 7.3 Complexity of bonds and importance of information

Some participants suggested that, notwithstanding the interactions with the Age Pension means test, the ‘complexity’ of the bond arrangements and insufficient information about payment options meant that people were paying large bonds thinking this was their best option. Fortus, for example, said:

Not enough prior education is available to residents and their families in understanding Bonds. For example, many aged care providers recommend the family home is sold to pay for a lump sum Bond. Consumers are often unaware Equity Release can be accessed to pay for the lump sum and/or periodical payments. Additionally they are unaware that if all/part of the Bond is paid periodically and ongoing, the family home may be rented out and the house is exempt from the Assets Test and the rental income from the Income Test for the purpose of the Age Pension. (sub. 463, p. 4)

When a person enters a residential care facility, their home is not counted as an asset for Age Pension purposes for up to two years (longer if a spouse or partner continues to live there). However, as long as a resident continues to pay part or all of the accommodation bond via a periodic payment and rents their former home, the value of the home is not counted in the Age Pension assets test nor is the rent received counted as income. As such, there is some incentive for care recipients to agree to pay some of the accommodation bond by periodic payment. To illustrate, consider the following cameos for a resident with a \$1 million home:

- Cameo 1: sell the home and pay an accommodation bond of \$1 million
- Cameo 2: pay an accommodation bond of \$150 000 and invest the remaining \$850 000 in an interest bearing asset
- Cameo 3: retain the home, rent it out and pay a \$150 000 bond payable by monthly instalments over five years.

As shown in the table 7.2 large bonds can result in poorer outcomes (compared with the other options) for taxpayers and the care recipient/bequest.

**Table 7.2 Big bonds = poor outcomes for taxpayers + individuals<sup>a</sup>**

	Cameo 1 <i>(\$1 million bond)</i>	Cameo 2 <i>(\$150 000 bond, invests \$850 000)</i>	Cameo 3 <i>(\$150 000 bond, rents home pays monthly instalments)</i>
Provider receives	\$103 068	\$41 294	\$30 485
Care recipient gain	\$4 241	\$38 974	\$45 864
Bequest	\$996 310	\$996 310	\$1 026 310
Taxpayers pay	\$18 619	\$0	\$6 864

<sup>a</sup> Assumes that the resident stays for one year and a borrowing cost by the residential aged care facility of 8.5 per cent, no transactions costs on the sale of the home and does not account for the cost to the Government of the Commonwealth Seniors Health Card.

Source: Commission estimates.

**Table 7.3 High bonds — an attractive option for providers**

<i>Bond</i>	<i>Interest<sup>a</sup></i>	<i>Retention</i>	<i>Total</i>
(\$)	(\$ pa)	(\$ pa)	(\$ pa)
100 000	8 500	3 690	12 190
200 000	17 000	3 690	20 690
300 000	25 500	3 690	29 190
400 000	34 000	3 690	37 690
500 000	42 500	3 690	46 190
600 000	51 000	3 690	54 690
800 000	68 000	3 690	71 690
1 000 000	85 000	3 690	88 690

<sup>a</sup> Assumes an interest rate of 8.5 per cent per annum as a conservative estimate of borrowings costs.

Source: Commission calculations.

Some participants suggested that the ability of older Australians and their families to ‘negotiate’ payment arrangements, including the size of a bond, is questionable. The Australian Guardianship and Administration Committee, for example, said:

The ability of a consumer to ‘negotiate’ a bond amount is clearly often questionable at best given the often emotionally charged nature of a consumer’s move from home to aged care; the general pre-requisite need to sell a family home and to pay an accommodation bond. (sub. 478, p. 2)

Another constraint on the negotiating power of care recipients is the quantitative restriction on bed numbers which enhances the negotiating power of providers by allowing them to charge what the market will bear.

Constrained competition can be addressed by reducing and ultimately removing controls over the number of places that currently reduce competition and restrict consumer choice. As discussed in chapter 5, many participants to this inquiry pointed to the costs associated with supply constraints and recent reviews have argued the need to remove the restrictions on the number of community care and residential places.

Department of Health Australia (DoHA) also acknowledged the costs associated with supply constraints:

Fundamentally, the planning ratios help manage the Commonwealth’s fiscal risk. However, they create an artificial scarcity that limits the scope for competition, blunts pressures for efficiency and innovation and deprives consumers of choice. This, in turn, means that suppliers face little threat of displacement and limited competitive pressure to be efficient, although the regulatory constraints placed on provider’s incomes do provide some incentives to achieve efficiencies. Market power is intensified locally because consumers seeking a place, especially in high-level care, often doing so as a

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time of emergency, and usually have preferences as to the location of the facility. These features further increase the market power arising from rationing, and add to the blunting of pressures for efficiency. (sub. 482, p. 52)

The Commission proposes the removal of restrictions on the number of community care packages and residential care beds as well as removal of the distinction between high and low care, with appropriate transitional arrangements to support this reform (chapter 17). This will improve providers' ability to respond to the needs of users and facilitate greater consumer choice of facilities where care can be received. Price regulations could be gradually relaxed as the level of competition in the sector increases (price regulations are currently in place to prevent the abuse of localised market power).

As competition reshapes the market, it should place downward pressure on bond prices and result in increased choice for care recipients. Deregulating supply will, however, increase the risk profile of providers and therefore raise the required return on investment, a point made by DoHA:

Currently aged care is seen as relatively low risk investment, and hence investors require a relatively low return in their investment given the security offered by the needs based planning arrangements (limited competition) and the guarantees associated with a government income stream. Reform to improve the efficiency of the industry through greater competition would increase the risk of the industry and hence the required rate of return. (sub. 482, p. 54)

It is often argued that removing supply constraints on bed numbers and community care packages would place a greater measure of fiscal risk on the Government. However, the Commission considers that the Government could still control its expenditure on subsidies through the criteria used to assess eligibility for approved care, the level of resourcing of care, and the co-contributions required from recipients of care (chapter 8). Indeed, DoHA acknowledged the role of the Aged Care Assessment Teams (ACATs) and means-testing in keeping the system sustainable:

The legislative framework of the Aged Care Act, and in particular the requirement for an independent assessment of need by Aged Care Assessment Teams, helps support sustainability by targeting services to those with greatest need. The Act's means testing arrangements for residential care also assist in this regard, both by altering the balance of public/private financing and by ameliorating the issue of moral hazard and provider induced demand. (sub. 482, p. 60)

### *Interaction of bonds with the Age Pension assets test*

But, constrained competition is only part of the story. The preparedness of some older Australians to pay large bonds is also driven by them wanting to meet the

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asset test for the Age Pension. They have an incentive to pay a large bond as, like the family home, the bond does not count towards the Age Pension assets test<sup>2</sup>. This overcomes a concern of many older Australians currently in receipt of the Age Pension who, if they sold their house and invested the capital, may no longer be eligible for a pension or part pension (with its attendant benefits, including lower co-contributions for aged care services and access to a health card).

Older Australians can be convinced to pay a large bond because it can mean they can not only receive the Age Pension (full or in part) but they can also reduce their care fees (residential care costs are income tested and full pensioners do not contribute to care fees in residential care). Currently around 90 per cent of all permanent residents in residential care receive a pension (Centrelink or DVA pension).

A number of participants raised concerns about what large bonds mean for taxpayers and the sustainability of the aged care system. Anna Howe, for example, said:

... the exemption of bonds from the Age Pension assets test has led to bonds becoming a mechanism for avoiding the means test, and comes at a considerable cost to taxpayers. ... Residents of aged care homes who are left with few assets, and hence little income from those assets, will not only qualify for a part or full Age Pension, but will also avoid having to pay means-tested fees. Providers can be seen as 'double dipping' by maximising interest earned on bonds, possibly well in excess of the Accommodation Charge, at the same time as receiving subsidies for care and basic daily fees paid from the Age Pension. (sub. 355, p. 25)

Uniting Care NSW/ACT also said:

... interaction with the pension means test makes it attractive for residents to trade-off higher entry bonds against lower daily fees. This creates opaque, poorly targeted transfers between taxpayers (who bear the costs of increased pension entitlements that result from higher bond payments) and providers of care (who benefit from the reduced price elasticity of demand with respect to entry bonds). While this also occurs in low care, the consequences are especially perverse in high care, where it creates a degree of taxpayer subsidy of extra service places (as only extra service providers can charge bonds, and hence benefit from the transfer). It is difficult to believe that any of these outcomes would be intended or desirable. (sub. 369, p. 22)

Overall, the incentives under the current arrangements encourage large accommodation bonds for three reasons:

- to maximise the size of the Age Pension received by the care recipient
- to minimise the cost of care for care recipients

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<sup>2</sup> And, since accommodation bonds are interest free, the income test is not relevant.

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- to maximise revenue for providers.

To the extent that these three objectives are achieved, the taxpayer picks up the tab.

There is also the prudential risk from the accommodation bond regime that is currently taken up by the Australian Government, as it acts as an unsecured creditor for residential care providers (and in turn provides a guarantee to older Australians purchasing a bond). These arrangements impose further costs on taxpayers. The Government has recently committed \$21.8 million over the next four years to support enhanced protections to further safeguard the more than \$10.6 billion of residents' savings held in aged care accommodation bonds by approved providers (DoHA 2010g) — see chapter 15.

The Commission considers that residential providers should be charged a fee to reflect the cost to taxpayers of providing the Government guarantee on accommodation bonds.

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

Essentially, the interaction of the Age Pension means test with the accommodation bond instrument, means that the care recipient and the provider will *not* be indifferent between payment options. In particular, care recipients and providers will be strongly biased towards bonds, and particularly towards bonds that exceed the cost of supplying the accommodation. To avoid distorting choices between accommodation payment options, the incentives shaping choices for care recipients and providers need to be neutral.

### **Some solutions**

#### *A first best option*

A first best option would involve having a means test for the Age Pension that treated income and assets in a consistent manner and did not exclude particular assets (such as accommodation bonds and the principal residence). Such an approach would recognise that an individual's (of family's) financial position is made up of both income streams and assets and that, arguably, it is unfair to treat people with the same financial position<sup>3</sup>, but with different mixes of income and assets, in different ways. The Pension Review Report (Harmer 2009, p. 121), said

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<sup>3</sup> In principle, a person could have exactly the same overall financial position with an income stream or an equivalent asset. A person's financial position comprises their assets and income.

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that ‘means testing needs to target payments in a way that does not induce inappropriate behavioural responses, and which is seen as fair and equitable’. The exemption of accommodation bonds from the asset test for the Age Pension appears to be inducing behavioural responses that are costly to taxpayers.

The Henry Review also acknowledged that different treatment of wealth under current means-testing arrangements reduces ‘fairness’.

Within the current two-part means test — the income test and the assets test — some assets are assessed under both tests, while other assets are assessed only under the assets test. This results in people receiving different levels of government payments even though they have the same level of wealth. This reduces the fairness of the means testing system. (2010, p. 533)

The Henry Review recommended a ‘comprehensive means test’ for determining access to income support payments that included deeming an income on most assets. And, while the Review recommended that accommodation bonds and owner-occupied housing continue to be exempt from the comprehensive means test, the Review did recommend a cap be applied to the exemption for owner-occupied housing as a way of increasing the fairness of the means test. The Commission’s terms of reference for this inquiry does not seek comment on the appropriateness of means testing for the Age Pension or the behavioural responses the test may invoke. A review of the aged care system is not the window through which options for Age Pension reform can be explored.

### *Alternative options*

In the context of the present means test arrangements for the Age Pension, the Commission has considered alternative (or second best) options, including:

- not allowing bonds
- placing a cap on the size of the bond
- changing incentives so that choices relating to the form of accommodation payment are less distorted.

### *Not allowing bonds*

The option of not allowing bonds and only permitting daily, monthly or other periodic payments would remove some choice and flexibility for care recipients and their families. Entry into a residential care facility often involves a significant rearranging of the financial affairs of the care recipient. Many older Australians and their families are attracted to making a single lump-sum payment (particularly if

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they have sold their home), recognising that they will have some of that capital returned at the end of their stay (typically returned to their estate).

While the assets of older people entering residential care could be invested elsewhere, given that the assets will be earning a return, older Australians who were entitled to the Age Pension when living in the community could lose part or all of their pension on entering residential care (while the owner-occupied home is exempt from the Age Pension assets test, the proceeds from the sale of the property are not exempt unless they are invested in an accommodation bond). This is not dissimilar to the disincentives age pensioners face when they sell their home and buy a less expensive (but often more appropriate) home, as the surplus usually becomes an assessable asset.

Not allowing bonds, while permitting providers to charge the equivalent of an accommodation charge for all forms of residential care that covered the costs of supplying the accommodation, would largely address the cross-subsidisation and ‘cherry picking’ problems under current arrangements. The beneficiaries of this option are taxpayers because more older Australians would be paying for their aged care costs and fewer would be entitled to the Age Pension. It would also address the inequities between users of high and low level care.

The main problems with this option are that it affects some older people’s eligibility for the Age Pension and reduces the accommodation payment choices for care recipients.

The Commission is not attracted to this approach.

*Should bonds be allowed, but with a cap?*

An alternative is to set a cap on the size of the bond. It could be a single dollar amount, but ideally in setting a cap, consideration should be given to reflecting variations in accommodation costs by location and amenity.

