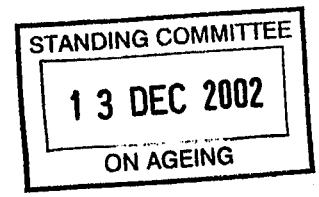
National Aged Care Alliance Secretariat
Australian Nursing Federation
PO Box 4239 Kingston ACT 2604
Tel: 02 6232 6533
Fax: 02 6232 6610
Email: anfcanberra@anf.org.au



13 December 2002

The Secretary
Standing Committee on Ageing
House of Representatives
Parliament House
CANBERRA ACT 2600

Dear Secretary

Please find attached a copy of the National Aged Care Alliance submission to the Inquiry into Long Term Strategies to Address the Ageing of the Australian Population Over the Next 40 Years.

The Alliance has also provided, as an Exhibit, a copy of its Discussion Paper, Options for Financing Long Term Care for Older People in Australia. This paper is also available from the Alliance website: *http://www.naca.asn.au/pdf/report_03.pdf*

The Alliance would like to meet with the Committee to discuss our submission and exhibit. We look forward to making these arrangements accordingly.

Yours sincerely

R. Gray

RICHARD GRAY
Alliance Secretariat
on behalf of the Alliance

Sponsoring Organisations Aged and Community Services Australia; Australian Medical Association; Australian Nursing Federation; Australian Nursing Homes and Extended Care Association; Catholic Health Australia; Council on the Ageing; Geriaction; Uniting*Care* Australia.

Participating Organisations Alzheimer's Australia; Anglicare Australia; Australian Association of Gerontology; Australian Divisions of General Practice; Australian Liquor, Hospitality and Miscellaneous Workers Union; Australian Pensioners' and Superannuants' Association; Australian Physiotherapy Association; Australian Society for Geriatric Medicine; Baptist Care Australia; Carers Australia; Health Services Union of Australia; Lutheran Church of Australia; Pharmacy Guild of Australia; Royal Australian College of General Practitioners; Royal College of Nursing Australia

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National Aged Care Alliance

Submission to House of Representatives Standing Committee on Ageing *Inquiry into Long Term Strategies to Address the Ageing of the Australian Population Over the Next 40 Years*

1. Introduction

The National Aged Care Alliance (the Alliance) is a body representing peak national organisations in aged care including consumer groups, providers, unions, and health professionals, working together to determine a more positive future for the residential aged care sector.

The Alliance welcomes the opportunity to submit to the House of Representatives Standing Committee on Ageing *Inquiry into long term strategies to address the ageing of the Australian population over the next 40 years.*

The Alliance's vision for aged care in Australia is that:

> All older people in Australia have access to planned and properly resourced integrated quality aged care services that are flexible, equitable, that recognise diversity and promote choice and respect for users and workers.

The delivery of quality aged care services requires informed consumers; a person-centred approach to care; adequately qualified and prepared staff; input from a range of qualified and competent professionals and care workers; quality facilities; enlightened policy makers advising a Government which has the necessary vision; and adequately resourced, competent and caring operators.

The key to a robust, efficient and effective aged care system is improved integration of care services between acute, residential, transitional, and home and community care sectors. The current situation of ineffective integration leaves consumers at a loss in moving purposefully through the system and results in unnecessary duplication and piecemeal health and aged care. Strategies must be implemented to improve the continuity of care across programs and to address any cost-shifting measures that impede quality care.

2. Recommendations

2.1 That health spending be seen as an investment rather than a cost with a move to health strategies that focus on the healthy well-being of individuals. Public health programs that focus on home-based services; local community-based health services; prevention of ill health; and promotion of a healthy lifestyle; will reduce costly hospitalisations and demand for residential care services.

2.2 That the current allocation process of aged care places be subject to examination, review and community debate.

2.3 That a new funding system be introduced for aged care based on a defined and properly costed and indexed benchmark of care. This benchmark of care must reflect the real costs of providing a quality aged care service in different regions around Australia, and allow for the flexible delivery of aged care services responsive to the needs of the individual.

2.4 That a national strategic response be developed now to address the serious staffing shortages in aged care in order to ensure that skilled staff are available to deliver quality care. Part of this response must include achieving and maintaining wage parity for all staff with their public hospital counterparts. It also needs to include integrated education and training for all staff working in aged care including specific care needs such as dementia and palliative care.

2.5 That access to, and funding of, dementia specific care be urgently reviewed.

2.6 That immediate strategies be implemented in community care that include:

- Increasing HACC funding by 20% as an initial injection to enable a more appropriate level of care to be offered to existing clients (with appropriate indexation of the program – starting at 8% – to ensure continuing growth).
- Expanding the number of Community Aged Care Packages.
- Expanding the Extended Aged Care at Home program.
- Reviewing the structure and relationships of community programs to achieve better integration and targeting of resources.
- Promoting best practice in respite care and develop incentives for specialisation and diversification of models of respite care including at home and residential based respite services.

2.7 That policies are developed that will ensure the medical care of residents is integrated with nursing, allied health and other care.

2.8 That the collaboration of doctors, nurses and allied health practitioners is encouraged and facilitated so that multidisciplinary practice guidelines can be developed and implemented.

2.9 That the Government encourage alliances between consumers, providers, professional associations and education institutions to promote and guide research and encourage participation in international comparative studies of health care in the aged care setting.

2.10 That all governments urgently address the disincentives that currently discourage the provision of care services in the aged care sector and the integration of services across the continuum of care.

2.11 That all Australian jurisdictions review and remove all legislative barriers to a nationally consistent continuum of care for older people in Australia.

2.12 That all accreditation processes established be independent of government, transparent and accountable.

2.13 That the role of carers in providing the foundation of care for frail older people be encouraged, supported and given better recognition through improving and better resourcing current programs within the community care sector; the provision of appropriate social security support; changes to superannuation policy to deliver adequate retirement incomes; and greater flexibility in the workplace to include input from carers.

3. Health spending

Over the next 40 years the demand for a range of quality services for older Australians will increase because of the rising number of older people in our population. While the overall population will increase by 30% by 2030, the population of people aged 80 or more will increase by over 200%[1].

By 2041 those aged 65 and over will represent 25% of the population compared with 8% 30 years ago and just over 12% currently. As the current 12% of people aged 65+ account for 36% of all health care expenditure, there will be major funding and service implications by 2041 when those over 65 will represent 25% of the population. Among this population will be a greatly increased number of people with dementia.

Currently the likelihood of being admitted to a residential aged care facility doubles with each 5 year increase in age, reaching 35% in people over 85[2]. Other predictors of admission are overwhelmingly health-related, rather than social. Of the 134,000 Australians diagnosed with dementia in 1996, about 50% were housed in residential care[3]. The prevalence of cognitive impairment is 54% in low level care (formerly called hostels) and 90% in high level care (formerly called nursing homes)[4].

The Australian Bureau of Statistics has also predicted that over the 25 year period to 2021, the number of Australians who will be living alone will increase by 70% from under 1.6 million in 1996 to over 2.7 million in 2021. For those aged 65 and over, the increase will be 90%. Without carer support systems, many more older people will require residential aged care at an earlier point in time. At present levels they will not be able to access community care.

The National Aged Care Alliance welcomes the direction of the health policy reform agenda endorsed by the Australian Health Ministers' Conference, particularly the recognition by all Commonwealth, State and Territory Health Ministers of the need to improve the interface between hospitals and primary and aged care services. The Alliance stands ready to work with all Health Ministers to achieve better outcomes.

The development of specific wellness initiatives for older people to reduce future demand on health services will mean a refocusing of health outlays. The significant shifts needed in the financing and structure of health care delivery will require the development of universally embraced medium and long term strategies.

Healthier ageing should not be taken for granted. A national goal of the majority of people entering old age as healthy as possible requires the development of initiatives at national, state, regional and local community levels.

The National Aged Care Alliance calls on governments to consider spending on health as an investment rather than a cost with a move to health strategies that focus on the healthy well-being of individuals. Public health programs that focus on home-based services; local community-based health services; prevention of ill health and promotion of a healthy lifestyle; will reduce costly hospitalisations and demand for residential care services.

