Australian Centre for Economic Research on Health

2nd Annual Policy Forum

Brisbane February 22nd 2008

Policy Issues in Aging

Henry ERGAS♣

Concept Economics and Monash University, Melbourne

♣ Address for correspondence: henryergas@concepteconomics.com.au. This paper draws on joint work with Dr David Cullen, of the Commonwealth Department of Health and Aging. However, the views it sets out are entirely my own, as is responsibility for any errors.

By “the aged care system” I mean the arrangements for providing domiciliary (“community”) and residential care to those among the elderly who require on-going and substantial assistance to carry out the basic activities of daily living. That system is an important but very under-studied element in Australian health care policy.

Australia has an extensive, largely government financed, aged care system, that currently provides residential care to around 155,000 people each night. While residential care accounts for over 80 per cent of “market” outlays[1] on aged care, there are also extensive domiciliary programmes, structured by level of need.

The Commonwealth government has primary policy responsibility for the provision of residential care, and for the higher disability forms of domiciliary care. To that end, the Commonwealth finances a large share of accommodation and care costs, with the Commonwealth paying some 50 per cent of costs in residential low care (i.e. care corresponding to lower levels of disability) and just under 75 per cent of costs in residential high care (i.e. care corresponding to higher levels of disability).[2]

Given that financial responsibility, the Commonwealth rations access to care places. More specifically, the Commonwealth uses “planning ratios” that specify the number of aged care places that are to be made available as a function of the population aged 70 and over. The number of places, expressed as a proportion of the relevant population, has increased substantially over the years, and – reflecting community demand – has been rebalanced towards a greater emphasis on domiciliary care, including at the very high disability end of the spectrum.[3] In turn, individual access to places is controlled through a process of needs assessment, based on medical evaluations that grade potential beneficiaries in terms of the degree of care that they require.[4]

---

1 That is, outlays excluding the costs of informal care. The opportunity cost of informal care, measured as the reduction in paid employment due to caring, is estimated to be about 0.6 per cent of GDP (that is, about 9.9 per cent of the value of formal health care). The cost of replacing the work done by informal carers, were their services no longer available, is of course much higher. It has been estimated that if all hours of informal care were replaced with services purchased from formal care providers and provided in the home, the replacement value would be about 3.5 per cent of GDP (that is, about 62.2 per cent of other formal health care).

2 Prior to reforms in 1997, low care residential care facilities were known as hostels, and high care residential care facilities were known as nursing homes.

3 The planning arrangements, which specify the number and location of places, have been in operation since 1985. The number of subsidised aged care places is currently capped at 113 places for every 1000 people aged at least 70. This cap was recently increased from the previous planning ratio of 100 places for every 1000 people aged at least 70, though some of this increase involves counting as part of the cap places that previously fell outside it. The supply of service type within this overall cap is also controlled, with 40 of those places being primarily for low level residential care, 48 for high level residential care, 21 for low level community packages and 4 for high level community packages. This represents a rebalancing towards high level residential care and towards domiciliary care, relative to the previous cap. Actual service provision ratios differ from these planning targets, however, largely because of the policy of ‘ageing in place’ (which allows a resident who enters a low care place for low care to remain in that place if and when he or she comes to need and receive high care). Reflecting that policy, around 58 of every 88 places are used for high care with the remaining 30 places used for low care.

4 This assessment is currently done by Aged Care Assessment Teams (“ACAT”), which are funded by the Commonwealth Government but managed by State Governments.

Reflecting the controls over the number of places, occupancy rates have been very high – typically, well over 90 percent. This means that finding a vacant place in an aged care home or a community care package can be difficult. In 2005-2006, for example, there were (on average) fewer than 3 vacant places each day for every 1000 people aged 70 or over in a third of the 71 aged care planning regions.

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

High occupancy and the associated queues confer localised market power on suppliers. At least in principle, suppliers’ ability to exercise that market power through higher prices is limited by extensive controls over the prices that aged care providers can levy on their residents. While the costs incurred by about a third of residents are entirely borne by the Commonwealth (other than the basic daily fee of 85 per cent of the age pension which is arguably a transfer payment by the Commonwealth), the vast majority of residents pay some part of the charges associated with these regulated prices, with the extent of this co-payment depending on highly complicated and somewhat opaque income and assets tests.[5]

The price controls are far from being fully effective. In particular, suppliers of low care are allowed to charge an accommodation bond that is essentially uncapped. In the last seven years, the average bond has almost doubled in real terms, from six to eleven times the annual basic pension. Although the bonds are paid for low care, the high level of charges partly reflects the scarcity of high care, as (under the Government’s “Aging in Place” policy) getting a low care place guarantees later access to a high care place.

Increases in bonds account for the bulk of the increase in income accruing to care providers over the course of this decade. This is true not only for providers of low care, but also for high care, with high care providers becoming increasingly dependent on held-over or transferred low care bonds to finance their operations. By 2005-06, only one third of aged care homes that catered predominantly for residents needing high level care did not hold any accommodation bonds, and the proportion seems to have fallen further since then. At the same time, substantial expansion has occurred in the “extra service” section of high care, which is allowed to charge accommodation bonds, with “extra service” places accounting for nearly 10 per cent of total claim days in 2007.[6]

---

5 Recently announced reforms have sought to simplify the structure of these means tests, and render them neutral as between different income sources, and in particular, as between pensioners and self-funded retirees.

6 The expansion in ‘Extra Service’ is all the more remarkable given the fact that the means-testing arrangements for aged care subsidies tend to penalise residents in ‘Extra Service’ homes. Thus, under current arrangements, the Commonwealth subsidy payable in respect of a resident in extra service is reduced by 25 per cent of the extra service fee that the resident pays. Providers are allowed to recoup this reduction from the resident. The net impact is that a resident effectively pays 125 per cent of the extra service fee.

