The Bethanie Group Inc

BRIEFING NOTE

CE: 01.01

23 June 2010

AGED CARE LEVY

I am one of only a few residential aged care providers still working in the sector who were present in the early November 1997 day long meeting in Parliament House in Canberra when High Care Accommodation Bonds, only very recently introduced into high care services, were withdrawn from the sector. The cost to aged care in Australia has been high. So too the political cost of that reform so early in the life of the then very new Commonwealth Aged Care Act 1997.

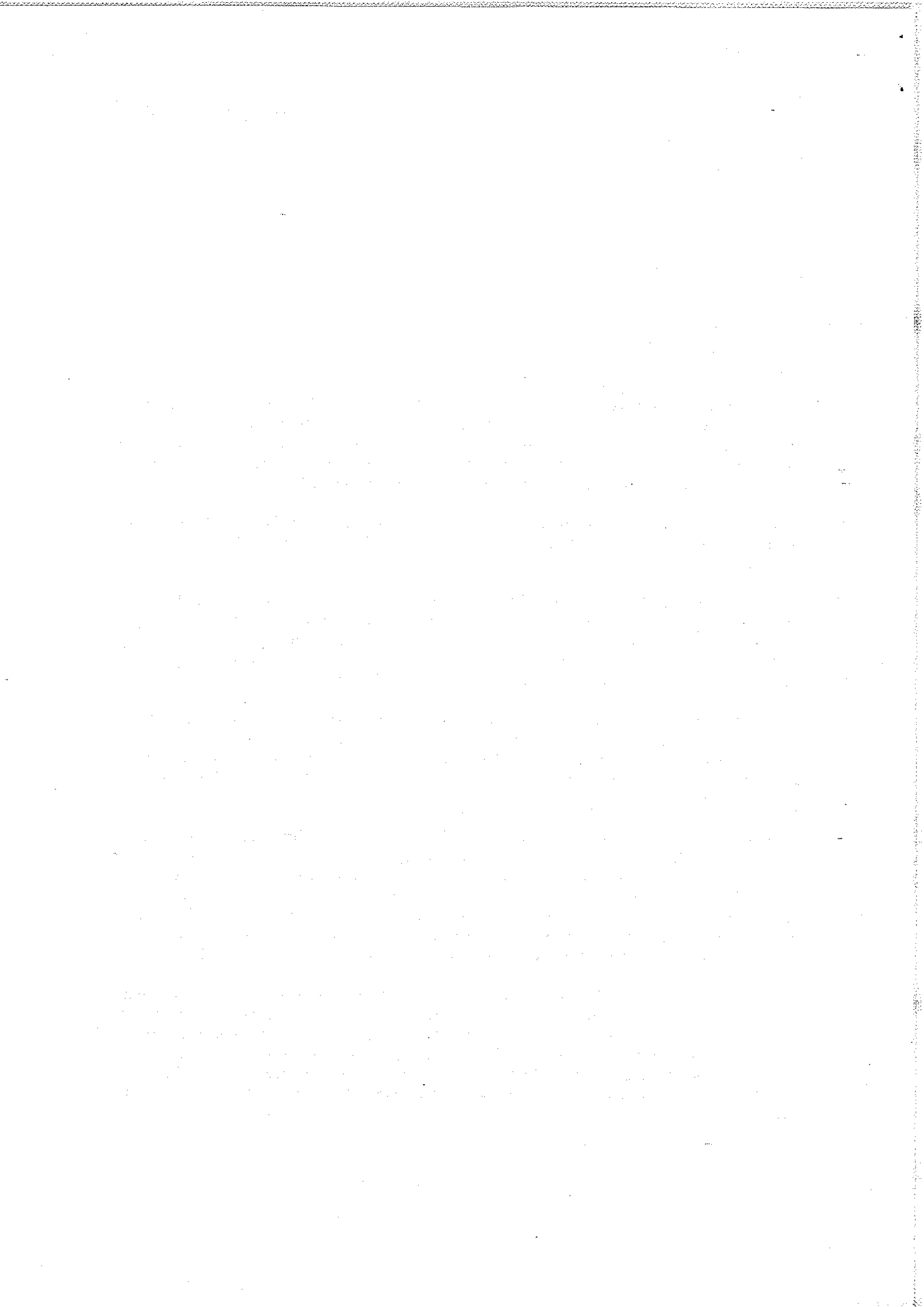
Since that time the funding of aged care in Australia has deteriorated to a point where I believe this once world leading aged care system is now on the brink of failure. But this is not an insoluble problem.

Along with the many positive reforms in quality assurance and service compliance comes the requirement of the strong supporting pillar of adequacy and reasonableness of funding – funding that is made transparent to the end user of services, their advocates, and providers alike. Our current funding methodologies are complex, over regulated (indeed in many instances minimised by regulation), and not transparent to the vast majority of Australian tax payers.

In addition, there are many aged care providers who still believe that accommodation bonds are the dominant panacea to the funding problems besetting the aged care sector. I was once one of those zealots who, for a considerable time post 1997, could not, or perhaps would not, think of viable alternatives to accommodation bonds that could solve at least the capital creation problems we confront today.

But times have changed, and so has my thinking. Having had the good fortune to travel to review international models and services and learn about alternative systems opens one's eyes and mind to the possibility of alternatives that might just work in the Australian landscape. I am always cautious against simply transferring a system from another economy and social structure to Australia and believing all we have to do is work at it to make it fit and behave the way we need it to. However, it is just possible that the principles and practices of alternative financing arrangement found in other countries might be essentially transferable if robustly considered with a mind set of "why not?"

That "why not" thinking led to some initial work by the Bethanie Group exploring different funding options to improve the sustainability of aged care funding in Australia. **Following some preliminary modelling and analysis, I came to the conclusion that an Aged Care Levy used as a form of social insurance to fund all aged care provided by the Australian Government would be the most effective way of meeting the needs of our current and future older Australians.** I need to emphasise here that my proposal is that Australia introduces a form of social insurance to **cover the cost of care.**



In order to test the implications and costs of such a model, Bethanie engaged KPMG in January 2010 to undertake further high level research to test such an alternative model of aged care funding. This approach to funding community and residential aged care – described as the 'Bethanie Model' in the Report – is the culmination of just over twelve months effort by Bethanie. The Report that I commissioned KPMG to prepare sets out a high level analysis of Australia's aged care system, current spending on aged care in Australia, alternative funding models used by other countries, and provides financial projections of future spending on aged care. I thank KPMG for their commitment to this work

The Report examines the social insurance systems for care of the frail elderly in both The Netherlands and Japan. It is known to me by comment from Dutch colleagues that the cost of social insurance for all forms of health, aged and disability care in The Netherlands has now risen to 12.15% of an individual's taxable income, with a ceiling on payments. Furthermore, due to the continuing impact of the recent global financial crisis the issue of rationalisation of services covered by this social insurance is now under debate. The Bethanie Model would not require expenditure anywhere near to that excess. Indeed it can be seen that the Bethanie Model considered in KPMG's report is cost neutral, involving no rise in the total cost of aged care for Australia compared to a 'business as usual' approach to funding aged care.

But there is no doubt that the cost of aged care in Australia will rise over the next forty years. KPMG's modelling of the costs of aged care – drawing on the projections of the Australian Government's third Intergenerational Report – predicts that total spending will rise from $12.5 billion in 2010 to $162.3 billion in 2040. As economist Henry Ergas[1] commented in May 2010 at an aged care workshop in Melbourne, "***Aged care will be as inevitable and pivotal a part of life in the first half of this century as we see Primary Schools today, and the development of those institutions in the first half of the last century***".

The aged care financing system we currently have is not working and so a credible alternative is urgently required to provide sustainability and ensure the viability of the aged care sector. In order to determine the cost to the nation of introducing social "long term care" insurance, KPMG has attempted to determine the costs of:

- community and residential care alone
- community and residential care and accommodation, and
- residential accommodation alone.

Finally, KPMG's Report provides an indication of the individual impact of introducing an Aged Care Levy by calculating its cost to Australia's workforce as a percentage of both "salaries and wages" and "total household income". These impacts were determined using the 'Bethanie Model' developed by The Bethanie Group In during this review.

The 'Bethanie Model' described in the KPMG Report shows that introduction of an Aged Care Levy (specifically designed to solely fund the costs of care services, as distinct from accommodation costs which are assumed to be funded from user fees) would raise $8.9 billion in 2010, rising to $115.7 billion in 2050. When calculated as a percentage of average wages and earnings, the Aged Care Levy would equate to 1.65 per cent in 2010, rising to 2.86 per cent in 2050. When calculated as a percentage of total household income, the Aged Care Levy would equate to 1.41 per cent in 2010, rising to 2.32 per cent in 2050. The additional cost of funding accommodation would be met through government subsidies for supported residents and resident fees.

[1] Ergas, H. 2010. At a Deloitte Australia sponsored workshop, Melbourne, 27 May 2010. Alternative funding sources for the Australian aged care industry.

Total costs of providing accommodation are expected to increase from $3.6 billion in 2010 to $46.5 billion in 2050. These figures were determined using publicly available sources of information, for example, the 2010 Intergenerational Report, and Bethanie estimates of cost. The Bethanie Model Aged Care Levy covers this cost of accommodation for supported residents. Under current funding arrangements, the responsibility of funding accommodation for supported residents – estimated by KPMG to be $1.3 billion in 2010 – is fully met by the Australian Government.

There will be comment that such a Levy is a new tax. I disagree. Simply put, the Levy ring-fences the payments that Australian taxpayers are already making towards the cost of aged care. Clearly, whilst this Levy is aimed at directing the appropriate amount of funds to aged care, we do at present pay care subsidies from Government consolidated taxation collection revenues. What a new Aged Care Levy will do is more transparently assist to identify the true cost of supporting care for frail elderly Australians, and the capital required for safety net covered care recipients. Is the proposed Levy set at an appropriately high level that it meets the cost of care needs, and provides a reasonable basis on which to build sustainability of the aged care sector, are questions that require further research.

In commissioning this Report, I am endeavouring to create robust debate about alternatives, bring some more market-oriented thinking to the table, and, if adopted, continue to provoke discussion about how more deregulated options for capital creation for those with means might be developed. I acknowledge that there will need to be policy and process developed around it, and would enthusiastically welcome such a debate. Importantly, although the Bethanie Model would involve in increase in residents' fees (up from an estimated total of $2.9 billion collected by all residential aged care providers under present arrangements during 2009-10 to $3.1 billion under the Bethanie Model), this would enable an end to the costly and complicated accommodation bonds system (estimated to have raised over $463 million for providers during 2009-10).

Finally, can the Government properly fund aged care into the future? If so, where will the finances come from? Government should be setting parameters and policy to allow industry to properly function. Therefore Government should be realistically recognising it cannot properly fund the care needs of our ageing population and give that population fair warning of the future financing constraints. Government should soon set up a scheme whereby that population can provide for itself. Consequently the aged care industry prepares the service and capital infrastructure needed with confidence that it can afford to pay its workers a proper wage and meet all the other costs of providing quality care for the frail aged in our society.

Under the Aged Care Act (1997), aged care in Australia has been on a thirteen year journey. It has been difficult to solve the questions about recurrent and capital funding requirements in the aged care sector, and we are not yet there. My aim with this report is to cause people to consider a different solution to the overall funding crisis on our aged care doorstep. The next forty years requires a level of thinking about systems and financing that exceeds the level of thinking and planning the aged care industry and Government have applied since the late 1990s – hopefully this work is a catalyst to provoke some of that much needed energy

I commend Bethanie's work to you.

Wayne L Belcher
Chief Executive

WLB:WLB [1006]

KPMG

HEALTH AND HUMAN SERVICES

ADVISORY

The Bethanie Group Inc

Aged Care in Australia- A Scoping Study
FINAL REPORT

June 2010

HEALTH AND HUMAN SERVICES

AUDIT ▪ TAX ▪ ADVISORY

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The Bethanie Group Inc has full responsibility for:

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- *sourcing appropriate legal and regulatory advice*
- *assessing the impact on banking and finance covenants*
- *assessing human resources and organisational structures, and*
- *negotiating with any third parties.*

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- *KPMG did not perform an audit or review on the data and estimates within the financial analysis, therefore, this report does not constitute an expression of opinion or conclusion intended to convey assurance on, and KPMG is not responsible for, the accuracy and completeness of the financial information presented.*
- *It is not possible to predict future events or anticipate all potential circumstances as market or other conditions may change, as such, future events may not unfold as expected and actual results achieved for the forecast periods covered will vary from the information presented and the variations may be significant.*
- *Baseline financial information and financial analysis have been reviewed by the Bethanie Group Inc.*

The Bethanie Group Inc retains full responsibility for the integrity of the Model and the projections contained therein. Our findings are based solely on the final version of the Model made available to us for the purpose of this engagement. We accept no responsibility for any subsequent changes to final version of the Model, including amendments to formulae or input data.

Any projections of the future financial performance of an entity are impacted by numerous factors that may influence the various components of the projections. Accordingly, we have not considered, nor do we confirm, underwrite or guarantee that any outcome provided by the Model will be achieved.

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The scope of the engagement did not include verification that recommended actions that may result from our work were implemented into any subsequent revised versions of the Model beyond the final version referenced above.

Our analysis does not constitute advice on whether the Model is 'fit for purpose' in respect of the operational and financial characteristics of the Model for the Bethanie Group Inc's purposes.

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The findings in this report have been formed on the above basis.

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1 Executive Summary

As our population ages over the next 40 years, Australia's governments and the aged care sector will be faced with various challenges in meeting growing community need. The Bethanie Group Inc (Bethanie) – one of Western Australia's largest aged care providers – has been exploring different funding options to improve the sustainability of aged care funding in Australia and has undertaken some preliminary modelling and analysis. Bethanie's work has identified that an Aged Care Levy on either salaries and wages or total income may be an effective way of funding current and future aged care services.

Bethanie engaged KPMG in January 2010 to undertake further research to test such an alternative model of aged care funding. This Final Report sets out an analysis of Australia's aged care system, current spending on aged care in Australia, alternative funding models used by other countries, and provides financial projections of future spending on aged care. Detail on the scope of this review is set out in Section 2.3.

1.1 Australian aged care system

Section 3 of the report provides a high-level overview of the Australian aged care system, setting out key directions for the Australian Government in aged care and considering the impact of the National Health Reform Agenda. It highlights a range of trends, strengths and weaknesses of the existing Australian aged care model that policy makers need to plan for.