4. Allocation of aged care places

The existing allocation of operational places is not meeting the access needs of considerable numbers of frail older people. The medium term strategic challenge is the question as to whether the current planning ratios are appropriate to meet the longer term care access needs of the approaching bulge of demand. The Alliance considers that this question requires examination, review and community debate.

The National Aged Care Alliance calls for the current allocation process of aged care places to be subject to examination, review and community debate.

5. Funding of aged care services

Australia has an aged care sector in which we can take some pride, however currently its funding base is not as secure as it needs to be to prevent longer waiting lists, and pressures on both the quantity and quality of future services. There has been a real decline in aged care funding at a time of rising demand for aged care services, and a lack of transparency in the Government's funding of residential aged care services because there is no benchmark.

The current funding bears no direct relationship to the actual costs of providing care. Unlike some other output-based funding models that are periodically tested against actual costs, aged care payments are not. The announcement by the Government in this year's Federal Budget of the Pricing Review will provide an opportunity for these issues to be examined and resolved through future Federal Budgets. Getting right the quality of care and the appropriate cost price for that care as expected by consumers of services and the community is fundamental.

The Alliance considers that the current funding system for residential aged care is an inadequate basis on which to provide quality care because the funding is inadequately indexed and does not reflect the real costs of providing care. The viability of aged care services will continue to deteriorate as the funding gap grows and as Australia's population ages.

The National Aged Care Alliance calls for the introduction of a new funding system for aged care based on a defined and properly costed benchmark of care. This benchmark of care must reflect the real costs of providing a quality aged care service in different regions around Australia, and allow for the flexible delivery of aged care services responsive to the needs of the individual.

6. Staffing of aged care services

There is an immediate need for a national strategic response to address the serious existing and projected staffing shortages in aged care in order to ensure that skilled staff are available to deliver quality care. Optimal health outcomes will not be achieved without an appropriately skilled and qualified workforce. Part of this response must include achieving and maintaining wage parity for all staff with their public hospital counterparts. Working conditions and wages for all staff in aged care must be attractive and competitive in order for the aged care sector to be able to recruit and retain quality staff to provide quality care. It also needs to include integrated education and training for all staff working in aged care including specific care needs such as dementia and palliative care.

The National Aged Care Alliance calls for a national strategic response to address the serious staffing shortages in aged care in order to ensure that skilled staff are available to delivery quality care; and calls on the Federal Government to develop a model of funding (mutually agreed by all stakeholders) that reflects the real costs of providing sufficient staff to achieve quality outcomes. Part of this response must include achieving and maintaining wage parity for all staff with their public hospital counterparts. It also needs to include integrated education and training for all staff working in aged care including specific care needs such as dementia and palliative care.

7. Dementia specific services

The Two Year Review of Aged Care Reforms identified that the adequate provision of specialist dementia residential aged care services is an existing policy priority needing to be addressed. The Alliance considers that the 40 year time frame for the development of long term strategies should not just focus on the distant future but identify immediate and short to medium term strategies to deal with existing issues.

The challenge of the provision of specialist dementia services cannot be left till the 'baby boomer' demographic bulge is upon us.

The National Aged Care Alliance calls for an urgent review of access to, and funding of, dementia specific care.

8. Community care

Through the current planning framework, the Commonwealth seeks to achieve and maintain a national provision level of 100 residential and Community Aged Care (CACPs) per 1,000 of the population aged 70 years and over. The target ratios are 40 high care places, 50 low care places and 10 CACPs per 1,000 of the population aged 70 years and over.

As at 30 June 2002, there were 42.4 operational high care places, 40.5 low care and 15.0 CACPs making a total of 98.0. The total number of allocated places however, were at 108.4, representing principally high and low care places that had not come on stream as operational.

The Commonwealth's strategy since 1992 has been to steadily increase the provision of community care in line with consumer expectations and to achieve a balance of care away from reliance on residential care. Forty two per cent of CACP recipients receive packages for more than 12 months and forty six per cent of all package recipients enter residential care[5].

As care in the community increases thus delaying or obviating the need for residential aged care, the above predictors of admission will change over the next 40 years. Styles of residential aged care will alter to more closely reflect the support needs of specific care groups, eg transitional, rehabilitative, palliative, dementia, disability and psycho-social.

The National Aged Care Alliance supports the enhancement of community-based care options as an alternative to residential aged care for older people living in the community. This enhances people's independence, and avoids premature admission or inappropriate stays in hospital or residential aged care.

Community based care options are also fundamental in supporting informal carers in providing the main source of help in day to day activities of frail older people. The increasingly ageing population and increasing number of people with age related or early onset disabilities, will result in an increased demand for informal care and community care services. The role of family and friends in providing informal care therefore needs to be appropriately supported and resourced to make it sustainable for carers and the community care sector in the medium to long term.

Quality community care is a critical factor in a positive experience of ageing for the 93% of those over 65 years of age who live in the community and want the choice of remaining at home.

The National Aged Care Alliance calls on the implementation of immediate strategies that include:

- Increasing HACC funding by 20% as an initial injection to enable a more appropriate level of care to be offered to existing clients (with appropriate indexation of the program – starting at 8% – to ensure continuing growth).
- Expanding the number of Community Aged Care Packages.
- Expanding the Extended Aged Care at Home program.
- Reviewing the structure and relationships of community programs to achieve better integration and targeting of resources.
- Promoting best practice in respite care and develop incentives for specialisation and diversification of models of respite care including at home and residential based respite services.
- Encouraging, supporting and giving better recognition to carers through improving and better resourcing current programs within the community care sector; the provision of appropriate social security support, changes to superannuation policy to deliver adequate retirement incomes; and greater flexibility in the workplace to include imput from carers.

9. Medical input into aged care services

Multiple coexisting medical conditions result in many people having particularly complex health care needs. These needs may be for active treatment aimed at cure or prolongation of life or may be essentially palliative and aimed at effective control of distressing symptoms. Failure to meet these care needs is the strongest predictor of depression among people in residential care settings[6].

Quality health care depends on the effective integration of medical, nursing, allied health and other care workers. Medical care is not effectively integrated within the broad range of services provided, and there are many disincentives to doctors and other staff working within residential aged care facilities, which are not just economic.

The National Aged Care Alliance calls for the development of policies that will ensure that the medical care of residents is integrated with nursing, allied health and other care and the introduction of incentives to encourage doctors to work in aged care.

10. Multidisciplinary practice guidelines

There is an international movement toward the development of multidisciplinary practice guidelines for all common conditions of ageing including the behavioural symptoms of dementia. These condition-specific guidelines outline the important elements of assessment and indicate the most well researched and beneficial medical, nursing and allied health interventions for each condition. The guidelines also clarify the inter-related roles of each professional discipline, and identify people for whom specialist support should be considered.

The National Aged Care Alliance calls on the Federal Government to encourage and facilitate the collaboration of doctors, nurses and allied health practitioners in order to develop and implement multidisciplinary practice guidelines.

11. Research

The capacity to conduct high calibre research is another pillar on which quality health and medical care can be progressively built. Strategic alliances need to be formed among providers, consumers, professional associations and educational institutions, to set priorities for targeted research and conduct studies monitoring adherence to accepted best practice and evaluating practice innovations.

Sound research, effective strategic planning, and strong public policy are essential prerequisites to ensuring that resources will be available and used to maintain a high quality of life for older people in Australia, and to reducing the need for more expensive hospital care.

The National Aged Care Alliance calls on the Federal Government to allocate specific funding for research in aged care and encourage alliances between consumers, providers, professional associations and education institutions to promote and guide research and encourage participation in international comparative studies of health care in the aged care setting.

12. Disincentives

The Alliance is concerned at the disincentives and barriers that currently exist which make it difficult for doctors, other health professionals, and carers to operate in the aged care sector, particularly in residential aged care facilities. These disincentives include an inequitable fee structure for doctors; inequitable wages for nurses and other care staff; the large number of non-face-to-face administrative tasks and red tape expected of GPs and care staff; the lack of integration of medical services in the aged care system; and the absence in many residential facilities of consultation rooms with adequate treatment facilities and plug-in computer facilities that would facilitate access to patient records.

The National Aged Care Alliance calls on all governments to urgently address the disincentives that currently discourage the provision of care services in the aged care sector and the integration of services across the continuum of care.