In short, we have a system that is both extensively funded and controlled by Government, but where the controls have been associated with likely substantial rationing of demand and the creation of localised market power.

This system has some strengths and significant achievements. Despite waiting lists, it performs reasonably well in terms of the extent and equity of access. Additionally, the capitated, disability-adjusted, nature of the payments made to care providers is arguably well-suited to the chronic character of the conditions being treated, although it can create incentives for skimping on quality, placing greater demands on the arrangements for quality of service regulation. That said, there are obvious strains on the system as a result of population aging.

The most direct consequence of the demographic trends is to necessitate a significant increase in supply. To meet 2007 planning ratios of 88 residential places per 1,000 aged persons in 2025, there would need to be an absolute increase of 83,100 low care places and 87,400 high care places. This would be a doubling in the number of places compared to today and is still likely to fall short of demand. At the same time, given changes in the incidence and nature of age-related disability on the one hand and in community preferences on the other, the structure of supply needs to change, with the share of domiciliary care and of high care residential care rising relative to residential low care.

As matters currently stand, it is not obvious that the sector is well-placed to finance this expansion or undertake required structural change. Despite significant increases in carried-over accommodation bonds, the average return on assets in 2004-05 in high level residential care was already only about half the average return in low level residential care. As the relative numbers entering low care decline, while the number of those seeking high care rises, the cross-subsidy from low care to high care will become ever less effective as a way of financing high care and its expansion. The latest increases in allowed prices (and associated subsidies) will ameliorate this situation but are not a long-term solution. This is all the more the case as costs are likely to increase as a result of intensified competition between the aged care sector and the hospital system for scarce medical and para-medical personnel. Equally, costs are likely to rise steeply in domiciliary care, especially as the trend decline in the availability of informal carers accelerates while the disabilities for which domiciliary treatment is being sought become more severe.

It is an open question whether the Commonwealth will be willing to finance the resulting shortfalls. Aged care funding currently consumes about 3 percent of Commonwealth revenues. That share is projected to treble by 2046-47, assuming Commonwealth revenues remain at their long term average of about 22 percent of GDP. The resulting fiscal pressures are likely to see moves to constrain spending on aged care, shifting a greater part of the financing burden on to care recipients.

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

Those trends notwithstanding, it is likely that the Australian arrangements are still at the relatively redistributive end of the international spectrum[7], and that longer term pressures for a rising element of "user pays" will persist, regardless of which Government is in office.

This is not necessarily inefficient. Indeed, in domiciliary care, where moral hazard is an issue, a reasonably substantial co-payment would be sensible (noting that currently, the Commonwealth-funded domiciliary schemes are not means tested). Moreover, given little or no labour/leisure substitutability among the very elderly, and an only muted effect of co-payments late in life on life-time labour/leisure decisions, a steeply progressive means-tested co-payment for aged care may be consistent with Ramsey-Mirlees optimal taxation. However, it needs to be recognised that such a steeply progressive co-payment may induce some inefficient behaviour (such as running down of assets and income, and investment in ways of evading the means test). Additionally, increasing the co-payment rate in residential care, and especially high care, imposes substantial wealth risk on the elderly population, which has little scope to buffer that risk through labour-force participation decisions.

The risk at issue is closely associated with longevity risk. The lifetime risk of requiring permanent residential aged care in Australia rises from around 35 per cent at birth to over 60 per cent at age 90. While the risk of requiring aged care rises with age, the variance of stay durations and hence of costs remains high, and indeed, appears to be increasing materially.[8] Exposing potential care recipients to that risk would accentuate the effective transfer of longevity risk on to individuals that has occurred as a result of the move from defined benefit to defined contribution superannuation.

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

---

7 Comparing the incidence of aged care costs is complex because it depends on the interaction of tax and transfer systems.

8 Thus, long durations are likely to become more common in high-level care, as that care becomes less of an immediate antecedent to death. Already, at all levels of frailty, residents with dementia remain in residential care for longer than other residents. Over the last four years, the proportion of discharges from permanent residential care that were in care for at least two years after admission has risen by 1.9 percentage points (from 38.6 per cent to 40.5 per cent). However, short stays will also remain common, and may become more so, both because of the greater prevalence of intermittent care and because many admissions continue to be as a result of acute events. In the last three months of 2006, for example, 10.9 per cent of discharges from high-level residential care occurred less than one month after admission and 12.2 per cent of discharges occurred between one to three months after admission, with 70.0 per cent and 69.8 per cent, respectively, of these discharges being due to death. As a result, the distribution of durations of residential care, which already is bimodal, may become even more so, with a bunching of durations at the relatively short and relatively long ends of the duration spectrum. These differences in duration map into potentially very large differences in the required co-payment, so that the income risk associated with the risk of entering aged care is relatively high.

However, even were this the case, there would be a compelling case to review aspects of the current arrangements.

There are ways in which the current entitlements – especially the supplementary payments for residents with few or no assets – could be reformed so as to be more effective in securing equitable outcomes. For example, it could be sensible to move to payments that took more account of local area characteristics (including costs and incomes), rather than being geographically uniform.

Additionally and importantly, a move away from controls over place numbers would be desirable, making the entitlement more of a voucher that could be exercised in a competitive market. The system would, in other words, move to being more of a transferable topping-up payment, usable both in domiciliary and residential care, with less control over prices and entry.

There are many practical difficulties involved in making such a move and any full transition away from the current arrangements is likely to be protracted. Given the extent of the long term demographic pressures, however, it would be highly desirable if greater attention were paid to the need for such fundamental reform, rather than to continued tinkering with the system as it now stands.