Policy Monographs

THE CENTRE FOR INDEPENDENT STUDIES

The Organisation of Residential Aged Care for an Ageing Population

Warren Hogan

Papers in Health and Ageing (1)

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Foreword

The demographics are unequivocal and undisputed. Over the last thirty years, average life expectancy in Australia has been steadily rising (every year it increases by more than three months) while birth rates have been falling. The result is that the average age of the population is increasing as we live longer but have fewer babies. In June 2006, 19% of Australians were under 15 years of age while 13% were over 65. Fast forward to June 2056, and it is predicted that only 15% will be under 15 but 26% will be over 65. The proportion of Australians over the present retirement age is thus expected to double to more than a quarter of the total population in the next fifty years.[1]

Extended life expectancy is, of course, highly desirable, and we can thank the extraordinary growth capacity of the capitalist market system for making it possible. As our society becomes richer, so labour becomes less arduous, nutrition improves, health and safety standards are raised, medical treatments improve, housing quality increases and people live longer. But the ageing of the population does create some problems, not least of which is that more sick and frail elderly people will need care at a time when the relative size of the economically-active population will be shrinking. One of the most important policy questions now facing us as a nation is how this care will be organised and paid for.

In 2002, the federal government commissioned Professor Warren Hogan to investigate the options and to make recommendations, and eighteen months later, in February 2004, Hogan published his report.[2] The report reviewed many of the problems which were hindering the expansion of so-called 'ordinary high care' by nursing home proprietors, but two in particular stood out.

First, the supply of nursing home beds was being artificially restricted by the system of government licensing. Eligibility for a nursing home ('high-care') bed is determined by an Aged Care Assessment Team, but when an elderly person is confirmed as in need of a bed, they still have to wait until a place falls vacant. Hogan found the average wait was about 50 days, but it could be as long as a year in some rural areas. The reason why the industry does not increase the supply of beds to meet this unsatisfied demand is that places are limited by the finite number of government licences that are issued. This system of centralised licensing allows the federal government to keep a lid on costs, but Hogan argued that it artificially depresses supply as well as favouring existing providers at the expense of new entrants to the market, who have to pay up to $60,000 per bed to buy licences from existing businesses.[3] Hogan recommended that the centralised allocation system should be replaced by an auction enabling existing and prospective nursing home proprietors to bid against each other for bed licences.

The second problem faced by the industry was a shortage of capital to fund new investment. When elderly people enter 'low-care' facilities, such as hostels or sheltered housing, they can be asked to lodge an accommodation bond, which is usually financed by the sale of their existing home. The service provider pays no interest on this money but uses it to offset borrowing costs incurred in development of the facility. When the resident eventually dies or leaves the facility, the bond is repaid, less a small retention sum not exceeding $3,000.

This system of accommodation bonds is not, however, available to 'high care' providers of nursing home places, and a key recommendation of the Hogan Report was that it should be extended to this sector. This self-evidently sensible proposal would have helped resolve a number of anomalies and unfairnesses arising out of the disparity between the funding arrangements for low care and high care. It would also have helped relieve the capital shortage in the high-care end of the industry.

We know that many of the people needing beds in high-care nursing homes in the coming decades will be sitting on substantial capital assets as a result of ownership of their own homes. Once they enter a high-care facility, they obviously no longer need to occupy these homes, which can therefore be sold without causing hardship or disruption and the money used to pay

a bond. Consistent with the 'user-pays' principle, a bond system financed in this way enables consumers to make some contribution towards the cost of their accommodation, but it avoids unfairly penalising those who have been thrifty in building up assets in the course of their lives, for the initial capital is returned to their estate when they die. While they are alive, taxpayers are relieved of some of the capital costs entailed in providing them with the nursing home accommodation they need, and when they no longer need this care, their assets are returned still largely intact.

Unfortunately, in modern politics, just because a proposal is sensible does not necessarily mean it will get adopted. Back in 1997, the Howard government had itself proposed a system of accommodation bonds for high-care nursing homes but swiftly back-tracked as baby boomer voters revolted at the prospect of losing control over their eventual inheritances from their ageing parents. Although the industry welcomed Hogan's 2004 report, it was therefore no surprise that the federal government did not, for it did not have the stomach for a re-run of the 1997 controversy. Nor, for that matter, did the federal opposition.

There is in political science an interesting literature on what is called 'non-decision-making'—the various ways in which governments may avoid making an awkward decision.[4] One of the most obvious and best-known strategies is simply to shelve a difficult report, and that is exactly what the Howard government did with the Hogan recommendations. For three years, as the problems in the aged care industry got worse, the government sat on its hands and did nothing.

Eventually, in February 2007, the government issued its response. Accommodation bonds were out. Instead, the government would put an additional $400 million or so into creating 7000 additional community care places (so elderly people could remain for longer in their own homes while having nursing support come to them), and nursing homes would be allowed to increase their accommodation fees by $26.88 per day, with the bulk of this being met by increased taxpayer-funded subsidies.[5]

It had taken three years to come up with this 'solution', but it took just three weeks for it to start to unravel. As representatives of the aged care industry and welfare agencies dealing with the elderly sat down with government bureaucrats to tease out the details, it became increasingly obvious that the new proposals had not been properly thought through and that they contained what the Minister for Ageing called some 'unanticipated impacts' which could rebound on the low-care sector of the industry.[6] The industry itself then withdrew its support for the new package, and the government retreated for yet another re-think.[7]

This is an issue that will not go away and which needs to be resolved. Peter Costello's own *Intergenerational Report* makes clear that the ageing of the population is a key policy priority, and we cannot afford to delay a decision for another three years while the government tries to duck a potential voter backlash. Nor will fiddling with fee levels deliver what is needed.