A fixed limit would be simpler and the limit could be set based on the average construction costs for new or rebuilt aged care beds as determined by DoHA or an independent body. Such an arrangement would remove the scope for consumers and providers to agree to very large bonds. Residents could, however, top up the capped bond by periodic or other payment methods, to meet the price to be paid for higher standards of accommodation.

A single capped amount carries the risk of getting the cap ‘wrong’ (so the price does not reflect the underlying value of the accommodation) resulting in the same

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problems that arise from the capped accommodation charge. An average capped amount also cannot accurately reflect the actual building costs of residential care across a diverse range of regions.

Capped bonds, if they are to reflect different building costs across different regions and allow variation in price based on varying quality and features, are complicated and could be open to criticism. The Australian Guardianship and Administration Committee said:

Placing a ‘cap’ on what can be charged is highly problematic due to the multiplicity of factors that could be involved, however an independent test of ‘reasonableness’ appears to be appropriate to implement. (sub. 478, p. 2)

One option would be to only allow providers to charge for accommodation using an advertised daily rental charge for calculating the cost of accommodation. This would vary by regions and the quality of the accommodation, but in itself presupposes a limit on the daily rental charge.

A capped bond places a limit on the assets that can be exempt from the Age Pension assets test and therefore results in different treatment of assets for those receiving care in the community and those receiving care in residential care.

On balance, the Commission is not attracted to this as a stand-alone solution.

### *Changing incentives so that choices about payment are not distorted*

An option for ensuring that accommodation payments reflect the underlying value of the accommodation *and* are equally attractive to care recipients and providers is to limit the amount providers can charge for a bond, to be the equivalent of a periodic accommodation payment that is commensurate to the underlying value of the accommodation supplied.

To ensure transparency and maximise competition, providers would be required to offer a periodic accommodation charge (that they set) and for that charge to be published. Providers could also choose to offer a bond option, but the value of the bond would need to be equivalent to (or less than) the periodic accommodation charge. It would also need to be published. This would improve the transparency of accommodation payments and older Australians’ understanding of the prices for accommodation in residential facilities.

The daily charge for those needing short term (including episodic) stays could be the same as for longer-term stays but with additional ‘turnover’ costs of entry and exit as appropriate, much the same as a hotel often charges a lower daily rate for a

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longer stay. Bond retention amounts (in their current regulated form) would be abolished.

Such an approach would mean that accommodation payments would be set by providers according to prevailing market conditions and would reflect different quality/features without requiring valuations of each and every facility. The Commission is attracted to this option as it would make transparent the 'price' of accommodation, provide flexibility on payment options, and give an incentive for providers to be neutral between receiving periodic charges or bonds. While some participants supported the idea of ensuring neutrality between periodic charges and bonds, and the requirement that all accommodation charges be published, others expressed concerns about how such an approach might work in practice (box 7. 4).

**Box 7.4 Participants' view on accommodation charges and bond equivalents**

**Aegis Aged Care Group:**

We agree with the Commission's view that the accommodation charge should be determined by the Provider based on the commensurate cost of the accommodation supplied. ... both the Accommodation charge and an equivalent accommodation bond should be set by the Facility and advertised. (sub. DR564, p. 2)

**Baptcare:**

A risk premium for RAC residents who are charged a bond, instead of an accommodation charge, will be required to ensure the bond covers the cost of accommodation. The two risks that would need to be priced into the risk premium would be the cost of uncertainty associated with the resident's length of stay and fluctuations in interest rates over that period. (sub. DR689, p. 2)

**DoHA:**

The Commission's proposal that residents have the choice to pay an accommodation charge through a periodic rather than a lump sum payment is already part of the current accommodation bond arrangements for low care. Even with such a requirement, there is a risk that care recipients who choose to make a periodic payment may be less 'attractive' to providers and face additional difficulties in negotiating access to care. (sub. DR694, p. 6)

A number of participants called for a 'formula' for calculating the periodic and bond equivalent amounts. Aged & Community Services Australia, for example, said:

Agreement on what is taken into account in determining the cost of accommodation is critical for ensuring payments actually cover the building and ongoing costs of providing residential care. Determining the cost of accommodation should be tied to key construction principles and associated costs. At a broad level ACSA asserts that these principles and the broad cost headings would, as a minimum, include land, construction, financing and a margin for the associated risk given an increasingly

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competitive market place. ... The final report should include these principle level categories for setting the cost of accommodation to guide development and support implementation (sub. DR730, p. 7)

The Commission is deliberately not being overly prescriptive about ‘how’ the periodic payments and bond equivalents should be calculated, rather, allowing providers to flexibly adapt the inputs to reflect their circumstances. The importance of flexibility, as noted by Aged & Community Services Australia, was also stressed by other participants. Catholic Health Australia, for example, said:

CHA supports the removal of the current regulatory restrictions on accommodation payments to allow consumers the choice of a rental or bond payment, subject to providers offering consumers an accommodation bond that is equivalent to, but not more than, ‘the cost of supply’. CHA’s support for this approach is conditional on the ‘cost of supply’ being determined by each provider based on local market conditions and building and room amenity. (sub. DR748, p. 8)

However, flexibility is desirable only to the degree that it does not subvert the objective of the equivalent payment options.

Some aged care providers raised concerns about the requirement to offer a periodic payment leading to a shift by care recipients away from paying bonds. One suggestion was that pensioners would sell their houses, place the full proceeds into the proposed Australian Government Pensioners Bond (now called the Australian Age Pensioners Savings Account, see below) and then pay the periodic payment from the Pensioners Bond (COTA, sub. 565). Others argued that as they rely on bonds to fund the construction of facilities, reduced bond amounts and reduced numbers of people paying bonds will significantly increase their risk profile. DoHA, for example, said:

Given that mismatches between the refunding and receipt of accommodation bonds can give rise to cash-flow and liquidity problems, there are potentially significant risks here. (sub. DR694, p. 5)

Cook Care Group also said:

Low Care or Extra service High Care are at most risk as they have an existing Bond Pool which is in danger of being depleted if bureaucratic interference rather than market forces and public choice are the determinants. They should not be exposed to having a depletion in the Bond Pool as this will activate a call on additional equity by financiers and many providers may not have this as all their assets are already secured by the banks. A call on equity would place the Bond Pool at risk as Bonds going out are not able to be replaced to retain the debt level. Some providers might fail and this is unfair as these providers are the ones whom have invested in new stock under the existing system. (sub. DR850, p. 1)

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In the short term, some providers may have to borrow to fund the payout of existing bonds, but this is a transitional issue as the Commission's proposed approach reduces the overall risk to providers by enabling an adequate return in all segments of the market (whereas currently providers argue that the returns on high care places are inadequate).

One option is to provide transitional assistance to help providers to reduce their reliance on bonds relative to periodic payments during the implementation period. This acknowledges that it may take some time for the commercial lending market to gain confidence in the sector being able to make a reasonable rate of return in all segments of the market (and therefore be able to service and repay borrowings). A proposal is discussed in chapter 17.

Some participants expressed concern about abolishing retention amounts, arguing that it would result in an escalation of current bond amounts as providers seek to compensate for a lost income stream. As Sir Moses Montefiore Jewish Home said:

At the current permissible retention of around \$3700 per annum and assuming a market interest rate of, say 6%, a provider would need to increase the bond amount by \$61 000 in order to recover the lost income. ... there is a compelling argument to suggest that the older person should have the right to pay retention of the amount they choose in order to offset the upfront cost. ... By denying the older person the option to pay retention, the system is effectively protecting the inheritance of the older person's beneficiaries at the detriment to the older person themselves. (sub. DR512, p. 1)

Village Baxter also said:

... we consider that a provider should be able to have retentions from a bond balance as a part of their contract with the consumer. We do not believe that this will lead to unfair contracts as consumers are empowered to move to alternative suppliers for their needs. The benefit of having a retention scheme for a bond is that it will enable providers to adopt creative approaches to the setting of bonds and should result in a lower bond being charged. (sub. DR 852, p. 3)

Provided that any retention amounts are linked to the published charge and bond amount, and care recipients are fully informed about the payment options, the Commission considers that such flexibility in payment options could be allowed. The objective is not to dampen innovation in payment options (it is important that providers can respond to the preferences of care recipients), but rather to have transparent pricing arrangements in place whereby the market value of accommodation is reflected in the accommodation charge.

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*Removing disincentives that make pensioners reluctant to move to more appropriate accommodation*

With accommodation bonds reflecting the market value of the accommodation, rather than their ability to pay, some age pensioners selling their homes to go into residential care or a retirement village could find themselves with surplus funds that would not be exempt from the Age Pension assets test (so they could lose part or all of their pension). This already acts as a significant disincentive for older people to move to more ‘appropriate’ accommodation for their care needs. The introduction of periodic accommodation charges in residential care, and bonds which more closely align to the value of the accommodation will add further to this disincentive. As Australian Unity argued:

According to current Centrelink arrangements, retirees moving into a retirement village are penalised for selling their existing house to move into a retirement village, since the equity released from the family home is added to their assets and decreases their pension amount. This has led to a tendency among pensioners to ‘arrange’ their finances in such a way that they can retain assets/income to pass on and maximise the pension.

The government should, in fact, be rewarding pensioners to better use their own income to maintain their own health and wellbeing, where it is possible for them to do so. (sub. 459, p. 1)

Chapter 12 discusses the broader welfare and health benefits from living in age appropriate accommodation. There can also be savings made from the delivery of care in congregate and age-friendly accommodation. There are sound public policy reasons, therefore, to remove such disincentives.

A number of submissions proposed schemes to increase the mobility of older Australians by exempting certain investments from the Age Pension assets test. For example, Australian Unity (sub. 265 and 459) proposed the introduction of a ‘Seniors Living Scheme’ to facilitate the downsizing from the family home to more appropriate seniors housing. The Financial Planning Association of Australia (sub. 376) proposed that there should be an exemption for all lifetime annuities from the Age Pension assets test.

One option, favoured by the Commission, is to establish a pensioners savings scheme, provided or backed by the Government, that would be available for age pensioners selling their homes. Under this arrangement any surplus funds from the sale of the home could be invested in the Government scheme. It would offer an alternative (or supplement) to an accommodation bond and be exempt from the Age Pension assets test. Older Australians using this facility could draw upon it to fund their day-to-day living expenses, their aged care costs or any other expenses. The scheme would be free of entry, exit and management fees. The Government could

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guarantee the capital and maintain its real value through indexation at the consumer price index (CPI) rate to make it more attractive than an accommodation bond which does not pay interest. However, further deposits to the savings scheme — beyond those realised from the sale of the principal residence — should not be permitted to ensure that the exemption from the Age Pension assets test is quarantined to the presently exempt principal residence.

The Government could directly provide the product, or contract the private sector to do so. But if the latter, the liability should stand on the Government's balance sheet. The savings scheme would only be available to age pensioners who wished to sell their own home. Many participants supported the idea of such a scheme (titled a Pensioners Bond Scheme in the draft report). COTA, for example, said:

The proposal that if you sell your house the money left over after the loan can go into an indexed government deposit and be exempt from the pension income and assets tests should be very welcome. It will significantly assist many people to pay for care and accommodation. (sub. DR565, p. 11)

Australian Unity suggested that it would boost interest in the retirement sector:

I think the pensioner bond scheme will really help to increase interest in the retirement sector. One of the most common reasons that people who are part-pensioners face is actually 50 to 300 thousand dollars, the general difference in price between their home and the unit that they purchase, so that can have a significant impact on their pension. (trans. p. 9)

Some questions, however, were raised about the adequacy of the CPI rate as the interest rate applied. For example, National Seniors Association argued the need for a positive rate of return on investment and suggested the long term Treasury bond rate on the basis that:

First, over the long-term, wealth invested in housing or other asset classes would be expected to achieve a real, positive rate of return, that is, a return above the rate of inflation (CPI). Without this prospect, many older people would be reluctant to sell their home and invest the proceeds in the Bond, even if otherwise this would be a sensible course of action to fund their expenses as they age.

Second, ... Government subsidies and the life-time stoploss limit on care costs will all rise over time. ... It is highly likely that such prices and costs would rise faster than the Consumer Price Index, quickly eroding the purchasing power of the capital invested in the Bond. This scenario makes it imperative that the Bond scheme deliver some measure of growth for consumers. (sub. DR832, p. 21)

The Commission considers the CPI to be the appropriate rate because of the significant advantage of funds under the associated scheme being exempt from the Age Pension assets and income tests (recognising the benefit to pensioners of retaining the Age Pension and associated benefits). Older Australians would

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continue to have the option of investing their funds elsewhere and earning the commercial rates available in the market.

Because of some confusion around the term ‘bond’, the Commission proposes that the scheme be retitled the **Australian Age Pensioners Savings Account** scheme. In implementing the proposed scheme, the Government should consider any necessary compliance measures to ensure that the scheme is used as it is intended and not abused. The Commission also suggests that the scheme should be kept as a Government-backed scheme (with private providers under contract) rather than allowing the private sector to offer competing products with an assets test exemption.

