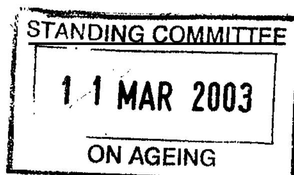
STANDING COMMITTEE
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ON AGEING

Submission to the House of Representatives Committee on Ageing

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This submission focuses on the need for **an aged care social insurance scheme** to provide a sustainable system of generating the capital funds required for aged care, primarily for residential aged care, but also including an element of capital facilities required for community care.

The submission addresses the criteria for sustainability in Commonwealth outlays set out in *The Intergenerational Report*, released as Budget Paper No. 5 in conjunction with the 2002-03 federal budget. This submission is presented in two parts:

In Part 1, the present capital funding arrangements are assessed against the criteria for sustainability.

In Part 2, a number of options are proposed to addressing shortcomings identified in the present arrangements.

The conclusion reached is that serious consideration should be given to developing an aged care social insurance scheme to generate a sustainable base for capital funding. The main arguments for a social insurance scheme are:

1. that such a scheme would considerably strengthen current funding arrangements by adding a third pillar to the present two pillars of general taxation revenue;
2. that there are a number of strong grounds for applying social insurance to capital funding as it is the most problematic part of the current funding system whereas the arrangements for daily living and care costs are sustainable;
3. that many options are available for the detailed design of a social insurance scheme for long term care, including options that would assist in building up a substantial fund in a relatively short time;
4. that prompt implementation of a social insurance scheme would generate a major flow of capital funding at the time it will be most needed, in about 25 to 30 years when the "baby boom" move into their late 70s and 80's, the ages at which likelihood of use of residential care increases exponentially, and when demands on the health care system will also escalate; and
5. Australia has a unique opportunity that is not available to already older countries and this opportunity should not be lost.

Part 1: Assessment of present capital funding arrangements against sustainability criteria

Current funding of residential aged care can be divided into three components, each of which presents different considerations for achieving sustainability:

Funding component	Considerations for sustainability
Daily living costs, covering food, laundry and so on, are covered by the basic care fee that all residents pay and which is in turn set at 87.5% of the Age Pension.	As all older Australians will have at least a pension level income, continuation of this funding component is not problematic.
Dependency related care funding is set on the basis of a schedule set by the Commonwealth and graduated over eight levels of resident dependency; these amounts are covered by the Commonwealth benefits, with some offset by way of means test care fees.	The cost of this component will depend on the dependency profile of residents and the cost of care services, the main part of which is staff wages. These costs will vary into the future and to provide care at the standard of the day, funding will have to be provided largely from general revenue at the time.
Accommodation costs are met by a complicated mix of user charges and subsidies which differ for facilities providing either high care (nursing homes) or low care (hostels). The Commonwealth pays a concessional resident supplement to equalize funding for low income residents who are unable to pay any or only part of the means-tested accommodation charge, or the entry payment to low care facilities. Very limited capital grants are available to assist with restructuring to ensure viability, mainly in rural and remote areas.	**The capacity of these arrangements to generate the necessary capital funding appears increasingly doubtful. A particular concern is that Commonwealth and user funds intended to be applied to capital costs may not be directed to this purpose, either currently through servicing loans or saved for future capital outlays. There are also risks that user payments for accommodation may not be effectively managed to generate future capital.**

Criterion 1: Promoting fairness in distributing public resources between generations of Australians

The present arrangements for funding aged care rely very substantially on general taxation revenue, and hence on transfers from young to old. A large part of user charges in residential care are in fact transfer payments by way of the Age Pension, most of which is paid as a Basic Care Fee. As of 1999-00, the basic care fee accounted for just on 25% of combined government and user payments for residential care. The means tested user charges for care and accommodation introduced from 1997-98 now generated around 5% of total funding.