This is why The Centre for Independent Studies is pleased to publish this paper by Professor Hogan, the author of the 2004 Report.

In what follows, Hogan makes clear that some of his thinking has developed further over the last three years. For example, he now believes that auctioning bed licences will not solve the problem of supply, for the total number of beds under an auction system is still fixed centrally. Instead, he now recommends scrapping all government controls on the supply of beds, leaving investment decisions to those who manage aged care institutions and topping up people's spending power with vouchers. He also acknowledges that some aspects of the government's February 2007 response to his report are valuable, not least the commitment to increasing the use of community care. And he reiterates some of the less-well publicised concerns expressed in his original Report, such as the need to attract more younger staff into the residential care industry.

But at the heart of this new paper is the re-assertion of the need for a system of accommodation bonds. Hogan reiterates that a key factor limiting the supply of extra beds is the high cost of developing new facilities. Allowing the industry to increase its user fees does not directly address

this problem, for it helps with the cost of current rather than new capital spending. The fair and efficient solution is to allow service providers to use the capital assets of their residents while they remain in the nursing home, and to return the capital, less a retention fee (which Hogan says should be set at 5%), when they leave or die.

The time has come for the government to stop prevaricating over this. Instead of ducking public opinion, ministers should be leading it by explaining and justifying the need for accommodation bonds to the electorate. This task would be made a lot easier if the opposition also agreed not to exploit the opportunity to make political capital out of this issue, for this is no time for point-scoring. If our political leaders believe Professor Hogan's 2004 recommendations for accommodation bonds would not work, they should explain why. Otherwise, they should implement them without further delay.

Note: *This is the first of a new series of papers to be published by The Centre for Independent Studies on the issue of 'Health and Ageing'.*

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Executive Summary

- In 2002, the federal government initiated a review of arrangements for federally-funded aged care, under Professor Warren Hogan. That Review published its report in February 2004. For most of the time since then, the government has avoided decisions on the politically contentious recommendations of Professor Hogan's report.
- In February this year, the government released a major aged-care policy package, designed to provide a framework for future development in aged care and to terminate the discussion of awkward issues raised by the Hogan report. It succeeded in neither.
- In one or two areas—such as professional development and the use of technological advances—the package was sensible. In most other respects it was deficient.
- The Hogan report recommended that bed allocations be decided either by an auction system or a central contracting agency; while both were an improvement on current methods, neither was entirely satisfactory, and have now been re-thought.
- The current financing of aged care depends very much on two features. First, all decisions on the primary allocation of resources are made centrally and bureaucratically, and are subject to the whims of the political process. Second, much funding depends on the unique instrument of the accommodation bond, effectively a loan from the client to the provider, most of which is repayable on death or exit, but, in the interim, providing a stream of income to the holder.
- The first feature limits both choice and competition, bringing neither satisfaction to the client nor efficiencies to the sector. The second discriminates against high-care accommodation (whose providers are not allowed access to bonds) in favour of low-care (whose providers are). The ability of boards and management to plan and provide is accordingly circumscribed.
- The February policy package has already begun to unravel, as unintended consequences have rapidly appeared. When it is next addressed by government, two basic reforms are therefore necessary.
- First, accommodation bonds must be available across the entire industry, high- or low-care. This is probably no longer contentious; although bipartisan support would be useful.
- Second, the primary method of client funding should be through a voucher, where money follows the patient rather than the provider. This may be thought of as analogous to a Medicare card, which entitles the holder to funding up to an agreed level for each medical service used. There would, of course, be Budget implications, but they are manageable.
- With an ageing population, the need to put aged-care funding on a sustainable basis is urgent. The two proposed reforms would do that, while ensuring the greatest possible degree of choice and competition.

Introduction

Some three years after the report from the Aged Care Review was lodged with the Australian government, issues fundamental to the conduct of aged care policies have yet to be addressed. The report was completed in April, 2004.[8] And it is not as if that report was the only review of the subject with proposals for consideration: a little over a year later, a Senate Committee report canvassed a number of proposals similar to those in the Aged Care Review.[9] Discussion and thinking about aged care issues, moreover, did not cease with the completion of these reports; rather, they generated further thinking on possible policy opportunities beyond those advanced in the Review. Indeed, in the time since the submission of the main report, my own thinking has gone beyond what was recommended in my report in some most important strategic aspects.[10]

The government's reaction to the Review has been piecemeal and sporadic. The announcement of a $1.5 billion package of reforms to aged-care arrangements in Australia on 11 February this year was the second instalment of changes following the submission of the Aged Care Review report in April, 2004. The first response had come in May 2004 as part of the provisions for the 2004–05 Budget. Thus nearly three years separated the two announcements—more than twice as long as the time allowed for undertaking the Review. In between the two, there were a few additional changes.

The strategy promoted by the February announcement had been foreshadowed last December in a speech by the then Minister for Ageing, Senator Santo Santoro, to the National Press Club.[11] Two specific points emerged from the Minister's speech, apart from the promise of a new policy package. First, and most critically, there was no immediate prospect of the use of accommodation bonds in ordinary high care. Secondly, the Minister spoke of the government's desire to '… draw a line under the Hogan Report'. It seems that the purpose of this was to bring to an end the very drawn-out and sometimes contentious coverage of the issues ever since the Report had been submitted three years earlier.

Accommodation bonds

Accommodation bonds have been the most important source of funding the expansion of aged care facilities over the past decade. Bonds are akin to corporate debt but provided by residents and potential residents, and subject to special conditions about repayment. They do not apply uniformly across different types of residential care because there is no provision for their use in ordinary high care. The value of accommodation bonds outstanding was about $5.3 billion in 2005–06.