Key issues for the Australian aged care system to contend with include[1]:

- the current lack of flexibility;
- inefficiencies;
- financial viability and sustainability of aged care providers; and
- the future demands an ageing population will place on these.

Demographic changes will see total government spending grow between 2016 and 2050 from 22 per cent to 27 per cent of GDP. This growth will see spending exceed revenue by 2.75 per cent of GDP[2].

Whereas recent aged care reforms have concentrated on quality and accessibility, the challenge over the next 10 years will be ensuring the viability and cost effectiveness of the aged care sector and adapting aged care funding to the growth in demand for care.

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[1] Australian Government. *A Healthier Future for all Australians- Final Report of the Hospital and Health Reform Commission*. June 2009.
[2] Commonwealth of Australia. *Australia to 2050: future challenges*. Attorney-General's Department, Canberra: January 2010.

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1.2 Funding of the Australian aged care system

Section 4 of the report seeks to document the funding of the existing aged care programs in Australia over the period 2004-05 to 2008-09. This analysis is used to explore Bethanie's estimations about current funding and implications for future funding requirements.

KPMG's investigations show that total aged care expenditure by the Commonwealth, state and territory governments in 2008-09 was approximately $9 billion.

1.3 Alternative approaches to funding the aged care system – International comparisons

Section 5 of the report highlights alternative approaches to the funding and delivery of aged care services by examining the Dutch and Japanese health and aged care systems. The Netherlands and Japan fund their health and aged care systems using mandatory social insurance schemes. This section identifies the Dutch and Japanese system characteristics, strengths and weaknesses, and applies these learning's to the delivery of aged care in Australia.

Mandatory social insurance schemes, such as those seen in the Netherlands and Japan can deliver health and aged care services with full population coverge at relatively lower cost to government than the Australian model[3]. Competition between insurers and providers in Netherlands is reported to drive system efficiencies and consumer choice and may offer a viable choice for Australia.

The introduction of a mandatory social insurance scheme in Australia would, however, be a very significant reform requiring major infrastructure such as government regulatory bodies. At a minimum, there would be a need for:

- appropriate regulations;
- measures to ensure quality, choice and equity;
- a risk equalisation mechanism; and
- sufficient competition to drive efficiency in the market.

Policy makers would need to determine whether individual insurance contributions would be added to a national funds pool or allocated to superannuation-style personal accounts. The former option – which would involve less change could be funded through the introduction of an 'Aged Care Levy' collected from Australian workers to provide quarantined funds for allocation to aged care services by the Australian

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[3] van de Ven W & Schut FT. "Universal Mandatory Health Insurance In The Netherlands: A Model For The United States?". *Health Affairs*, vol. 27, no. 3; 2008: pg. 771-782

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Government. The alternative funding model proposed by Bethanie is in line with this approach to funding.

1.4 Financial projections

Section 6 applies the 'Bethanie Model' funding option to conditions in Australia over the next forty years in order to test the impact of the introduction of an Aged Care Levy on funding sustainability. The results of the financial modelling of two scenarios for the years 2010 to 2050 are provided. The two scenarios modelled are:

1. an 'As Is' scenario; and

2. a 'Bethanie Model' scenario.

Under the two models, expenditure has been split into costs relating to 'care' and costs relating to 'accommodation'[4].

The financial modelling shows that under an 'As Is' scenario, the total cost to government of funding aged care will increase from a total of $9.6 billion in 2010 to an estimated $124.9 billion in 2050. Further detailed analysis found that the cost to government of funding community care programs is projected to rise from $2.7 billion in 2010 to $35.0 billion in 2050. The cost of residential aged care will also undergo considerable growth over the same period, and projected to rise from $6.9 billion in 2010 to approximately $89.8 billion in 2050. During the same period, total resident fees and bond income collected by residential aged care providers are projected to rise from $3.0 billion in 2010 to $37.5 billion in 2050.

In contrast, the 'Bethanie Model' shows that introduction of an Aged Care Levy (specifically designed to solely fund the costs of care services, as distinct from accommodation costs which are assumed to be funded from user fees) would raise $8.9 billion in 2010, rising to $115.7 billion in 2050. When calculated as a percentage of average wages and earnings, the Aged Care Levy would equate to 1.65 per cent in 2010, rising to 2.86 per cent in 2050. When calculated as a percentage of total income, the Aged Care Levy would equate to 1.41 per cent in 2010, rising to 2.32 per cent in 2050. The additional cost of funding accommodation would be met through government subsidies for supported residents and resident fees. Total costs of providing accommodation are expected to increase from $3.6 billion in 2010 to $46.5 billion in 2050.

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[4] Note: This terminology reflects that used in the Australian Government's *Residential Care Manual*, with 'care costs' referring to the costs of meeting the care needs of residents (i.e. mainly being human resources and medical supplies) and 'accommodation costs' referring to costs such as hotel-type services, cost of food, utilities and capital maintenance.

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1.5 Potential strengths and weaknesses of the Bethanie model

According to the Bethanie Group, the potential strengths of such a model for funding aged care include:

- a mechanism for funding current and future aged care requirements that is transparent and provides clarity for taxpayers, which may increase the likelihood of public support for the levy;
- certainty amongst service providers that funding will be available which should promote long-term decision making;
- greater flexibility and responsiveness to market forces in the provision of services to meet demand (within boundaries set by Government);
- simplification of funding for aged care services, and in particular the cessation of the aged care bond system;
- removal of pressure on government to fund rising aged care costs through general taxation; and
- greater understanding amongst the public as to the true costs of aged care over the short, medium and long term.

We have identified some potential weaknesses associated with such a model. These include the:

- need for future funding of accommodation-related costs through direct payments made by service users (residents) at the time of service provision;
- continued role of government as the primary funder of aged care (in contrast with the Dutch and Japanese systems);
- the need to offset the loss of income from bond holdings with an increase in resident fees; and
- continued reliance on the working population rather than by service users to bear the costs of a large proportion of future aged care. Demographic changes will mean that this pressure is instead set to increase.

1.6 Issues for further consideration

Given the issues discussed above, there are a number of issues that should be considered when undertaking detailed analysis of the potential strengths and weaknesses of the alternative model of aged care funding proposed by Bethanie. These include the following:

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- Should ring-fenced aged care funds be invested over the long-term (in line with superannuation funds or a 'future fund') or simply expended in the year they are raised?

- Would an Aged Care Levy better be drawn down into a common funding pool or into personal accounts (similar to superannuation)?

- Would a Dutch-style mandatory social insurance scheme, in which consumers purchase aged care products from competing private sector insurers, produce greater efficiencies and cost effectiveness?

- In circumstances where a taxpayer dies prior to drawing down from the aged care fund, would their contributions be paid out to?

- How will the system be administered under the proposed funding model and which agency / agencies would be responsible for this?

- Due to difficulties in confirming actual total costs of the provision of providing aged care services (due to the large number of providers), the financial modelling undertaken by KPMG of the Bethanie Model relies on the assumption that the total costs of providing aged care services in 2009-10 is equal to the income received by service providers from sources such as government grants, residents fees and bond interest and retentions. Given indications from aged care providers and some research that actual costs of providing care may exceed the income available to providers, further research to determine the true cost of delivering aged care would benefit the sector.

Further consideration of these issues will be required as more detailed analysis of an Aged Care Levy approach to funding aged care is undertaken in the future.

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2 Background

2.1 Aged Care in Australia - A road to nowhere, or a light at the end of the tunnel?

The CEO of the Bethanie Group Inc produced a thought leadership paper in May 2009 titled *"Aged Care in Australia - A road to nowhere, or a light at the end of the tunnel?"*. This paper stated highlighted that the current state of residential aged care in Australia is characterised by:

- fragmented payment systems between State and Federal funders (community care);
- increasing disharmony between the Department of Health and Ageing (DoHA) and aged care providers;
- insufficient recurrent revenues;
- insufficient capital creation revenues;
- excessive red tape and complexity; and
- at least 40 per cent of residential aged care providers failing to break-even in real terms.

Bethanie has estimated that the current costs of aged care in Australia to the Australian Government (DoHA) are over $11.3 billion per annum. The main funding sources for the sector are the *Home and Community Care (HACC)*, *Community Aged Care Package (CACP)*, *Extended Aged Care at Home (EACH)*, *Extended Aged Care at Home Dementia (EACH-D)* and *Aged Care Funding Instrument (ACFI)* programs.

2.2 An alternative funding model: The Bethanie Model

The existing funding model of residential aged care is taxation based with recurrent funding transfers from DoHA to aged care providers. Through the 'Aged Care in Australia' document, Bethanie proposed an alternative funding model under which the proportion and quantum of recurrent funding provided by DoHA would significantly be reduced by implementing an Aged Care Levy on wages and salaries to fund all aged care services.

Bethanie has undertaken some preliminary modelling and analysis of alternative models that could be used to fund aged care. Early findings were that the development of an Aged Care Levy would be the most efficient mechanism for funding current and future residential aged care. Initial modelling by Bethanie indicated that the level of levy required as a proportion of taxable income would be 2.51 per cent at current prices.

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KPMG has been engaged by Bethanie to undertake further research and analysis to test such an alternative model to fund future aged care costs.

2.3 Scope of work

Stage 1 Initial scoping study of the work associated with producing a detailed paper to Government on an alternative funding model for residential aged care in Australia based on a quarantined levy on wages and salaries.

Stage 2 This scoping study was followed by a detailed analysis of the proposals put forward by Bethanie with the objective of assisting in the development of a funding proposal that is supported by the necessary financial modelling and projections. This work was designed to ensure that any subsequent submissions to Government are supported by robust analysis.

The detailed scope and methodology for this project is set out at Appendix A.1.

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3 Australian aged care system

This chapter provides a high level overview of the Australian aged care system, setting out key directions for the Australian Government in aged care and considering the impacts of the National Health Reform Agenda. It highlights the trends, strengths and weaknesses of the existing Australian aged care model that policy makers need to plan for.

Aged care in Australia is essentially delivered in three different settings:

- Care delivered in the home, referred to as 'community based care';
- Care delivered in a residential aged care facility, which is classified as either 'low care' or 'high care'. Low care covers provision of accommodation, living support and personal care. High care covers these plus nursing and palliative care and provides full-time support; and
- Care delivered in the medical setting (e.g. hospital, specialist, primary health care). Care in the medical setting is not considered by this report.

During 2008-09, 211,345 people received permanent residential care in aged care homes and 41,873 received short-term respite care in aged care homes. This equated to about eight per cent of the population aged 65 and over. A further 64,111 people received home or community based care in lieu of residential care, 12,635 received transition care on discharge from hospital and about 862,400 individuals received HACC.

On 30 June 2009[5] there were 228,038 operational aged care places nationally, an increase of 2.2 per cent over the previous year. This included 178,379 residential places, 47,431 community care places and 2,228 transition care places. These places were located in 2,783 aged care homes delivering residential care, which had an occupancy rate of 92.9 per cent over 2008-09. Occupancy rates were 93.8 per cent in 2007-08 and 94.5 per cent in 2006-07, indicating a decline in occupancy rates in recent years.

The majority of the services were delivered in major cities, with the remainder located in regional and remote areas. Aged care services have historically been provided by a range of not-for-profit and private enterprise organisations, which are in turn represented by a number of peak bodies at both the state / territory and national levels.

In servicing these needs, the total Australian Government expenditure for ageing and aged care during 2008-09 was $9.1 billion. Of this total, the Australian Government allocated a little under $6.5 billion through the payment of subsidies and supplements

[5] Australian Government Department of Health and Ageing. *Report on the Operation of the Aged Care Act 1997 - 1 July 2008 to 30 June 2009.* Commonwealth of Australia; Canberra: 2009a. Accessed 20 April 2010 at www.health.gov.au/internet/main/publishing.nsf/Content/ageing-roaca-09-toc~ch1.

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to approved providers of residential aged care based on an aged care service assessment of each resident's level of care.

3.1 Key directions for the Australian Government in aged care

The Australian Government aims to ensure that all frail older Australians have timely access to appropriate care and support services as they age by providing: information assessment and referral mechanisms; needs-based planning arrangements; support for special needs groups and for carers; a choice of service types; and high quality, accessible and affordable care through a safe and secure aged care system[6].

Since 1996, the aged and community care system has undergone significant reform. Concerns around quality of care and accessibility were first addressed through the *Aged Care Act 1997*. Greater flexibility in residential care support was achieved through bringing together the nursing home and hostel sectors, thus allowing providers to offer both high and low care, and (for the first time) enabling ageing in place. This reform was followed by the development of an integrated quality assurance framework. Structural reforms have also increased the availability of care in the community, while new funding arrangements have been introduced to support the overall sustainability of the residential care sector.

The Australian Government's aged care policies have continued to reflect:

- a focus on quality, with ongoing accreditation of residential care providers and new quality assurance mechanisms within the community care sector demonstrating the Government's commitment to best care;

- an emphasis on increasing the viability and cost effectiveness of the residential care sector (and more recently community care provision);

- increasing choice for older people, with the expansion of community care options, reflecting the demand for a preference to remain at home as long as possible; and

- the need for greater integration across the community care sector (under *A New Strategy for Community Care - The Way Forward*).

Key reforms that have recently shaped residential care in Australia have included the:

- *2003 Review of Pricing Arrangements in Residential Aged Care ('The Hogan Review')*, which concluded that there were opportunities to improve the quality and cost effectiveness of care for older Australians with key challenges in terms of

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http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Aged%20care%20in%20Australia

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simultaneously maintaining affordability; ensuring equity of access; upgrading the quality of care; and increasing the efficiency of providers;

- *Australian Government's response to the Hogan Review.* The Australian Government responded first in 2004 with the $2.2 billion package *Investing in Australia's Aged Care: More Places, Better Care* and more recently in February 2007 with the $1.5 billion package *Securing the Future of Aged Care.* The packages focused on supporting the sustainability of the residential care system while increasing the availability of community care options, to enable older people to remain in their homes for as long as possible;

- *Aged Care Funding Instrument (ACFI),* which was developed in response to industry concerns about the Resident Classification Scale (RCS) and became the new funding instrument for basic subsidy in residential aged care from 20 March 2008. The ACFI is a resource allocation instrument which is used to help determine the level of care required by residents. The ACFI focuses on care needs related to day-to-day, high frequency care. This approach is appropriate for measuring the average cost of care in longer stay environments. Although the ACFI measures the care needs of individual residents, the instrument is designed to deliver funding to the financial entity that is responsible for delivering the care services (e.g. the aged care home). Once applied across all residents, the ACFI is intended to provide sufficient precision to determine the overall relative care needs profile of the entity and the related funding; and

- *Building Certification deadline.* The December 2008 certification deadline mandated certain lifestyle amenity requirements in buildings approved for residential aged care, addressing the maximum number of residents per room, ratio of residents to bathrooms, showers and toilets, and space and dignity requirements. The more important requirements have been around fire and safety matters. Facilities that do not achieve a minimum score for these matters can fail certification. This policy may have assisted recent industry consolidation.