13. Legislative barriers

The Aged Care Act 1997 and the various State and Territory operator licensing and regulatory requirements that impact variously across the acute, residential and community care sectors need to be reviewed and aligned in order to remove the barriers to achieving a nationally consistent continuum of care for older people.

The National Aged Care Alliance calls on all Australian jurisdictions to review and remove all legislative and practice barriers to a nationally consistent continuum of care for older people in Australia.

14. Quality assurance

The administrative costs of compliance with the quality assurance process need to be factored into Government funding of aged care as a way of ensuring that the Government, accrediting bodies and approved providers are mindful of, both the costs of accreditation processes and the costs associated with continuous improvement in the quality of the services.

Further education and information programs and products should be developed to increase consumer knowledge and understanding and to support their involvement in the accreditation process, and to clarify the roles and responsibilities of the Minister, the Agency and the Department in accreditation, complaints and compliance processes.

The National Aged Care Alliance calls for an accreditation process that is independent of government, transparent and accountable.

15. Summary

The National Aged Care Alliance has a vision for aged care in Australia that will give all older people in Australia access to planned and properly resourced integrated quality aged care services that are flexible, equitable, that recognise diversity and promote choice and respect for users and workers.

The Alliance considers that the House of Representatives Standing Committee on Ageing should use this vision as an essential plank in its report on the long term strategies to address the ageing of the Australian population.

In February this year the Alliance released a Discussion Paper: *Options for financing long-term care for older people in Australia*, confirming that the long term financing of aged care is a major focus of future work for the Alliance. The Alliance is including this Paper as an Exhibit to its Submission. A copy of the Discussion Paper can be located on the Alliance website at: *http://www.naca.asn.au/pdf/report_03.pdf*

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Options for Financing Long-Term Care

for Older People in Australia

A discussion paper prepared by Jan Webster, Webster Associates Pty Ltd
for the National Aged Care Alliance

July 2001

Options for Financing Long-Term Care for Older People in Australia
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Published by the National Aged Care Alliance
July 2001

Disclaimer
This publication is commissioned research and does not necessarily represent the views of the National Aged Care Alliance or its member organisations.

ISBN XXXXXXXXXX

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Aged & Community Services Australia

Alzheimer's Association

Anglicare Australia

Australian Association of gerontology

Australian Liquor, Hospitality & Miscellaneous Workers Union

Australian Medical Association

Australian Nursing Federation

Australian Nursing Homes & Extended Care Association

Australian Pensioners & Superannuants Federation

Australian Society for Geriatric Medicine

Baptist Community Services

Carers Association of Australia

Catholic Health Australia

Council on the Ageing

Geriaction

Health Services Union of Australia

Lutheran Church of Australia

Royal College of Nursing Australia

Uniting*Care* Australia

Overview and Introduction

Australia's aged care program

When compared with most other developed countries, Australia has a very good program of long-term care for the aged. This is not to say that there are no problem areas or that we can afford to be complacent about it. Quality of aged residential care is assessed and monitored through accreditation and certification processes. Access to residential and community services is based on expert assessment by a national network of Aged Care Assessment Teams using agreed eligibility criteria.

Aged care service providers are mainly in the not-for-profit sector and the for-profit sector, although a small proportion of services are provided in the public sector. Cost control is achieved through Government regulation of the numbers of residential aged care places and Community Aged Care Packages (CACPs), of resident classification; and of the subsidies paid for the different levels of care. There is an increasing emphasis on *ageing in place* – ie on providing the supports needed to compensate for increasing disability without the necessity for the person to have to change their place of residence. Community Aged Care Packages are funded by the Commonwealth Government. Older people with disability who do not have access to CACPs may be in receipt of services delivered under the Home and Community Care (HACC) program such as Meals on Wheels, Day Care and/or Domiciliary Nursing. The HACC program is funded by the Commonwealth and State Governments.

Financing long-term aged care in Australia – current situation

Australia's long-term aged care program currently has just two main sources of funds, or *pillars* of financing. Residential and community aged care are financed by a large pillar of general revenue and a much smaller pillar of user contributions. The user contributions, in turn, are largely drawn from users' age pensions, which are also financed from the general revenue pillar. (Howe AL 1999).

Long-term aged care financing differs significantly from the financing of the other two components of support for older people – retirement incomes and health care. Australia's approach to financing retirement incomes is widely recognised as having considerable strength arising from its three pillars of financing – a general revenue pillar for the age pension, a superannuation pillar funded by compulsory contributions made throughout the working lifetime and a third pillar of private savings (Howe AL 1999). Howe points out that there is also a small fourth pillar relating to earnings. Health care also has a number of pillars of financing – general revenue, the Medicare levy, consumer contributions for services and private health insurance.

Demographic change has raised concerns about our continuing ability to finance high quality aged care into the future, particularly in view of its limited funding base. In a recent paper Howe noted that the former Australian Government devoted itself to developing a high quality aged care program but did not pay sufficient attention to how it was to be funded (Howe AL 1999).

The 1996–97 reform of the aged care program reflected the new Government's efforts to reduce Government outlays in all areas. The reforms were intended to reduce Government outlays by increasing user payments for residential care. Means tested increases in user contributions to residential care were introduced and efforts were made to require the payment of accommodation bonds for nursing home care, with the funds coming if necessary, from the sale of the family home. The latter requirement met with so much resistance however, that it had to be abandoned and replaced with a more modest accommodation charge.

While the changes introduced in 1997 slightly increased the size of the user contribution pillar, the continuing heavy reliance on general revenue to finance long-term aged care means that this program is less secure than the other main programs for the aged. This is particularly so at a time when all Governments appear to be committed to reducing taxation and Government expenditure. The problem will be increased with the demographic changes that will occur over the coming decades.

Demographic change

Although Australia currently has a relatively young population, compared with many other developed countries, its population is ageing and *it will continue to do so for the foreseeable future* (Madge A 2000) In 1997 people aged 65 years or more comprised 12% of the population. By 2031 22% of the Australian population will be aged 65 years or more (Table 1). Of greater importance for aged care planning is the size of the population of people aged 80 and over

(the oldest old or the very old), as most of the need for long-term care occurs in this group. The number of people aged 80 and over, who currently comprise about 22% of the 65 + age group, will increase by about 200% in the period between 1997 and 2031 to about 28% of the 65+ age group (Table 1) (Madge A 2000).

Table 1 shows that there will be a slow but continuing increase in the proportion of the population aged 65 and over until 2010–11. The size of this group relative to the rest of the population will increase more sharply however, from 2011 when the oldest members of the *baby boom* cohort reach the age of 65. The increase in the proportion of the population aged 65+ is not only due to increased longevity but also to the declining numbers of younger people.

Table 1 also shows that over the 35 years covered, the female share of the population aged 65+ will decline. This is as a result of a projected increase in male longevity greater than the projected increase for females.

Table 1 Projections of Australia's aged population*, 1996–97 to 2030–31 (Reproduced from Madge A 2000)

Year	Aged pop. to total pop.	Aged dependency ratio**	Aged 65+	Aged 80+	The 'very old' to total aged pop.***	Female share of aged pop.
	%	%	'000	'000	%	%
1996-97	12.1	18.2	2244	501	22.3	56.3
1997-98	12.2	18.2	2282	514	22.5	56.2
2000-01	12.4	18.4	2403	583	24.3	55.9
2005-06	13.0	19.2	2657	713	26.8	55.1
2010-11	14.3	21.0	3036	820	27.0	54.3
2020-21	18.4	28.1	4220	997	23.6	53.3
2030-31	22.3	35.8	5405	1518	28.1	53.4

** Australian Bureau of Statistics (ABS) population projections series 2. The ABS notes that such projections are not forecasts and are based on particular assumptions about births, deaths and net migration.*

*** Population aged 65 or more to population aged 15 to 64 years as a percentage.*

**** Population aged 80 and over as a percentage of the population aged 65 and over.*

Source: ABS Cat. No. 3201.1 and 3222.0 from the Econdata database (August 2000)

Australia's continuing ability to fund the cost of long-term aged care from general revenue and user fees will be challenged by the increasing size of the aged population over the coming decades. Table 1 shows that the increase in the total aged population begins to accelerate appreciably from 2011, while the most rapid increase in the size of the cohort of people aged 80 and over will occur between 2020–21 and 2030–31. This latter change is likely to place the greatest strains on our continuing ability to fund long-term aged care.