Increased user charges faces two limitations in addressing sustainability. First, the introduction of increased user charges in residential care was seen to be a means of limiting intergenerational transfers by transferring some of the cost to the current generation of older people. These charges however fail to achieve the goal of reducing transfers between generations by increasing transfers *across the lifetime of each generation* because they are levied only at the time of use of residential care. Rather than spreading costs across the individual's lifetime, and so tapping lifetime resources, the current user charges depend very much on the resources that the individual has at the very end of their life.

The second limitation follows on from the first. The current generation of users of residential aged care have generally low incomes and few assets other than home ownership. The attempt to tap these housing assets by imposing accommodation bonds for nursing home care in 1997 proved massively unpopular; the perceived threat of reducing the main form of inheritance in Australia was not acceptable to the community. Further, while some see rising incomes of future generations of older Australians as conferring increased capacity on users to pay for aged care, the need for aged care is highly selective of very old women. This group will remain the poorest of even richer future generations.

Criterion 2: Maintaining Commonwealth debt at low levels; this helps maintain low domestic interest rates which, over time, promote private sector investment.

The Commonwealth does not incur any direct debt in the operation of aged care programs, but domestic interest rates are critical to the capacity of aged care providers to participate in general capital markets. The Commonwealth is not a direct provider and State and Local Government provision has remained stable in terms of numbers of beds for over a decade now and so constitutes a smaller share of provision. In this situation, the financial viability of private and not-for-profit providers is of increasing importance for the future sustainability of aged care, and several causes for concern can be identified.

First, while the present funding arrangements include a component intended to cover capital costs, there is no way of ensuring that these funds are so used. These funds come in part for user payments of entry charges or daily accommodation charges, or from the Commonwealth Concessional Resident Payment which equalizes income to providers on the part of low income residents who cannot afford the means tested accommodation payments. This income will be applied to servicing loans in some instances, but otherwise there is no way of ensuring that these funds are set aside for capital purposes, or that they are securely invested to generate future capital that is re-invested in aged care facilities. There is thus a risk that a part of these funds will have been used for other purposes or unwisely invested and so they will not be available for future capital. To the extent that subsequent capital works are on a lower scale than expected on the basis of the funding that has already been provided, both Government and users will have paid more than they should have.

Providers vary considerably in their capacity and inclination to participate in the capital market and to take on debt. Large and longstanding providers have considerable capacity

to generate capital reserves from entry charges to their existing facilities and not-for profit providers can also direct donations and revenue from fund raising to capital reserves. Other providers do not have these reserves and some not-for profit agencies are unwilling to take on large debts for new ventures. At the same time, there is no requirement that any provider who is able to generate substantial capital has to re-invest in aged care facilities, other than to maintain existing facilities to a minimum standard.

An increasing number of private and not-for-profit providers of aged care under the Commonwealth program are involved in other provision of retirement accommodation, and so have other investment opportunities to which they will turn if they need to make higher returns. The main form of alternative investment is retirement villages, with both independent units and serviced apartments. These facilities provide a reasonable alternative to hostels, at least for those requiring mainly social support and only limited personal care. Additional care services are usually provided on an as needs basis through accessing the Home and Community Care Program and Community Aged Care Packages, with user charges applying on the basis of assessed income. Some larger providers also offer an option of purchase of care services from an in-house provider. While being able to offer a Commonwealth approved nursing home and CACPs as part of a retirement villages operation is a strong selling point, the interaction between the non-government funded retirement accommodation and the funded services is not well recognised in the Commonwealth program.

Criterion 3: Providing greater stability and certainty of fiscal outcomes, contributing to an environment more conducive to long term productive investment.

The residential aged care sector has become unstable in recent years due to two main influences of government policy. First, the requirements of the 1997 Aged Care Act for higher building standards have generated considerable restructuring of the residential aged care sector. Existing providers have faced major decisions about upgrading to meet the initial building standards by January 2001, and the higher standards required by 2008. As well as redeveloping their own facilities, the exit from the sector of some smaller providers has increased the market in bed licenses and increased the demand for capital.