The continuing challenge for the Australian Government will be to keep up with the increasing costs of care as well as supporting the sustainability of the residential aged care sector across Australian. Some of the issues that the Government will need to consider when considering the future resourcing of the wider aged care system include:

- ensuring that both quality and choice are maintained;

- the impact of the new Aged Care Funding Instrument on provider capacity; and

- the impact that new regulations will have on providers (e.g. building certification, food authority standards and new regulations around elder abuse).

At the same time, changes to Australia's demography as the population ages are introducing new challenges for the aged care sector. The most recent Productivity

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Commission review of aged care in Australia[7] noted that the most recent trends in Australian aged care have been characterised by:

- increasing numbers of older Australians requiring care;
- greater reliance on user contributions;
- increasing emphasis on community care;
- greater proportion of residents in high level care;
- decreasing numbers of small residential facilities; and
- increasing investment by private for-profit providers.

The transition of the cohort of ageing 'baby boomers' through the aged care system will provide a key challenge to the sustainability of the aged care sector over the next 40 years and especially during the years 2030 to 2050 as this enters the residential care setting. The Government's third Intergenerational Report[8] (IGR3) states that the number of people aged 85 and over is expected to more than quadruple over the next 40 years, from 400,000 or 1.8 per cent of the population to 1.8 million or 5.1 per cent of the population by 2050. At the same time, the number of workers in the economy to support our older Australians will fall from five working-age people per aged person today to 2.7 working-age people per aged person. These ageing and health pressures are projected to result in an increase in total government spending from 22.4 per cent of GDP in 2015-16 to 27.1 per cent of GDP by 2049-50. Consequently, spending is projected to exceed revenue by 2.75 per cent of GDP in 40 years time. As IGR3 advises:

> An ageing population will have consequences for economic growth and government finances. The challenge is to develop responses that will mitigate these consequences in the most effective way and minimise the size of the adjustment costs in the future.

3.1.1 Impact of the National Health Reform Agenda

National health reforms have dominated the recent health and political agenda in Australia. On 20 April 2010, following conclusion of the 29th Council of Australian Government (COAG) meeting, a number of significant health reforms were announced[9].

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[7] Productivity Commission. *Trends in Aged Care Services: some implications. Commission Research Paper.* Productivity Commission; Canberra: 2008.
[8] Commonwealth of Australia, 2010, op cit.
[9] Council of Australian Governments. *Council of Australian Governments Meeting, 19 & 20 April 2010, Canberra: Communiqué.* COAG; Canberra: 2010. Accessed 22 April 2010 at www.coag.gov.au/coag_meeting_outcomes/2010-04-19/docs/Communique_20_April_2010.pdf.

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These reforms include a full takeover of funding responsibilities of aged and primary care by the Australian Government, which will include transfer to the Commonwealth of current resourcing for aged care services from the Home and Community Care (HACC) program (except in Victoria). The Commonwealth announced an additional investment of $739 million for aged care, including $280 million to the state and territory governments for those eligible for aged care who are staying a long time in public hospitals. This investment will support around 5,000 places or beds and 1,200 packages of care by 2013-14. The Commonwealth will also establish a network of one-stop shops for people needing information and access to aged care. COAG members agreed to release more land for aged care facilities and accelerate planning approval processes to enable aged care facilities and places to become operational more quickly.

The reforms will also see the establishment of a National Health and Hospitals Network, which will fund public hospitals through approximately 90 Local Hospital Networks, and the introduction of primary health care organisations – to be known as Medicare Locals – responsible for improving service integration and reducing access gaps in defined regions.

3.2 Strengths of the existing Australian model for delivery of aged care services

The Australian aged care model is increasingly focussing on delivering care in the home for as long as possible[10]. As models of care and capacity through multidisciplinary teams have improved, care has become more effective. In turn, this has allowed delay in admission to residential aged care facilities. Assessment processes have been focussed on identifying people's care needs, an approach that enables older people and their family to consider the most appropriate care options.

The Australian system is also characterised by an emphasis on quality. Care provision is tightly regulated and ensures number, composition, quality, price and location of places[11]. This approach means that there is significant capacity for the Australian Government to influence the sector. Through these controls, the Australian Government can ration the use of services, and thus control fiscal exposure. However, this emphasis comes at some cost, with concerns raised about excessive regulation and administrative burden resulting from quality compliance measures.

While the costs incurred by around a third of residential aged care residents are borne entirely by the Australian Government (other than the basic daily fee which equates to 84 per cent of the age pension and is arguably a transfer payment by the Australian Government), the vast majority of residents pay some part of the charges associated

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[10] Bruen, W. "Aged care in Australia: past, present and future", *Australasian Journal on Ageing*, vol. 24, no. 3, pp. 130-133: 2005.
[11] Ergas H. "Providing Aged Care: the case for reform", *Agenda: a Journal of Policy Analysis and Reform*, vol. 16, no. 2, pp. 21-44: 2009.

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with these regulated prices. The extent of this co-payment depends on income and assets tests.

Although Australia, like most developed nations, faces the challenge of an ageing population, many older Australians will be able to reap the benefits of our superannuation policies and strong economic performance. The Productivity Commission[12] observed that an increasing number of older Australians will benefit from the higher levels of income and wealth required to purchase aged care services. This group represents the wealthiest households in Australia, with a net worth of around $381,000 on average, compared to about $292,500 on average for all Australians.

3.3 Weaknesses of the existing Australian model for delivery of aged care services

A number of reviews have been undertaken which identified key weaknesses in the existing Australian model for the delivery of aged care services. These key weaknesses included:

- a lack of consumer choice;
- a lack of responsiveness to customers;
- low incentive to invest;
- low economies of scale; and
- poor financial viability.

These issues are considered in more detail below.

<u>Lack of consumer choice</u>

According to Bruen[13] and Ergas[14], consumer choice among subsidised services in Australia is severely limited, with the majority of people compelled to take the first available service due to a lack of options. However, increasing supply to enhance choice would cause homes to operate with less than 100 per cent occupancy and hence incur losses. There is little real opportunity for people to move between aged care services, and people often feel they must take the first available place rather than wait for their preferred facility, especially if they are waiting in hospital.

<u>Lack of responsiveness to customers</u>

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[12] Productivity Commission, 2008, op cit.
[13] Bruen, 2005, op cit.
[14] Ergas, 2009, op cit.

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Ergas goes on to argue that there is little incentive for aged care providers to be entrepreneurial and responsive to older people and their families – the lack of choice means they are a captive market. Government regulations mean that providers cannot simply open more beds or facilities in order to increase their market share, further blunting the drive to attract clients through innovation and quality. Ergas considers that the consequence of these restrictions is "persistent productive inefficiency". In turn, lack of choice leads to price controls to prevent price gouging and local monopolies, reinforcing the cycle of Government regulation while encouraging further distortions, including allocative inefficiency, as places may not be allocated to those who most value them.

Low incentive to invest

According to Ergas, government control over price means there is a longer-term risk that prices will not be allowed to reach levels that cover efficient costs. Again incentives to invest are reduced, especially where the cost of delivering services is high; e.g. rural and remote areas. The market is unable to respond quickly to the need for more places when and where they are needed, and providers are unable or unwilling to make long-term investments in their businesses.

Low economies of scale

As a consequence of the issues raised above, Ergas states that the residential aged care industry continues to be characterised by a high proportion of small providers, with the average provider operating 2.3 aged-care homes and 128.1 operational places (as at June 2006). 65 per cent of providers operate just one home and 71 per cent of providers operate fewer than 100 places. Furthermore, many providers seem to be unable to break this cycle, being too small or restricted by government regulation to achieve economies of scale.

Poor financial viability

Ergas concludes that the current system is not sustainable, with provision of high care dependent on cross subsidisation from low care, where bond payments provide extra income. As demand for high care outpaces that for low care, sustainability will become even more tenuous.

Business surveys such as the Grant Thornton *Aged care survey*[15] support Ergas' conclusions. The latest survey report notes that residential aged care providers throughout Australia are experiencing low and deteriorating financial returns at a time of unprecedented demand for high care services. Infrastructure rules aimed at limiting the number of residents sharing facilities have resulted in a dramatic slow down in new residential care developments while consumer are seeking modern accommodation. However, changes to the funding brought by introduction of the Aged Care Funding Instrument (ACFI), which redistributes government funding from low to high care, is driving facility diversification and better enabling care in place.

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[15] Grant Thornton. *Aged Care Survey 2008: Second Report*. Grant Thornton; Australia: January 2009.

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Additional concerns

Bruen stated that Aged Care Assessment Teams (ACATs) need to be able to respond far more quickly to need. Better training, clearer delineation of eligibility criteria, more independence from hospital policies on treating the aged, and better liaison with providers all need to be addressed.

Bruen also believes that improving coordination across sector boundaries is another must for aged care. The frail aged person experiences a range of care providers who often do not appear to be aware of previous (or concurrent) treatments. This problem occurs across all sectors – from general practitioner to ACAT, from hospital to community care, from community care to residential care, from hospital care to residential care.

Summary

- About eight per cent of the population aged 65 and over is receiving some form of aged care. The majority of care is delivered in the home or community setting; less than one fifth of aged care recipients receive care in the residential aged care setting. There is a trend towards delivery of more care in the community setting.
- Last year there were 228,038 operational aged care places in Australia. This included 178,379 residential places. Occupancy rates were 93 per cent.
- Demographic changes mean increasing numbers of older Australians require care. The need for care will accelerate over the next forty years as the baby boomer generation ages. In residential aged care, there is a trend to more care delivered as high care.
- The ageing population will drive government spending at the same time as the working age population will shrink as a proportion of the total population. Total government spending on health and aged care is expected to grow from 22 per cent of GDP in 2015-16 to 27 per cent by 2049-50. Spending will exceed revenue by 2.75 per cent of GDP in 40 years time.
- The baby boomer generation represents the wealthiest households in Australia, with a net worth of around $381,000 on average, compared to about $292,500 on average for all Australians.
- Reforms over the last 15 years have concentrated on improving the quality and accessibility of aged care. More recent reforms have aimed to improve the viability and cost effectiveness of the residential care sector.
- Government regulation of residential aged care places is stifling the responsiveness of aged care providers to market forces, leading to limited investment and a lack of choice for consumers. Financial viability is a concern for many aged care providers.

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4 Funding of the Australian aged care system

This chapter of the report seeks to document the funding of existing aged care programs in Australia over the period 2004-05 to 2008-09. This analysis is used to check Bethanie's estimations about current funding and implications for future funding requirements.

4.1 Historical funding of current Australian Aged Care programs

The aged care programs that will be examined below are:

- the Home and Community Care program (HACC);
- Community Aged Care Packages (CACP);
- the Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACH D) programs; and
- Residential Aged Care funding.

4.1.1 Home and Community Care program (HACC)

Governments' funding contributions for the HACC program are agreed annually between the Australian Government Minister for Ageing and the relevant state or territory minister, and include an indexation factor applied to funding provided in the previous financial year, as determined by each government.

In addition, both levels of government contribute a real growth component to the HACC program funding. Australian Government growth funding for the program is distributed among the states and territories using an equalisation strategy, to ensure that all per capita funding for the program is the same across all jurisdictions by 2010-11.

During 2007-08, 835,269 clients received HACC services. Funding from the states and the Australian Government totalled $1.652 billion. 3,300 HACC funded agencies provided services.

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Table 1: HACC funding for 2007-08[16]

	Australian Government funding $m	State and territory funding $m	Total program funding $m	Percentage increase (incl. indexation 2.3 per cent)
NSW	305.192	204.736	508.928	7.26
VIC	246.835	164.831	441.666	7.12
QLD	223.082	122.032	345.114	11.50
SA	85.407	53.173	138.580	8.18
WA	100.979	65.406	166.385	8.70
TAS	26.306	19.412	45.718	9.09
NT	6.998	3.187	10.185	8.60
ACT	11.940	12.487	24.427	8.65
Australia	**1,006.739**	**645.264**	**1,652.003**	**8.40**

Australian Government funding for HACC in 2008-09 totalled $1.094 billion – an increase of 8.1 per cent over total funding provided in 2007-08. Total combined Australian Government and state and territory government funding for 2008-09 was $1.793 billion, an increase of $134.6 million over the previous year[17].

Australian Government funding included $3.8 million in extra, one-off, unmatched funding to states and territories in 2008-09 to build on and extend the work previously agreed by COAG for improved, nationally consistent arrangements for access, assessment and referral for HACC. The extra funding recognises costs associated with implementing these changes and will be available only to those states and territories that implement agreed community care reforms.

4.1.2 Community Aged Care Packages

Community Aged Care Packages (CACPs) are packages of personal assistance and care services. CACPs are individually tailored packages of low level care designed to support frail older people with complex care needs in their own homes.

The table below shows the number of CACPs allocated to service providers as at 30 June each year over the five years from 2005 to 2009 and the percentage increase in available packages, by state and territory.

[16] Commonwealth of Australia. *Home and Community Care Program- 2007-08 Annual Report.* Attorney-General's Department; Canberra: 2009. Accessed 22 April 2010 at www.health.gov.au/internet/main/publishing.nsf/Content/hacc-annual-report-07-08.htm.
[17] Australian Government Department of Health and Ageing, 2009a, op cit.

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Table 2: Number of allocated CACPs at 30 June each year from 2004-05 to 2008-09, by state and territory[18]

	2005	2006	2007	2008	2009	Percentage increase between 2008 and 2009
NSW	10,579	12,021	12,613	13,487	14,204	5.3
VIC	7,893	9,113	9,562	10,135	10,582	4.4
QLD	4,957	6,000	6,525	6,972	7,935	13.8
SA	2,786	3,184	3,292	3,464	3,565	2.9
WA	2,518	3,192	3,230	3,456	4,062	17.5
TAS	849	983	970	1,021	1,101	7.8
NT	539	625	569	587	641	9.2
ACT	416	456	489	514	604	17.5
Aust.	**30,537**	**35,574**	**37,250**	**39,636**	**42,694**	**7.7**

The Australian Government's recurrent expenditure on CACPs increased from $447.8 million in 2007-08 to $479.7 million in 2008-09 – an increase of more than seven per cent nationally.