Introducing such a scheme that is exempt from the Age Pension means test, in conjunction with the Commission’s other proposals, will change the dynamics of the age care market including incentives for paying large accommodation bonds for three reasons:

- the market power of providers will be reduced with the freeing up of supply
- residents will not be able to avoid assessed care co-contributions by paying large bonds
- the Australian Age Pensioners Savings Account will be more attractive than an accommodation bond as it will maintain its real value over time.

Providers may seek to exploit the continuing exemption of accommodation bonds from the Age Pension assets test and the government guarantee on accommodation bonds in response to the new competition from the Savings Account. One response might be to pay interest on accommodation bonds, which would still be a more attractive form of debt to providers than bank debt. However, as the Government is providing considerable concessions to providers by allowing the assets test exemption and providing the guarantee, it should not allow providers to pay interest on accommodation bonds.

### **What about accommodation costs for short-term stays?**

A further issue is the approach to charging for accommodation for shorter stay transitional residents such as those using facilities for residential respite, transitional care, reablement, rehabilitation and sub-acute care. Typically individuals requiring care in such facilities also continue to pay for the cost of their principal residence and this provides a rationale for not requiring them to pay the full cost of the extra accommodation. This point was recently made in an OECD paper:

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Higher user charges for the cost of B&L [board and lodgings] in a nursing home contrast with the significantly lower charges paid for the accommodation in hospitals or other short-stay acute care settings. The main rationale for the difference in cost treatment lies in the notion of what is considered as a principal residence. Typically, for those receiving care on a temporary basis, either in hospital or in a nursing home, one's principal residence continues to be the house or apartment. (Colombo et al. 2011, p. 273)

For those services more closely aligned to health care, the costs of accommodation could be included in a total care package of costs that are largely publicly funded — drawing on the policy adopted for acute care in public hospitals. For residential respite, daily or weekly subsidised accommodation charges could apply.

### **What about those people who can't pay for their accommodation?**

One of the objectives of the *Aged Care Act 1997* (the Act) is to facilitate access of older Australians to residential aged care where they do not have the financial capacity to meet accommodation costs (box 2.1). To meet this objective, the Australian Government has obliged residential aged care facilities to meet a supported resident ratio and pays accommodation supplements to approved providers for eligible residents.

An assets test is used to determine eligibility for a supported resident.<sup>4</sup> A sliding scale of accommodation charges applies as the level of assets increase. Hardship provisions are also available for care recipients (DoHA 2010n).

Facilities are expected to meet regional targets (set by DoHA) for places for supported residents. The targets range from 16 per cent to 40 per cent and are calculated using the Socio-Economic Indexes for Areas. The amount of the accommodation supplement paid for a supported resident depends on:

- the level of the resident's assets
- whether or not the service meets fire and safety requirements
- the proportion of supported residents in the facility.

Facilities with more than 40 per cent of supported residents receive the full rate of the accommodation supplement. Facilities with 40 per cent or less of supported residents receive only 75 per cent of the accommodation supplement.

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<sup>4</sup> There are also some grandfathered categories: concessional and assisted residents. For the purposes of this inquiry, these are treated generically as 'supported' residents (see DoHA 2010n).

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Many facilities with extra service status are exempted from the supported resident ratio requirement (extra service status is only granted if the arrangement will not affect the access of supported residents to residential accommodation in their region). However, the ratio does apply to the non-extra service places in a service where the extra service is a distinct part of the overall facility. In 2010, around 310 or 8 per cent of all Residential Aged Care Facilities (RACF) provided extra service places.

In 2009-10, \$515.4 million was paid to providers as accommodation supplements for residents who were unable to meet the full cost of their accommodation. At June 2010, accommodation supplements were provided to 63 218 supported residents (including concessional and assisted residents). This equates to around 39 per cent of residents receiving supplements for accommodation costs (DoHA 2010n).

### *Participants raised concerns about supported residents*

Some participants raised concerns about services being maintained in areas of high socio-economic disadvantage if planning ratios and bed licences were phased out. For example, Mercy Health said:

The deregulation of bed licences, and the removal of the socio-demographic allocation model, is likely to lead to an increase in the number of beds provided in areas of relative affluence, to the detriment of lower socio-economic areas. (sub. 215, p. 10)

A number of participants were also critical of the current mandatory requirements and the structure of the accommodation supplements. Aged Care Association Australia SA, for example, said:

The claimed intention of this policy is to ensure equity of access for supported residents, however the policy unfairly penalises facilities which cannot meet the ratio target, and works perversely to restrict access to different potential residents in different situations. (sub. 309, p. 5)

Melbourne Citymission stated:

We are regularly moving backward and forwards across this 41% threshold level, at times achieving only 38% to 40.7%. In these situations, the Supplement rate that we currently receive is only \$12.31 per day rather than the \$18.82 full rate. This represents a 35% penalty. For Melbourne Citymission, the annualized impact of this penalty is \$42,000. (sub. 173, p. 22)

The requirement to have more than 40 per cent supported residents in a facility to access the full rate of the accommodation supplement means that the payment is based (to some extent) on the proportion of supported residents rather than the cost

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of supplying the accommodation. The significance of the 25 per cent discount is also likely to distort providers' decisions about supported residents. As Hogan said:

For many providers there must be a selection bias favouring concessional and assisted residents because the incremental cost of not having at least 40 per cent of residents in those two categories is so drastic. ... This means the principle of equality of access for all those seeking entry to aged care facilities is set aside. Subject to the expectations of death occurring in the resident population, the likelihood is for management to aim for a ratio of at least 43 per cent in the larger RACFs having more than 60 beds and obviously higher in the ones with fewer residents because the cost of dropping below the 40 per cent ratio is so dire. A fundamental strategic need in the immediate years ahead is for full funding of the concessional and assisted residents so the 40 per cent requirement may be abolished. (2004b, p. 14)

### *The Commission's proposals for supported residents*

The supported resident payment should be a clearly defined payment for accommodation and the payment should be sufficient to meet the full cost of providing an approved basic standard of accommodation (so that providers are prepared to offer places to supported residents without a minimum supported resident ratio requirement). If the payment is set at a level to meet the costs of supply, providers would not need to rely on cross-subsidies in order to provide supported resident accommodation.

Accordingly, the Commission proposes that the proposed Australian Aged Care Commission (AACC), on a periodic basis, make transparent recommendations to the Australian Government on the subsidy rate for an approved basic standard of residential care accommodation covering supported residents on a regional basis (or subregional basis where there are significant cost variations within regions). The subsidy would also need to be adjusted over time based on independent evidence about the cost of supply including an appropriate allowance for regional differences.

In the draft report, the Commission proposed that the accommodation subsidy for a supported resident could be based on the cost of a two-bed room with a shared ensuite. This proposal was rejected by many participants. Many providers argued that it was less than the current building certification standard for new residential facilities. Also, that it was a lower standard than that being provided in new developments in response to expectations by care recipients and their families. The South Australian Government, for example, said:

Most adults do not share accommodation with people who are not family, let alone bedrooms and bathrooms. ... Dignity, respect and privacy, as well as, health, safety and infection control etc are significant for all residents irrespective of their ability to pay and should be recognised. Basic standard accommodation should be set to meet

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community standards on the basis of single rooms with bathrooms to ensure older people maintain as much as a ‘normal’ life as they age. (sub. DR847, p. 12)

Catholic Health Australia also argued that single rooms are more appropriate given the higher and more complex care needs of residents:

The rising prevalence of dementia, the increasing proportion of residents with higher levels of acuity and complex care needs (which is expected to continue if people are given the chance to receive care in their own homes) and the requirements of sensitively providing palliative and end of life care, are also driving an accommodation standard which allows care to be delivered with greater privacy and dignity. With regard to dementia care and other forms of care, there are also behaviour management and clinical reasons for single room accommodation. (sub. DR748, p. 10)

Other participants recognised that there can be advantages for residents from shared room arrangements (such as social connectedness) as well as for taxpayers. The Returned & Services League of Australia Ltd, for example, said:

Placing every resident ... in single rooms would place financial pressures on government, and thus taxpayers, and has the potential to impact on the sustainability or viability of the aged care system into the future. It can also be argued that in today’s society those with limited finances are generally accommodated in less lavish surroundings, thus having tiered levels in aged care facilities reflecting circumstances in the general community. ... By setting the Government contributions at the level of a two bed room, accommodation options could potentially be limited for those who are financially disadvantaged. (sub. DR705, p. 3)

A significant proportion of people in high level care are not well placed to benefit from a single room with dedicated ensuite. A high proportion of high level care recipients are incontinent or require assistance with toileting and showering. For assisted toileting and showering a large bathroom, that can facilitate a wheelchair, is generally more appropriate than an ensuite. While families can feel better about relatives being in single ensuite rooms, as noted by a number of providers and care staff, this is not always in the best interest of the person receiving the care.

There is no right or wrong answer to the question of what standard of accommodation the subsidy for supported residents should cover. What is relevant for policy is striking an appropriate balance between the needs of people who are unable to pay for their accommodation, community views about ‘acceptable’ standards of accommodation and the burden on taxpayers. The standards established for new aged care facilities give some indication of community views about what is considered an appropriate standard of accommodation.

As outlined in chapter 12, all new buildings constructed since July 1999 are required to have on average (for the whole aged care facility) no more than 1.5 residents per room and no room is to accommodate more than two residents. There

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is also a mandatory standard of no more than three residents per toilet, including those off common areas, and no more than four residents per shower or bath. Aged care facilities constructed prior to July 1999 are required to have no more than four residents accommodated in any room, no more than six residents sharing each toilet and no more than seven residents sharing each shower or bath.

In the draft report, the Commission sought views on whether the level of accommodation payment for supported residents should vary according to the age of the facility. A number of participants (see, for example, the Combined Pensioners & Superannuants Association, sub. DR760) were not in favour of this proposition. Catholic Health Australia, while agreeing with the proposed variation in the supported resident accommodation subsidy in principle, also said it:

... does not consider that the age of the building should be the measure used as age is not necessarily correlated with amenity, including privacy and dignity. (sub. DR748, p. 11)

The Commission acknowledges that accommodation that fails to meet the July 1999 standard of accommodation could be provided at a lower cost but that this assumption may not always hold true. For example, some buildings constructed prior to the new standards may have had extensive renovations but cannot be modified to meet the new standard. In such cases, providers should be able to make a case for the higher subsidy rate to the proposed AACC based on evidence about the costs of providing the accommodation.

Overall, the Commission proposes that the subsidy for supported residents accommodation be based on the 1999 accommodation standard of 1.5 beds per room. The Commission also proposes that accommodation payments based on care needs (such as for people requiring end-of-life care, those with challenging behaviours or those arising from social disadvantage) be subsidised via care entitlements (as well as block funding in some circumstances).

#### *A better targeted supported resident payment?*

Access to either a full or partial supported resident accommodation supplement is — and should continue to be — subject to means testing. The burden on taxpayers of a higher subsidy for supported residents could be lessened by tightening the eligibility criteria for supported residents. A tightening of these criteria would also be consistent with the principle that individuals who can afford to pay for their accommodation should meet these costs (chapter 6).

Currently, the assets test for a supported resident includes their former principal residence. However, the resident's former principal residence is not counted as an

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asset if, at the time of the assets assessment or the date of entry into care (whichever is earlier):

- a partner or dependent child is living there
- a carer eligible for an income support payment has lived there for at least two years
- a close relative who is eligible for an income support payment has lived there for at least five years (DoHA 2011h).

These exemptions ensure that these ‘protected persons’ are able to remain living in the resident’s home.

The exclusion of the principal residence from the assets test for the supported resident payment (under the above conditions) is inconsistent with the Commission’s principle that care recipients with the financial means to do so should pay for their accommodation. The ‘protected person’ exclusion also has equity implications. Two people of equal means could receive different levels of taxpayer-funded accommodation support depending on whether or not a ‘protected person’ remains in the resident’s (former) principal residence. To better target the assets test and align the current arrangements with the Commission’s funding principles (chapter 6), the Commission proposes that a resident’s share of the value of their principal residence be included in the total assets test. Accordingly, the exclusion of the principal residence from the total assets test where a ‘protected person’ remains in the principal residence should also be abolished.

To achieve the important objective of allowing an existing ‘protected person’ to continue to remain in the principal residence, the Commission is proposing that there would be guaranteed access to its proposed Government-backed Australian Aged Care Home Credit scheme (AACHCS) and the existing option of deferred payments (chapter 8).

DoHA was approached for data on the number of people currently qualifying as supported residents on the basis that a ‘protected person’ was living in their former principal residence. Unfortunately, that data is not collected. Instead, DoHA suggested that an approximation could be made by examining ACAT records for people who had been assessed between 1 July 2007 and 29 October 2010 and who subsequently took up an intensive aged care place (which could have been in either residential or community care). These data suggest (if each person were equally likely to enter residential care) that:

- around 30 per cent of supported residents would be assessed as a home owner with a ‘protected person’ living in their former principal residence (and

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consequently the person's former principal residence is not counted as an asset in the total assets test)

- 25 per cent would be assessed as a home owner who did not have a 'protected person' living in their former principal residence
- 45 per cent would be assessed as a non-home owner.