Understanding the issues and promoting discussion – the role of the National Aged Care Alliance

A number of recent publications on the subject of financing long-term aged care have pointed out the need for action in this area (Howe AL and Sarjeant H 1999; Howe, AL 1999; Australian Institute of Primary Care 1999; Fine M and Chalmers J 1998; McCallum J et al 1998; Savage E 1998; Somogyi S et al 2000).

There is still time to introduce measures to improve the stability and security of funding for aged care in the coming decades, but not much time. It was the recognition of this that caused the National Aged Care Alliance (the Alliance) in the latter half of 2000 to take steps to better inform itself about the issues.

In September 2000 the Alliance, commissioned Jan Webster of Webster Associates Pty Ltd to develop a paper to help it in its deliberations on the future funding of long-term aged care. The brief was quite specific – the paper should provide *a brief, easy to read overview of the main options for financing long-term care that have been proposed in Australia in recent years.* The paper was to be developed on the basis of a number of papers the Alliance had identified from the recent Australian literature and was to include a list of criteria by which options could be evaluated. The Alliance also requested that the paper should contain a bibliography of relevant papers from the international literature. The report prepared for the Alliance in October 2000, with minor editing in March 2001, is reproduced as Paper 1 in this publication.

At about the time of its completion, two major Australian papers on this topic were published. One was a report prepared by the Financing the Ageing Committee of the Institute of Actuaries of Australia entitled *Financing the Ageing – Now is the time to act* (Somogyi et al 2000). The other paper was a Staff Research Paper for the National Productivity Commission entitled *Long-Term Aged Care: Expenditure Trends and Projections* (Madge A 2000) published in December 2000.

Members of the Alliance requested the preparation of a second paper. This report would contain summaries of these publications as well as of the National Commission of Audit's 1996 *Report to the Commonwealth Government*, and a Background Paper for the Economic Planning and Advisory Council – Australia's Ageing Society (Clare R and Tulpule A 1994).

It was also requested that the paper (Paper 2 in this publication) should contain a summary of the findings of the UK Royal Commission on Long-Term Care, *With Respect to Old Age: Long-Term Care – Rights and Responsibilities* 1999, and a summary of the outcomes of the German reforms.

Paper 1 thus sets the scene by identifying a number of possible approaches to funding long-term aged care in Australia. Readers are warned however, that:

> *It is important to treat the different options set out in the paper as illustrative rather than definitive or prescriptive. They show how the different approaches might work, and how they might be arranged in order to achieve the objective of a secure and stable funding model for long-term care in Australia.*

Paper 2 contains some information that was not available at the time of writing the first paper and other information that it was later recognised would be relevant to the issue.

Following consideration of the two papers, the National Aged Care Alliance decided to distribute them more widely with the objective of promoting broad discussion and debate on financing long-term aged care. This publication is the result of that decision. It comprises this introductory section and the two papers. There has been some revision of the papers for the wider audience now proposed for them.

Summary of issues

It is clear from the two papers that follow that there are many different approaches that could be taken to financing aged care. Most have advantages and disadvantages. It is important to recognise that it is quite possible to have a range of different components of the total package of funding. Although a number of the issues that follow are expressed as alternatives to each other, it may be quite reasonable for one component of the funding package to be funded in one way (for example, pre-funded and/or private) and another in the alternate way (pay-as-you-go and/or public). Key issues for consideration include:

- Should there be a single funding source or should the aim be to broaden the funding base with two or more sources of funds?

- Should the funding approach be a pay-as-you-go (PAYG) approach – in PAYG schemes current benefits are paid from revenue raised in the current year – examples of PAYG schemes (and their sources of funds) include: Medicare (compulsory levy), private health insurance (voluntary premiums) and the age pension (general revenue). Alternatively, should the program be forward funded or pre-funded? In pre-funded schemes, contributions are made into a fund over a considerable period of time to build up a fund from which benefits are paid at some time in the future. Examples of pre-funded schemes include superannuation schemes and life insurance.
- Should contributions be voluntary or mandatory?
- Should the funding be arranged through the public or the private sectors?
- If long-term care, or a component of it is to be funded from public revenue, how should this be raised:
  - through general taxation; or
  - through a specific levy on income – a hypothecated tax (a PAYG or pre-funded social insurance scheme).
- If insurance arrangements are to be made in the private sector, should the premiums to be paid be mandated by Government as with the SGC or subject to conditions set by Government as with private health insurance, or determined on the basis of risk as with motor vehicle or life insurance.
- Should the level of contribution to be paid for long-term care be flat rate or income related?
- Would it be more or less advantageous for payments to be linked to some other payments such as the Medicare levy or the Superannuation Guarantee Charge?

Conclusion

How we should finance long-term care of the aged is a debate we have to have, and one that we need to have now. As noted at the beginning of this paper, Australia has an aged care program in which we can take some pride. Its current funding base is not as secure as it should be, however. The demographic changes that are underway and that will accelerate from about 2011, are already applying pressure to the system.

The discussion has to start somewhere. The National Aged Care Alliance has developed this publication in order to inform the people who are likely to have a particular interest in this topic. It is hoped that readers will find it helpful and that it will stimulate wide discussion of this important issue.

Jan Webster, March 2001

Paper 1, Part 1
Options for Financing Long-Term Care for the Aged in Australia

1. Introduction and purpose of this paper

This is the first paper on the subject of financing long-term care for the aged in Australia commissioned by the National Aged Care Alliance (the Alliance) in September 2000. The Alliance has identified a number of recent Australian papers covering a range of approaches on this topic which are to be covered in this paper (see references).

The purpose of the paper, as set out in the brief, is to:

> *provide a comprehensive, easy to read overview of the main options for financing long-term care that have been proposed in Australia in recent years.*

The reason for requesting the paper is to:

> *assist the members of the National Aged Care Alliance to consider the financing issue at the broadest level and determine what further work or presentations may be helpful to advance its thinking on this issue.*

Paper 1 originally provided scant demographic data as its readership was presumed to have a reasonable knowledge of the demographics of ageing. In the preparation of the final (consolidated) paper for a wider readership, relevant demographic and other data have been included in the introductory section.

2. Contents

This paper (Paper 1) has 3 parts. Part I contains the introduction and background information. Part 2 sets out 5 options under three headings for funding long-term care of the aged. Part 3 discusses how the work of the National Aged Care Alliance might move forward and provides a brief bibliography of overseas literature which could be helpful to further thinking in this area.

3. Overview

It is important to treat the different options set out in the paper as illustrative rather than definitive or prescriptive. They show how the different approaches might work, and how they might be arranged in order to achieve the objective of a secure and stable funding model for long-term care in Australia. A number of the possible approaches set out in the papers reviewed have so little detail, that, if it were considered that there could be merit in the approach, a much more detailed model would need to be developed and costed. The options for financing long-term care for the elderly are listed below.

Table 2 sets out a classification of the five options described in Part 2 of this paper.

Table 2 Classification of the options for financing long-term care of the aged described in this paper

Method of funding	Responsibility for risk	
	Individual	**Shared or pooled**
Pay-As-You-Go (PAYG) (current costs are paid from current revenue)	Option 2(b) EQOLL "opt out"	**Option 1. PAYG funded from general revenue:** maintaining the status quo (for publicly funded component of LTC) – the rate of contribution from national wages required to fund residential LTC would rise significantly over time. **Option 2(a). EQOLL levy:** mandatory, income related payment of a levy to a fund to cover the current long-term aged care costs. This is a PAYG form of social insurance. **Option 2(c). Uniform PAYG:** Contributions would be paid into a fund at a higher rate than required in the first two years to build up a fund that would even out payments over subsequent years. This is a PAYG form of social insurance.
Forward funding	**Option 4. Private insurance schemes:** Individuals could take out insurance to cover themselves for the possible costs of LTC in the future.	**Option 3. Pre-funding social insurance schemes:** Mandatory contributions would be made into a fund which, on maturity, would fund long-term care.
Mixed funding models – a pillars approach		**Option 5. Creating at least 3 pillars of funding for LTC:** This approach could have a pre-funded component of LTC together with a PAYG component and a user contribution.

LTC – long term care
EQOLL – ensuring quality of later life (McCallum et al 1998)

4. Evaluation criteria

The following evaluation criteria for a financing scheme for long-term care in Australia are drawn from the papers reviewed.