Table 3: Australian Government expenditure for Community Aged Care Packages, from 2004-05 to 2008-09, by state and territory[19]

	2004-05 $m	2005-06 $m	2006-07 $m	2007-08 $m	2008-09 $m	Percentage increase: 2007-08 to 2008-09
NSW	113.1	124.1	140.1	153.1	165.7	8.3
VIC	83.5	94.3	106.5	118.0	125.8	6.6
QLD	49.9	54.7	63.3	71.9	77.7	8.1
SA	30.7	33.1	37.2	41.1	43.2	5.1
WA	26.8	29.0	34.4	37.9	40.2	6.1
TAS	9.4	10.1	11.1	12.1	12.8	5.7

[18] Ibid.
[19] Ibid.

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	2004-05 $m	2005-06 $m	2006-07 $m	2007-08 $m	2008-09 $m	Percentage increase: 2007-08 to 2008-09
NT	5.4	6.3	6.6	7.7	7.9	2.2
ACT	4.5	5.0	5.7	6.0	6.5	9.4
Aust.	**323.3**	**356.6**	**404.9**	**447.8**	**479.7**	**7.1**

4.1.3 Extended Aged Care at Home and Extended Aged Care at Home Dementia

The EACH and EACH D programs provide high level aged care to people in their own homes, complementing the CACPs which provide low level care.

The EACH program provides coordinated and managed packages of care, tailored to meet the needs of the individual. Packages are flexible in content but generally include qualified nursing input, particularly in the design and ongoing management of the package. Services available through an EACH package may include clinical care, personal assistance, meal preparation, continence management, assistance to access leisure activities, emotional support, therapy services, and home safety and modification.

The EACH D program provides individually tailored packages of care for frail, older people with dementia who have complex care needs and who are assessed by an ACAT as requiring high level care, wish to remain living at home, and are able to do so with the assistance of an EACH D package. The care packages provide services necessary to support the person at home, including nursing care and / or personal assistance.

Table 4: Number of allocated EACH and EACH D packages at 30 June each year from 2004-05 to 2008-09, by state and territory[20]

	2004-05	2005-06	2006-07	2007-08	2008-09	Percentage increase between 2008 and 2009
			EACH			
NSW	611	874	1,083	1,415	1,700	20.1
VIC	478	718	882	1,106	1,356	22.6
QLD	289	439	532	691	973	40.8

[20] Ibid.

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	2004-05	2005-06	2006-07	2007-08	2008-09	Percentage increase between 2008 and 2009
SA	155	230	286	355	399	12.4
WA	155	235	299	406	689	69.7
TAS	50	75	90	119	152	27.7
NT	40	60	70	83	100	20.5
ACT	50	70	87	111	146	31.5
Aust.	**1,828**	**2,701**	**3,329**	**4,286**	**5,515**	**28.7**
			EACH Dementia			
NSW	0	225	450	675	787	16.6
VIC	0	166	331	497	569	14.5
QLD	0	115	231	351	523	49.0
SA	0	58	116	179	194	8.4
WA	0	58	116	174	321	84.5
TAS	0	20	40	60	86	43.3
NT	0	10	20	30	38	26.7
ACT	0	15	30	45	50	11.1
Aust.	**0**	**667**	**1,334**	**2,011**	**2,568**	**27.7**

Australian Government recurrent expenditure on EACH and EACH D packages of care increased to a combined total of $256.3 million in 2008-09. Expenditure on EACH packages increased by more than 22 per cent nationally, to reach $172.7 million (see Table 5 below).

Table 5: Australian Government expenditure for Extended Aged Care at Home packages, from 2004-05 to 2008-09, by state and territory[21]

	2004-05 $m	2005-06 $m	2006-07 $m	2007-08 $m	2008-09 $m	Percentage increase: 2007-08 to 2008-09
NSW	9.7	19.9	31.8	45.4	57.7	27.2
VIC	9.7	19.5	29.7	39.9	46.3	16.0

[21] Ibid.

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	2004-05 $m	2005-06 $m	2006-07 $m	2007-08 $m	2008-09 $m	Percentage increase: 2007-08 to 2008-09
QLD	5.1	9.9	17.1	21.7	26.3	21.2
SA	2.9	5.9	9.6	12.6	14.6	15.6
WA	3.0	4.8	8.1	11.6	15.9	37.0
TAS	1.1	1.9	2.7	3.5	4.5	29.8
NT	0.8	1.5	2.1	2.6	2.9	10.5
ACT	1.2	1.9	2.8	3.8	4.5	18.2
Aust.	**33.3**	**65.3**	**103.9**	**141.1**	**172.7**	**22.4**

Expenditure on EACH D packages continued to increase significantly, reaching a total of $83.6 million in 2008-09 – an increase of more than 44 per cent over 2007-08 (see Table 6 below).

Table 6: Australian Government expenditure for Extended Aged Care at Home Dementia packages, from 2006-07 to 2008-09, by state and territory[22]

	2006-07 $m	2007-08 $m	2008-09 $m	Percentage increase: 2007-08 to 2008-09
NSW	7.3	18.7	28.2	50.9
VIC	4.6	16.1	22.1	37.2
QLD	2.2	9.3	13.3	43.2
SA	1.9	5.2	7.7	48.5
WA	0.7	4.2	6.9	64.5
TAS	0.5	1.9	2.5	30.4
NT	0.8	0.9	0.9	1.2
ACT	7.1	1.3	2.0	51.0
Aust.	**25.1**	**57.7**	**83.6**	**44.9**

[22] Ibid.

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4.1.4 Residential aged care

During 2008-09, a total of 211,345 people received permanent residential care in Australia's aged care homes. The following table gives an indication of the distribution of residents in aged care homes across Australia as at 30 June 2009.

Table 7: Number of permanent residents by state and territory and by level of care, at 30 June 2009[23]

Care level	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Aust.
High	39,682	28,800	20,566	12,100	9,464	2,892	291	1,118	114,913
Low	14,489	12,439	8,026	3,276	3,853	1,234	99	534	43,950
Total	**54,171**	**41,239**	**28,592**	**15,376**	**13,317**	**4,126**	**390**	**1,652**	**158,863**

Note: *The number of residential aged care recipients is less than the overall number of places available because a small proportion of places are vacant at any one time and around 2 per cent of places are used for respite at any one time.*

Australian Government funding for residential care subsidies and supplements has risen from $6.0 billion in 2007-08 to $6.5 billion in 2008-09. This includes funding appropriated through the Health and Ageing portfolio as well as funding for veterans in residential care through the Veterans' Affairs portfolio. These combined appropriations are paid as subsidies and supplements to aged care homes through payment systems managed by Medicare Australia.

Table 8: Australian Government recurrent residential aged care funding, from 2004-05 to 2008-09, by state and territory[24]

	2004-05 $m	2005-06 $m	2006-07 $m	2007-08 $m	2008-09 $m	Percentage increase: 2007-08 to 2008-09
NSW	1,749.3	1,849.7	1,959.8	2,084.2	2,248.1	7.9
VIC	1,237.2	1,317.0	1,396.4	1,495.4	1,626.8	8.8
QLD	903.0	953.7	1,005.0	1,058.8	1,127.9	6.5
SA	505.9	550.3	590.8	632.1	680.2	7.6
WA	414.0	441.1	465.2	495.5	536.7	8.3
TAS	140.7	147.2	153.3	161.5	167.7	3.9
NT	15.9	17.7	17.3	17.9	18.6	4.0

[23] Ibid.
[24] Ibid.

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	2004-05 $m	2005-06 $m	2006-07 $m	2007-08 $m	2008-09 $m	Percentage increase: 2007-08 to 2008-09
ACT	48.0	51.6	54.2	57.7	61.3	6.4
Aust.	**5,021.5**	**5,339.0**	**5,655.5**	**6,002.9**	**6,474.0**	**7.8**

The following table shows recurrent residential aged care funding broken down by different types of subsidies and supplements. Principle subsidies and supplements are outlined in Table 9 below. Full details can be found in the Residential Care Manual 2009[25].

Table 9: Summary of Australian Government residential aged care payments by subsidy and supplements[26]

Type of payment	2004-05	2005-06	2006-07	2007-08	2008-09
	$m	**$m**	**$m**	**$m**	**$m**
Basic Subsidy					
Permanent	4,272.0	4,516.0	4,762.7	5,006.4	5,325.4
Respite	85.4	92.3	101.5	106.6	128.2
Conditional Adjustment Payment	75.6	159.3	250.0	353.8	471.0
Primary care Supplements					
Oxygen	6.8	7.7	8.4	9.2	10.2
Enteral Feeding	11.2	11.6	11.0	10.8	10.2
Payroll Tax	81.7	88.5	94.4	99.3	104.1
Respite Incentive	0.0	3.5	8.5	8.4	10.1
Hardship					
Hardship	5.7	5.6	5.6	5.9	5.0
Hardship (Accommodation)	0.0	0.0	0.0	0.0	0.4
Accommodation Supplements					
Accommodation Supplement	0.0	0.0	0.0	4.7	104.1
Interim Accommodation Supplement	0.0	0.0	0.0	95.8	0.0

[25] Australian Government Department of Health and Ageing. *The Residential Care Manual*. Commonwealth of Australia; Canberra: 2009b.
[26] Australian Government Department of Health and Ageing, 2009a, op cit.

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Type of payment	2004-05	2005-06	2006-07	2007-08	2008-09
Transitional accommodation supplement	0.0	0.0	0.0	1.6	28.8
Viability	14.3	15.1	15.7	15.1	14.8
Supplements relating to grandparenting					
Concessional	298.8	302.5	308.1	307.0	267.5
Transitional	78.6	60.6	46.4	36.2	28.1
Charge Exempt	4.4	3.4	3.0	2.7	2.2
Pension	286.6	293.9	297.6	300.6	247.0
Income testing reduction	-157.7	-183.6	-213.5	-251.1	-242.9
Other reductions	-48.9	-53.0	-57.1	-57.1	-61.8
Other	7.0	10.1	13.3	-52.8	21.3
Total	**5,021.5**	**5,333.6**	**5,655.5**	**6,002.9**	**6,474.0**

The resulting average levels of Australian Government payments per aged care resident are shown in Table 10 below.

Table 10: Average Australian Government payments (subsidy plus supplements) for each permanent residential aged care recipient, from 2004-05 to 2008-09[27]

	2004-05	2005-06	2006-07	2007-08	2008-09	Percentage increase: 2007-08 to 2008-09
High care residents	$43,200	$44,000	$45,150	$47,200	$48,550	2.9
Low care residents	$15,500	$15,800	$16,300	$17,050	$17,750	4.2
All residents	**$33,450**	**$34,600**	**$36,000**	**$38,000**	**$40,100**	**5.5**

4.2 Summary of aged care funding in Australia in 2008-09

Based on the aged care funding set out above, total government funding of aged care programs in 2008-09 is estimated at almost $9 billion.

[27] Ibid.

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Table 11: KPMG's estimates of aged care funding in 2008-09

Service	Cost per client per day	Number of clients	Total cost of program in 2008-09
HACC	$5.85	835,269	$1,783,000,000
CACP	$30.78	42,694	$479,700,000
EACH	$85.79	5,515	$172,700,000
EACH – D	$89.19	2,568	$83,600,000
Residential aged care (combined low and high care)	$111.65	158,863	$6,474,000,000
Total			**$8,993,000,000**

Table 12: KPMG's estimates of aged care funding in 2008-09 by care vs accommodation

Service	Total funding in 2008-09
Community care	
HACC	$1,783,000,000
CACP	$479,700,000
EACH	$172,700,000
EACH – D	$83,600,000
Total community care expenditure	*$2,519,000,000*
Residential care (care only)	
Basic Subsidy	
Permanent	$5,325,400,000
Respite	128,200,000
Conditional Adjustment Payment	471,000,000
Primary care Supplements	
Oxygen	10,200,000
Enteral Feeding	10,200,000
Payroll Tax	104,100,000
Respite Incentive	10,100,000
Hardship	5,000,000
Income testing reduction	-$242,900,000

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Service	Total funding in 2008-09
Total residential care funding	*$5,821,300,000*
Total community and residential (care only) funding	**$8,340,300,000**
Residential care (accommodation only)	
Hardship (Accommodation)	$400,000
Accommodation Supplements	
Accommodation Supplement	104,100,000
Transitional accommodation supplement	28,800,000
Viability	14,800,000
Supplements relating to grandparenting	
Concessional	$267,500,000
Transitional	$28,100,000
Charge Exempt	$2,200,000
Pension	$247,000,000
Other reductions	-$61,800,000
Other	$21,300,000
Total residential care (accommodation only)	**$652,400,000**
Total aged care funding	**$8,993,000,000**

4.3 Verification of cost estimates included in Bethanie's financial forecasts

Bethanie's 'Aged Care in Australia' paper included some estimates of the costs of the various aged care programs. These are set out in the table below.

Table 13: Bethanie's estimates of aged care expenditure in 2008-09

Service	Cost per client per day	Number of clients	Cost per annum
HACC	$3.38	850,000	$1,048,050,000
CACP	$41.37	37,997	$573,756,600
EACH	$119.59	2,999	$130,907,400
EACH – D	$134.66	872	$42,859,585
Residential low care	$108.49	50,830	$2,012,809,546

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Service	Cost per client per day	Number of clients	Cost per annum
Residential high care	$173.43	119,170	$7,543,258,411
Total			**$11,351,641,541**

As can be seen from the tables above, there are significant variations between the cost assumptions used by Bethanie in their calculations and the KPMG research into the cost of aged care programs in 2008-09. In particular, Bethanie's estimate of total residential aged care costs (i.e. residential low care plus residential high care costs) totalled over $9.5 billion alone, whilst KPMG's research indicates that a significantly lower cost to government of $6.5 billion was incurred in 2008-09. KPMG understands that the key reason for this variance is the inclusion of residents' fees in the estimates made by Bethanie. When such fees (estimated by the AIHW to be around $2.1 billion in 2005-06[28] and estimated by KPMG to be $2.3 billion in 2009-10[29]) are excluded, the Bethanie estimates of residential aged care costs are in line with KPMG's research.

Similarly, KPMG's research indicates the higher costs to government of the HACC program in comparison with Bethanie's estimates ($1.8 billion against Bethanie's estimate of $1 billion). KPMG understands that the primary reason for the variance is that Bethanie's estimates exclude state government funding of the HACC program.