The limited data on the value of assets (ABS Household Expenditure Surveys (HES), used in Bradbury (2010), the Survey of Income and Housing, and the Household, Income and Labour Dynamics in Australia Survey (HILDA)) point to the significant capacity of some older people to contribute, in part, to the costs of aged care, as well as to the growing wealth of those aged 85 years and over. But, as noted in chapter 3 and appendix E, these data are at best indicative for older people due to the small sample size.

Tightening the criteria for the supported resident status as discussed above would reduce the cost to taxpayers. Such savings may provide scope to change the current total assets test thresholds (a minimum of \$39 000, tapering out at \$102 544 as of March 2011). Alternatively, these savings could be directed elsewhere.

Because the Commission was unable to obtain current and robust data on the value of the principal residence, it was unable to draw any conclusions about the implications of applying different assets test thresholds. The Commission proposes that the Australian Government undertake further research and modelling to consider the scope to amend the thresholds in the current total assets test for supported resident accommodation payments.

Abolishing the exemption of the principal residence from the asset test as a result of the presence of a 'protected person' is likely to have some flow-on effects for the proportion of supported residents in each region. The Commission suggests that the Government review the supported resident ratio in each region to ensure they reflect the level of need for such places. Chapter 9 discusses the use of Medicare Locals or Local Hospital Networks as the basis for determining the regional distribution of the offices of the Australian Seniors Gateway Agency (the Gateway). The Commission is proposing that the calculation of the regional supported resident ratio be aligned with the region used for the Gateway. However, in some cases, a subregion may be a more appropriate geographical area because of heterogeneity in asset prices in a region.

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*Are mandatory requirements still needed?*

A subsidy that reflected the full cost to providers of offering accommodation for supported residents should mean that providers would be prepared to offer sufficient accommodation and, therefore, the supported resident ratio obligation could be abolished (as recognised by Hogan 2004b). But some participants expressed concerns about whether existing social inclusion objectives underlying the ratio obligation could be met in its absence. DoHA, for example, said:

Clearly, an important element underpinning the Commission's reform proposal is that the changes will engender a positive response from the market, with competition leading to greater consumer choice and efficient pricing. However, as the Commission acknowledges, some areas of market failure are inevitable. Further consideration could be given to how to address these issues. ... In particular it is worth noting that almost 40 per cent of aged care services, representing more than 30 per cent of places, are located in such areas, which is a significant achievement noting that these areas account for around a third of aged care services. (sub. DR694, p. 5)

To maintain aged care places for the financially disadvantaged and those in rural and remote areas after the planning ratios are phased out, the Commission proposes that mandatory requirements for providers to make places available for supported residents should continue — at least during the transition period. However, the supported resident supplement should be payable in full irrespective of whether a facility has 40 per cent of its places taken by supported residents, provided it has achieved the relevant regional ratio.

Where providers do not meet the supported resident ratio in their region, the Commission proposes that a sliding scale of fines be levied — the size of which would depend on the severity of the non-compliance. (That is, financial penalties would become progressively larger the greater the shortfall against the required ratio.) This arrangement is consistent with the proportionality principle (chapter 15) and would mean that the current arrangements (which discounts the full subsidy by 25 per cent when a supported resident ratio of 40 per cent is not met) would become redundant.

Some participants supported the removal of the exemption for extra service providers in meeting the supported resident obligation. For example, ECH, Eldercare and Resthaven said:

Provided lead times are adequate, and in view of the proposed uncapping of prices and supply, there should be no reason why existing Extra Service providers should not be subject to the same requirements as all other providers in relation to the care of Supported Residents (say after 5-10 years). (sub. DR616, p. 4)

Others, however, were of a different view. For example, Advantaged Care said:

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Whilst the removal of [extra service] status is identified it is imperative that existing extra service places remain exempt going forth from the concessional ratio requirements, otherwise these facilities may become retrospect[ively] fully unfeasible. (sub. DR780, p. 2)

The Commission proposes that with the removal of the extra service status provision that the current supported resident ratio obligation exemption available to such extra service facilities (or parts of facilities) also be phased out and be part of a negotiated settlement (chapter 17).

*Should the supported resident ratio obligation be tradeable within regions?*

To improve the scope for providers to tailor services to different client groups, the Commission proposed in the draft report that facilities should be able to trade their supported resident ratio obligation with others in the same region so that facilities could provide more or fewer supported resident places in line with their preferred service model approach. To support these arrangements, the Commission also proposed that the AACC would approve all proposed trades and administer any related regulations and compliance with these quotas.

A number of participants expressed concern about this proposal. A common concern was that it would result in ‘ghettos’ developing. Benetas, for example, said:

... we have some concerns about this in terms of the possibility of setting up ghettos within regions — if they were tradeable — and particularly in large regions where trades are made. All of a sudden there’s only a few facilities left with a large number of supported residents. (trans. p. 14)

In the context of quota trading arrangement, the size of a region would matter. Supported residents should not be required to move unreasonably large distances in order to access a place. On the other hand, moving voluntarily to be closer to family should not be precluded. Accordingly, this is one consideration that the proposed AACC could consider in determining whether or not to approve a proposed trade between providers. Medicare Australia suggested a register of supported residents could be established that was ‘user friendly for providers and flexible enough to allow for possible future policy changes’ (sub. DR804, p. 10).

Catholic Health Australia (sub. DR748) also raised questions about the practicality of tradeable quota obligations, particularly if the quota policy was to be subject to review within a five year period. Having considered the issues raised, the Commission proposes that during the first stage of the five year transition period, the Australian Government should introduce a pilot scheme whereby providers could transfer up to 50 per cent of their obligation per facility with other providers within the same region. A review during the second stage of the transition period

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would assess the performance of the pilot scheme and the desirability of applying a trading regime more generally (chapter 17).

For the pilot quota trading arrangement to work, it would need to enable the proposed AACC to:

- authorise and register the trading of supported resident ratio obligations within a region
- develop a system of tracking and verification to ensure the required number of supported resident places in each region was continuously being met.

An alternative approach would be to incorporate supported resident accommodation places in particular regions into a competitive tendering system with bids sought on the amount of government subsidy needed for capital and operating costs to provide a service. Such an approach was suggested by Cam Ansell and Jim Toohey:

Abolish the provisions relating to mandatory requirements of places to financially disadvantaged persons in favour of a Commonwealth tender processes (externally managed by organisations experienced in government tenders) for the provision of a required numbers of places within existing or new facilities for a period of time consistent with economic viability. Tenders should be assessed on the basis of economic efficiency and the standard of care and accommodation guaranteed for residents. (sub. 464, p. 8)

Under this approach, the market would determine the value of the subsidy, which would eliminate the need for an independent body to determine the appropriate value of the subsidy by region. But many participants raised concerns about competitive tendering for supported residents (for example, COTA Australia, sub. DR565; Mercy Health Aged Care Services Brisbane, sub. DR788; NSA Knox Branch, sub. DR580; UnitingCare Australia, sub. DR788). Practical considerations such as what would happen to those people who became eligible for supported resident status if they were in a facilities that had not bid for supported resident places were raised.

The option of competitive tendering to cover the ongoing provision of accommodation to supported residents could be considered at the time of the proposed five year review. The Commission's study *The Contribution of the Not-for-Profit Sector* (PC 2010b, chapter 12) provides guidance on appropriate issues that should be considered by the Government when contracting services.

*Should the supported resident subsidy be provided to individuals or providers?*

Currently, the supported resident supplement is paid directly to providers and the Commission proposes that this arrangement would continue, at least during the

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transition phase. However, similar to other Australian Government entitlements made to individuals (including those proposed in this report), it is reasonable to consider the costs and benefits of paying the supported resident accommodation subsidy directly to individuals.

The Commission considers that the pros and cons of paying the supported resident subsidy to individuals as part of their entitlement, rather than directly to providers, should be reviewed during the transition period (chapter 17).

RECOMMENDATION 7.1

***The Australian Government should remove regulatory restrictions on the number of community care packages and residential bed licences. It should also remove the distinction between residential high care and low care places.***

RECOMMENDATION 7.2

***The Australian Government should remove regulatory restrictions on accommodation payments, including the cap on accommodation charges in high care. It should also abolish the charging of regulated retention amounts on accommodation bonds. The Government should mandate that residential aged care providers:***

- ***offer and publish periodic accommodation charges***
- ***where offered, publish accommodation bonds and any combinations of periodic charges and bonds.***

***The Australian Government should require that, when a provider offers an accommodation bond, the bond does not exceed the equivalent of the relevant periodic accommodation charge. The paying of interest on accommodation bonds should be prohibited.***

RECOMMENDATION 7.3

***The Australian Government should establish an Australian Age Pensioners Savings Account scheme to allow recipients of the age and service-related pensions to establish an account with the Government (or its agent) with some or all of the proceeds of the sale of their principal residence.***

- ***The account would be exempt from both the Age Pension assets and income tests and would pay interest equal to the prevailing consumer price index to maintain its real value. All accounts would be free of entry, exit and management fees.***

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- *Apart from the proceeds from the sale of a principal residence (including the sale of any subsequent principal residences), no other amounts should be able to be deposited into the account.*
  - *Account holders would be able to flexibly draw upon the balance in the account.*

RECOMMENDATION 7.4

*The Australian Government should charge residential providers a fee to reflect the costs of providing the Government guarantee on accommodation bonds.*

RECOMMENDATION 7.5

*To ensure sufficient provision of the approved basic standard of residential aged care accommodation for those with limited financial means, providers should continue to be obliged to make available a proportion of their accommodation to supported residents. The Australian Government should set the level of the obligation on a regional basis.*

*Where providers do not meet the supported resident ratio obligation in their region, a sliding scale of penalties should be levied, where the size of the penalty would depend on the severity of the non-compliance. The current pricing arrangements (which apply a 25 per cent discount to the full rate of the accommodation supplement when facilities do not have more than 40 per cent supported residents) should be abolished.*

RECOMMENDATION 7.6

*For supported residents, the Australian Government should set a subsidy level for the approved basic accommodation standard of residential care which reflects the average cost of providing such accommodation. The subsidy should be set regionally and on the basis of the July 1999 building standard (an average of 1.5 beds per room). A lower subsidy level should be paid to those facilities which do not meet the July 1999 building standard. The Australian Aged Care Commission should be empowered to consider exceptional circumstances for those facilities which do not meet the July 1999 building standard and make an appropriate recommendation to the Australian Government to increase the level of the supported resident accommodation subsidy for these facilities.*

*To better target the supported resident accommodation subsidy, the relevant share of a person's former principal residence should be included in the total assets test and the exemption of the principal residence when there is a 'protected person' remaining in the former principal residence should be abolished. To allow an existing 'protected person' to continue to remain in the former principal residence, there should be guaranteed access of the resident to the Government-backed Australian Aged Care Home Credit scheme and the existing option of deferred payments. Further research and modelling should be undertaken to consider the scope for assessing the total assets test thresholds for supported resident accommodation payments.*

## **7.2 Everyday living expenses — applying the principles**

Community aged care services can, where needed, provide some assistance with everyday living, such as food preparation and housecleaning. Residential aged care facilities provide care recipients with meals, laundry and cleaning services, either at a standard quality or 'extra service' level. All residents of aged care facilities who receive the standard service for activities of daily living pay the same fee, regardless of means, equivalent to 84 per cent of the single Age Pension.

'Extra services' or lifestyle extras (such as increased food choices, newspaper delivery, massages, etc.) attract an additional extra service daily fee. This charge reduces a provider's residential care subsidy by 25 per cent of the extra service fee they charge clients (box 7.5).

And, as discussed above, a further regulatory implication is that if a high-care resident receives extra services their provider can charge them a bond for their accommodation. Such funding arrangements can act as a disincentive to use extra services, although with constrained supply, some Australians are effectively forced to buy an extra service place because an alternative is not available.

Under the current system, no more than 15 per cent of places in each state or territory can be approved as extra services and there are caps on the maximum proportion of places that may be extra services in particular regions. Providers must also have their prices approved by DoHA and can only change the prices they charge once every twelve months.

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### Box 7.5 About extra service places

Around 310 residential aged care facilities (or 8 per cent of all residential aged care homes) provided extra service places in 2010. 83 per cent of extra service residents were high care and 17 per cent were low care residents.

To be approved for extra service status, an aged care service must offer a significantly higher standard of accommodation, food and services than the average standard in an aged care service that does not have extra service status.

The benchmarks are met by providing a list of extra service choices that providers can offer. Providers must score at least 60 out of a possible 100 points in order for the significantly higher criterion to be satisfied, and must achieve minimum scores in the three categories of accommodation, food and services. Each category allows points to be earned for innovation and special features. There is also a mandatory requirement in regard to building standards.

Extra service fees can vary for different places in an aged care facility, for example, a provider can set a higher fee for a bigger room with a private bathroom, but the average daily extra service fee across all extra service places in the facility must be more than \$10.

If a resident is occupying an extra service place, their care subsidy is reduced by 25 per cent of the approved extra service fee for that place. For example, if the extra service fee for a place is \$20 per day, the Government subsidy for a resident receiving extra service care will be reduced by 25 per cent or \$5 per day. Effectively, the extra service amount is \$25.

Sources: DoHA (2009f, 2010h).