Rejecting of their use in ordinary high care reflects a failure to understand their critical funding role. It denies the role for simple 'user-pays' policies to meet the needs for care of an ageing population in coming decades—a very strange policy stance, given how much policy is directed to the opposite outcome in areas such as the provision of superannuation.

Bonds are not the only basis for residents to contribute towards construction costs: daily charges or their equivalent can be put in place that may have the same, or similar, effects. If the focus of a new strategy in aged care is to be on flexibility and choice, both providers and users of services and their families should have opportunities to offer and to make choices. Just because providers are able to accept accommodation bonds, it does not mean they must do so. The use of accommodation bonds is attractive to boards and management compared with charges because of their contribution to the capital needs of the aged care entity; whereas accommodation charges simply meet the costs of servicing the capital which still must be raised and, most importantly with debt, repaid. Accommodation bonds offer a self-replenishing means of funding.

There is an assets test which indicates whether or not the potential resident has sufficient wealth with which to provide an accommodation bond. At present, the bulk of the bond is repayable on departure (or death) subject to some minimum sum—the retention payment—being deducted annually as a capital servicing charge but for no more than five years.

The somewhat complicated nature of the accommodation bond must be grasped. It is a liability to the borrowing entity, but the instrument is designed to confer value on the provider who holds

it quite apart from the retention sum mentioned above. What makes the accommodation bond different from corporate debt is that the owner does not receive interest on it. Thus the entity holding the bond enjoys an income stream which in other markets would accrue to the asset holder. So the net present value of this income stream is an asset in the hands of the liability holder. This may help to understand why the selling price of an aged care facility that accepts accommodation bonds includes a premium which reflects the income stream arising from the value of the bonds, despite their being liabilities.

If the accommodation bond is understood as a loan towards the cost of a residence in an aged-care facility, it will then be seen as having similarities to the partial payment and servicing costs of a mortgage when securing accommodation in a family home. Just as the holder of a mortgage on a residence is subject to some low risk of the occupier not meeting service charges, the aged-care resident has some risk that the entity owning the facility will be unable to meet the repayment of the bond on his or her departure. And, indeed, since the Report was submitted the Australian government has taken legislative steps to guarantee all outstanding balances on these bonds.

The discrimination is against the less well-off in Australian society.

Under existing provisions, providers may require accommodation bonds of residents in low-care facilities. In contrast, providers of ordinary high-care facilities are not allowed to seek accommodation bonds, unless a resident has been classified as low-care on admission. The distinction between high care and low care reflects history which is interesting but should no longer bear upon current practices. (The complex history of aged care has been spelt out in a supporting document to the Review.[12])

There are, however, major exceptions to this distinction: those places known as 'extra-service high-care facilities' are allowed to seek accommodation bonds. The 'extra' provided relates to services to residents in this category of facility but not to the care and its quality according to formal requirements. Whether this is realised in practice is a matter on which opinions differ.

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

Another exception effectively applies to those residents initially in low care who elect to 'age in place'; that is, they remain in the same location while receiving what amounts to high care. This measure ensured that residents of low-care facilities did not have to move to another location so long as they could receive effective care.[13] A substantial proportion of residents in low care are 'ageing in place'.

The impact of this discrimination is to make investment in ordinary high-care facilities less attractive than in any other type of aged-care facility. So long as this discrimination is maintained, the disincentive will be there. Compensating increases in accommodation charges applying to residents and additional subsidies from the Australian government to providers of services for pensioners, do not generate the capital required for development of more facilities. Yet high-care needs will increase relative to low-care in coming years, especially given the greater desire for various categories of domiciliary care now part of official policy since the February statement.

There is a growing consensus in favour of abolishing this discrimination, to make accommodation bonds accessible to all segments of aged-care services. The momentum has gathered pace in the past couple of years, with every prospect of something like universal acceptance. This recognition comes not least from an awareness of how the existing prohibition has meant that low-care residents are effectively subsidising ordinary high-care residents

Unfortunately aged-care matters cannot escape history. So long as there is a chance that populist demagoguery will prevail, despite all the evidence for the emergence of a broad consensus across the aged-care industry and beyond, the political leadership in Australia, both government and opposition, will reflect policy paralysis in this sphere.[14]

Accommodation bonds have been the sole means of bringing flexibility to an otherwise rigid pricing and funding system arising out of central planning. Bonds have allowed access to funds for meeting the servicing costs of capital funding not otherwise effectively provided through government subsidies and payments, or approved charges on residents. Access to accommodation bonds in low care and extra-service high care has also helped support provision of facilities in high care, especially in those facilities where a mix of care between low and high is offered.

Accommodation bonds have enabled a transfer of costs from the government to the users of services; a policy seen as desirable by the political leadership ever since the embracing of universal superannuation contributions. Present political leadership cannot apparently look a gift horse in the mouth.

The February policy announcement

As previously noted, this policy announcement was characterised as a package to compensate for the unwillingness of the Australian government to allow accommodation bonds in ordinary high care, and also to bring finality to consideration of the so-called Hogan Review.[15] Neither was achieved. The offering is flawed.

Its main strategic feature is the relatively greater commitment to supporting care in the community rather than in residential facilities.[16] Working on the basis of places per thousand in the population over the age of 70, the total number of places will rise from 108 to 113. At present about 20 of these are devoted to community care, while the balance is directed to residential care, roughly in the proportion of 48 in low care and 40 in high care. By 2011 the community segment will rise to 25 and the residential 88 will be divided equally between high care and low care. With more people remaining longer in their places of residence, this increased provision for high care is timid. The expansion of community care will cost about $412 million over the four years to 2011.