KPMG has liaised with Bethanie in updating the methodology used to support the financial modelling of aged care cost projections over the next 40 years to reflect these revised cost estimates.

Summary

- Total aged care expenditure by Australian governments in 2008-09 was approximately $9 billion.

[28] Australian Institute of Health and Welfare. *Australia's Welfare 2007*. Cat. no. AUS 93. AIHW; Canberra: 2007.
[29] See *Section 6.2: Results of KPMG projections* in this report.

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5 Alternative approaches to funding the aged care system – International comparisons

This section of the report investigates alternative approaches to the funding and delivery of aged care services by examining two international models. It seeks to identify the system characteristics, strengths and weaknesses, and to apply any learnings to the delivery of aged care in Australia.

There are a great many models across the world for funding health and aged care. To maintain a manageable scope and at the request of Bethanie's CEO, KPMG has reviewed funding models from the Netherlands and Japan for detailed analysis. These countries are notable for:

- employing funding models based on a 'user pays' principle;
- offering their citizens universal coverage, and
- for their strong health outcomes.

5.1 Netherlands

5.1.1 Outline of the Netherland's health system

Since 2006, the Dutch health system has been built around two mandatory social insurance schemes, legislated by the Dutch Government under the:

- *Health Insurance Act 2006 (Zorgverzekeringswet or ZVW),* covering **curative health care services** under a regime of managed competition; and
- *Act on Exceptional Medical Expenses 1968 (Algemene Wet Bijzondere Ziektekosten or AWBZ),* covering **long-term care** services under a regime of price and supply regulation.

Under the **ZVW**, each person who legally lives or works in the Netherlands is obliged to buy individual private health insurance, with a legally prescribed benefit package, from a private insurance company[30]. Insurers are legally obliged to accept each applicant for a basic insurance contract at a community-rated premium and without exclusion of coverage because of pre-existing conditions.

To ensure the sustainability of the system, all individuals pay an income-related contribution, collected as a tax, to a Risk Equalisation Fund (REF). Employers in turn compensate their employees for these contributions. In addition, all adults have to pay

[30] van de Ven W & Schut FT. "Universal Mandatory Health Insurance In The Netherlands: A Model For The United States?". *Health Affairs*, vol. 27, no. 3, 2008: pg. 771-782.

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a premium directly to their chosen insurer. Each insurer sets its own community-rated premium. For high-risk insured people, insurers receive a high-risk adjusted equalisation payment from the REF. For low-risk insured people, insurers must pay an equalisation payment to the REF.

People may also purchase voluntary supplementary health insurance for benefits not included in the mandatory basic insurance; e.g. dental, physiotherapy, eyeglasses, alternative medicine and cosmetic surgery.

Under the **AWBZ**, the insured are provided with chronic and continuous care which involves considerable financial consequences, such as care for the aged or for disabled people with congenital, physical or mental disorders[31]. As with the ZVW, contributions are collected from each person legally living or working in the Netherlands through the income and payroll tax systems (as a percentage of taxable income in the lowest two income tax bands) to pay for services provided through the AWBZ. The scheme is funded by premiums paid by the people, by a state subsidy and by personal contributions from care recipients.

Reform of Dutch health care has been built on the assumption that competition and consumer choice can significantly improve the quality and efficiency of health care. However, to avoid adverse consequences for universal access, competition is strictly regulated[32].

Health expenditure in the Netherlands during 2007 was 9.8 per cent of GPD[33]. By comparison, for the same period the proportion of GDP was 8.9 per cent for the OECD (average), 8.7 per cent for Australia, 8.1 per cent for Japan, 8.4 per cent for the UK and 16 per cent for the USA. The overall costs of the Dutch system is therefore higher than in comparable countries as a proportion of GDP.

5.1.1.1 Administration of the AWBZ

A number of semi-autonomous government agencies administer the AWBZ:

- The *Centre for Assessment of Care (Centrum Indicatiestelling Zorg or CIZ)* is responsible for undertaking a needs assessment for all applicants for long term care support.
- The *Health Insurance Board (College voor Zorgverzekeringen or CVZ)* is responsible for implementation of the ZVW and AWBZ. The CVZ provides advice to the Dutch Government about the two Acts and is responsible for financial

[31] Website of the Dutch Ministry of Health, Welfare and Sport, "Exceptional Medical Expenses Act". Available from www.minvws.nl/en/themes/exceptional-medical-expenses-act/. Accessed March 2010.
[32] Maarse H. "Health care reform - more evaluation results". *Health Policy Monitor*, April 2009. Accessed 16 April 2010 at www.hpm.org/survey/nl/a13/1.
[33] OECD website. *OECD Health at a Glance 2009: Key findings for Japan*. Accessed 16 April 2010 at www.oecd.org/document/33/0,3343,en_2649_34631_44219681_1_1_1_1,00.html.

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administration for the AWBZ, including oversight, budget setting and payments for the *Care Offices (Zorgkantoor)* that allocate care to patients.

- 32 *Care Offices (Zorgkantoor)* are the regional face of the AWBZ. They perform care assessments, contract service providers, set individual *Personal Budgets (Persoonsgebonden Budget or PGB)* that can be used to purchase care for patients / clients, promote quality of care through financial incentives and regularly consult with patients, providers and local authorities. Health care insurers are typically contracted to operate Care Offices.

- The *Central Administration Office (Central Administratie Kantoor or CAK)* is responsible for financial administration of the AWBZ, including calculating and collecting patient copayments (calculated using income tax data), and determining the funds Care Offices will hold for PGBs.

- The *Netherlands Care Authority (Nederlandse Zorg Autoriteit or NZa)* is responsible for monitoring competition in the market and conformance with acts and regulations. The NZa also sets the maximum fees that care providers may charge.

- The *Health Care Inspectorate (Inspectie voor de Gezondheidszorg or IGZ)* is responsible for maintaining the quality of services. The IGZ provides quality improvement advice and support to services and may close non-complying services.

5.1.1.2 Care providers under the AWBZ

Long-term care providers, including aged care providers, are mainly not-for-profit organisations, although some for-profit organisations operate in the home care area. Care providers are required to compete on the basis of price and quality for annual contracts with the relevant regional *Care Office* (although payments to care providers are actually made by the *Central Administration Office*). Providers operate with a set budget, meaning that care is rationed and new care applicants may be placed on a waiting list if available funds are low.

There are three main types of aged care providers: nursing homes, residential homes and home care providers. Other care providers under the AWBZ deliver mental health care, care for the disabled and parts of preventive health care.

5.1.1.3 Care under the AWBZ

Entitlements under the AWBZ are defined in terms of six broad functions which can be arranged for indicated care in consultation with a care provider[34]:

[34] Ibid.

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1 personal care; e.g. help with taking a shower, bed baths, dressing, shaving, skin care, going to the toilet, eating and drinking;

2 nursing; e.g. dressing wounds, giving injections, advising on how to cope with illness, showing clients how to self-inject;

3 supportive guidance; e.g. helping the client organise his / her day and manage his / her life better, as well as day-care or provision of daytime activities;

4 activating guidance; e.g. talking to the client to help him / her modify his / her behaviour or learn new forms of behaviour in cases where behavioural or psychological problems exist;

5 treatment; e.g. care in connection with an ailment; and

6 accommodation; e.g. some people are not capable of living independent lives, but require sheltered housing or continuous supervision in connection with serious absent-mindedness. In some cases, a client's care requirements may be too great to address in a home environment, making admission to an institution necessary.

Prior to receiving support, a person must undergo a *care assessment* performed by a *Care Office* to determine if care is required, what type and how much. Following the care assessment, a person may be either allocated services or set a *personal budget (PGB)*, which can be used to purchase necessary care and assistance.

5.1.2 The Netherlands' aged care system

Residential aged care in the Netherlands is provided under the AWBZ. 'Care for older people' is usually grouped under *Caring, Nursing and Home care (Verzorging, Verpleging en Thuiszorg or VV&T)*. These care types are provided in the following settings:

- nursing home, for residents with long term health conditions requiring medical care (comparable to high care in Australia);
- residential home, for residents not capable enough to remain in independent accommodation (comparable to low care in Australia); or
- individual's home.

As noted above, aged care providers – nursing homes, residential homes or home care providers – are contracted by a *Care office*.

Additional supports such as social support (home care or transportation) may be provided by local authorities under the *Act on Social Support (Wet Maatschappelijke Ondersteuning or WMO)*, leading to some fragmentation of care as assessments and intake are managed separately.

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Therefore, for example, a client of the health system with co-morbidity who wants to remain in their own home, could receive home modifications, a wheelchair and welfare arrangements such as meals-on-wheels under the WMO, personal care and nursing under the AWBZ, and medication, GP care and sometimes a hospital appointment under the ZVW[35].

5.1.2.1 Strengths of the Netherlands' approach to delivering aged care

According to the Netherlands Bureau for Economic Policy Analysis[36], reforms of the long term care system over the last decade have improved its efficiency and flexibility. Full health insurance coverage was already available for the population, but the Risk-Equalisation Fund shares risk and ensures insurers do more than just target young, healthy customers.

Supply-side elements have been abolished in favour of demand-side elements – in other words, the system has become more patient centred. *Personal budgets* have become more important and care is better tailored to clients' specific needs by being more flexible. Clients can choose whether to receive an entitlement as care in kind or in the form of a personal care budget, or as a combination of the two. Client-linked budgets also enhance efficiency.

The reforms aimed to increase the flexibility of health-care supply. Thus, the classification of health care, as used for medical indication, became more general – moving from a product-oriented classification (where products were related to specific products of institutions) to a classification of health-care functions (such as personal care).

Strengths identified by van de Ven and Schut[37] include the inducements for competing insurers to be prudent buyers of managed care on behalf of their insured populations. Although the supply side is still quite heavily regulated by the government, insurers and providers are expected to gradually gain more freedom to negotiate prices, service and quality of care. Furthermore, the financial levers are allowing insurers to integrate with health care providers and to provide care in their own facilities using their own staff (such as primary care centres and pharmacies). Insurers may also provide their gate-keeping GPs with incentives to stimulate integrated and coordinated care, resulting in integrated care organisations that give a significant role to primary care.

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[35] Bussemaker J, State Secretary of Health, Welfare and Sports. "The Future of the AWBZ – A Detailed Explanation." Letter to Gerdi Verbeet, The President of the House of Representatives, The Hague: 12 June 2009. Accessed 16 April 2010 at www.sitra.fi/NR/rdonlyres/67A42441-0DC9-4954-BC2D-C41971944A1E/0/VGNthefutureoftheawbzadetailedexplanation.pdf.

[36] Netherlands Bureau for Economic Policy Analysis website. *Summary of CPB Document 54 – A Snapshot of the AWBZ: An Analysis of Strengths and Weaknesses.* March 2004. Accessed 21 April 2010 at www.cpb.nl/eng/pub/cpbreeksen/document/54/doc54_summary.pdf.

[37] van de Ven W & Schut F, 2008, op cit.

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5.1.2.2 Weaknesses of the Netherlands' approach to delivering aged care

Aged care in the Netherlands has a number of weaknesses common to the AWBZ. van de Ven and Schut describe Dutch health care reform as "a work in progress"[38].

The health care system is expensive and it has been increasingly difficult to contain rising health costs. The range of different agencies involved in the sector, including funders, insurers, coordinating bodies (i.e. *Care Offices*) and care providers means the system is complex for consumers to navigate, responsibilities are unclear and care often fragmented. As a result, inefficiencies occur. Efforts continue to improve the quality and responsiveness to consumer preferences of care.

A number of drivers have been identified for these higher costs. These are set out below:

Poor budgeting - Analysis prepared by the Netherlands Bureau for Economic Policy Analysis[39] (NBEPA) in 2004 found that demand-driven health care operating without tight budgets and featuring an increasing role for client-linked budgets worsens the manageability of rising health-care costs. The NBEPA predicted that client linked budgets would considerably increase collective costs to the extent that previous volunteer aid will need to become financed collectively.

Demand driven nature of care - Escalating costs may be partially attributed to ageing, individualisation, declining waiting lists and hidden demand. However, rising costs may also be attributed to restructuring problems. At that time, the old supply-driven incentive structures had yet to be adjusted to the new situation of demand-driven care.

The NBEPA identified the key challenge posed by efficient delivery of health care as being the requirement for incentive structures in a demand system that differ markedly from those of a supply system. The system lacked financial incentives for the Care Offices to provide efficient provision of health care. Even more problematic, executive bodies had a perverse incentive because administrative costs were budgeted and health-care costs fully compensated. The incentive structure for enhancing medical quality also required improvement.

Shortages in care provision - Shortages existed in the provision of care, especially with respect to nursing homes. This made efficient purchasing of care more difficult. In particular, there were insufficient incentives to increase the provision of residential long-term care. At the same time, rising costs were a concern. The Dutch Government had few options for containing costs; these included: allowing entry to profit oriented providers, improving efficiency, increasing out-of-pocket payments and reducing the uniform basic benefit package. At the same time, the Government had to ensure that shifting costs to consumers did not reduce accessibility to services.

Obstacles abounded to more effective competition between health-care providers. The tendency towards coordination and not competition among providers in Dutch long-

[38] Ibid.
[39] Netherlands Bureau for Economic Policy Analysis, 2004, op cit.

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term care was deeply rooted. Also, mergers in many regions in the past resulted in higher concentrations of health-care providers. A further obstacle to competition was the lack of transparency on the quality of care.

Recent developments

Recent analysis of the AWBZ showed many of these challenges remain. In a letter to Parliament in 2009, the State Secretary of Health, Welfare and Sports, Jet Bussemaker, set out the future directions for the AWBZ[40]. Dr Bussemaker noted that structural problems remain, with a need to build greater cohesion between local organisations and providing more community care, so that clients can request low threshold care involving a small number of carers. Fragmentation of services is occurring, and Bussemaker called for better coordination between the AWBZ, WMO (Social Support Act), ZVW (Healthcare Insurance Act) and other systems, in line with clients' needs. Due to the complexity of disabilities and conditions, people often receive support and care under multiple different systems, which need to be delivered in a properly coordinated manner. This includes communicating clearly what care and support options are available and where the client can obtain them.

The Government has recently introduced changes to reduce the bureaucratic burden on care providers arising from providing information to insurers. *Care Offices* have jointly drawn up a set of standard requirements to tie in with the statutory frameworks. Care providers are now required to issue a management statement confirming that they meet the requirements. Additional information may only be requested in cases of serious doubt or in the event of a spot check or inspection. In all other cases the information provided in the management statement and the annual corporate social responsibility statement must suffice. Rules around use of *personal budgets* have also been tightened to address fraud and misuse.