Catholic Health Australia described extra services as:

... a flawed and unsustainable concession towards choice in a system of rationed supply. Choice should not be reserved for a minority; its delivery begets even more regulatory complexity and perverse outcomes. Funding individuals eligible for assistance under the *Aged Care Act 1997* on an entitlement basis, allowing people choice of services and who delivers them and lifting restrictions on what services providers can offer, is a much more effective model for the provision of aged care services. (sub. 217, p. 13)

Blue Care, commenting on the supply restrictions for extra services, said:

The regulation of extra services, rather than allowing supply to be determined by the market, has resulted in market imperfections with over supply in some market catchments, and deprivation in others. (sub. 254, p. 10)

Participants were generally supportive of removal of the regulatory restrictions on extra services and the retention of the 84 per cent of the single Age Pension as a minimum charge for basic daily living expenses in residential care (Aged &

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Community Care Victoria, sub. DR735, Aged & Community Services Australia, sub. DR730).

BlueCross Community and Residential Services (sub. 441) recommended that the daily care fee for pensioners remain at the current percentage of the Age Pension, but that the daily living expenses fee for non-pensioners should be uncapped and negotiated between the care recipient and facility operator. Others, such as Aegis Aged Care Group, argued that while residents should continue to pay for the daily cost of living with their pensions, or equivalent, they ‘should be allowed to pay for additional services as required without those services being classed as “extra services” in distinct facilities or distinct parts of the facility’ (sub. 206, p. 2).

Alkira Aged Care questioned the basis for the daily living expenses fee:

Presently the everyday living expenses are a set amount simply based on 84% of the aged pension. It is not based on what real costs are and it is not based on anything else except the single aged pension and not what people have a capacity to pay.... In essence there is a great deal of difficulty in containing the costs of everyday living expenses within the \$39.50 per day that is allocated. That system is not sustainable and therefore the recommendations to proceed to paying for additional services is appropriate but certainly needs to be looked at in the light of real costs. (sub. DR696, p. 3)

Stewart Brown and Co also provided some evidence to suggest that, in a residential aged care setting, everyday living expenses can differ between people at the lower end of the frailty scale and those at the higher care needs end (sub. DR842).

The Commission considers that the minimum regulated daily charge could remain for all residents (the Age Pension is designed to ensure access to an adequate basic standard of living). However, care recipients should be able to negotiate for services (type, quantity and quality) that are additional to those covered by the basic daily fee. The Commission’s proposed AACC should also assess and provide transparent advice to the Australian Government about the appropriateness (or otherwise) of charging 84 per cent of the Age Pension for basic living expenses.

In a less regulated market, aged care providers would be able to better respond to the preferences of a wider range of care recipients. Restrictions on the purchase of additional services not only means that individuals may not be able to purchase services they value but it also stifles competition in the delivery of higher quality services. The Commission recommends the removal of the extra service category so that any care recipient wanting additional everyday living services can purchase them.

*The Australian Government should remove the regulatory restrictions on supplying additional services in all residential aged care facilities, discontinue the issuing of extra service bed licences and remove the distinction between ordinary and extra service bed licences.*

## 7.3 Care costs — putting the principles into practice

### Current co-contribution arrangements

Many older Australians currently receiving care make some contribution to the cost of their personal and health care (whether in the community or in residential care), with these co-contributions dependent on means testing using income and assets tests. But, as discussed in chapter 5, one of the problems with the current arrangements is the inconsistency in co-contributions charged to older Australians using aged care services. As acknowledged by DoHA, under current arrangements:

There is [also] considerable dissonance between the approach taken to fees and means testing in the Home and Community Care Program and in the Commonwealth's packaged community care and residential care programs. (sub. 482, p. 50)

### *Co-contributions for community care*

The Australian Government and the state and territory governments have developed a draft National HACC Fees Policy (which sets out principles and explanatory notes) to provide a consistent framework for collecting fees. However, there appears to be little consistency in the application of the principles across the states and territories. For example, in Victoria care recipients are charged low level fees if their income is less than around \$33 000, while in Western Australia those with income below \$45 000 are charged the lowest level fees (table 7.4).

Scheduled fees for services also vary between the states — for example, the suggested scheduled fee for respite for someone with income above \$71 000 in Victoria is \$29.40, while in Western Australia for someone with income above \$50 000 the schedule recommends full cost recovery.

**Table 7.4 HACC income ranges and scheduled fees for selected services, Victoria and Western Australia, 2010**

	Victoria			Western Australia		
	Low	Medium	High	Level 1	Level 2	Level 3
Individual	<\$33 233	>\$33 233 <\$71 343	>\$71 343	<\$44 922	<\$44 923 <\$50 000	>\$50 001
Couple	<\$54 044	>\$54 0144 <\$95 374	>\$95 374	<\$73 047	>\$73 048 <\$80 000	>\$80 001
Domestic assistance (per hour)	\$5.30	\$13.10	\$28.40	\$8.00	\$10.00	Cost recovery
Personal care (per hour)	\$3.90	\$7.90	\$32.50	\$8.00	\$10.00	Cost recovery
Respite (per hour)	\$2.60	\$3.90	\$29.40	\$8.00	\$10.00	Cost recovery

Sources: Victorian Government, Department of Health (2010); Western Australian Government, Department of Health (2010).

Care recipients receiving several support services per week from one or more HACC providers are protected from paying excessive fees through a ‘fees cap’. In Western Australia the fee cap is \$56 per week for care recipients on the lowest income range and \$138 per week for the highest income level. HACC fees are lower than those set for Australian Government care packages (table 7.5).

**Table 7.5 Aged care services funding by funding source**

	Average public cost per recipient in 2010	Average private contribution per cent <sup>a</sup>	Average Government share per cent
Residential high care	51 550	26	74
Residential low care	20 150	53	47
EACH packages	39 250	4	96
EACH-Dementia packages	43 450	4	96
CACPs	12 700	10	90
HACC		5	95
Other Australian Government programs (for example, National Respite for Carers)	Variable	No compulsory contribution	100

<sup>a</sup> Earlier estimates provided by DoHA to the Senate Finance and Public Administration Committee Inquiry into Residential and Community Aged Care in Australia suggested that the average private contribution for community care packages was around 16 per cent for CACPs and 5 per cent for EACH and EACH-D packages.

Sources: Henry (2010); DoHA (2009h, 2010e, 2010n).

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The 2008 Community Care Census reports that the average private contribution for CACPs is around 10 per cent of the cost of supply and around 4 per cent for EACH and EACH-D packages. While the majority of care recipients paid a fee for a packaged care service, there were variations in the overall proportion paying fees across these programs:

- 89 per cent of CACP recipients
- 94 per cent of EACH recipients
- 95 per cent of EACH-D recipients.

The average fee paid overall by packaged care recipients was \$29.01 per week — \$27.86 for CACP, \$36.61 for EACH and \$36.51 for EACH-D (2010e).

Full Age Pension care recipients cannot pay more than 17.5 per cent of their income for an Australian Government-provided community care package (around 90 per cent of community care package recipients received some form of government pension or benefit in 2008) (DoHA 2010e). While some services provided through community care packages may cover everyday living expenses (for example, meals), a flat rate of 17.5 per cent of pensioners' income is unlikely to reflect the cost of providing these services (services for which it would be appropriate to charge pensioners and that would be consistent with charges in residential care). However, if the services covered by a 17.5 per cent flat rate were for personal care services, this would involve charging for a service that the income of a full-rate pensioner is not designed to cover (and full pensioners in residential care are not required to contribute to personal care costs). Personal care costs represent a high proportion of the costs of EACH and EACH-D packages.

Clients with income above the full rate of the Age Pension can be charged up to 50 per cent of that additional income for community care packages and the amount that can be charged is uncapped by the costs of care. As such, providers have an incentive to 'cherry pick' wealthier recipients of care and face weaker incentives to provide care for the least well-off. If wealthier recipients pay for more than the cost of their care, they effectively cross-subsidise lower paying recipients. This is inequitable and involves providers playing a redistributive role. The Henry Review questioned whether this was an appropriate way to ensure people with limited means can access care:

Ensuring that people with limited means can access care would be more appropriately financed through broad-based taxes, rather than through an effective tax on care users. (2010, p. 640)

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### *Co-contributions for residential care*

In residential care, the Government pays a basic care subsidy which may be augmented with supplements, such as for oxygen and enteral feeding. Residents who have sufficient income can be asked to contribute to the cost of their care through an income-tested fee. The amount of subsidy payable is reduced by the amount of the income-tested fee.

The Aged Care Funding Instrument (ACFI) is used to determine the level of assistance for both personal care and some health care costs. The ACFI divides care into three domains and each domain has three funded levels. The subsidy paid to providers is the lesser of the sum of the amounts payable in each domain (activities of daily living, behaviour supplement and complex health care supplement) and the maximum ACFI rate (currently \$172.89 per day). For example, the cost of care for a resident assessed as requiring a high level of care for activities of daily living, a low level of care in relation to the behavioural supplement, and medium level of care under the complex health care supplement would be \$137.26 per day or \$50 099.90 per year (table 7.6).

**Table 7.6 Daily ACFI rates, 1 July 2010 to 30 June 2011**

<i>Level of care</i>	<i>Activities of daily living</i>	<i>Behavioural supplement</i>	<i>Complex health care supplement</i>
Nil	\$0.00	\$0.00	\$0.00
Low	\$30.32	\$6.93	\$13.64
Medium	\$66.03	\$14.36	\$38.86
High	\$91.47	\$30.25	\$56.11

*Source:* DoHA (2010o).

Residents with total assessable income above the full pensioner rate pay an income tested fee as a contribution towards the cost of their care. While an income rather than an assets test applies, the income test deems a certain rate of return on assets depending on the type of asset. The maximum income tested fee payable is calculated as 5/12<sup>th</sup> of assessable income above the maximum income of a full single pensioner (DoHA 2010n). However, a resident's income tested fee cannot be greater than the lesser of:

- 150 per cent of the basic Age Pension
- the cost of their care as determined by the ACFI (DoHA 2009e).

The cap on charges for personal care in residential care currently provides benefits to wealthier care recipients which are not available to their high wealth counterparts receiving care in the community. Taxpayers pick up the care cost bill for care

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recipients who, given their income levels, could pay more for the care. The Henry Review recommended a consistent effective marginal tax rate for these costs of care:

For higher income ranges, ... the total effective marginal tax rate can fall. ... A more consistent approach to means testing would be to target a consistent effective marginal tax rate until these costs are covered. (2010, p. 638)

### **Is there a fairer and more efficient way of sharing the costs of care?**

Care costs need to be affordable both for people needing care and for taxpayers. Given that over the next few decades the overall cost of providing aged care is expected to grow significantly, the challenge is to design a system that balances the need to protect care recipients from the financial risks associated with requiring aged care with ensuring that expenditure on aged care is sustainable for taxpayers.

As discussed in chapter 6, on both equity and efficiency grounds, there is a case for providing some basic universal coverage for age care services (because of the close link between aged care and health care) and not exposing individuals to the high costs of extended intensive care (catastrophic costs), irrespective of their capacity to pay. But the call on taxpayer funds and the issue of fairness across generations also calls for the targeting of subsidies to those people with the highest care needs. This raises the question — how should subsidies be targeted?

#### *What should be in the basket of subsidised aged care services?*

Restricting what is in the basket of subsidised services and ‘who’ can access the services is one way of ensuring that care is directed to those with the highest need and the community gets the best value for the limited pool of taxpayers’ money. But what services should be included in the basket of subsidised services and why? As discussed in box 7.6, this question should be answered via an analysis of the costs and benefits.

That said, while often the costs to taxpayers of providing services can be estimated with some degree of certainty, the benefits (particularly in terms of the wellbeing of care recipients and carers and avoiding adverse outcomes), can be more difficult to quantify. As Grabowski, in an article on the cost-effectiveness of non-institutionalised care, said:

Although costs are typically straightforward to measure, gauging the effectiveness of long term care services is more nebulous. ... Effectiveness may include such dimensions as health and functioning, longevity, unmet needs, satisfaction with care, informal caregiver (e.g., spouse) support, life satisfaction and morale, and the degree of

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social interaction. ... Thus, even if noninstitutional services are associated with higher aggregate costs, the services may still be cost-effective because of an even greater increase in aggregate effectiveness. (2006, p. 5)

And, the benefits that are relevant in this equation are those that are additional to the benefits that would arise through private decisions (known as ‘additionality’).

### **Box 7.6 Decision rules for allocating resources**

Governments face a difficult task in deciding on what aged care needs to support and hence what services should be subsidised. This task is made more complex where the main returns to the increasing expenditure come in improved wellbeing for older people resulting in reduced costs to the government in the future. But even in this case, such savings are uncertain and this uncertainty should be taken into account.

Economists have long argued for a cost-benefit approach to such decisions. On the cost side of the ledger are the costs to taxpayers (including any deadweight loss in raising taxation revenue), while on the benefits side are the improvements in wellbeing of older people and their carers and any future savings in costs. While the costs of providing a service can be estimated with some degree of certainty, the benefits are more uncertain. They need to be measured wherever possible to reduce this uncertainty and improve the allocation of resources within the aged care budget and across the public budget.

The net benefits are highest when resources are allocated to those services that have the greatest expected return. This return depends on the:

- effectiveness of the service in reducing the future need for care (change in the probability of an adverse outcome given the service), or in improving wellbeing
- risk of an adverse outcome that will require care, or reduced wellbeing, in the absence of the service
- value of avoiding the adverse outcome, or the value of avoiding a loss in wellbeing.