In an effort to offset the discriminatory impact of its unwillingness to allow accommodation bonds in ordinary high care, the Australian government announced new schedules of accommodation payments and charges for all new residents, thus increasing the sums accruing to providers of these facilities. Sums amount to an additional $755 million over four years; of this, about $490 million will come from the Australian government and the balance from residents. In effect, the basic accommodation subsidy will rise from about $17 per day to about $26.88 per day, with differing schedules of introduction—immediately for some new residents, and in staged intervals of $2 every six months for others. There will be only asset tests for determining qualification for this maximum subsidy. This means that pensioners and self-funded retirees will be treated on a common basis.

The new measures apply from 20 March 2008. In the interim, an additional $3.50 per day for each high-care resident will be paid between 1 July this year and that date in March next year, at a cost of $96 million. This total package will be implemented fully by March 2010. Then the daily maximum will lift to $32.38 in three stages by September 2011.

Accommodation bonds have been the sole means of bringing flexibility to an otherwise rigid pricing and funding system.

Unanticipated were the consequences for the provision of low-care facilities. The same government payments as in high care will apply on the same test of asset values and not income. There will, however, be no increase in residents' contributions. This stems from the fact that the increased charges paid by residents in high care were considered to be a means of stimulating the relative spending on investment in that category. Furthermore, those new residents in low care not qualifying for concessional arrangements will no longer be required to pay a daily fee of $7.40, further reducing payments to boards and management offering low-care facilities.

The most obvious confusion here lies in taking resources out of low care when the declared purpose was to stimulate investment spending in high care facilities. But the main concerns have been the unanticipated consequences of the policy announcement.[17] These seem to have arisen from the ways in which the official approach to the analysis of the measures announced reflected

aggregate analysis for the industry, and did not account for the possibilities of different outcomes when applied at the level of individual entities.[18] Additionally, calculations of impacts should have better reflected the transition period when residents in all facilities would be a mix of 'old' and 'new' residents as determined under these new provisions.

The additional funding in high care may provide as much as $3.50 per day per resident, or nearly $1300 per resident in a year. This sum does not provide enough to service the costs of borrowings to fund a new bed in high care. Thus the broad purpose of the policy announcement has not been met. The average cost of providing a new bed is between $100,000 and $120,000 and the servicing costs of borrowings on an annual basis would be between $8500 and $10,000.[19] It's a long way to Tipperary!

A contradictory stance on accommodation bonds between low care and high care remains.

The failure to analyse the great variety of aged-care funding needs between providers of high care due to official over-reliance on aggregate calculations may not be the only cause of dissatisfaction among providers. Central to any understanding of the issues with this controversial package is the additional factor of the 'out-of-phase' transition payment of $3.50 per day per resident.[20] This one-off payment incurs an annual rate of government spending of around $133 million. But the provision does nothing for projections of future income streams against which boards and management must make their assessments of whether or not new investments in ordinary care facilities should be made. This payment is akin to the previous stopgap payments of $3500 and $1000 per resident at the end of June in 2004 and 2005 respectively; the contribution is in each case has been to balance-sheet liquidity rather than providing any direct stimulus to investment outlays.

That a package designed to foster investment in high-care facilities should have damaging consequences for low care is hard to fathom. The abolition of the charge of $7.40 per day, payable to providers by those who are not concessional residents, is explained by the fact that providers of low-care facilities will be able further to increase the value of the accommodation bonds lodged by that category of resident. But that daily sum amounts to about $2700 a year. To compensate for that loss of revenue, therefore, simple arithmetic requires that boards and management would need to raise substantial additional bond money from each resident. This could be as much as between $30,000 and $35,000.

The complexity of the damage inflicted on low care provisions goes further. The new arrangements bring together threshold arrangements for pensioners, the so-called concessional residents, and for self-funded retirees.[21] The impact of the withdrawal of the $7.40 per day is most onerous in the case of those self-funded retirees who have assets greater than the value which would put them on an equal footing with pensioners. This value is less than $52,500 but not near the $132,000 that had been the value under prevailing arrangements, above which pensioner residents paid the equivalent of the pensioner supplement of $7.40 per day. Self-funded retirees with relatively low assets will not be in a position to provide higher value bonds as expected in the official February statement. Providers will therefore not be in a position to secure 'compensation' through higher bonds. Restoration of the abandoned $7.40 per day for these residents is vital to the future financial stability of those aged-care providers who have a substantial proportion of this category of resident. Close to 25% of accommodation bonds may be less than the $128,000. The preferred policy would be to restore the $7.40 per day charge which should never been part of the package afflicting low care.

Quite apart from the obvious uncertainty involved in surrendering the certainty of a recurrent payment for the possibilities of higher-value accommodation bonds, there remains the contradictory stance on accommodation bonds between low care and high care. In low care the value of these bonds should be maximised while they are denied any role in ordinary high care. Confusion is added to this contradiction when the efforts of the Australian government to promote accommodation bonds are recognised: when assessing the value of assets to determine whether or not a person qualifies for government support, not only is the value of the family home excluded from the calculations of that valuation but also the value of any accommodation bond lodged.[22]

The cost of this aged-care package, at $1.5 billion, has been represented as comparable to the $2.2 billion offered in the May 2004 Budget. This is not true, because about one-sixth of this recent package does not come from the Australian government but from residents and their families, reflecting user-pays approaches. This feature, when combined with the one-off component to which attention has been drawn, does not make for a powerful stimulus to investment spending in ordinary high care.

Aged Care Funding Instrument (ACFI)

Discussion so far has concentrated on policies designed to meet the accommodation needs of residents in aged-care facilities. The third item in the February announcement was directed to the provision of care, not accommodation. The most important funding measure for care is the new Aged Care Funding Instrument. The measures as announced are broadly in line with much of what came out of the Review.