The second source of instability has been the very wide fluctuations from year to year in bed approvals. The number of new places approved annually has fluctuated from none in 1996 and 2000, to 14,000 in 2001 when there was a double "catch-up" approval round. In other years from 1992 to the present, there have been around 2,500 to 3,000 places approved annually. These very wide fluctuations have four adverse effects on sustainability:

1. They create great uncertainty for providers who may be seeking to combine new places with redevelopment of existing facilities to achieve greater economies of scale and to offer both high care and low care services;
2. They lead providers to over-bid and over-commit themselves, leading to subsequent failures to realise projects and shortfalls in planned provision.

3. They require the sector to gear up and wind down in short cycles rather than continue a steady level of development, with effects felt at all stages throughout the development process from land acquisition to engaging architects and builders and finally commissioning and staffing facilities..
4. There will be flow-on effects for Commonwealth recurrent funding as beds come on stream, with much more marked increases in Commonwealth outlays in some years compared to others.

A much more regular approvals process is required, with an annual allocations of places linked to population growth. As population growth and related need can be predicted with a reasonable degree of certainty, there is every reason to have a steady growth of residential care and community care services rather than wild fluctuations from year to year.

Criterion 4: Reducing the risk of Australian living standards fluctuating significantly due to international economic shocks, and providing greater capacity for the government to deal with future uncertainties.

In shifting the risk of capital investment in aged care to providers, the Commonwealth has reduced its capacity to deal with future uncertainties.

This problem is compounded by the extent to which Commonwealth funding that is intended to provide for capital may not be effectively managed and so not be available for future investment. While it is likely that providers who have borrowed to undertake upgrading and expansion will use these funds to service loans, the situation is quite different for those providers who do not have current loans to service and who rather have to manage these funds to provide a future source of capital. There are very major variations in the capacity of individual providers to manage such investment funds.

- Ideally, Commonwealth funding would support providers who have the capacity and intention to build up capital reserves and make future investments in aged care services.
- There is a risk however that a proportion of both government funds and user payments intended for capital will go to providers who lack either the capacity and / or intention to make future commitments to aged care.
  - Providers who are intent on expansion but have little capacity to manage capital and undertake new developments will be bad risks; the Commonwealth has already moved to rescind bed approvals where providers have not made substantial progress in two years.
  - Those who have the capacity to undertake capital development but are not inclined to do so may be able to accumulate substantial reserves to use as they see fit, but cannot be required to re-invest in aged care.
  - Alternatively, some providers who have accumulated capital funds through Commonwealth and user payments may wish to redevelop their existing facilities in areas where the level of need is lower than in other areas, but the Commonwealth has no capacity to direct funds that are already in the hands of providers to areas of greatest need. Such capital spending will be contribute little to achieving

Commonwealth goals of equity of access and will perpetuate mal-distribution of services.
- There may be some providers who have neither the capacity nor intention to continue in the sector. Operators with old facilities that do not warrant upgrading, or face other problems such as being land-locked and unable to rebuild to required standards, may allow facilities to run down and exit the industry, taking any accumulated capital funding as a bonus on top of the sale of bed licences.

The outcome of current uncertainties in wider capital markets in the short term is likely to be that aged care providers seek higher returns on their investments, leading to pressure for increased government outlays without necessarily generating in creased provision or higher quality of care. In the current climate, the risk to future capital resources is high, either through loss or very low returns from unwise investment decisions.

In the longer term, if funds intended for capital are not available at a future date, the Commonwealth may have no option but to provide further funding, and may have to do so in future economic climates when other demands on government funds are also high.

Criterion 5: Ensuring governments continue to provide essential goods and services that the private sector does not sufficiently provide.

Increasing reliance on providers to make decisions about capital funding of services that are receive substantial public funding for their operating costs is at odds with the Commonwealth's own acknowledgement of its responsibility for ensuring equitable access to aged care services for all Australians in need of care. While the planning processes are designed to ensure this outcome, there is no clear connection between these planning process and the sources through which capital funding is secured for aged care. The result is that while the Commonwealth can control development of services in places where they are *not* required, it cannot do a great deal to promote provision in under-provided areas apart from approve bed licenses as raising the capital to convert licenses into operating beds rests almost totally on providers.