As the effectiveness of the service, the risk of adverse outcomes, and the value of avoiding the adverse outcome are not common to all those needing care, screening to identify which services should be provided to a client is needed to get the best returns to aged care funding. But more broadly, governments need to decide which services should attract a subsidy and which should not. In doing this, governments need to weigh the cost to taxpayers against the benefits of including a service.

Where there is uncertainty about effectiveness, risk, or value, governments need to invest in analysis to reduce this uncertainty. This may involve trials and controlled experiments, or targeted data collection from providers and their clients. Better analysis of existing data, especially if data sets can be linked, will also improve the understanding required to ensure the system is funded at a level that maximises wellbeing.

*Sources:* Weissert, Chernew and Hirth (2003); Hubbard. (2007).

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There are some good reasons for targeting support on nursing and basic personal care needs, including that there is greater scope to crowd out private provision of domestic care services than personal care (hence the issue of ‘additionality’). Assessment of the need for domestic care is also more subjective than that for personal care and health care services (Colombo et al. 2011). In a number of OECD countries, subsidies for domestic care or practical help (IADL) are less comprehensive than those for health and personal care (ADL) and care assessment mechanisms give more weight to the inability to perform ADL than IADL.

That said, making the distinction between personal and domestic help can be difficult, especially where services are jointly provided to high-care-need users. Also, limiting the basket of services to support personal care may not enable older people with particular conditions, such as early stages of dementia, to remain living in the community as often they do not require assistance with personal care but need support with domestic care (such as assistance with shopping and financial affairs).

The risk of moral hazard and ‘free riding’ is also likely to be a bigger concern in the low-level community services (such as home maintenance and meals) than for personal care services. For example, individuals are unlikely to demand assistance with showering and toileting unless they really need it, but cleaning, household maintenance, and gardening services are generally services considered desirable (box 7.7). An effective assessment tool for determining the actual need for aged care services is one way of dealing with the moral hazard/free rider problem (chapter 9).

An additional way of dealing with this problem is to only provide an entitlement for low level community services to those care recipients who have high level needs. This would overcome concerns about people with early stage dementia who may largely require assistance with domestic activities. The OECD reports that coverage of support for some IADL activities, as in Sweden, Denmark, Germany and Luxembourg, has helped to prevent dependent people with relatively high care needs from moving to even more expensive care settings (Colombo et al. 2011).

One possible downside to this approach is that if subsidised low level care services are only available to those people with high-level needs as part of their overall service menu, this could give people an incentive to argue they have higher level needs and could crowd out informal care. A good assessment process, however, should mitigate this.

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### **Box 7.7 Moral hazard and free riding in aged care**

Any government program that provides services to people at a subsidised (or no) cost should ensure that those, and only those, who need the service receive it. In the aged care context, a free rider is someone who accesses a service that they do not need, while moral hazard arises because a person's needs may not be easily observable (asymmetric information), and the costs arising from this behaviour are not borne by the person making the choices.

Free riding raises the costs of the aged care system without commensurate benefit. Few people would accept help with personal care (showering, toileting) unless they really needed it. However, cleaning, household maintenance, and gardening services are generally desirable. Offering a substantial subsidy to anyone over the pension age could see a massive growth in demand for these subsidised services. An effective gatekeeping system that approves subsidies on the basis of need is necessary to manage free rider problems.

Effective gatekeeping requires verification of the need for the service. For home help services, gatekeeping is currently undertaken by HACC providers who allocate their fixed budgets to those they assess as having the greatest need (i.e. by queuing). Under the proposed gateway, the data provided on a person's assessment form needs to be validated to manage the risk of free riding in these low level support services.

In aged care, one concern is that people who do not really need a service will withhold information in order to access the subsidised service. For example, a person may have a need for home help, but has this service provided by family or friends, or has purchased this service on an on-going basis. As with free riding, when this happens the public cost of providing this service to the person will exceed the incremental benefit.

Moral hazard can also arise when people do not access a service despite the potential for this service to reduce their longer-term care needs. The moral hazard arises where the person aims to avoid an immediate cost to themselves (including intrinsic costs such as admitting they need care), while recognising that this is likely to result in higher costs borne largely by others later on. If people do not believe that their choice will influence their future costs of care it is not technically moral hazard, but the problem of under use of lower intensity 'preventive' services is still of concern. Moral hazard is best addressed by aligning the incentives for people to apply for a program with the net benefits of their accessing the program — giving them an incentive to fully share information on their situation and their needs. The role of the gate keeper in extracting this information will be improved if the risks arising from withholding information fall on those with the information.

*Source: Pauly (1968).*

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Many participants, however, argued the importance of encouraging people to access services that promote independence and avoid dependence which in turn would improve the sustainability of the aged care system. Silver Chain Nursing Association, for example, argued that:

The new paradigm should be based on the premise that early intervention to optimise functioning and promote healthy ageing can delay or prevent the development of further disability and reduce the subsequent need for home care and other aged care and health services. Research indicates that 70 per cent of restorative care recipients do not require ongoing support services and their quality of life is significantly enhanced as a result of receiving these services.

This new paradigm could be operationalised within a service model in which older individuals referred and assessed as eligible for funding for home care services are referred to a community restorative program prior to the care recipient being provided with 'standard' support and maintenance services if they still require it. (sub. DR796, p. 4)

The Royal District Nursing Service, Victoria also said:

Our experience working in promoting wellness and restoration with the Active Service Model (within the Health and Community Care (HACC) program in conjunction with the Victorian Department of Health, and in New Zealand as a provider of Home Based Support Services) has shown that an active service model approach can delay and indeed reverse the level of care required. Initial figures from our work with Auckland District Health Board have indicated an increase in volume of discharges from care as a result of this approach, which has led to increased client independence, and larger numbers of clients graduating to a lower level of care need. (sub. DR546, p. 2)

Clearly one of the most fundamental ways to reduce the costs of aged care and improve the wellbeing of older Australians is to help them remain independent. However, one of the criticisms of current low-level community services is that they create dependency rather than promote independence. Hence the push for more short term reablement programs.

Building the evidence on what forms of low level community services are most effective at both containing expenditure on aged care over the longer term and improving the wellbeing of care recipients and carers is crucial for securing the best value from taxpayers' money in this area.

#### *What about targeting by applying different subsidies (or co-contributions)?*

When thinking about what level of subsidy should apply to what services, it is important to balance the incentives generated by requiring people to contribute an amount for a service (when people pay for, or contribute a material amount for a

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service they are more likely to value the service and demand quality) with the benefits that the service provides. A number of participants raised the possibility of co-contributions (if set too high) being a deterrent for people to access services, which could mean that older people would not access care or seek less care than was appropriate. For example, South Eastern Migrant Resource Centre said:

When costs are prohibitive for those at the disadvantaged end of the care spectrum, there is a delayed drain on the public health system. Problems that could be dealt with earlier and less expensively develop into more costly and drastic health difficulties. (sub. 126, p. 3)

Australian Meals on Wheels also said:

If our meal price to clients rises to a level where clients cut their spending and reduce the number of meals they need to sustain their nutrition requirements, their health will be compromised and the likelihood of requiring higher and more expensive hospital care is inevitable. (sub. 209, p. 1)

This reinforces the need for the design of any targeting or co-contribution regime to take into account the variability of the capacity of older people to pay. But, there is also a trade-off to be made between targeting and the complexity of the regime. The more steps there are in a co-contribution scale the better the targeting and equity of the regime. The fewer the steps in a co-contribution scale the easier it is to apply and the easier it is for people to understand.

The level of co-contribution could also be varied for different types of services. One option is to vary the subsidy according to how close the service is to health care. To be consistent with the principles set up in chapter 6, health services provided as part of aged care should attract the same subsidy in aged care as they do in health care. This approach could see a lower subsidy (higher co-contribution) for basic support (such as transport and home maintenance), a higher subsidy for personal care, with the highest subsidy for the health care component of aged care (nursing, palliative care). Under such an approach, the total number of subsidies available would depend on the specified service types and the number of levels in the capacity to pay test. For example, if there were three levels in each, there would be 9 levels of co-contribution to be administered. There is a trade-off to be made between fine tuning incentives (by having different levels of subsidies by service type and avoiding cost shifting between aged care and health care) and complexity.

Another option is to exempt some services, such as restorative programs, from co-contributions. A number of OECD countries (including Canada and the United Kingdom) have recently moved to providing some short term home-care services free of charge. For example, the United Kingdom recently announced that reablement would be free for everyone who could benefit from it when they need

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home care for the first time on the basis that it was a way to keep people independent and well for longer (HM Government, 2010, p. 95).

Based on the evidence on reablement programs (see chapters 6 and 9), the Commission considers that in addition to health and personal care services and low level community support services for high level care recipients, the aged care service basket should include an intensive reablement program and such a program should be highly subsidised, if not free of charge (see chapter 9 for further details).

### *What test for capacity to contribute to care costs?*

On both equity and fiscal sustainability grounds, co-contributions for aged care should be linked to a person's financial capacity to contribute to the cost of their care, with a greater contribution from those better able to pay.

A person's capacity to pay is shaped by their income and wealth and the majority of older Australians' wealth is held in their home (box 7.8).

As discussed earlier in the chapter, the means test for the Age Pension includes an assets test which excludes the value of the owner-occupied home or an accommodation bond. The question is whether the pension assets test is the appropriate test for subsidised aged care services. The Henry Review argued that:

... charges for the costs of care should be set so they do not harm income adequacy in retirement and are consistent with pension means testing. ... Following the approach in the income support system, means testing should not be designed to force the drawdown of assets, but instead target the income from assets. (2010, p. 637)

The aim of the Age Pension assets test is to assess individuals' (potential) income from their assets and is designed so as not to erode the value of people's assets. When becoming eligible for an Age Pension, most people can look forward to another 15 to 20 years of independent living with no need for aged care services, so allowing people to retain their home and income earning assets makes sense. But, as people move towards the end of their lives (typically the time they require aged care) the logic of excluding particular assets (the home and accommodation bonds) from tests for public subsidies weakens considerably. A different approach to subsidising care and support for people who are disabled can also be justified on the grounds that people who acquire a disability often have had no or less opportunity to accumulate wealth to meet their costs of care (particularly if a disability is acquired early in life). Older people, on the other hand, in many cases will have accumulated assets over their lifetime.

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In principle, people in the same financial position, but different combinations of income and assets, should be treated the same way. But, as discussed earlier, the Age Pension income and assets tests are already in place (and not the subject of this inquiry), so from a pragmatic perspective, moving to a more comprehensive means test for subsidised aged care services can only be justified if it makes a considerable difference to the equity and sustainability of the aged care system.

**Box 7.8 Older Australians' capacity to pay for care and support**

Wealth projections suggest that by 2030 older Australians will own around 47 per cent of total household wealth, although they will only make up around 19 per cent of the population. This suggests that asking younger Australians to pay higher taxes to fund aged care, while also being required to save more to fund their own retirement, is inequitable. So what is the capacity of older Australians to pay for their care?

Data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey conducted in 2006 shows that the medium net worth of households headed by a person aged 65-75 years was \$443 000 and \$332 000 for households headed by a person aged 75 years plus. The principal residence makes up most of this wealth — the 65-75 years median household holds 79 per cent of their net worth as a principal residence increasing to 90 per cent for the median 75 years plus household (RBA 2009).

The HILDA data provides some insight into the distribution of household assets for older households. Using data from 2002, it was estimated that the bottom 10<sup>th</sup> percentile of households headed by a person aged 75 plus had \$17 200 in assets, those in the 30<sup>th</sup> percentile had \$145 400, those in the 70<sup>th</sup> percentile had \$380 600, while those in the 90<sup>th</sup> percentile had \$828 000 (in 2006 dollars). As the net worth of the median household had grown by almost 29 per cent from 2002 to 2006, these numbers are likely to be similarly higher.

The ABS Survey of Income and Housing in 2007-08 found that average (mean) weekly household income declined with age after retirement up until 80 years plus. In 2005-06, average weekly disposable income fell from \$516 for households headed by a person aged 65-69 years to \$433 for the 75-79 year households, but rose to \$454 for the 80 years plus households. This pattern remains the same even after adjusting for housing costs. It has, however, changed over time. In 1988-89, the oldest households had the lowest average weekly disposable income, while the 75-79 year households were slightly above the average for the 65-69 years households.

The average income data tends to overstate the capacity of the median household to pay as it includes the tail of the distribution — the high wealth and high income households. And capacity to pay, once people move towards the end of their lives, is better defined by their wealth rather than their income.

*Sources:* HILDA Release 7; RBA (2009); Heady, Warren and Wooden (2008); Bradbury and Gubhaju (2010).

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HILDA data shows that in 2006, 14 per cent of full pensioners had assets in excess of \$500 000, while 13 per cent had less than \$6000 (HILDA 2010). As such, a system that uses the pension test for determining co-contributions is likely to be considerably less equitable than one that applies a more comprehensive means test for subsidised aged care services. And, because of a limited aged care budget, there will be fewer resources to pay for care for those people with the least capacity to pay.