This funding mechanism is fundamental to the financial viability of aged-care facilities. Once the condition of the resident is assessed, then the moneys associated with that condition flow to the aged-care service facility, in short, the provider. Not surprisingly, much of the work of the Review was directed to the existing funding mechanism known as the Resident Classification Scale (RCS). The bulk of submissions and discussions around Australia sought simplification of the RCS provisions. There were very serious and genuine worries about the confusion of the necessary care plans for supporting individual residents with the need to validate the financial claims appropriate to their condition. The evidence required to support claims for funding under the RCS provisions has been onerous. The comprehensive record-keeping, and its cost, was the source of most criticism of the existing system, especially the opportunity costs in senior staff time and attention.

A comprehensive analysis of the evidence about the effectiveness of the existing arrangements and the scope for simplification was a major undertaking in the Review process. There can be no question about the great quality of this work and the clarity of the results. The scope for simplification was clear.

Subject to additional provisions for supplements needed to support residents experiencing neurodegenerative problems or in palliative care, the recommendations were for a simplified RCS system. There was no suggestion that these additional supplements be incorporated within the existing funding structures of the RCS arrangements.

Consideration of the new ACFI arrangements was long drawn out in discussions and consultations. What has been in serious contention is whether or not the fewer basic funding categories would be offset by a proliferation of intra-category techniques bringing a large number of funding permutations. On the available evidence this does not appear to have eventuated, though the apparent tally of 64 categories (including the unfunded low-care ones) remains impressive. The need for much record-keeping has been abandoned because comprehensive information will be required only when there are requests for additional funding due to greater needs. There have been so many permutations in the ACFI provisions that these comments should be treated with caution until some kind of finality is reached with application in the real world.

The critical feature, however, is the re-weighting of provisions to take account of the strategic shift to community care. There the decision to maintain separately the additional supplements relating to neurodegenerative afflictions and palliative needs has implications for funding. The total cost of the new measures will be about $390 million over four years, bearing in mind that existing residents will not change from current arrangements until their needs are reclassified.

The new measures will only apply immediately to new residents (that is, those entering aged care on or after 20 March 2008). Unless the classification of existing residents under the present RCS system is reviewed and changed, they will remain on the RCS scale of payments until 2011 when uniformity under the new ACFI provisions will apply. In this way, the full costs associated with the changes will not be met until the end of the transition.[23] A measure of the implications can best be grasped from the provisions made for the two additional supplements which will cost about $96 million over the four years of the transition. The full-year costs would be about $50

million. There is uncertainty with all of these estimates, because the expectations for securing upgrading of the care needs of existing residents must be hostages to fortune.

Other implications may be noted. The greater emphasis on domiciliary care is not just a matter of shifting out of the lesser categories of residential low care. Provision is there quite specifically for more intensive care associated with more demanding requirements of high care, including conditions associated with Alzheimer's and dementias. But it needs to be noted that greater reliance on living within the community will increase demands for respite care at residential facilities, including high-care respite. This in turn will require a reconsideration of the existing arrangements for offering that care which, because of turnover of people, is more expensive than longer-term residential low care. There is need for greater flexibility in arrangements so that boards and management can make decisions about the relative balance of facilities on offer between residential low care and respite care.

Two necessary strategic shifts

Bed allocations

Seen in the light of population trends, provision for increasing the number of beds is central to all future developments in aged care. In the Review, possible policies for the allocation of funded beds were considered by way of two options. The first approach was the introduction of an auction system, whereby providers would make bids for bed licences. The alternative was a contracting agency, which would negotiate prices of beds across different categories of residents with the bed authorisations going to those offering the lowest prices for service. But there are problems with both these proposals.

Foremost, with both proposals the number of beds would remain centrally, administratively, determined, with the funding still attached to the beds. The auction system would allow some competition, to the extent that bidding would lessen reliance on administrative determinations alone as between suitably qualified entities. The suggestion suffers, however, in that it would involve taking funds out of the industry in the form of the values established by the auction prices. This would occur at the very time that the quest for expansion should mean maximising the funds available to support investment. And the number of beds to be put to auction would still be determined centrally. The contracting agency approach would not foster any substantial competition between entities, other than opening up the possibility of gaining lowest cost services, because the numbers of beds allocated would still be determined administratively.

The impact of the existing centrally-planned arrangement with bed allocations needs to be understood. Users and their families bear the brunt of the rigidities perpetuated by this policy. It does not address matters of access and choice. Getting access to any facility offering care is only one aspect. Choice is about the ability of potential residents and their families to select from a range of facilities, not simply queuing for the next available bed at one particular facility. Under the present arrangements, certification of need by an Aged Care Assessment Team (ACAT) is not a guarantee of a place in residential or community care. All it offers is a certification for entry should a place be available.

Capacity in residential aged care has been more or less fully used, although some vacancies have been occurring in some low-care facilities. The control of bed allocations establishes a fiscal constraint unrelated to the demand for beds. In this way the fiscal risk to government is minimised.

Market risk for providers has also been minimised under existing arrangements. Strict controls on beds funded by the government define the scope for competition between providers: it has been negligible. This explains the survival of many small providers operating just one facility, most commonly in the 'for profit' sector, and especially in Victoria. The limit on competition means that existing providers can survive and explains the 'cottage industry' nature of the residential aged-care sector. Regulation serves to shield providers from the competition which would induce both greater efficiencies and improved quality of service. But the very complexity of the regulatory structures further hampers efforts to monitor and require improvement, whatever the provisions for accreditation and standards may lay down. With restraints on capacity through bed allocations

and little spare capacity anywhere, efforts to impose sanctions that might close down defective facilities are frustrated by the lack of spare places to which residents of delinquent institutions might be transferred.[24]

The *Aged Care Act 1997* together with its regulations amount to a system of protection for existing providers against the entry of new competition. Control of bed allocations is the instrument by which this protection is maintained. What is being witnessed in this major service sector activity is a playing out of the familiar competition versus protection scenario witnessed in Australia's international trade two decades ago. And this prevails while national competition policies are supposedly in place to ensure competitive outcomes which will secure gains in efficiency and quality.