There are many areas where provision is below the Commonwealth planning benchmarks but where sufficient additional bed provision is not forthcoming. In some regions that are less attractive to providers, there have been persisting shortfalls of hundreds of places for many years. These deficit areas are not only rural and remote areas, where there is very limited capacity to charge high entry payments to low care facilities, but also include some inner and middle distance suburbs of capital cities where suitable sites are in short supply and very highly priced, and again, sections of local populations may not be able to make high entry payments. Areas that are unattractive to providers thus remain without adequate facilities, particularly when there are sufficient opportunities in other areas. Further, while expansion on the part of existing providers in the under provided areas offers many advantages, these are the very providers who may have greatest difficulty in generating the necessary capital.

The Commonwealth has to rely on very different configurations of provider sectors to realise the planned levels of services in different areas. Not only are there differences in the involvement of the for-profit, not-for-profit and government sectors between low care and high care, and between the states, there are also considerable variations within the two non-government sectors in the ways in which individual facilities operate as part of larger corporate entities. It is not possible to obtain a clear picture of the corporate structure of the industry from published data, but it is apparent that some of the large not-for-profit entities are at least as large if not larger than the largest private sector corporate providers.

The role of the large corporatised providers is increasing; as well as securing most of the newly approved places, small single operator homes that become unviable are being taken over. While offering economies of scale and other advantages of management expertise, this transformation of the industry is occurring unevenly and likely future trends are not readily appreciated. Two effects of this development that are apparent however are that the major providers are acquiring considerable corporate power, which can be exerted in their dealings with government and local communities, and at the same time, some areas may have only marginally viable, sole operators offering services. The security that the Commonwealth seeks to afford to all residents and their families, and ensuring equity of access to all in need, lies increasingly in the hands of providers, and is becoming increasing variable.

Part 2: Options for addressing shortcomings identified in the present arrangements: a Social Insurance Scheme for Aged Care

The solution proposed to the problems of sustainability that are already evident and that will increase in future is the introduction of an Aged Care Social Insurance Scheme. The detailed design of such a scheme is beyond the scope of this submission, but thinking along these lines is now evident among several policy analysts and industry groups in Australia, including the Aged Care Alliance, the Institute of Actuaries of Australia, major not-for-profit groups, and the recent Myer Foundation exercise, *A Vision for Aged Care in Australia in 2020.*

A paper presenting a model of a social insurance scheme was presented at the Productivity Commission Conference on Policy Implications of the Ageing of Australia's Population in 1999 (see attachment 1). A fully funded option was found to have a number of advantages over the other three options, namely a pay-as-you-go system in which premiums paid in any year covered the costs incurred in the same year, a uniform PAYG system that moderated the increase in costs arising from increased ageing in the future, and an individually funded system. It was estimated that a premium of 2% of national wages would be sufficient to cover the cost of the capital component of aged care, about 1/3 of total funding.

There are four main areas in which an aged care social insurance scheme could enhance sustainability of future funding, particularly capital funding, of aged care.

1. Strengthening funding arrangements with a third pillar of social insurance

Current aged care funding relies on only two "pillars" – taxation revenue and user charges. Adding a pillar of social insurance would add a third pillar and so strengthen the whole of the funding arrangements. In particular, by providing a source of forward funded capital, social insurance would serve as a buffer against downturns in the wider business cycle for aged care investment, and in turn, marginally moderate the business cycle.

A social insurance approach to aged care funding in Australia is highly consistent with and would complement both the Medicare Levy and the Superannuation Guarantee that are already in place. Both have proved "painless and popular" taxes with the community, and a social insurance scheme for aged care could be expected to gain similar acceptance.