The State Secretary raised a number of concerns about the current structure of Care Offices. These include inadequate incentives to implement the AWBZ in a client-centred manner[41] and problems due to multiple contact points for clients[42]. Disadvantages arise from insurers' role in administering *Care Offices* and hence implementing the AWBZ on behalf of the other insurers (and their policy holders) while competing against each other in the care purchasing market for ZVW care. Finally, there is a lack of choice for policy holders unable to 'vote with their feet'; although care insurers are responsible for implementation under the AWBZ, their policy holders remain dependent on their regional care office for service and purchasing of AWBZ care.

Health care reforms are expected to continue through to at least 2012.

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[40] Bussemaker J, 2009, op cit.

[41] For example, there is no direct relationship between the care office and the insured party, and therefore no intrinsic interest in keeping AWBZ premiums affordable. The care offices themselves do not have a financial interest in implementing the AWBZ.

[42] For example, clients can deal with the municipality for the WMO, the care office for the AWBZ and the care insurer for the ZVW.

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5.2 Japan's aged care system

5.2.1 Outline of Japan's health system

Like the Netherlands, the Japan has a mandatory social insurance system covering all citizens[43,44]. Japanese people must purchase one of several main types of insurance, linked to either their job or the municipality in which they live:

- *Employee's Health Insurance*, under which employers and employees share costs and rules and standards are set by the government. This type is split into the:
  - *Government-Managed Health Insurance (GMHI)* system, which covers employees working for small to medium-sized corporations and their dependants. GMHI is directly managed by the government;
  - *Society-Managed Health Insurance (SMHI)* system, which covers employees of large companies, and are independently established and managed by representatives of the employer and employees; and
  - *Mutual Aid Societies (MAS)*, which cover national and local government employees, also independently established and managed by representatives of the employer and employees;
- *National Health Insurance (NHI)*, also known as *Citizens' Health Insurance*, which covers those not eligible for Employee's Health Insurance such as the self-employed (e.g. farmers, contractors), the unemployed, retirees and expectant mothers. Municipal governments provide this health insurance to all eligible persons living in their jurisdiction; and
- *Long-term Care Insurance (LTCI)*, also known as *Health Insurance for the Elderly*, which covers the elderly (65 and over) and people who suffer from disabilities (aged 40-64). This long-term care insurance offers home, respite or institutional care. The majority of care costs are covered by the insurance; however individual consumers must pay a 10 per cent copayment. Municipal governments administer LTCI services.

The central government determines which services are covered and sets the fee-schedule for providers every two years. Consumer copayments are regulated, while consumer insurance fees vary between insurers from 10-30 per cent. Management of health insurance, including other issues such as setting contributions, varies between insurers. Across the insurance system plans are generally the same, with benefits including hospital, physician and dental care, as well as pharmaceuticals.

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[43] www.kaiseredu.org/topics_im_ihs.asp?imID=6&parentID=61
[44] Tatara K, Okamoto E. Japan: Health system review. *Health Systems in Transition*, 2009; 11(5): 1–164.

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The GMHI and NHI systems receive higher government subsidies due to the higher costs and lower revenue capacity of their customers. SMHI and MAS funds do not receive any subsidies. A risk sharing pooling fund is used to subsidise insurers with more elderly customers than the national average – all health insurers pay into this pool. Japanese people living below the poverty line are eligible for welfare support and receive free medical services.

5.2.1.1 Administration of the Japanese health insurance system

A number of agencies are involved in administration of the Japanese health insurance system. These include:

- the Ministry of Health, Labour and Welfare. Key bureaus involved in aged care under the ministry include:
  - Health and Welfare for the Elderly, which regulates and supervises long-term care insurance, elderly dementia and the health of the elderly;
  - Health Insurance and Pension, which regulates and supervises health care insurance and provides plans to improve the insurance system. The Pension Bureau is responsible for national and industrial pensions; and
- the Social Insurance Agency, an external organisation of the Japanese Ministry of Health, Labour and Welfare which is responsible for the administration and operation of Employees' Health Insurance, Seamen's Insurance, Employees' Pension Insurance and the National Pension;
- over 5,000 health insurers operated by employers (SMHI and MAS), municipalities (NHI), and the central government (GMHI).

5.2.2 Japan's aged care system

Care of the elderly is considered a national responsibility. In 1993, due to high hospitalisation rates and bed days for the elderly (known as 'social hospitalisation')[45], the national government began increasing the number of nursing home beds, adult day-care centres and home health aid providers. Reforms also sought to integrate the previously vertically divided system of health, medical and welfare services, to shift to comprehensive local services while offering consumers greater choice. Municipal governments undertook comprehensive assessments to determine local needs for long-term care in the community setting. This survey covered the entire population of

[45] At this time, almost half of all beds were filled by elderly patients, of whom more than a third stayed for longer than a year. See Mitchell O, Piggott J & Shimizutani S. "Aged-Care Support in Japan: Perspectives and Challenges" *Benefits Quarterly*, vol. 22, no. 1; pg. 7-19: 2006.

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disabled elderly dwelling in home settings and served as a baseline for the *Long-term Care Insurance (LTCI)* system[46].

During the 1990s, the 10-year *Gold Plan* enhanced social service support, but a continued reliance on taxation to finance this acted as a budgetary restraint. Nursing home placements increased, but home care support remained unavailable.

In 2000, LTCI was introduced to cope with the impacts of an ageing population and reduce high hospitalisation rates. Under LTCI, people aged 65 and over (category I) and people aged 40–64 with specific disabilities (category II) receive in-home services (at home care) and services at facilities (institutional care)[47,48]. Institutional care can only be provided by non-profit nursing homes and hospitals while home-care services may also be provided by private for-profit firms.

Three types of nursing homes provide institutional care:

- long-term care welfare facilities for the elderly (special nursing homes);
- long-term care health facilities for the elderly; and
- long-term care medical facilities for the elderly (which include dementia wards and hospitals with enhanced long-term care services).

Service eligibility is determined by local committees that conduct an assessment of applicants' medical and physical status. The applicant is allocated to one of seven categories, each with specific benefits attached. A care plan is prepared for LTC services such as home visits or day treatment (in-home services), respite care or long-term care (institutional care). Medical care is managed separately by the person's general practitioner and is funded under the national health care system.

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[46] Tatara K, Okamoto E. Japan: Health system review. *Health Systems in Transition*, 2009; 11(5): 1–164.
[47] Tatara & Okamoto, 2009, op cit.
[48] Mitchell O, Piggott J & Shimizutani S. *Developments in Long-Term Care Insurance in Japan. Australian School of Business Research Paper No. 2008 ECON 01*. Australian School of Business, University of New South Wales; Australia: 2008.

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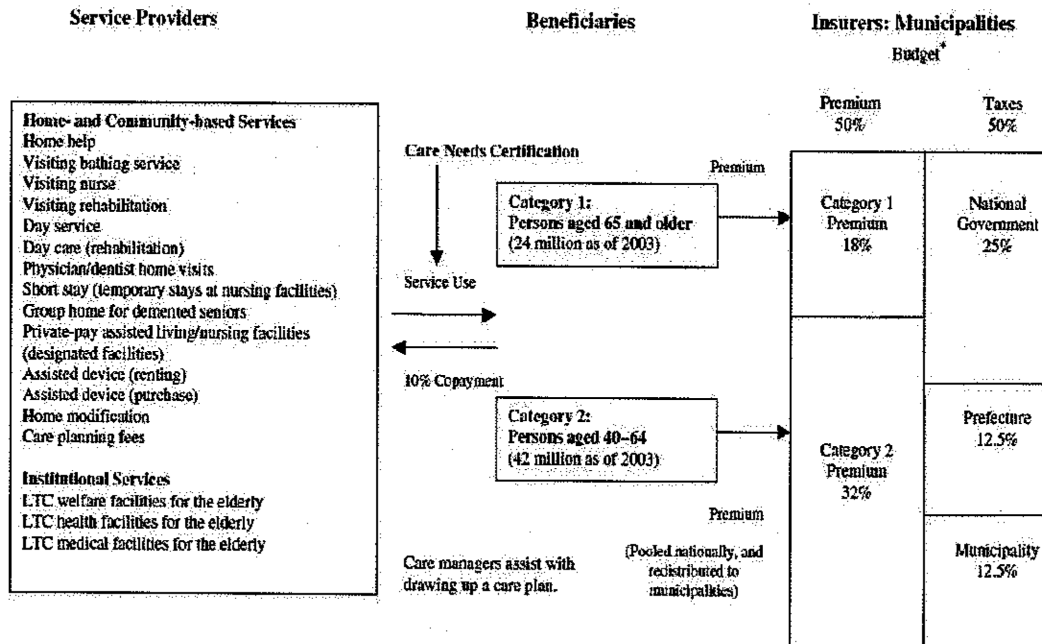
Figure 1: The Japanese LTC system[49]



LTCI is financed as a 'pay-as-you-go' program, paid for by taxation, worker premiums and user fees[50,51]. Workers premiums (aged 40+) cover about one-third of the annual budget; elderly premiums (aged 65+) cover about 17 per cent; and the government picks up the rest – approximately 25 per cent from the central government, 12.5 per cent from the prefectures and 12.5 per cent at the municipal level. LTC premiums are means tested and vary across municipalities. Prices of services and units of care are set by the central government, which also has a role in setting eligibility standards and determining who is entitled for care. Premium prices are set locally by the municipal authorities.

LTC users also face out-of-pocket copayments when they receive services and care. These include a 10 per cent co-insurance amount for each insured service, and meal charges, 'hotel' costs such as water, electricity and gas when in a nursing home. Copayments are set by service and type of care and vary depending on the consumer's care level (but not income level). Once a lower threshold limit is reached, the consumer is responsible for 100 per cent of additional costs until an upper threshold called the 'high-cost long-term care service limit' is reached. Above the upper threshold, all additional expenses are covered by the LTC program. This upper threshold can be adjusted for low-income consumers, in some cases by more than half.

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[49] Tsutsui T & Muramatsu N. "Care-needs certification in the Long-Term Care Insurance System of Japan", *Journal of the American Geriatrics Society*, vol. 53, pp. 522-527: 2005.
[50] Mitchell et al, 2006, op cit.
[51] Mitchell et al, 2008, op cit.

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5.2.2.1 Strengths of Japanese approach to delivering aged care

Japan has long been celebrated as having some of the best health outcomes in the world, including

- the longest life expectancy,
- low hospitalisation rates; and
- one of the lowest infant mortality rates.

Health care is readily accessible, involves few co-payments and has remained relatively low cost at around 8.1 per cent of GDP[52]. International comparisons of mortality from avoidable causes among 19 OECD countries in 2002–2003 showed that Japan had the eighth lowest rate of avoidable deaths for males[53]. Tatara and Okamoto refer to the role of regular health checks in reducing demand for services. It is also often noted, however, that the traditional Japanese diet and high levels of regular exercise play a significant role in achieving the strong Japanese health outcomes.

Mitchell et al (2006)[54] note that eligibility for aged care services is determined based on condition, rather than income and / or assets. Eligibility must be re-evaluated every six months. Needs assessments are thorough, ensuring services are matched to the consumer's individual needs.

The authors also note that providers compete locally for patients along several dimensions including quality of care (but not prices), and that local authorities in Japan are given much autonomy in the execution of policies.

Introduction of LTCI has correlated with a fall in the number of hospital beds. In a later article, Mitchell et al (2008)[55] write that in a five year period (2001-2006), the number of hospital beds per thousand persons aged 65+ fell by 17 per cent on average, whereas the beds dedicated to LTC rose by almost four per cent. Mitchell et al's analysis showed that the 75+ age group is demanding and obtaining higher levels of LTC services over time. It is clear that Japan has been successful in re-orienting the aged care system away from hospital based care to care delivered in the home and nursing home settings.

5.2.2.2 Weaknesses of Japanese approach to delivering aged care

As with all systems, Japan's health system has a number of weaknesses and faces significant challenges as the impact of population ageing increases. McKinsey and

[52] McKinsey & Company. *The Challenge of Reforming Japan's Health System.* McKinsey & Company; Japan; November 2008.
[53] Tatara & Okamoto, 2009, op cit.
[54] Mitchell et al, 2006, op cit.
[55] Mitchell et al, 2008, op cit.

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Co.[56] write that the system as a whole is characterised by over-servicing. Although Japan suffers from a clinician shortage, patients see clinicians at significantly higher rates than in other OECD nations (13.8 consultations per capita per year versus an OECD average of 6.9 in 2003), and stay in hospital for three times as long. Although health checks are mandated, the country has suffered from a lack of coordinated public health campaigns in areas like smoking and has had a lack of chronic disease prevention programs.

McKinsey and Co. also identified high insurance premiums as a problem, with many people opting not to pay their insurance premiums despite legal requirements that they do so. Insurance must be purchased – including any premiums owing from un-payed years - before care can be accessed, although households can purchase temporary access to care by paying two years worth of premiums owing. As a consequence, in 2008 more than 300,000 households were without any coverage and 1.1 million households had only temporary coverage.

Mitchell et al (2006) identified regional variations in provision and capacity of LTC as one consequence of the system's "decentralised yet centralised" approach. Variations in age structure across regions mean that some municipalities will face increasingly higher costs in servicing their population as it ages. Availability of resources and supports varies also. Future rationing of entitlements is a possibility, although the introduction of consumer copayments in 2008 has added to revenues to fund services.

5.3 Implications and learnings for Australia

A number of features of the Dutch and Japanese approach to delivering aged care are attractive to policy makers in Australia. Both models have achieved full population coverage while ensuring the cost to government of providing health and aged care is relatively lower than in other OECD countries such as Australia[57]. Although the overall cost to the Netherlands' health system is high compared to other OECD countries, the Japanese health system is less expensive. Both models strike a balance between individual and collective social responsibility. Government regulation, subsidies and risk sharing measures ensure equity of access in those systems.

The Dutch and Japanese approaches also diverge in some areas. In the Netherlands, competition between insurers and between health care providers is used to drive efficiency, quality and choice for consumers. In Japan, there does not appear to be portability between insurers as these are either a fund operated by the individual's employer, local government or the central government depending on the type of insurance and the individual's type of employer. As a consequence, consumer choice is limited and competition-driven efficiency negated. Commentators have observed that service quality is a concern and inefficiency in the form of over-servicing is actually

[56] McKinsey & Co, 2008, op cit.
[57] http://www.aihw.gov.au/publications/hwe/hea05-06/hea05-06.pdf

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leading to access problems[58]. The role of government in the Netherlands is limited to regulator and part funder, and its insurance system is not as subject to regional variations as Japan's municipal-driven approach – a clear advantage in a country as geographically diverse as Australia.