The solution to these dilemmas demands the abandonment of any regulated procedure for bed allocations, leaving the investment decisions to the boards and management of providers. They alone should be responsible for making investment decisions and determining the range and quality of services they might offer subject to standards laid down by an accreditation and standards agency.

Some reservations may be expressed about the applicability of deregulation in remote and those rural areas where supporting services are lacking. In remote and rural situations where facilities might be established, there are grounds for implementing an auction system with bids sought on the fiscal support needed for capital outlays and operating budgets. This approach has the advantage over the existing allocation of beds by administrative fiat in that existing regional providers and potential newcomers may bid on an equal footing. A further advantage accruing from this approach would be to thwart the proliferation of very small-scale facilities, much less than thirty beds, already existing in too many locations and providing an ineffective means of funding aged-care services. Somewhat more than 30% of facilities have forty beds or less, being well below the minimum efficient size for most locations.

Users' choice

If investment decisions are left largely to the boards and management of aged-care entities (and possibly other providers with domiciliary arrangements), the funding of aged care must be redirected—from the providers to the users. This would be achieved by issuing vouchers to residents and potential residents for that part of the cost of the care which is to be met by government. The recipients and their families might then take the vouchers to aged-care facilities to judge the best place in which to secure the appropriate level of care. The determination of need would be made as at present through the assessments made by ACATs. The difference would lie in simply funding the users of services in aged care on much the same basis as that on which they secure their health care, namely through the government voucher known as a Medicare card.

Some may have reservations about this change if those in need lack the capacity for choice. But in practice it would be no different from what applies now when the seriously incapacitated, unsupported by families, are dependent on staff in hospitals, aged-care entities, charitable service places and similar community groups, for succour.

This shift involves no radical structural upheaval. What is radically different is the existing arrangement under which the resident or potential resident has no right to choose. Note how this circumstance differs from the broad experience of access to health care. The Medicare card held by Australian residents provides access to the services of general practitioners, in the first instance, on the initiative of the individual card-holder. The Medicare card is a voucher. The fiscal budget is exposed to the decisions of each individual in the population over whom no direct control is exercised. The Australian government is exposed to the moral hazard of open access to government funding. What applies to the population as a whole, and to the elderly for access to medical advice, is withheld from the provision of aged-care services. This is discriminatory, massively so.

This shift in arrangements would change the relative balance of interest and commitments between the major participants. Government would be exposed to greater fiscal risk but this would not be novel or unmanageable, being the common experience in all health commitments. Aged-care vouchers would be a modest increment over what is now in place in the areas of health

and pharmaceuticals. Providers would be negotiating directly with users of services rather than with government. This should afford relief from the perpetual conflict between government and providers.

Interim pricing adjustments

Timeliness bears upon the need for considering the Conditional Incentive Supplement—known, in officialese, as the Conditional Adjustment Payment.

This pricing measure had its origins in a recommendation from the Review designed as a price incentive, offering an additional 1.75% increase in payments to providers over four years, over and above the regular adjustments based upon the so-called COPO index. This specialised index was devised by the previous government to apply to Commonwealth Own Purpose Outlays. Contentious features of this type of index are the lack of transparency in its construction and prices which reflect official forecasts.

The additional supplement or payment was seen by the Review as an incentive to providers for seeking gains in efficiency and productivity. The recommended term of four years was essentially to provide an interim measure while the processes for restructuring and re-ordering priorities in policy arrangements for aged care were put in place. These processes have taken longer than anticipated, at least by the Review. Effectively, the halfway mark has been well and truly passed. The February statement effectively extends the transition period for implementation of some work from the Review through to 2010 if not 2011.

The need to contemplate extensions to this supplement may be justifiable.[25] The basic COPO structure remains in place and has never been reviewed, although a commitment of the previous government to do that was made soon after the initial arrangement was put in place. This has long since lapsed and the objections to this opaque measure have not been met.

A meaningful review and reconstruction of the COPO procedures—even if only as applicable in aged care—would take time. In view of the limited time left to reach decisions on long-term commitments, the best approach would be to extend the annual CAP adjustment of 1.75% for another three or four years.

Workforce issues

The prime importance of growth in devising policy in this area applies no less forcefully to the workforce involved in aged care activities. These are matters bearing upon management as much as any other group. Many issues have been spelt out in terms of education and training but not exclusively so. Commitments to research on aged care topics will bear upon future performance in terms of quality and efficiency. The Review pressed hard the view that boards and management need to be imaginative, as some already are, to attract more and younger people into aged-care activities. Confidence in this position was based on the knowledge of impressive programmes put in place by some providers: in their internal training schemes; the organised use of external training facilities; and the subsidising of postgraduate studies for staff, which revealed substantial talents.

Boards and management need to be imaginative, as some already are, to attract more and younger people into aged-care activities.

The need for careful reflection on possible strategies was thought especially important for the recruitment and retention of nurses, whether registered or enrolled ones. The average age of registered nurses was found to be substantially higher than that for the nurse population as a whole, though the differences varied from one state to another. Large conglomerate aged-care entities might be best placed to offer child care facilities and permanent part-time contracts for staff with babies and young children. In a world of relatively declining numbers in the workforce, management especially might give greater priority to fitting work schedules to the commitments of staff, rather than the other way around—as has been all too often a rigid practice in the past.