Many design options are available, but four are worth noting as they could see a significant fund built up in a relatively short time:

1. So as not to impose an undue burden on young adults with responsibilities for raising young families, premium payments might only commence at age 40, but continue on past retirement age, as currently occurs in several overseas schemes.
2. As those who reach retirement age in the next decade will only have paid premiums for a relatively short time, but will be the first to need aged care services, the design of the scheme could include provision for an additional means tested contribution linked to individual's access to superannuation funds, with the option of payment as a discounted lump sum, or a continuing higher premium.
3. An adjustment in indexation of the Age Pension that would deduct the continuing premiums payable by those in receipt of the Age Pension; this arrangement would in effect be a trade off between a small reduction in current income and increased certainty about the affordability of aged care when it was required, at a lower future cost than would otherwise have been the case.
4. The funds which the Commonwealth currently directs to Accommodation Payments but which it cannot guarantee will be used for capital purposes could instead be more effectively channeled through the social insurance fund.

2. Establishing a bridge between capital funding and planning

A social insurance scheme for aged care offers a number of means of linking the Commonwealth planning processes and capital funding. Operated in conjunction with a regular annual allocation of new approvals, the scheme would overcome the wide fluctuations in approvals and new investment that characterise the system at present. Allocations from the fund could be made in a variety of ways, including low interest loans and grants, and take account of other factors affecting the financing of the sector at any given time.

By generating a capital fund independent of existing provider, a social insurance scheme would reduce reliance on the decisions of providers to realise Commonwealth policy goals and planned program outcomes. A substantial capital fund controlled by the Commonwealth would counter the increasing influence of a small number of corporatised providers, in both the for-profit and not-for-profit sectors, but without requiring government to become directly involved in service provision. An independent fund would give the Commonwealth considerable capacity to ensure capital funding was available to areas of greatest need and to address under-provision of places, with a variety of incentives to attract providers to those areas.

The fund could be operated by an independent body along the lines of the Health Insurance Commission, with a board that included representatives from the industry and the community.

3. Application to capital funding

The grounds for applying a social insurance fund to capital are not only related to the problematic nature of this area of funding. The other grounds for focusing an insurance based fund on capital include:

- capital facilities are shared between many individual users;
- the lifetime of the facility extends well beyond the period of occupancy of individual;
- most individuals would be unable to meet the capital cost of their care at the time of use;
- ensuring that facilities will be available when they are needed requires joint action that is beyond the capacity of any individual to undertake, and involves long term planning and investment by Government and providers, on the basis of current and future population need;
- exit from residential care most commonly occurs through death; requiring individuals to make a contribution to funding that involves a repayment to the individual's estate is unnecessarily complex and a burden on providers, and especially when the period of occupancy has been short.
- at the same time, alternative and more appropriate means of funding are more readily available, and likely to remain available, to cover daily living costs and the costs of care.

4. Time for action

The many unresolved issues concerning capital funding of aged care mean that it is time that action was taken to develop an alternative funding system. Australia is fortunate in having time to take effective action.

If a social insurance scheme it to play the part that it could in meeting the need for capital funds for aged care for the cohorts of baby boomers who will reach age 70 from 2020 onwards, action is required now. If the baby boomers are contribute to their own future aged care, they need to be provided with a vehicle for doing so in the near future. A fund

established by 2005 would have matured and be generating substantial funds precisely at the time when demands on public funds for health care for the ageing population will be growing most rapidly.

Action to commit Australia to a fully funded long term care insurance scheme could draw on a range of recent international experience in reforms to long term care funding. This experience shows that there is no single solution, but that different countries are designing schemes that address their particular needs and that are compatible with funding approaches to health care and retirement incomes, and in some cases, can drive reforms in those related policy areas. A social insurance scheme is not a complete solution that fully replaces all other sources of funding but rather an additional part of wider funding systems that draw on a range of sources of funding. Recent development of long term care social insurance schemes in countries as diverse as Israel, the Netherlands, Austria, Germany and Japan demonstrate varying mixes of funding from user charges, tax revenue and insurance. None of those schemes are however forward funded, and Australia's demographic trends give it an opportunity to prepare for future ageing that is not available to countries that are already older.

It is an opportunity that should not be lost.