Noting that the majority of older Australians will continue to receive either a full or part pension looking out to around 2050 (table 7.7), the Commission considered three options:

- all people receiving a full or part Age Pension would receive the full rate of subsidy, with self-funded retirees receiving a lower rate of subsidy (option 1)
- people receiving a full Age Pension receive the full rate of subsidy, those on a part pension receive a lower rate, and self-funded retirees receive the lowest rate (option 2)
- an assets means test (includes the principal residence, accommodation bonds, and the Commission's proposed Australian Age Pensioners Savings Account scheme) with three levels of subsidy based on the level of assets. Those with assets below the median of \$350 000 receive the full subsidy (the Age Pension assets test also allows non-home owners assets of \$313 250 for a single pensioner and \$389 500 for a couple for full pension, as at March 2011). Those with assets below the 80<sup>th</sup> percentile of \$550 000 receive the mid rate of subsidy, while those with assets above the 80<sup>th</sup> percentile receive the lowest rate of subsidy (option 3).

Table 7.7 shows the shares of older Australians that would be eligible for the three different levels of government subsidy under the three eligibility rule options. This is an indicative calculation, but it demonstrates the lock-in of adopting the existing Age Pension means test as the basis for eligibility of different levels of aged care subsidies (option 1).

Options 2 and 3 start with a fairly similar share receiving the full rate of subsidy, but they diverge over time. It should be noted that, as those at the older end of the retirement age spectrum are more likely to have lower assets, the eligibility criteria in options 1 and 2 will understate the shares that will be eligible for full and mid level aged care subsidies.

Initial cost projections undertaken by the Commission show that using the Age Pension means test for aged care costs is the least sustainable option for taxpayers. Applying the assets means test, on the other hand, results in the percentage of older

Australians eligible for a full aged care subsidy declining from around 50 per cent in 2010 to around 15 per cent in 2050, with those on the lowest subsidy rate increasing from around 20 to 75 per cent.

**Table 7.7 Older Australians eligible for various subsidies under different eligibility criteria**

Rate of subsidy	Option 1	Option 2	Option 3
	Existing Age Pension means tests	Full and part Age Pension recipient criteria	Assets means test
	%	%	%
<b>2010</b>			
Full	83	55	50
Mid	0	28	30
Low	17	17	20
<b>2030</b>			
Full	77	39	23
Mid	0	38	22
Low	23	23	55
<b>2050</b>			
Full	76	36	15
Mid	0	40	10
Low	24	24	75

Source: Commission estimates, based on Treasury projections.

The Commission proposes the use of a comprehensive means test for determining care recipients' co-contributions. The comprehensive means test would involve a combined income and assets test. Participants' views on the proposed comprehensive means test for care varied (box 7.9).

For the income assessment, the Age Pension income test could be used — for ease of understanding by older people and for efficiency of administration. However, the assets test needs to overcome the Age Pension's exclusion of the principal residence and accommodation bonds. A further complexity of the current Age Pension assets test is that lump sums arising from the sale of a home, but invested in instruments other than housing or accommodation bonds of similar value, are not exempt assets. The Commission therefore proposes that care recipients be subject to an assets test on those assets exempt from the age pension assets test (such as the principal residence and accommodation bonds) and the income test on the interest deemed to accrue from assets included in the age pension assets test. Such an approach would retain the familiarity with, and efficiency of, a Centrelink pension assessment. It would not affect the person's ongoing eligibility for the Age Pension.

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### **Box 7.9 Participants' views vary on a comprehensive means test for care**

#### **The Benevolent Society:**

We also support the view that those with considerable wealth (e.g. in housing assets) should be expected to pay more of their aged care costs, with the proviso that they should be able to do so without having to sell their home at a time of crisis (and possibly unnecessarily if their health improves). (sub. DR805, p. 2)

#### **Older People Speak Out:**

...nothing more clearly shows the failure so far to understand this age group than the proposal that the very frail aged should sell or reverse mortgage their home in order to pay for nursing home care. These are the generations who suffered the Great Depression and the World War 2: they went without, and afterwards were determined at all costs to pay off their home for their old age, and to ensure they leave the home to their children so they would not have to suffer as they had done in their younger days. (sub. DR746, p. 2)

#### **Challenger Limited:**

It is reasonable to expect that those who have sufficient means make a contribution to the cost of their care. If the cost structures and co-payments for that care are determined on a rational and predictable basis that will provide a foundation for the provision of financial products designed to assist the aged to meet their co-payment obligations and give them more choice in relation to their care. (sub. DR785, p. 3)

#### **National Seniors Australia:**

NSA is not opposed outright to the Commission's proposal to include the family home in the comprehensive aged care means test. We note, however, that this is a very contentious issue, as evidenced by member responses to our survey on the overall direction of aged care reform proposed by the Commission. Two-thirds (67%) of respondents disagreed with the inclusion of the family home in the comprehensive means test, with more than one third (36%) strongly disagreeing with the proposal. This was the most negative response received to all the Commission's proposals and points to the very large task that the Commission will have in persuading the seniors' community of the proposal's merits. (sub. DR832, p. 20)

#### **DoHA:**

The Commission's reform proposals recognise the need to finance the increasing costs of care into the future, through a new proposed co-contribution regime that would include the family home in the means test for determining what consumers contribute towards the costs of their care in both community and residential settings. They also provide for the impact of this to be moderated through its proposed pension bond and home equity release scheme. This element is important in removing perverse incentives for consumers to pay higher accommodation bonds. However, it could also have a significant impact where there is a spouse or dependent also living in the home. (sub. DR694, p.6)

#### **Combined Pensioners and Super Association of NSW:**

CPSA questions the wisdom of including the family home in care co-contribution assessments when there is a large body of evidence that suggests access to community care prevents more expensive residential aged care and hospital care in the future. (sub. DR760, p. 12)

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### *Consistency between co-contributions in the community and residential care*

For there to be consistency between co-contributions for community and residential care, there needs to be a consistent test on an individual's capacity to pay. Many participants called for a move away from providers determining older Australians' ability to pay for community care costs and for contributions to be determined by Government (as for residential care). For example, Blue Care said:

The government should give strong consideration to operationalising means-testing and administration of client payments for community care (and possibly other care services) through the social welfare or Medicare system, rather than at the service interface. (sub. 254, p. 54)

Some participants noted the difficulties that providers have in determining care recipients' capacity to pay. Catholic Community Services, for example, said:

... service providers face challenges in gauging a client's 'actual' ability to pay. These challenges include clients who are asset rich but cash poor, those who refuse to contribute, those who refuse to disclose their financial situation and those who have many additional costs such as medication and allied health interventions. The current system requires case managers / coordinators to make a judgement call on whether to reduce or waive fees. ...The Australian Government has well-established systems for means-testing which is used to assess eligibility for pensions and other benefits. (sub. 256, p. 2)

And Catholic Health Australia pointed out that inconsistent means testing results in poor targeting:

Consistent with CHA's view that those that can afford to should contribute towards the cost of their care and support services, it will be necessary to introduce nationally consistent income testing for these services. This would make the provision of these services more affordable for the community, allow available public funds to be directed to those most in need, and would not impede further growth in the private market for these services. (sub, 271, p. 21)

The limited extent of means-testing for community care and poor targeting of support also increases the cost to taxpayers. DoHA expressed concern about what this could mean for demand for community care over time:

... the different means testing treatment of community and residential care will, over time, induce greater demand for community care, as recipients of that care are not required to bear as a large a portion of the cost as they would be required to bear if they were receiving residential care. (sub. 482, p. 61)

To facilitate greater consistency in the approach to means-testing and to determine co-contributions across community and residential settings, the Commission proposes that means-testing of care recipients' contributions to care costs in both settings should be undertaken by Centrelink and coordinated by the proposed the Gateway (chapter 9). This should not only improve equity, but also provide the

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scope for subsidised services to be better targeted to those with the greatest need. This proposal was generally supported by participants. The Benevolent Society, for example, said:

We support the simplification and standardisation of co-contributions payable by care recipients ... Co-contributions should be based on affordability and capacity to pay and be set at such a level that they do not negatively affect care recipients' social inclusion and ability to participate in the community. We support in principle the proposal that the assessment of user contributions should occur through the Gateway Agency. (sub. DR805, p. 2)

But consistency in co-contributions within community care and across community and residential care also requires consistent assessment and entitlements across all care settings. While residents currently in residential care are assessed against the ACFI and providers receive subsidies based on the assessed care needs, in community care each of the three community care packages only offer a single subsidy level. As discussed in chapter 9, the Commission is proposing a new comprehensive aged care funding instrument that would assess individuals' needs and consistently apply entitlements (based on need, and not on whether care is provided in the community or in residential care). A person who requires care and support would go through the single assessment process. The assessment would identify the person's care and support needs and link to this the government's set of scheduled fees (taking into account additional costs associated with location, special needs, etc.). Co-contributions would be set based on the person's capacity to pay.

The introduction of the comprehensive aged care funding instrument should overcome the inconsistencies in assessment of need and the single financial capacity test similarly overcome inconsistencies in co-contributions for care and support services across care settings (see chapter 9 for more detail).

For both ease of administration and consistency, the Commission proposes that the same scale of co-contributions should be applied across all care services (with those having the least financial capacity paying the lowest co-contribution). Currently, recipients are not required to disclose the value of their home for the purposes of either the Age Pension or for determining co-contributions for care services. The Human Services Portfolio of Medicare Australia indicated that achieving consistency in co-contributions across community and residential care, and ensuring that people with the same wealth are treated equally, would require significant changes to supporting infrastructure:

- Medicare would need to significantly expand its rules based system
- Centrelink would be faced with an increase in the volume of requests for income and assets tests for aged care (sub. DR804, p. 9).

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To propose a comprehensive means test (particularly for low levels of support) may seem disproportionate and, given administrative costs, inappropriate. However, the currently applied co-contribution arrangements are not appropriate because they are often arbitrary in nature, lacking any obvious rationale and relationship to a person's capacity to pay. The Commission considers that the proposed comprehensive aged care means test should apply across all Australian Government subsidised services (the Australian Aged Care System, see chapter 9). The co-contribution would apply to the total value of the care entitlement.

Under the Commission's proposed new arrangements, older Australians with less complex needs would be able to access community support services directly or via a referral or an entitlement from the Gateway. Some of the community services would receive a level of block funding from the Australian Government (such as care for the homeless), and many would receive funding support from other levels of government (chapter 9). Direct access would obviate the need for a Gateway assessment and Centrelink financial capacity test. Accordingly, the simplified means testing for low level services, as proposed in the draft report, is not required.

### *Easing the way*

Under the proposed comprehensive means test there will be older people who lack the income to meet their care and support costs. Some participants raised concerns about people on low incomes not being able to access services because of their costs. Full pensioners and low income older Australians receiving care in the community, for example, are unlikely to have sufficient income to pay for their care costs, despite their overall wealth, and this points to the need for financial products that allow the unlocking of equity in homes and deferred payments. The need for such options was acknowledged by Aged Care Association of Australia and Deloitte:

... domiciliary care provided in the family home obviously cannot be funded through the sale of that home, though there may be ways other than sale of unlocking the consumer's equity in his or her home. (sub. 285, p. 7)

Catholic Health Australia also said:

Copayment policies ... have to take into account that the lifetime savings of most Australians are in the form of home ownership. The illiquid nature of this asset can constrain payment options for individuals, with potentially adverse financial consequences if lack of flexibility does not allow choice of payment arrangements that suit personal financial circumstances and objectives. (sub. 217, p. 32)

As discussed in chapter 8, the Commission acknowledges a role for the Government is to provide a means by which older people can use their accumulated wealth to

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contribute to their aged care costs. Consequently the Commission is proposing the establishment of a Government-backed Australian Aged Care Home Credit scheme which would enable older Australians to draw down on the equity in their home to contribute to the costs of their aged care and support.

#### *A lifetime stop-loss for 'out-of-pocket' care expenses*

On both equity and efficiency grounds, the Commission considers that while everyone with the capacity to pay should contribute to the cost of their care, older Australians should not be faced with having to pay for very high or catastrophic costs of care — there should be a limit to their out-of-pocket expenses irrespective of their financial circumstances.

Intensive care for extended periods of time is very expensive. Under a system of co-contributions, those with the highest care needs and a capacity to pay face the highest costs. The Commission proposes that, combined with new co-contribution arrangements, a lifetime stop-loss mechanism be put in place to protect individuals against very high out-of-pocket expenses for aged care, recognising that voluntary insurance arrangements to do this do not exist and are not really feasible (chapter 8).

There are a number of ways that such a limit could be implemented. It could cut in either after a certain period of time of paying care costs (for example, after paying the cost of intensive care for a number of years), or after an individual had made a specific level of financial payout.