But inasmuch as the great bulk of those employed in aged care are assistants, being personal-care workers, career opportunities should apply no less to them. The skills needed to perform

effectively in aged care are impressively wide and growing. As greater understanding emerges from research and technological developments, such as with respect to Alzheimer's and dementias, the range of personal and technical requirements is certain to broaden. Electronic and telecommunications advances embodied in concepts such as the 'smart house' will offer further and different career paths.

The application of satellite technology, reflecting the innovative skills of a major aged-care provider but now embodied in the Aged Care Channel, has permitted the widespread dissemination of programmes for continuous improvement and specific training needs at very low costs. This facility allows the spread of ideas and experiences in ways not available in the past owing to the high cost of transport, especially in rural settings. It is pleasing to record the substantial penetration of the channel into aged-care establishments, as measured by the entities participating. This development owes everything to the initiatives of former Minister for Ageing, Kevin Andrews.

The February statement rightly continues the thrust for education and training of the aged care workforce, as well as support for technological improvements along with research funding, especially in the spheres linked to neurodegenerative diseases. On the evidence available, the political leadership has accepted and responded to the challenges in this area. This is especially so with the applications of all those skills associated with telecommunications and computer applications.

Pricing themes

Extra-service high care

This category owes its existence to the regulatory discrimination associated with the prohibition of accommodation bonds in ordinary high care. The rate of growth of these facilities points to both a substantial demand for access and a capacity to pay. So long as administrative procedures hamper the expansion of capacity to meet the apparent demand, the need for their reconsideration is essential. By limiting growth in capacity the administrative processes are creating rents, or unearned increments of profit, to be enjoyed by providers. In so doing, market distortions are perpetuated and users cannot secure access to the facilities they seek.

So long as administrative procedures hamper the expansion of capacity to meet demand, the need for their reconsideration is essential.

In this situation, the aim should be to expand facilities to the point where prices can be left for users and providers to settle.

Price taxing

The Australian government should also review the one specific impost on charges for extra-service high care. This is the so-called 'claw-back', whereby the provider must repay to the Australian government 25% of the fee excess over scheduled prices which users of this type of facility pay. This in turn forces prices higher in a market where bureaucracy controls supply. There is no sense in allowing a price mechanism to work in one aspect of aged care but then to thwart its application by claiming back some proportion of a margin allowed for by administrative decree.

If the purpose of the 'claw-back' is to recover some part of the government subsidy which applies to all residents, then the appropriate consequences of its imposition should be the withdrawal in their entirety of those subsidies to extra-service high care, while allowing providers to charge what may be agreed with the user of the service. This would mean also abolishing any control on the number of beds directed to extra-service high care. The government's interest should be in the quality and service provided.

Retention values

The value of accommodation bonds has risen sharply in recent years; but this reflects high asset valuations across Australia, rather than the ways in which extra-service high care has been fostered. Yet the provisions governing the sums retained from those bonds to fund capital servicing have been stagnant, unlike the values associated with the bonds.

Retention sums have remained much as they were a decade or so ago. Any reasoned reflection

would suggest that the present retention limit, now around $3,000 per year and arrived at long ago, is trivial in relation to present values, whether measured in asset or cost terms.

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

Unfortunately, any adjustment would not help ordinary high care; but the increment of funding might provide a basis for the boards and managements of aged-care entities to bring some proportion of any new facility under construction or refurbishment into ordinary high care.

Other prices

The whole paraphernalia of prices and associated commitments for aged care is laid down by administrative fiat. These are fixed prices, not maximum ones. Providers of aged-care services must adhere to the schedules or expose themselves to challenge. There is no allowance for the flexibility which should naturally arise from individual needs. Little discretion exists for adaptation to circumstances: for example, when a married couple needs access to residential care, but one is in a much different category of care from the other. Willingness to place them together does not help the provider because this could infringe the regulations governing the relevant government subsidy. The cost of this essentially charitable action must be borne by the provider.

The freeing-up of pricing schedules, if only by specifying maximum prices, would go some way towards easing the means by which boards and managements might effectively exercise their discretion. Flexibility in funding should not rest on accommodation bonds alone.

Prospect

The February Statement and its precursor, the speech to the National Press Club by the then Minister for Ageing, Senator Santo Santoro, in December last year, provided the setting for judging aged care policies.[26]

The main features were much more than the two main themes listed by the Minister and to which reference has been made earlier. For aged care, the one significant strategic shift spelt out was that towards an increase in care in the community for the elderly relative to residential care. Reflecting this revised approach, a new funding instrument directs more resources into residential high care, signalling the intention to have more low care provided in the community.

The desire of the Australian government to 'draw a line' under the Hogan Report was expressed in December and reiterated in remarks associated with, and subsequent to, the February Statement. The apparent purpose was to bring to an end the very drawn out coverage of issues ever since the report was submitted in April 2004. The intention has not been realised. Quite apart from the failure to address strategic structural issues, official comments point to various matters still being unresolved. This is most evident, though not exclusively so, in the remarks that '… on this notion of Government policy as a matter of instalments: we will continue to work with the industry … but we want to see an actual market response to this part of the package before we look at changes.'[27] And then the Conditional Adjustment Payment lingers, awaiting renewal and extension.

But the main thrust of the February Statement is to put forward policy measures whose real purpose is to offset the unwillingness of the Australian government to put in place accommodation bonds in ordinary high care. The result has been a set of changes that give high-care providers nothing like the funding they need to service the capital outlays necessary to expand the number of beds in high care. The repercussions for low care, meanwhile, have been onerous; efforts to patch up the problem will not help remedy a misguided effort. By refusing the straightforward solution to a basic funding challenge in high-care service provisions through using accommodation bonds, band-aid remedies have brought confusion and inadequate outcomes.