The question therefore is could a Netherlands-style competition-based social insurance system for aged care be established in Australia?, If so, what steps would be required to make this happen?

In 2009 the National Health and Hospital Reform Commission[59] (NHHRC) considered this concept, and recommended further investigations about the introduction of a 'Medicare Select' scheme for the entire health system. Some the NHHRC's recommendations are included in the list below.

In looking specifically at the aged care sector, we would expect that at a minimum Government would need to:

- develop **regulations** to protect consumers, covering aspects such as access, equity, prices and copayments and a role for a consumer ombudsman;
- determine the **age** at which individuals will be required to start contributing to mandatory insurance in order to ensure the viability and sustainability of funds, and at which age individuals will start receiving services;
- determine if individual insurance contributions would be added to a **shared, risk-adjusted funds pool** or allocated to superannuation-style **personal accounts**;
  - Under the first option, it would need to be determined if competing insurers would operate separate funds pools or the Australian Government would operate a single national funds pool.
  - Under the second option, individual contributions to personal accounts could be managed and possibly invested to maximise this revenue, much as superannuation contributions are currently managed and invested. However, depending on the size of their contributions, economic conditions and the success of investments, consumers could be faced with rationed aged care and equity gaps.
- establish a **risk sharing / equalisation** mechanism so that costs of providing universal coverage are shared by insurers and the public;
- determine the mix and roles of **public and private** providers;

[58] Mitchell O, Piggott J & Shimizutani S. Aged-Care Support in Japan: Perspectives and Challenges. January 2004.
[59] National Health and Hospital Reform Commission. *A healthier future for all Australians: Final Report of the National Health and Hospitals Reform Commission – June 2009*. Commonwealth of Australia; Canberra: 2009.

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- determine the mix of services offered and design service **prices**, aged care service 'plans' or products and establish contracting arrangements;
- ensure a sufficient number of insurance providers to ensure **competition** in the market to drive quality, efficiency and choice. Portability between insurers will also be important to drive competition;
- allow time to build a **funds pool**, both at the individual insurer level and for a risk equalisation pool, before consumers begin drawing down on services; and
- develop **accountability** and performance monitoring such as access targets, quality indicators and performance benchmarks.

Introduction of a Netherlands-style approach would be subject to the public acceptability of commercially driven system and the Australian Government's appetite for such a reform. It is notable that the Australian Government has not pursued the NHHRC's recommendations regarding 'Medicare Select' and such a scheme was absent from COAG announcements on 20 April 2010.

A hybrid of the Dutch and Japanese aged care systems could see an approach under which Australian workers pay an aged care specific levy, collected in a style similar to the Medicare levy (i.e. a pay-as-you-go tax) that would be collected as a national funds pool managed by the Australian Government. A model similar to this proposition is considered in the next chapter of this report.

Summary

- International models demonstrate that mandatory social insurance schemes can deliver health and aged care services with full population coverage at relatively lower cost to government than the current Australian model[3]. This does not, however, mean that overall health and aged care expenditure will be lower.
- The Netherlands model may provide an alternative for Australia as competition between insurers and providers drives efficiencies and consumer choice. There may be significant barriers to the implementation of a Japanese-style model in Australia due to our distinct geography and the considerable variation between communities.
- Implementation of a mandatory social insurance scheme in Australia would require significant new infrastructure including government regulatory bodies. At a minimum, there would be a need for appropriate regulations, measures to ensure quality and choice, a risk equalisation mechanism and sufficient competition to drive efficiency in the market.
- Policy makers would need to determine if individual insurance contributions would be added to a national funds pool or allocated to superannuation-style personal accounts.
- A model adapted to the Australian context could involve an 'Aged Care Levy' collected from Australian workers to provide quarantined funds for allocation to

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aged care services by the Australian Government.

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6 The 'Bethanie Model' option for funding residential aged care

This chapter applies the 'Bethanie Model' funding option to conditions in Australia over the next forty years in order to test the impact of the introduction of an Aged Care Levy on funding sustainability. The results of the financial modelling of two scenarios for the years 2010 to 2050 are provided. The two scenarios modelled are:

1. an 'As Is' scenario; and
2. a 'Bethanie Model' scenario.

Under the two models, expenditure has been split into costs relating to 'care' and costs relating to 'accommodation'.

The methodology employed by KPMG in testing the Bethanie Model, including assumptions made during modelling, is described under Appendix A.2. An overview of the financial impact that each scenario has on the costs of funding aged care is set out below. Please note that any projections of future financial performance are based upon judgement and opinion as to the numerous factors that may influence the various components of the projections. Accordingly, we will not consider, nor confirm, underwrite or guarantee that any outcome provided by the Model will be achieved.

6.1 The Bethanie Model

As detailed in previous sections, the existing Australian funding model for residential aged care is taxation based through recurrent funding transfers from the Australian Government Department of Health and Ageing to aged care providers. Through the 'Aged Care in Australia' document, Bethanie proposed an alternative funding model under which the proportion and quantum of recurrent funding provided by the Department of Health and Ageing would be significantly reduced through implementing an Aged Care Levy on Australians' wages and salaries or total income to fund all aged care services.

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6.2 Results of KPMG projections

6.2.1 Projected aged care costs under an 'as is' scenario

Under the first, 'as is' scenario modelled by KPMG, the cost to government of funding community care programs is projected to rise from $2.7 billion in 2010 to $35.0 billion in 2050. This includes funding for HACC, CACP, EACH and EACHD. The cost to government of funding residential care and the accommodation costs of supported residents will rise from $7.0 billion in 2010 to $89.8 billion in 2050. This leaves a total cost to government for aged care of $9.6 billion in 2010 and $124.8 billion in 2050. This includes the community care costs outlined above and the cost of residential care.

Based on the assumptions outlined in Appendix A.2, resident fees are expected to rise from $2.4 billion in 2010 to $31.5 billion in 2050, and income from bonds are expected to rise from $0.5 billion in 2010 to $6.0 billion in 2050. Accordingly, total resident fees and bond income collected by residential aged care providers is expected to rise from $3.0 billion in 2010 to $37.5 billion in 2050.

The total cost of aged care to Australia is expected to rise from $12.5 billion in 2010 to $162.3 billion in 2050.

Table 14: 'As is' scenario

	June 2010	June 2020	June 2030	June 2040	June 2050
Community care costs					
Total community care costs	$2,696,728,721	$5,603,855,269	$11,029,880,796	$20,172,210,736	$34,957,035,593
Residential care costs					
Care & accommodation	$6,929,522,845	$14,399,684,625	$28,342,417,368	$51,834,577,955	$89,825,711,726

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	June 2010	June 2020	June 2030	June 2040	June 2050
Total community and residential care costs	***$9,626,251,566***	***$20,003,539,894***	***$39,372,298,164***	***$72,006,788,691***	***$124,782,747,318***
Accommodation costs					
Residents fees	$2,428,302,053	$5,046,059,378	$9,931,989,811	$18,164,311,583	$31,477,486,271
Bond income (bond retention and interest)	$463,734,761	$963,649,945	$1,896,719,938	$3,468,852,928	$6,011,280,413
Total fee and bond income collected by RAC providers	***$2,892,036,814***	***$6,009,709,323***	***$11,828,709,749***	***$21,633,164,511***	***$37,488,766,683***
Total cost of aged care	**$12,518,288,381**	**$26,013,249,217**	**$51,201,007,913**	**$93,639,953,202**	**$162,271,514,002**

6.2.2 Aged care costs under a 'Bethanie Model' scenario

Under the 'Bethanie Model' scenario modelled by KPMG, the costs of funding community care remains unchanged – rising from $2.7 billion in 2010 to $35.0 billion in 2050. Likewise, the costs of funding residential care (excluding accommodation type costs) remains unchanged – rising from $6.2 billion in 2010 to $80.8 billion.

Based on the Bethanie Model assumptions, the total cost of providing care-type services through community and residential care settings would potentially rise from $8.9 billion in 2010 to $115.7 billion in 2050. Care services would be funded via an Aged Care Levy. When calculated as a percentage of average wages and earnings, the Aged Care Levy would equate to 1.65 per cent in 2010, rising to 2.86 per cent in 2050. When calculated as a percentage of total income, the Aged Care Levy would equate to 1.41 per cent in 2010, rising to 2.32 per cent in 2050.

The costs of providing accommodation would be met through government accommodation funding for supported residents and resident fees. Government accommodation funding for supported residents would rise from $1.3 billion in 2010 to $17.5 billion in 2050. The

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collection of bonds would cease, and subsequently residential aged care providers would no longer earn interest on these holdings (under the 'as is' scenario, this income equates to $0.5 billion in 2010 and $6.0 billion in 2050). Consequently, resident fees would be expected to rise from current levels in order to meet this shortfall, amounting to $3.1 billion in 2010 and $33.0 billion in 2050.

The total cost of aged care to Australia remains the same as under the 'As is' scenario - rising from $12.5 billion in 2010 to $162.3 billion in 2050. However, under the Bethanie Model scenario, the Government would only need $1.3 billion in funding from consolidated revenue in 2010 and $17.5 billion in 2050 - a reduction of over 86 per cent. The remainder of aged care funding needs would be met by the Aged Care Levy and resident fees.

Table 15: Bethanie Model scenario

	June 2010	June 2020	June 2030	June 2040	June 2050
Care costs					
Care costs - community	$2,696,728,721	$5,603,855,269	$11,029,880,796	$20,172,210,736	$34,957,035,593
Care costs - residential	$6,230,897,643	$12,947,927,727	$25,484,972,849	$46,608,685,302	$80,769,603,903
Total care costs to be funded via Aged Care Levy - community & residential	***$8,927,626,364***	***$18,551,782,996***	***$36,514,853,645***	***$66,780,896,039***	***$115,726,639,496***
Aged Care Levy as % total earnings of all employees	1.65%	1.97%	2.37%	2.64%	2.86%
Aged Care Levy as % of total income	1.41%	1.72%	2.00%	2.18%	2.32%
Accommodation costs					

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	June 2010	June 2020	June 2030	June 2040	June 2050
Total accommodation costs	***$3,590,662,017***	***$7,461,466,221***	***$14,686,154,268***	***$26,859,057,163***	***$46,544,874,506***
Analysis of how accommodation costs will be funded					
Government accommodation funding supported residents	$1,347,934,521	$2,801,034,419	$5,513,182,312	$10,082,890,059	$17,472,945,890
Less basic daily fee paid by supported residents	($881,977,802)	($1,827,759,641)	($2,534,493,369)	($3,247,772,218)	($3,965,106,255)
Total residential fee income	$3,124,705,298	$6,488,191,443	$11,707,465,325	$20,023,939,322	$33,037,034,872
Total accommodation funding available	***$3,590,662,017***	***$7,461,466,221***	***$14,686,154,268***	***$26,859,057,163***	***$46,544,874,506***
Total costs of Aged Care	**$12,518,288,381**	**$26,013,249,217**	**$51,201,007,913**	**$93,639,953,202**	**$162,271,514,002**
Total residential cost to government - care & accommodation (to be funded via consolidated revenue)	*$1,347,934,521*	*$2,801,034,419*	*$5,513,182,312*	*$10,082,890,059*	*$17,472,945,890*
Reduction in consolidated revenue funding over 'as is scenario'	*$8,278,317,045*	*$17,202,505,474*	*$33,859,115,852*	*$61,923,898,632*	*$107,309,801,429*
	86.0%	*86.0%*	*86.0%*	*86.0%*	*86.0%*

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6.3 Potential strengths and weaknesses of the Bethanie model

The potential strengths of such a model for funding aged care include:

- a mechanism for funding current and future aged care requirements that is transparent and provides clarity for taxpayers, which may increase the likelihood of public support for the levy;
- certainty amongst service providers that funding will be available, which should promote long-term decision making;
- greater flexibility and responsiveness to market forces in the provision of services to meet demand (within boundaries set by Government);
- simplification of funding for aged care services, and in particular the cessation of the aged care bond system;
- removal of pressure on government to fund rising aged care costs through general taxation; and
- greater understanding amongst the public as to the true costs of aged care over the short, medium and long term.

There are also, however, some potential weaknesses associated with such a model. These include the:

- need for future funding of accommodation-related costs through direct payments made by service users (residents) at the time of service provision;
- continued role of government as the primary funder of aged care (in contrast with the Dutch and Japanese systems);
- the need to offset the loss of income from bond holdings with an increase in resident fees; and
- continued reliance on the working population rather than by service users to bear the costs of a large proportion of future aged care. Demographic changes will mean that this pressure is instead set to increase.

6.4 Issues for further consideration

Given the issues discussed above, there are a number of issues that should be considered when undertaking detailed analysis of the likely benefits and drawbacks of the alternative model of aged care funding proposed by Bethanie. These include the following:

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- Should ring-fenced aged care funds be invested over the long-term (in line with superannuation funds or a 'future fund') or simply expended in the year they are raised?
- Would an Aged Care Levy better be drawn down into a common funding pool or into personal accounts (similar to superannuation)?
- Would a Dutch-style mandatory social insurance scheme, in which consumers purchase aged care products from competing private sector insurers, produce greater efficiencies and cost effectiveness?
- In circumstances where a taxpayer dies prior to drawing down from the aged care fund, would their contributions be paid out?
- How will the system be administered under the proposed funding model and which agency / agencies would be responsible for this?
- Due to difficulties in confirming actual total costs of the provision of providing aged care services (due to the large number of providers), the financial modelling undertaken by KPMG of the Bethanie Model relies on the assumption that the total costs of providing aged care services in 2009-10 is equal to the income received by service providers from sources such as government grants, residents fees and bond interest and retentions. Given indications from aged care providers and some research that actual costs of providing care may exceed the income available to providers, further research to determine the true cost of delivering aged care would benefit the sector.

Further consideration of these issues will be required as more detailed analysis of an Aged Care Levy approach to funding aged care is undertaken in the future.