To be acceptable any scheme to finance long-term care for the aged should meet some or all of the following criteria:

- it should provide for security and stability of funding into the foreseeable future;
- it should be consistent with our approach to the other key provisions for old age, viz. with provisions for retirement incomes and health care;
- it should be universal – ie it covers every older person in need of long-term care;
- it should be equitable – ie contributions are made according to the ability to pay and benefits are provided on the basis of need;
- it should be effective – ie it should deliver the level of funding required for the programs it covers;
- it should be efficient – ie it delivers the required funding when and where it is required and it does so at the lowest possible cost;
- it should not rely too heavily on inter-generational transfers, particularly as there will be periods in the future where a large cohort of older people will have to be supported by a relatively small working age population;
- it should provide a means whereby people can save for all or part of their own long-term care needs at a time when they can afford to do so;
- it should not require high levels of user contributions at the point of consumption;
- it should have the capacity to change in response to changing conditions or requirements.

The following additional criteria for a financing scheme for long-term care for the aged are taken from the Report of the UK Royal Commission on Long Term Care (1999). The financing scheme should:

- promote independence, self-respect, dignity and choice;
- not unduly limit old people's choice of care, distort their preferences through unsatisfactory incentives, or create stigma;
- go a long way towards making services provided for LTC as valued and as jealously guarded as those provided by the National Health Service;
- recognise the principle of equal care for equal need.

5. Community care

In all industrialised nations there is a growing concern to make appropriate community care available to elderly people, wherever possible, in preference to residential care. It is to be expected that over the coming decades there will be an increasing emphasis on community care within the spectrum of services that make up long-term care in Australia. Part 2 of this paper sets out 5 options, under 3 main headings, for financing long-term care, and, wherever possible, includes cost information, mainly from two papers – one by Howe and Sarjeant (1999) and one by McCallum et al (1998). The projected costs of proposed models identified in the McCallum et al paper include both residential and community care. The Howe and Sarjeant costings are for residential care only. The latter authors state that *the costs of community care can be factored in* by inflating total costs by 20%. Alternatively, as this equals the current user contribution to residential care, community care costs could be covered by the full cost projections and by retaining user fees.

Paper 1, Part 2

Options for Financing Long-Term Care for the Aged in Australia

A Pay-as-you-go schemes

The PAYG option covers those approaches that would provide expenditure for long term care in any given year from revenue raised in that year. Some examples of this approach are the public funding component of the current funding arrangements for long-term care and community care as well as funding of the age pension. The range of possibilities within this option thus includes:

- maintaining the status quo with respect to the public funding of LTC;
- increasing tax rates in line with the projected increases in the cost of LTC;
- introducing a levy, or hypothecated tax, to fund all or part of LTC on a PAYG basis examples are:
  - the EQOLL levy proposed by McCallum et al (1998);
  - the uniform PAYG scheme proposed by Howe and Sarjeant (1999).

PAYG schemes funded by a levy are one form of social insurance scheme. Social insurance schemes can however, be used to pre-fund social programs as discussed below (Option 3).

Private insurance for long-term aged care is different, however. Private health insurance is an example of a PAYG private insurance scheme. Individuals can claim benefits from the scheme while they continue to pay their premiums. While private insurance to pre-fund long-term aged care is a possibility, a PAYG private insurance scheme would seem to be impossible.

Option 1. Pay-as-you-go funded from general revenue

Maintaining the status quo does not really appear to be a viable option. The increasing contribution from national wages that will be required to fund the current level and standard of long-term residential care would, over time, have a significant impact on taxpayers and the community.

In their paper prepared for the Productivity Commission and the Melbourne Institute (1999), Howe and Sarjeant have projected that the rate of contribution

from national wages required to fund residential LTC, as a PAYG system over the next 50 years, will rise from 1.8% in 1998 through 2.9% in 2018 to 6.4% in 2048 (Table 3).

Table 3 Rate of contribution from national wages required to fund residential aged care for PAYG, Uniform PAYG and Fully Funded Options (per cent) (Howe AL and Sarjeant H 1999)

Year	PAYG	Uniform PAYG	Fully Funded
1998	1.8	2.0	-
2008	2.4	2.0	4.8
2018	2.9	2.2	3.9
2028	4.0	2.5	3.7
2038	5.3	2.7	3.7
2048	6.4	3.0	3.6

Option 2. Pay-as-you-go funded by a levy

2(a) EQOLL levy

McCallum et al (1998) propose a different kind of PAYG scheme funded by a levy referred to as the Ensuring Quality of Later Life (EQOLL) levy. This would be like the Medicare levy and would be collected with income tax as is the Medicare levy. It is a hypothecated tax – ie a tax collected for a specific purpose and only able to be used for that purpose.

It is proposed that the rate for the levy should be that required to fund the *increase* in costs over the coming decade with user co-payments returning to the level that existed prior to the introduction of the 1997 Aged Care Act. It is estimated that the contribution rate would be 1.1% of taxable income of participating taxpayers.

It is quite reasonable to consider models (either in a PAYG or pre-funded system) that apply to funding only part of the costs of long-term care, such as the increasing costs. An obvious precedent for this approach is the Medicare levy which was introduced to fund the increasing costs of health care.

The figure of 1.1% of income is based on projections only to 2011. For this reason it should be treated with some caution. The authors state that the accuracy of projections over any longer time becomes more doubtful and this is why they have been reluctant to make longer term projections. The problem about this is that 2011 marks the beginning of at least three decades of accelerated ageing of the Australian population.

Given the size of the increases in the costs of LTC projected by Howe and Sarjeant in the second, third and fourth decades of the 21st century it is clear that we are not dealing with a stable system at this time. Thus, the time frame may be insufficient to develop an adequate view as to the likely future financial requirements for long-term care.

2(b) EQOLL *opt out* model

McCallum et al (1998) propose that *the public aged care insurance scheme would be the default.* People could opt out of the scheme (ie receive a tax rebate for the contributions made) by taking an alternative option such as aged care insurance, provided they could prove that they had made *equivalent contributions* to it (McCallum et al 1998, p.32).

An alternative arrangement proposed in the EQOLL paper is that people would be permitted to invest their 1.1% of income in *Continuing Care Retirement Communities that offered a full, self-contained range of aged care and health services for senior citizens.* This approach, it is suggested, would *give people an incentive to develop their own models of residential care* (McCallum et al 1998, p.32).

Without information on how either the private aged care insurance or the retirement communities proposals would work, it is difficult to comment in detail. It must be said however, that allowing people to opt out of a levy that funds a PAYG scheme would reduce revenue to the EQOLL fund and threaten its capacity to pay the required level of benefits.

2(c) Uniform PAYG

Howe and Sarjeant propose that it would be possible to even out the impact of the rapidly rising costs of a PAYG scheme by establishing a fund like a defined superannuation benefit fund. Contributions (or a levy) *as a uniform percentage of total earnings* would be paid into the fund and costs would be met from the fund. In the first two years of the scheme the contribution rate would be 2.0% of national wages, higher than the 1.8% of national wages in those years for a simple PAYG scheme. By increasing the contribution rate by about 11% over the first two years of the scheme (ie by a 0.2% contribution rate) a fund can be built up to cover later liabilities and reduce the size of contributions required in later years with an unmodified PAYG scheme. Table 3 shows the required rates of contribution from national wages for the PAYG, Uniform PAYG and Fully Funded options described by Howe and Sarjeant (1998).

Advantages and disadvantages

Advantages

- PAYG schemes deliver benefits from the year they are introduced;
- Public financing from revenue raised through payments which are progressive in nature is seen as an equitable and efficient way of financing necessary human services (Australian Institute for Primary Care 1999) These characteristics are not however, limited to PAYG schemes and it would be possible for a PAYG scheme to have a flat contribution rate – although this would be unlikely;
- PAYG schemes eliminate the need for a period of *double contribution* that must occur during the development phase of a fully funded scheme, when the on-going needs of the current aged must continue to be met while current working people save for their own LTC;
- By building up reserves at the beginning of the scheme, the uniform PAYG model has greater stability than simple PAYG schemes and may be more acceptable and less subject to being corrupted over time by political decisions.