The failure to abandon the centrally-planned controls on bed allocations and the restraints on user choices continues to frustrate efforts to secure competitive gains in efficiency and flexibility in choices available to users of aged-care services. There is no incentive to pursue quality of service.

Flexibility is about granting authority to participants in the industry, most of all boards and management, to determine how aged care might be offered so as to satisfy immediate needs which may be local or regional rather than national. Choice is about the scope for users to have a basis for selection of locations when seeking residential facilities. Choice is about boards and management determining their investment outlays on new or replacement capacities as well as shifting between low-care and respite-care offerings in their facilities. The underlying purpose is for enhanced competition and stimulus to quality, the two going hand in hand.

'Drawing a line' under the Hogan Report cannot nullify either the issues or the policy proposals canvassed here. Any line in the sand of political and administrative myopia will be blown away exposing the rock of hard issues not to be eroded easily.

Endnotes

1 Department of Health and Ageing, Health and Ageing Factbook 2006 (Canberra: DoHA, 2006), http://www.health.gov.au/internet/wcms/publishing.nsf/Content/Factbook2006-1~factbook2006-ch1-introduction~chapter1-sect-3.

2 Warren Hogan, *Review of Pricing Arrangements in Residential Aged Care* (Canberra: Commonwealth of Australia, April 2004).

3 Louise Dobson, 'Nursing home operators face beds auction', *Sydney Morning Herald*, 8 March 2004.

4 See, for example, Peter Bachrach and Morton Baratz, *Power and Poverty* (Oxford: Oxford University Press, 1970); Peter Saunders, *Urban Politics: A Sociological Interpretation* (Harmondsworth: Penguin, 1979).

5 Sophie Morris and Eli Greenblat, '$1.5 billion boost for aged care', *Australian Financial Review*, 12 February 2007.

6 John Breusch, 'Aged-care reforms fall short', *Australian Financial Review*, 2 March 2007.

7 The May 2007 federal budget made financial provision for increased nursing home fees from March 2008, matched by increased government subsidies, so it seems that the government has decided to press on with the broad strategy outlined in the Minister's February statement.

8 Warren Hogan, *Review of Pricing Arrangements in Residential Aged Care: Report* (Canberra: Commonwealth of Australia, April 2004), pp xxviii and 368.

9 Australian Senate, *Quality and equity in aged care*, Community Affairs References Committee (Canberra: Commonwealth of Australia, June 2005), pp xxiv and 206.

10 See, for example, Warren Hogan, 'Critical Themes and Strategies', *Forum, National Aged Care Industry Council* (Canberra: May 2006); Hogan, 'Aged Care Strategies and Policies', *Economic and Social Outlook Conference 2006, Session 7D* (Melbourne: November, 2006); Hogan, 'Policy Issues in Aged Care', *34th Conference of Economists*, University of Melbourne, 26–28 September 2005.

11 Hon Santo Santoro, address to the National Press Club, Canberra, 13 December 2006, with questions and responses.

12 David Cullen, *Historical Perspectives: The evolution of the Australian Government's involvement in supporting the needs of older people,* Background Paper No 4, Review of Pricing Arrangements in Residential Aged Care (Canberra: DoHA, 2003).

13 'Ageing in place' is more extensive than suggested by the formal count. Some providers agree to keep residents for so long as they can effectively and efficiently do so. This means asking residents and their families to seek other locations should needs rise to the highest categories of care requirements.

14 Historically, 'for profit' providers were confined to offering high-care facilities only until a little more than a decade ago. Thus the 'not for profits' could draw upon accommodation bonds as well as their exempt tax status to secure established positions and to subsidise ordinary high care when such facilities were deemed necessary. Little wonder there have been problems with high-care facilities more than low-care.

15 This claim to bringing finality to the Hogan review is qualified in subsequent commentary. When referring to matters of capital adequacy and accommodation bonds in ordinary high care, the then Minister referred to the notion of Government policy as a matter of instalments, and awaited 'an actual market response to this part of the package before we look for changes'.

16 Santoro, 'Reforms Secure The Future For Aged Care', Media Release SS13/07, 11 February 2007.

17 Santoro, address to the Tri-State Conference, Albury, 25 February 2007, p 8.

18 As above, p 9.

19 These estimates do vary from state to state as well as regions within states. Many observers would consider a wider range between $110,000 and $140,000 a more representative range from contemporary experiences but much depends upon the type of construction and the extent of prefabrication. These costs are net of land costs. Their exclusion is essential for any comparison because the variety of outcomes with land values is great ranging from inner city acquisitions to using land owned already.

20 Santoro, address to Tri-State Conference, p 10.

21 No mention is made here of the requirement to have 40% of these residents in a facility if full funding is to be paid by the Australian Government. This provision, which conflicts with principles of equal access to aged care for all, is a further reflection of official uncertainty about their funding provisions providing fully for these categories of residents.

[22] Basically this measure was designed to ensure that an aged-care resident selling her or his home would not endanger their pension rights so long as the value extracted from the sale was lodged as an accommodation bond. In general, the measure works to foster payment of substantial accommodation bonds, which, if sufficiently high, may well offset some other charges otherwise paid out of taxable income.

[23] Perhaps a note of caution should be entered even here, because it still may be possible for a resident under grandparenting arrangements to stay on RCS provisions interminably.

[24] In a theoretical setting, the existing aged-care regulatory arrangements might best be described as overdetermined. Thus regulations about bed allocations and revenue flows have effects impeding the effective application of requirements for quality and standards.

[25] Department of Health and Ageing, *Securing the future of aged care for Australians* (Canberra: DoHA, February 2007), Media Kit, p 20 and Additional Notes, p 11.

[26] Santoro, address to the National Press Club, 2006.

[27] Santoro, address to Tri-State Conference, p 8.

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