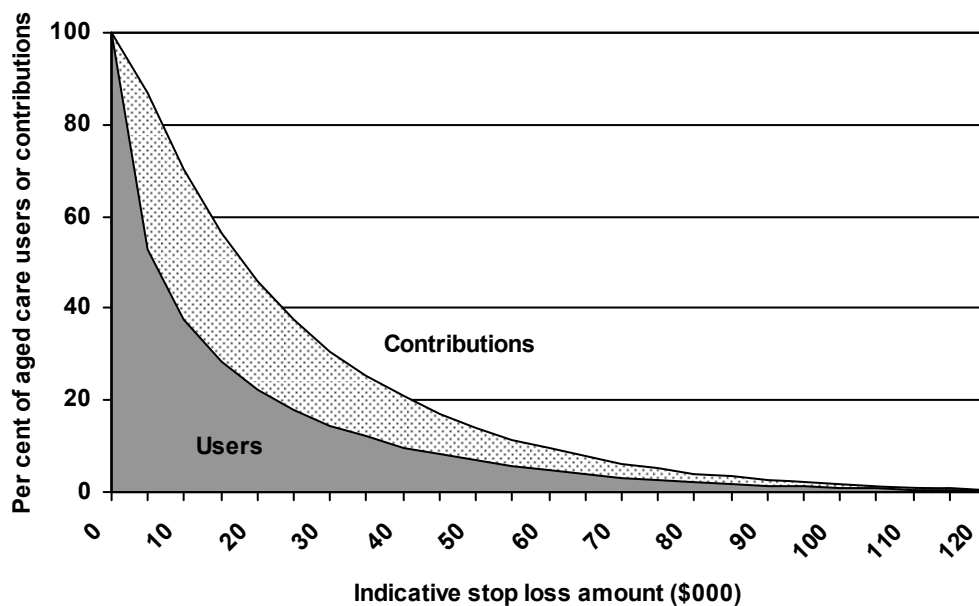
The United Kingdom recently announced a National Care Service which supports universal entitlement and protection from catastrophic costs of care. Commencing in 2014, anyone staying in residential care for more than two years would receive fully subsidised care after the second year (HM Government 2010).

Annual and lifetime limits should apply only to approved care services. Amounts above these limits would be a de facto insurance scheme as any very high out-of-pocket expenses for subsidised aged care services would be fully publicly funded. This suggests that limited liabilities should be based on a whole of life basis rather than an annual basis. In the Commission's view, the stop-loss should cut in at the same point for everyone.

Based on a costing analysis of the Commission's proposed arrangements, assuming co-contributions for care range from 0 to 25 per cent (see next section), a stop-loss of around \$60 000 would cover 10 per cent of private contributions (about 5 per cent of recipients) would need to be set at around \$60 000 (figure 7.1). That would mean that older Australians requiring close to the highest level of care and

who were paying the highest assumed co-contribution rate of 25 per cent of their care costs, would take around five years to reach the stop-loss limit. Assuming co-contributions for care ranging from 0 to 35 per cent, a stop-loss that covers around 11 per cent of private contributions (around 5 per cent of recipients) would need to be set at around \$70 000. Taxpayers would pay for all remaining care costs once a care recipient has reached the stop-loss limit (appendix E).

**Figure 7.1 Projected percentage of care recipients expected to reach indicative stop-loss amounts with a 25 per cent maximum co-contribution**



*Data source:* Commission estimates.

Any specified financial limit would need to be indexed. The Commission's proposed AACC should recommend on the most appropriate form and rate of indexation (chapter 15).

Some of the practicalities associated with a stop-loss arrangement include:

- when the clock starts ticking for the stop-loss would be linked to when people are assessed or start to receive services (this could be facilitated via the proposed Gateway and the comprehensive aged care funding instrument)
- proof of purchase of services (receipts from care recipients, electronic records)
- a record keeping system.

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### **Box 7.10 A lifetime stop-loss limit – participants' views**

#### **Benevolent Society:**

The proposed lifetime stop-loss limit has many attractions as a way of ensuring that care recipients and their families are not exposed to excessive costs. It is preferable to systems that require users to run down their savings until almost nothing is left. As such it is likely to attract wide community support. (sub. DR805, p. 3)

#### **Peninsula Health:**

Given the potential for lifetime costs to become very high, it is reasonable to propose a limit on the expenditure any one individual can be required to make via co-contributions for care. (sub. DR650, p. 6)

#### **Royal District Nursing Service:**

The introduction of a stop-loss is an important safety net. However, determining a single figure across Australia (e.g. \$65,000), does not represent the same financial impost for all Australians as the cost of living can vary significantly between states, and within states. (sub. DR546, p. 2)

#### **The Salvation Army Aged Care Plus:**

... supports the principle that care recipients should not be faced with having to pay for very high or catastrophic costs of care but that these costs should be 'risk pooled'. Therefore, a lifetime stop-loss mechanism is supported whereby the tax payer would pay for all remaining costs for an individual (excluding accommodation and everyday living expenses) who has reached the amount determined as the stoploss limit. (sub. DR567, p. 7)

A number of participants supported the lifetime stop-limit proposal (box 7.10). National Seniors Australia, for example, said:

... we welcome the proposal for a life-time stop-loss limit on co-contributions to care costs, as this should give older Australians greater 'peace of mind', knowing that they will not face crippling care costs as they age and can preserve much of their accumulated wealth. (sub. DR832, pp. 18-19)

As discussed in chapter 6, the lifetime risks of requiring aged care services and the potential costs of such care are not well understood. To make Australians more aware of these risks and the potential cost of aged care (so they can be better prepared financially), the Commission considers that there is merit in a public education campaign. Such a campaign could take place at the same time that the community is made aware of the proposed lifetime stop-loss for care costs. This information could also be made available via the Gateway.

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## **A new care co-contribution regime**

### *Consistent co-contributions*

As discussed above, to overcome the complexities and discontinuities between the levels of co-contributions made by care recipients across community care packages and residential care, the Commission is proposing a new single national co-contribution regime which would apply across all approved aged care services, irrespective of whether they are delivered in the community or in a residential aged care facility. Under such a regime, co-contributions would vary according to the price of the service and the person's financial capacity to pay.

As part of its analysis, the Commission prepared projections based on a range of co-contributions (appendix E). The guiding principles for the projections of the care co-contribution regime were that:

- co-contributions to care costs are consistent regardless of the care setting
- no one should pay more than the cost of their care
- those with limited means only make a small contribution, generally comparable with current arrangements.

In developing cost projections, the Commission looked at the impact of applying maximum care contributions of 25 and 35 per cent of care costs. For residential care, the co-contribution was assumed to begin at zero, while in community care the minimum payment (excluding hardship provisions) was assumed to be 5 per cent of care costs.

The co-contribution to care was assumed to be based on a comprehensive means test (as discussed above) covering a person's assets and income. The income deemed to accrue on assets subject to the Aged Pension means test was included as income for determining a person's care co-contributions, while all other assets were subject to the care asset test.

The Commission assumed that care recipients with an annual income below \$17 443 (excluding pension supplement) and relevant assets below \$39 000 (the minimum asset test threshold at March 2011) would pay the minimum co-contribution for their care setting (community care or residential care) towards their care costs. For every dollar in income or assets that a person has above the thresholds, they are assumed to make a larger co-contribution to their care costs, until they reach the maximum care co-contribution rate. As an example, the

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maximum co-contribution to care costs in the community would be paid by someone with an annual income of over \$40 000 when their relevant assets reached:

- \$441 000 if a maximum 25 per cent care co-contribution was assumed
- \$740 000 if a maximum 35 per cent care co-contribution was assumed.

The relevant asset thresholds for reaching the maximum care co-contribution if the same person was in residential care would be \$551 000 and \$851 000 for the 25 and 35 per cent maximum co-contributions respectively.

The Commission estimates that 66 per cent of community care recipients and 76 per cent of residential care recipients would pay a care co-contribution of 15 per cent or less in 2013. Further detail on the Commission's projections are provided in appendix E.

DoHA suggested that further work needed to be undertaken on the proposed new co-contributions, noting that:

While the proportion of care recipients making a significant contribution would increase from around 12-25 per cent to 70 per cent under these proposals, charges for residents on higher incomes would decrease due to the proposed stop-loss mechanism. For example, current arrangements allows for residents with very high incomes to pay up to \$50 000 per year towards their care costs, and potentially several hundreds of thousands of dollars over their full period of care, significantly higher than the Commission's indicative lifetime stop-loss limit of \$60 000. (sub. DR 694, p. 6)

The Commission agrees that further analysis on options for means testing care co-contributions is warranted. But, as acknowledged earlier, the evidence base for such analysis currently limits what can be done. Effort should be directed towards obtaining more robust data to support further analysis of the distributional impacts of the proposed different means tests. The expertise of government agencies and departments in implementing means tests should also be drawn on.

As discussed in chapter 6, the decision about the levels of co-contributions is one for the Government in balancing the relative proportion of care recipient contributions and taxpayer funding.

### **A body for determining costs of care and accommodation**

A major concern of participants to this inquiry was the appropriateness of indexation arrangements for determining the cost of care and accommodation on which government subsidies are based.

The Commission considered indexation arrangements as part of its 1999 inquiry into nursing home subsidies and found that, with other sources of income for

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providers largely tied, inadequate increases in subsidies after allowing for efficiency improvements would, in one way or another, compromise the delivery of quality care. While not putting forward a view on the most appropriate indexation methodology, it recommended that:

Basic subsidy rates should be adjusted annually according to indices which clearly reflect the changes in the average cost of the standardised input mix, less a discount to reflect changes in productivity. (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 to improve their productivity.

There was widespread support among participants of this inquiry for the establishment of an independent body to determine the cost of care and annual indexation methodology, a role analogous to the proposed Independent Hospital Pricing Authority for the National Health and Hospitals Network (box 7.11).

**Box 7.11 Widespread support for an independent body to determine costs and appropriate indexation**

Aged Care Association Australia and Deloitte:

What is needed is an independent mechanism for calculating an appropriate economic cost of care & personal services and levels of hotel and accommodation services. The task of undertaking this cost assessment should be allocated to an independent Authority or Commission (ie consider the possibility that that function be undertaken by the new Hospital Pricing Authority) for the ongoing evaluation, calculation and administration of this cost mechanism. This can then serve to be the price setter, whereby Government as purchaser, can determine the level of services it will fund and to who it will fund into the aged care system. (sub. 285, p. 13)

Blue Care:

Establish an independent body to benchmark each year the true cost of care including regional variations and to estimate input cost increases and the required level of indexation of subsidies.

Adjust the accommodation supplement over time based on independent evidence as to building development costs, clinical and community norms regarding standards of accommodation and regional disparities. (sub. 254, p. 4)

Catholic Health Australia:

... because the fees and subsidies reflected in the current ACFI rates are historically based and indexed to minimum wage adjustments, they do not reflect contemporary care practices, standards or labour market conditions. The reforms, therefore, should provide for periodic independent reviews of the cost of care to inform the setting of care subsidies and fees, undertaken by a body such as the proposed Independent Hospital Pricing Authority. (sub. 217, p. 14)

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A transparent methodology was also seen as particularly important. Blue Care, for example said:

Implement a transparent method of estimating input cost increases that is relevant to the residential aged care and community care sectors and capable of being subjected to external scrutiny and review. (sub. 254, p. 3)

The Commission proposes that the AACC (chapter 15) would, as one of its functions, recommend the costs of delivering care (community and residential) and of providing a basic standard of accommodation for supported residents. Participants pointed to the importance of the AACC liaising with experts and providers when recommending the cost of delivering care. The Royal District Nursing Service said:

RDNS strongly advocates liaison with providers and expert clinicians when setting the price structure. If the set price does not reflect the true cost of quality service delivery for a customer base in different geographies with different service requirements, it may have the opposite effect to what is intended. Customers may not be faced with a diverse group of quality providers with interesting and exciting service offering — but a few providers offering the bare minimum. (sub. DR546, p. 1)

COTA Australia argued that the move to independently recommended prices should be one of the first and highest reform priorities:

We strongly endorse the move to fund on the basis of prices recommended by an independent agency and that these prices would be mandated for services attracting the government subsidy.... It is vital that moving to independently recommended pricing be one of the first and highest priority steps in implementation of the Final Report. Even if higher prices are phased in over a couple of years they need to be set as soon as possible. Without prices that truly reflect the cost of care the Commission's integrated blueprint will not have the confidence of consumers, providers or unions. (sub. DR656, p. 9)

Care recipients' co-contributions should be regularly reviewed by the Government based on transparent recommendations from the proposed AACC.

#### RECOMMENDATION 7.9

***The Australian Government should:***

- ***prescribe the scale of care recipients' co-contributions for approved aged care services which would be applied through the Australian Seniors Gateway Agency***

- 
- *set a comprehensive means test for care recipients' co-contributions for approved aged care services. This test should apply the Age Pension income test. The test should also apply an assets test to the relevant share of a person's assets which are excluded from the age pension means test (such as the principal residence, accommodation bonds and the proposed Australian Age Pensioners Savings Account).*

*To facilitate greater consistency in co-contributions across community and residential care, comprehensive aged care means testing to determine care recipient co-contributions to care costs in both settings should be undertaken through the Australian Seniors Gateway Agency by Centrelink.*

*The care recipients' co-contributions scale should be regularly reviewed by the Australian Government based on transparent recommendations from the Australian Aged Care Commission.*

RECOMMENDATION 7.10

*The Australian Government should set a lifetime stop-loss limit comprising the care recipients' co-contributions towards the cost of approved aged care services (excluding accommodation and everyday living expenses). Once the limit has been reached, no further care recipients' co-contributions would be required for those services.*

*With a stop-loss limit in place, the Australian Government should exclude aged care costs from the net medical expenses tax offset.*