Disadvantages

- Whether revenue is collected in the form of a levy or as additional taxation, it is, in reality, an additional tax (albeit a hypothecated tax);
- In a rapidly growing system, such as LTC for the aged will be in the first half of this century, the need to match revenue with expenditure would lead to the need for frequent and large increases in the taxes or levies applied;
- The tax or levy relies on inter-generational transfers which become a particular problem when the contributing generation is relatively small and the generation for whom benefits are provided is relatively large. Table 3 demonstrates this problem in the later decades of the PAYG option;
- The Howe and Sarjeant projections show that a fairly rapid rise in contribution rates will be required to fund the whole system, if no averaging is undertaken.

Discussion

The probable costs of any given model are important in considering its usefulness as an option for financing Long Term Care, although as already noted, it is possible to decide to fund all or part of the scheme with a new charge. While the EQOLL levy at 1.1% seems quite modest, it is not clear whether that could be sustained over time. The cost projections contained in the paper by Howe and Sarjeant show significant rises in costs occurring just after the period over which the cost projections in the paper by McCallum et al are made.

It needs to be recognised that if a pre-funded approach is introduced to fund some or all of long-term care, the need for PAYG payments will not diminish or disappear until the LTC fund can begin to deliver benefits. The time required to bring the fund to maturity may be of the order of 35 years. Unless very skilfully managed, the double contributions that would be required over that period could be a considerable burden for working aged people throughout that period. The size of this problem could be reduced if pre-funding were introduced to fund a part, rather than the whole of the LTC program.

The Report of the UK Royal Commission on long-term care of the aged (see summary in Paper 2) contains an explanation of the Commission's decision not to recommend a forward funding approach to financing LTC. One of the reasons given is the burden for young people who would have pay for the care of people who are currently old at the same time as they pay for their own long-term care and pensions at some time in the future, as well as for their education.

PAYG schemes are more susceptible to political change than are pre-funded schemes, and thus overall are less secure. Between the different PAYG models (general revenue funding or levy) there are also differences in security. The funding for programs funded from general revenue is less secure than for those covered by a levy or hypothecated tax. Both approaches are affected by rises and falls in employment rates and earnings, but Governments have some discretion about how general revenue is spent and little or no discretion about the funds derived from a specific levy. This extra flexibility could, of course, be beneficial for the funding of long-term aged care as it could enable funding to be expanded in response to population growth, unpredicted additional demand or a decision to enhance the quality of care.

It is known that Treasury does not favour levies or hypothecated taxes as they reduce flexibility. The UK Royal Commission had the same reservation and added that this approach to funding tends to set priorities in stone.

Another important consideration regarding PAYG schemes is that of inter-generational transfer. The age pension and LTC aged care are paid for with transfers (through the taxation system) from the working age group to another group, the majority of whom no longer pay taxes. When the size of the tax-paying group is large and the dependent older group small, the amount that each tax-payer has to contribute may not have a major impact on the taxes people pay. When the position is reversed as it will be over the coming decades, the position changes.

Most of the discussion of inter-generational transfer in the papers reviewed addresses this issue as if the only inter-generational transfers are those occurring when taxpayers pay for a benefit provided for non-taxpayers (the dependent young and the dependent old). This is plainly not the case. The recent public reaction to the Government's proposal for accommodation bonds to be paid for nursing home entry arose in part out of the fact that families expect that older people will transfer assets to the younger members of their families when they no longer need them. The sale of Government assets is another form of intergenerational transfer from former taxpayers to current taxpayers which has not been discussed in the literature reviewed.

B Forward funding

All or part of the long-term aged care program could be forward funded or pre-funded. Forward funding occurs when contributions over time build up a fund to cover the costs of benefits at some time in the future. Life insurance is a good example of pre-funding. The policy objectives for pre-funding long-term care include:

- Pre-funding allows people to pay for their long-term care at a time when they can afford to do so;
- Pre-funding provides the incentive and means for compulsory or voluntary saving by individuals to fund their own needs in old age – and currently in Australia increasing saving is seen as an important economic policy objective.

Option 3. Pre-funding through social insurance schemes

Social insurance schemes collect contributions as a form of hypothecated income tax for a specific social purpose – in this case for long-term care. The paper prepared by the Australian Institute for Primary Care (1999) sets out the following features of social insurance schemes:

- Levies can be income related as with the Medicare levy (progressive);
- Provision must be made for those who cannot make contributions – Government subsidies could achieve this;
- Social insurance schemes may either be required to meet the costs of service provision for all eligible people annually, ie PAYG; or
- They may be pre-funded schemes required to meet the future costs of care that will be required by current contributors;
- In order to meet the future needs of current contributors a significant social insurance fund needs to be created. "Prudential requirements prevent fund managers, including governments, from using these funds to meet current demand (Australian Institute for Primary Care 1999, pp.14–15).

Howe and Sarjeant (1999) also propose a compulsory forward funded option which would require individuals to contribute during their working lives to a fund from which the costs of their long term care needs in retirement could be met. The fund could presumably either be managed in the public sector as Medicare is, or in the private sector as with the compulsory superannuation scheme.

The costings contained in their 1999 paper show that this approach would have relatively high initial contributions (see Table 3) in order to build up a fund, which by 2035 would cover the long-term residential care needs of people aged over 65.

Modelling by Howe and Sarjeant (1999) and McCallum (1998) would suggest that a fully funded social insurance scheme for long-term aged care could would require a premium of about 4% of national wages collected over a 40 year period. Howe (1999) notes that this amount could however, be reduced by about two thirds if a three pillar approach to the funding of LTC for the aged were introduced. This approach will be discussed under Option 8 below. Howe estimates that if contributions to the scheme extended beyond retirement, as in Japan and Germany, the premium for the scheme would be about 1.5% of income.

McCallum et al (1998) also propose a social insurance scheme when they suggest that an investment of 1.1% of taxable income could be made through *an approved quality of life insurance fund offered through the Australian superannuation funds* (McCallum et al 1998, p.32). Although it is unclear from their paper whether they propose that it should be a PAYG or a forward funded scheme, it is assumed that its being linked to superannuation means that it is forward funded. They propose that the Government would encourage employers and unions to include supplementary superannuation-based aged

care payments in all future enterprise productivity agreements. It does not seem that the contribution rate proposed would be the rate required to pre-fund the whole scheme, but it is not clear how the remainder of the program would be funded.

Advantages and disadvantages

Advantages

Some of the advantages of social insurance schemes are identified by the Australian Institute for Primary Care (1999), by Howe (1999) and by Howe and Sarjeant (1999) as follows:

- They are universal – there are no problems of adverse selection;
- (They give) *increased security of benefits which are fully funded until the contributing cohorts exit* (Howe AL and Sarjeant H 1999);
- As fully funded schemes they reduce inter-generational transfers;
- Younger generations may be more prepared to support older generations who have contributed to the cost of their own LTC;
- They can broaden the tax base for social expenditure and provide greater security of funding in areas such as LTC for the aged;
- Some forward provision for aged care would protect older and younger generations in the event of future economic downturn;
- Howe and Sarjeant (1999) show that the contribution rate for the forward funded option falls below the rate for the PAYG option at about the time when the health system will experience the greatest demands arising out of population ageing;
- Modelling the various options shows that the fully funded option is less sensitive than the PAYG options to variations from assumptions about interest rates and increases in wages and costs (Howe AL and Sarjeant H 1999);
- McCallum et al (1998) argue that an advantage of the superannuation linked scheme is that it would be seen as an income security measure.

Disadvantages

Howe and Sarjeant have pointed out that, on the basis of their cost modelling, the main disadvantage of the forward funded option is that it has higher initial contribution rates than the PAYG or uniform PAYG funding option to build up reserves. They point out however, that in the longer term the fully funded scheme has lower and more uniform rates than the PAYG scheme (Table 3).

The Australian Institute for Primary Care states that social insurance schemes have not been in favour with the Australian Treasury or Department of Finance for the past two decades.

Option 4. Pre-funding through private insurance schemes

Fine and Chalmers (1998) state that if the main motive for the 1997 changes to the financing of LTC was to provide additional private revenue into the system, a private or public insurance scheme could be an option. Savage (1998) also recognises that this would be an option, as does McCallum et al (1998).

While not recommending such an approach, Howe and Sarjeant have provided costings for a scheme in which each individual would fund his/her own long-term care needs through insurance. There is a much heavier cost for females than males, and for older people joining the schemes than for younger people.