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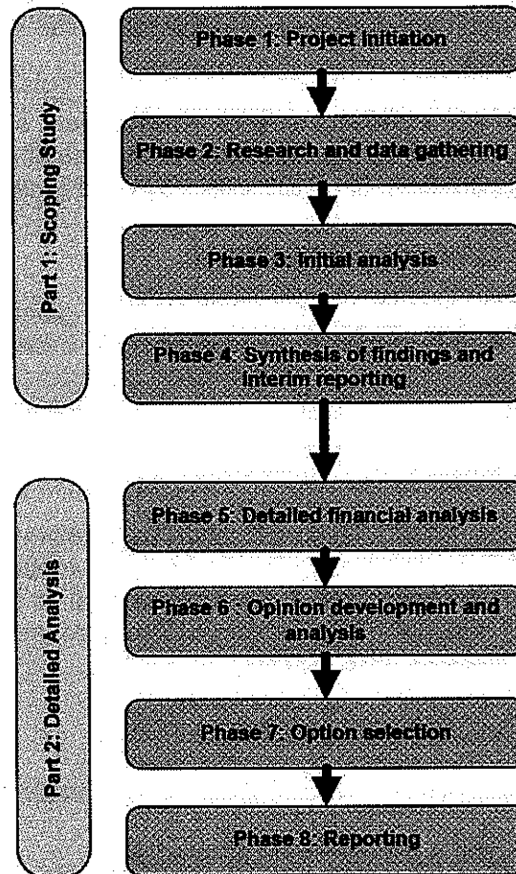
7 Appendices

A.1 Project scope and methodology

A.1.1 Proposed approach and methodology

The diagram below sets out KPMG's proposed methodology for this project.

Figure 2: Overview of project approach



These phases and activities are discussed in further detail below.

Part 1 Scoping study

<u>Phase 1 Project initiation</u>

Our first step in undertaking the engagement will be to meet with the CEO of Bethanie. The objectives of this meeting are:

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- to gain a full understanding of the nature of the outcomes required by Bethanie and confirm our proposed project plan;
- to confirm the roles of the Bethanie CEO, the KPMG team and other key project contacts;
- to agree with the CEO the format and content of the detailed written report;
- to clarify communication mechanisms with Bethanie's staff in order to ensure a seamless transition of information and ideas; and
- to determine an approach and reporting format for the provision of ad hoc advisory services to Bethanie.

We envisage that all key members of your KPMG client service team will attend this preliminary meeting. Based on the outcomes of this meeting, KPMG would finalise the project plan and submit this for the CEO's approval within one week of our meeting.

Phase 2 Initial research and data gathering

This phase of the project will involve the KPMG team gaining an understanding of the work undertaken by Bethanie to-date as well as undertaking a desk-top literature scan to identify other similar research which has been undertaken in Australia and overseas in recent years in respect of alternative models for the funding of residential aged care.

Phase 3 Initial analysis

During this phase, the KPMG team will undertake review and analysis of the work which has already been undertaken by Bethanie in respect of the modelling of the future costs of residential aged care in Australia as well as the work done on assessing the likely costs and benefits of Bethanie's stated preferred funding option of a Fee System funded through a Medicare levy.

Phase 4 Synthesis of findings and interim reporting

This phase of the review will provide KPMG's initial assessment of:

- alternative residential aged care funding models;
- the completeness and accuracy of the financial analysis undertaken to-date by Bethanie; and
- the additional work that is required to develop a robust proposal to present to the Australian Government and/or political imperatives.

The outcome of this phase of the engagement will be an interim report which summarises the work undertaken to-date as well as KPMG's recommended next steps for Part 2 of the project.

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Part 2 Detailed analysis

Phase 5 Detailed financial analysis

Dependant on the outcomes of Part 1 of the project, this phase of the project will involve the KPMG team undertaking detailed financial analysis to support the proposal for the establishment of an alternative residential aged care funding model. KPMG's actuarial service will review the methodology used for the financial analysis.

Whilst the detail of this analysis will be determined by the work done under Part 1 of the project, KPMG would anticipate that it would primarily focus on:

- financial modelling of future residential aged care costs; and
- analysis of projections relating to future demand for aged care.

Phase 6 Reporting

The reporting stage will involve preparation by the KPMG team of a draft report and a final report. However, in order that Bethanie have sufficient opportunity to provide feedback on the key findings, we propose to present the key findings of the project back to the CEO and other key members of the Executive team prior to submission of the draft report.

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A.2 Modelling methodology and assumptions

KPMG has examined the Bethanie Model in detail and has worked with Bethanie in projecting the outcomes of introducing an 'Aged Care Levy', collected and allocated by the Australian Government to fund the costs of community and residential aged care in Australia.

KPMG has worked with Bethanie to project the likely impacts of implementing the Bethanie Model for every year from 30 June 2010 to 30 June 2020 and for the years 2030, 2040 and 2050.

A.2.1 Basic modelling assumptions

In undertaking this modelling, Bethanie has made a number of assumptions. The original data sources and the modelling assumptions are set out below:

- Due to difficulties in confirming actual total costs of the provision of providing aged care services (due to the large number of providers), the assumption is made that the total costs of providing aged care services in 2009-10 is equal to the income received by service providers from sources such as government grants, residents fees and bond interest and retentions. Whilst there is research to suggest that actual costs of providing care – particularly residential aged care – may exceed the income available to providers, for the purpose of this analysis the assumption is made that aged care income equals aged care cost for the 2010 financial year.

- The current mix of community and residential aged care services (i.e. HACC, CACP, EACH, EACH-D and residential aged care) will be maintained by government. The proportion of persons using these services and the proportion of total government funding allocated to each program will also be maintained at current rates.

- Demographic modelling is sourced from the Australian Treasury's third Intergenerational Report[60] (IGR3) to provide population projects across the 0-14, 15-64, 65-84 and 85 and over age cohorts. Although other demographics estimates are available, for example through the Australian Bureau of Statistics, IGR3 figures have been used for forecasting to maintain consistency with other data used for the modelling.

  - An aged dependency ratio showing the number of working age persons required to support non-working age persons (i.e. aged 0-15 and 65 and over) has been calculated using these figures.

  - Labour force participation and unemployment projections from IRG3 are also used to project the employed workforce.

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[60] Commonwealth of Australia, January 2010, op cit.

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- An annual wage inflation rate of 4.0 per cent has been sourced from IGR3. The IGR3 calculated this 4% annual wage inflation as inflation plus 1.6% productivity growth.

- Average weekly earnings for all employees and household income for 2008-2009 have been sourced from the Australian Bureau of Statistics[61].

  - Average weekly earnings for all employees have been used to determine the average per annum total earnings of all employees and the total national earnings of all employees.

  - Total household income has been sourced from the same ABS release. KPMG has assumed that all sources of income used to compile the total gross income for Australia are taxable at the same rate for all individuals aged 15 years and over and has used this total figure for modelling.

  The IGR3's estimate of 4.0 per cent annual wage inflation rate was used to project growth in wages and income.

- The demand for government spending and total operating costs of providing community aged care have been projected.

  - The proportion of the population receiving support under each of the CACP, EACH and EACH-D programs[62] and HACC[63] and the daily cost of care have been calculated and used to develop projections for these programs. The baseline cost per client per day was derived based on costs and number of clients for 2008-09. The cost per day has been increased each year in line with wages inflation.

  - It is assumed that the proportion of the 65 and over population receiving support from these programs will continue at current rates.

  - KPMG notes that EACH and EACH-D are relatively new programs (since 2005-06) and have been growing at a significant rate. The approach taken is therefore likely to underestimate the cost of these programs. The increased focus on keeping people in their own homes as long as possible is likely to increase demand as a percentage of the population over 65. However it is not possible to quantify this demand, and hence KPMG has assumed the proportion of the 65 and over population receiving support from these programs will continue at current rates.

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[61] Australian Bureau of Statistics. *1350.0 - Australian Economic Indicators, Jun 2010.* ABS; Canberra: Released at 11:30 am (Canberra time) Mon 31 May 2010. Accessed 3 June 2010 at http://abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1350.0Jun%202010?OpenDocument#Publications.
[62] Australian Government Department of Health and Ageing, 2009a, op cit.
[63] Commonwealth of Australia, 2009, op cit.

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- The demand for government spending and total operating costs of providing residential care have been projected as follows:
  - The proportion of people aged 65 and over requiring residential care is assumed to be constant over time. KPMG notes that the proportion of residents aged 85 and over is significantly higher than the proportion of residents aged 65 to 84. Given that the government appears to be supporting people to stay at home as long as possible through community care programs, it may be likely that residential care becomes even more high care focussed. However it is not possible to quantify this demand, and hence KPMG has assumed the proportion of the 65 and over population requiring residential care will continue at current rates.
  - The percentage of supported residents (i.e. residents receiving government subsidies, not including fees derived from pensions) has been calculated by KPMG using demographic data and reported numbers of people receiving care. Supported residents are estimated to be 37.5 per cent of all residents, or 62,688 persons in 2010. This percentage has been calculated on the basis that of the 162,253 people receiving care in residential homes as at 30 June 2009, financial support was being provided for 18,843 supported residents, 37,598 concessional residents and 4,469 assisted residents[64].
  - Supported resident contributions (paid as the basic daily fee) have been calculated by assuming all supported residents pay 84 per cent[65] of the age pension of $644.20 (the amount for single persons) towards the costs of their accommodation[66].
  - KPMG calculated the per day government contribution to the cost of providing residential care ($113.69 in 2010), based on total per annum government spending on residential care divided by total number of recipients of care divided by 365 days. To determine the income derived from resident fees, KPMG used estimates from an annual industry survey by Stewart Brown[67] that indicated that residential income as proportion of total revenue is 29.4 per cent. This figure was used to calculate the total costs of providing residential aged care, estimated by KPMG to be $161.14 per client per day, amounting to $9.8 billion for all clients in 2010.
  - An annual aged care cost inflation rate of 4.0 per cent has been applied to per person expenditure and used with demographic projections to project future costs to government of residential care. This rate has been used as the key

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[64] Australian Government Department of Health and Ageing, 2009a, op cit.
[65] Australian Government Department of Health and Ageing. 2009b, op cit.
[66] Aged care pension effective from 20 March 2010, see Centrelink website, Age Pension Payment Rates. Accessed 8 June 2010 at www.centrelink.gov.au/internet/internet.nsf/payments/age_rates.htm.
[67] Stewart Brown. *Stewart Brown Aged Care Financial Performance Survey. Six Months Ending 31 December 2009.*

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driver for increases in aged care costs comes from wages and salaries. The annual wage inflation rate included in IGR3 was 4% over the 40 year period.

- The cost per resident was been split between accommodation and care costs.

- Demand rates for community and residential care have been taken from a point in time estimation, being 30 June 2009. KPMG has assumed demand at this time is reflective of average occupancy rates. However, this may not be the case if significant changes in occupancy occurred at this time.

A.2.2 Alternative scenarios

KPMG has modelled costs for two scenarios – an 'as is' scenario and a 'Bethanie Model' scenario. Assumptions underpinning these models are set out below.

A.2.2.1 'As is' scenario:

- As per current arrangements the Australian Government continues to fund community and residential aged care services from consolidated revenues.

- Residential aged care providers will continue to collect resident fees plus income derived from retention of bond (i.e. interest, retention fees and accommodation charges).

- KPMG derived a daily cost to government of providing residential care only (i.e. not including accommodation costs) by determining government subsidies for care costs to equal $5.8 billion (see Table 12) and dividing this by the number of permanent residents and then 365 days.

  - The terminology reflects that used in the Government's *Residential Care Manual*[68], with 'care' costs referring to the costs of meeting the care needs of residents (i.e. mainly being human resources and medical supplies) and 'accommodation' costs referring to costs such as hotel-type services, cost of food, utilities and capital maintenance.

  - In making this assessment, KPMG has assumed that the basic subsidy, conditional adjustment payment, primary care supplements, hardship supplement and income testing reduction are all applied to care costs. KPMG has further assumed that all other subsidies, supplements and reductions are applied to accommodation costs and that these will be continued through to 2050; i.e. supplements and reductions relating to grandfathering and transitional arrangements have been continued rather than phased out.

- The daily cost of care was estimated to be $104.41 per resident in 2010.

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[68] Australian Government Department of Health and Ageing, 2009b, op cit.

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- KPMG derived a daily cost of accommodation to government for residents by determining government subsidies for accommodation costs to equal $0.7 billion (see Table 12) and dividing this by the number of permanent residents and then 365 days.
  - The daily cost of accommodation was estimated to be $11.46 in 2010.
  - A total cost to government of funding accommodation was calculated to be $0.7 billion; this figure was added to residential income allocated to accommodation cost (i.e. 29.4 per cent of the total cost of residential care, which will be $9.8 billion in 2010).
  - Therefore, the total cost of accommodation for residents was calculated to be $3.6 billion, from which a daily total cost of accommodation of $58.91 per resident was calculated.
- To determine the income derived by providers from bonds, KPMG used a Stewart Brown estimate that bond and accommodation charges pay for 4.7 per cent of total costs.

A.2.2.2 'Bethanie Model' scenario:

- Individual contributions will be collected and managed by the Australian Government as an *'Aged Care Levy'*. The *Aged Care Levy* will fund all 'care services'. This is defined as including all community aged care costs (i.e. for HACC, CACP, EACH and EACH-D) and residential aged care costs currently funded by government grants classed as care payments (see Table 12 at Section 4.2).
- Accommodation bonds will be ceased (effective from 30 June 2009) and bonds currently held by residential aged care providers will be repaid over a period of five years.
- Resident fees will be retained to cover 'accommodation costs'. These costs include hotel services and capital costs. This requirement for continued resident fees will account for the movement of the ageing 'baby boomer' cohort into an older age bracket, which would result in an unsustainable burden on the employed workforce. It is also noted that the baby boomer cohort is Australia's wealthiest[69] and therefore best able to sustain a user-pays fee collected at the time care is delivered.
- The total cost of accommodation is calculated as $3.6 billion. This total consists of government funding of accommodation costs for supported residents in 2010 of $1.3 billion (total accommodation costs of supported residents less supported resident contributions of $882 million) and the total income from residents fees, $3.1 billion.

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[69] Productivity Commission, 2008, op cit.

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- 36 per cent of residents are assumed to receive government support. The remaining 64 per cent are assumed to pay the full accommodation costs.

- The Bethanie Model would therefore see the Government paying the residential care and accommodation costs for supported residents (less that covered by the resident contributions provided by supported residents).

- Income raised from resident fees is projected to rise from a total of $2.4 billion under the 'as is' scenario to $3.1 billion under the Bethanie Model scenario (for 2010). This increase is primarily due to the loss of income from bond interest and retentions under this model.

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