Membership of private LTC insurance schemes could be compulsory but are almost always voluntary and there are usually multiple insurers. Unlike private health insurance, where Government dictates that there should be a flat premium for each level of benefits, private LTC insurance would almost certainly reflect individual risk in the premiums set. In countries where they exist, older people face high premiums and women must pay higher premiums than men. Private insurance is not universal – about 10% of applicants for LTC insurance in the UK are rejected on medical grounds (UK Royal Commission on Long Term Care 1999).

Advantages and disadvantages

Advantages

- Such schemes provide individuals who can afford them with a protection against risk and enable them to spread their LTC costs over a longer period.

Disadvantages

The disadvantages of LTC private insurance schemes identified in the papers reviewed and other literature are too numerous to list here. Some of the more important ones follow:

- Overseas experience with voluntary private insurance has been that such schemes have not been successful because:
  - they have difficulty in recruiting members, despite the provision of incentives by a number of States in the US, and there may be insufficient pooling of risk (Fine and Chalmers 1998, Savage 1998);

  - there may be an adverse selection process – ie people who consider themselves likely to be at higher risk of needing LTC are more likely to join (Savage 1998);
- Voluntary private insurance schemes, by definition, are not universal;
- In concluding its specific comments on private LTC insurance the UK Royal Commission into Long Term Care (1999) said:

  The Commission conclude that private sector solutions do not and in the foreseeable future, will not offer a universal solution (Section 5.40);
- The time between contributions and pay-out may be considerable and thus neither the insurer nor the insured may have sufficient knowledge about what will be covered by the policy in 20 or 30 years time, nor how adequately the benefits provided by the insurer will cover the costs of the insured at that time (Fine and Chalmers 1998);
- The fact that individuals have contributed to an insurance scheme may make it more likely that they will choose to use formal aged care services rather than to rely on informal care arrangements, thus distorting projections on utilisation rates and premium setting (Fine and Chalmers 1998).

Discussion

Unlike a number of OECD countries, Australia does have some time before the funds needed for LTC for older people will become a serious burden. It would be possible to implement a pre-funding scheme now which, on maturity, would be capable of financing the LTC needs of the aged over most of the period where very high contributions would be required to fund a PAYG scheme.

There are a number of positive features of a fully funded system. However it must be remembered that, in developing such a scheme, it is necessary for contributors to pay for the current needs of older people (probably through the tax system) at the same time as they are making contributions to build up the new fund. In the Howe and Sarjeant model, the *double payments* would occur over a 35 year period. With no great public concern about a crisis in aged care it may be hard to gain public support for contribution rates of 4% of income for the pre-funded scheme on top of the taxes people pay to cover current long-term aged care. More acceptable contribution rates could be achieved by funding only a part of LTC with a social insurance scheme (Option 4).

Although bureaucracy, and in particular Treasury, is known not to favour social insurance schemes to fund public programs, there are some features of the approach that would presumably be approved. For instance Fine and Chalmers

(1998) point out that, with a single payer, there is a greater capacity to control and constrain service provision than there would be with multiple competing insurers.

A social insurance scheme would need to be subject to the same planning, regulation and cost control as currently applies to long-term care programs for the aged. Since its inception, the German scheme has operated each year with a small surplus.

There appears to be little to recommend private insurance as a funding pillar for LTC for the aged in Australia.

C Mixed models – a pillars approach to financing long-term aged care

As noted above, Australia's arrangements for retirement incomes and health care for older people are regarded as having strength because each program has a number of different funding sources or *pillars*. By contrast long-term care of the aged has one very large pillar of funding from general revenue which even funds most of the user contributions through the aged pension, and a very small pillar of funding from private (non-pension provided) contributions.

The changes introduced in 1997 attempted to increase the size of user contributions by accessing the assets of income poor people. This approach was not very successful, and it seems probable that to increase the resources available for long-term care, particularly in the future, it will be necessary to have a wider funding base.

Option 5. Mixed models

5.1 Model developed by Howe and Sarjeant

The financial modelling undertaken by Howe and Sarjeant (1999) provides a break-down of the costs of long-term care as follows:

Basic living cost The basic living cost (ie board and lodging) would be the same for each resident and would only change over time in line with general costs in the community. In residential care at present the basic resident fee is set in relation to the Age Pension, which meets these costs in the same way it does for people living in the community. The Age Pension accounts for about 18% of the total cost of RCS category 3 residential care. In discussing this model, Howe and Sarjeant propose that because nearly all individuals (except recently arrived migrants) are in receipt of an income at least as great as the

Age Pension, the basic cost of living can be excluded from the cost of care to be covered by forward funding. They propose that exclusion of the Age Pension would allow for a pension linked co-payment to be maintained.

Cost of care The cost of care would vary between individual residents and will vary over time. The main component in the cost of residential aged care – is the cost of (personal and nursing) care which accounts for 71.5% of the cost of an RCS category 3 resident. It is noted that estimating the costs of care over time is particularly difficult due to their general variability and the probability of changing standards over time. It would be expected that there would be a need at some point in the future to supplement care costs to meet contemporary standards of care. Because of this it is proposed that there could be an advantage in recognising a *base care cost* and a *variable care cost*. The base care cost would be the minimum care benefit which all residents receive and the variable care cost would be the difference between this and the costs of higher levels of care.

Capital cost The remaining 10.2% of the cost of an RCS category 3 resident is the capital cost, which the authors have assessed at $12 per day, based on the current Accommodation Charge. Capital costs cover land, buildings, construction of new facilities and refurbishment of existing ones.

Howe and Sarjeant state that *there are some grounds for making future provision for only part of the total cost of aged care* (p.376). Such an approach would assume that some or all of the existing provisions for LTC would continue.

The proposal that any new funding arrangement should not aim to fund the total projected costs of the system is justified by the argument that the accuracy of any projections over such a long lead time cannot be guaranteed. It is recommended that it may be better to avoid the risk of there being too great or too small a fund for the actual LTC requirements, by having more than one source of funds for the long-term care program.

Howe and Sarjeant's proposal is that:

Basic living costs The current arrangements concerning basic living costs in long-term residential care ie that residents should pay a co-payment based on the Age Pension, should not change. Thus the basic living costs should be exempted from the cost of care to be covered in advance. The justification for maintaining the basic living costs as the responsibility of each resident is that prior to his/her admission to residential care, each person is responsible for these costs while living in the community.

Costs of care The only really predictable cost of care is the basic care cost which applies to every resident in long-term residential care. Howe and Sarjeant state that *estimating costs of care over time is difficult, and any provision for care costs is likely to require supplementation to meet contemporary standards... (because of this) ...it may not be advisable to attempt to provide for the full care cost, but ...it may be appropriate to cover at least a base level of care which would provide a floor under higher levels of care.* (Howe A.L. and Sarjeant H. 1999, p.378) Based on this discussion it is argued that:

- the variable component of the care costs of long-term care should be covered (on a PAYG basis) by public funding;
- the basic care costs should be included in the costs of care to be covered in advance.

Capital cost There are a number of features of capital costs that suggest that it would be most appropriate that they should be funded through a forward funding scheme. Amongst the most important of these is the variability of the capacity of providers to fund and engage in capital development. Another important feature is that the large amounts required for capital development mean that government and industry need a secure base for capital planning and forward commitments. Howe and Sarjeant therefore propose, in this model, that capital costs should also be included together with the care costs to be covered in advance.

In summary, this proposal creates three pillars of funding for long-term aged care:

- Basic living costs would continue to be paid by the individual resident as a user contribution;
- The variable costs of care would be covered by public funding as an annual budget expenditure;
- Capital funding (10% of total cost) and a standard base level of care (20% of total cost) would be covered in advance, which could be by way of a social insurance scheme.

It is estimated that, on the basis of the estimates for the fully funded option, the contribution rate for this third pillar of funding proposed in this model would be 1.4% of national wages in 2008, a figure that would fall to 1.08 % from 2028 (Howe AL and Sarjeant H 1999).

5.2 Model developed by Fine and Chalmers

Fine and Chalmers (1998) propose a variation of the mixed model in which a social insurance scheme could be linked with Medicare *to cover the field of extended care.* Their proposal appears to be for a fund that would have both a PAYG feature and a savings scheme whereby *healthy people of working age could be enabled to pay into a scheme which would provide care for them if they later needed ongoing care.* The savings component, it is argued, would make the scheme comparable, in many ways, to the Superannuation Guarantee Scheme. Individuals would retain responsibility for the cost of basic accommodation, whereas the proposed fund would cover necessary *health care* in any setting – the community, hostel or nursing home.

It is argued that linking the proposed fund to Medicare could *promote the integration of service delivery* and *prevent problems of cost shifting* (Fine M and Chalmers J 1998, p.45–46).

Advantages and disadvantages

Advantages

The main advantages of combined models such as those described above are:

- They spread risk – by not relying on one funding source or one financing approach – ie they may have both PAYG and fully funded elements. In the Howe and Sarjeant model the less predictable component – the variable care costs – are covered by PAYG public funding, and the more predictable capital and base level care costs covered by a fully funded arrangement;
- The new contribution rate for pre-funding capital and base level care, as projected by Howe and Sarjeant would be relatively modest at 1.4% and would reduce in about 30 years time;
- By making the variable cost of care a public funding responsibility, the Howe and Sarjeant model addresses the concern expressed by Fine and Chalmers (1998) and others that future funding arrangements for LTC might require older people to pay for their health care, which would be inequitable when compared with access to services covered by Medicare;
- The pre-funded component encourages saving for retirement;
- They create a more secure base for the funding of long-term care;
- Fine and Chalmers' proposal for linking a proposed new fund to Medicare would have the advantage of emphasising the need for consistency between the financing of health care and of long-term care for the same group of people.

Disadvantages

- The main disadvantage of any combined model relates to the need to provide an interim funding mechanism for the components covered by pre-funding until the fund to cover them reaches maturity – this problem is much less serious than it would be if the whole scheme were to be pre-funded.

Discussion

In her 1999 paper, Howe describes the *pillars approach* to long-term care funding and proposes that long-term care should be funded by three pillars – by adding a social insurance pillar to the existing public funding pillar and consumer co-payments pillar (Howe AL 1999). Fine and Chalmers (1998) also recognise the value of diversifying funding across more than two pillars.

The strength of this model lies in its diversity and in the fact that the new fund proposed would not be excessively costly. The possibility of factoring in the cost of community care has been referred to above.

More work would need to be done to identify the feasibility and relative benefits of linking the social insurance component to Medicare.

It does not seem likely that linking the fund to Medicare would in itself increase the integration of services. Nor does it seem likely that it could prevent cost shifting. There is considerable cost shifting between the different programs already funded by Medicare. In general where individual programs have their own budgets, there are incentives for cost shifting.

Paper 1, Part 3
Options for Financing Long-Term Care for the Aged in Australia

1. Next steps – where to from here

1.1 Understanding and identifying approaches

There are many options for financing long-term care in Australia. A number of options have been set out in this paper. It is recommended that these options should not be treated like an array of discrete models from which one or more is to be selected.

The different models illustrate how the different approaches work, and how they might be arranged in order to achieve the objective of a secure and stable funding model for long-term care that is equitable, efficient, of high quality and would be acceptable to the Government and the public.

The Bibliography attached to this document identifies a number of papers on overseas LTC programs that may warrant some further consideration. However, a scheme to finance long-term care for older people must be right for the society and context in which it is to operate. In Australia we have our own unique social, financial and philosophical environment, which must ultimately dictate how we shape the future financing of long-term care.

It is noted that the key issue to be focused on is the financing of long-term care for older people. Howe (1999) has stated that the previous Labor Government devoted itself to developing a high quality aged care program, but did not pay sufficient attention to how it was to be funded.

1.2 Selecting a range of approaches capable of delivering a desirable LTC financing system

Important matters to be considered include the relative merits, in the Australian context, of:

- PAYG and Fully Funded schemes;
- Whether a new scheme should aim to fund the program in total or in part;
- If a pillars approach is considered appropriate, what those pillars might be and what components of the system they should fund;

- Whether or not a new scheme should be linked to other components of the existing health and welfare system, such as Medicare or the superannuation system.

1.3 Promoting wide discussion and debate

The information set out in Paper 2 throws additional light on the issues and options set out in Paper 1.

This is a topic that needs and deserves wide discussion and debate. The authors whose publications have been discussed in Paper 1 deserve great credit for the work they have done to stimulate and inform that discussion and debate.

With this publication the National Aged Care Alliance is taking the next critical step along the path to a secure and stable funding system for long-term care for the aged.

Bibliography

In the preparation of this Bibliography, the authors' abstracts have been used or modified wherever possible, in order to ensure a concise but comprehensive description. This is acknowledged wherever it occurs.

Cuellar AE and Wiener JM 2000 *Can Social Insurance for Long-Term Care work? The Experience of Germany*, Health Affairs Vol. 19, No. 3, May/June

In 1994 Germany enacted a universal-coverage social insurance program for long-term care to largely replace its means-tested system. The program has achieved many of its stated policy goals: shifting the financial burden of long-term care off the states and municipalities; expanding home and community-based services; lessening dependence on means-tested welfare; and increasing support of informal caregivers. Many of these goals were reached without exploding caseloads or uncontrolled expenditures. Long-term care in Germany is funded by a mandatory, universal social insurance program administered by the sickness funds. Premiums are 1.7% of salary and shared equally by employers and employees. In order to reduce employer resistance, one paid public holiday was eliminated from the German calendar. Retired people pay half of the premium. In addition to financing, the paper addresses eligibility and assessment, benefits, availability of services and quality assurance (adapted from authors' abstract).

Campbell JC and Ikegami N 2000 *Long-Term Care Insurance Comes to Japan*, Health Affairs Vol. 19, No. 3, May/June

Japan has moved decisively toward *socialization of care* for the frail elderly by initiating public, mandatory long-term care insurance (LTCI) on 1 April 2000. The LTCI program covers both institutional and community-based caregiving. Everyone age forty and older pays premiums. Everyone aged sixty five and older is eligible for benefits based strictly on physical and mental disability in six categories of need. Benefits are all services, with no cash allowance for family care, and are generous, covering 90 percent of need. Long-term costs seemed not to be a major consideration in program design. Consumers can choose the services and providers they want, including use of for-profit companies (authors' abstract).

Feder J Komisar, Harriet L and Niefeld M 2000 *Long-Term Care in the United States: An Overview*, Health Affairs Vol. 19, No. 3, May/June

Although long-term care receives far less US policy attention than health care does, long-term care matters to many Americans of all ages and affects spending by public programs. Problems in the current long-term care system abound, ranging from unmet needs and catastrophic burdens among the impaired population to controversies between state and federal governments about who bears responsibility for meeting them. As the population ages, the pressure to improve the system will grow, raising key policy issues that include the balance between institutional and non-institutional care, assurance of high quality care, the integration of acute and long-term care, and financing mechanisms to provide affordable protection (authors' abstract).

Ashton T 2000 *New Zealand: Long-Term Care in a Decade of Change*, Health Affairs Vol. 19, no. 3, May/June

Long-term care in New Zealand incorporates a mix of public and private funding and provision. After a decade of structural change, the purchasing of almost all publicly funded health and social care is now the responsibility of one central agency. Services for older persons are poorly integrated, and there are problems of access to and quality of some services. Efforts are being made to address these problems. The challenge now is to ensure that this groundwork is not lost amid the turmoil of yet another round of restructuring by and enthusiastic, newly elected, government. Long-term care for the elderly is financed through a mix of public subsidies and private payments. Residential and home-care services attract different levels of public subsidy, with any co-payments generally increasing as the level and costs of care increase (authors' abstract with modification).

Merlis M 2000 *Caring for the Frail Elderly: An International Review*, Health Affairs Vol. 19, No. 3, May/June

The ageing of populations throughout the industrialised world has focused attention on long-term care. This paper compares provisions for long-term care in the countries participating in the second Commonwealth Fund International Symposium on Health Care Policy held in October 1999. The Symposium brought together health ministers, public officials and policy analysts from five major English speaking countries to review common concerns and innovative solutions. The seminar also examined long-term care systems in two countries which had moved in different directions – Denmark and Germany. It is noted that a brief outline of Australia's provisions for long-term care for the aged is somewhat inaccurate – it is hoped that the remainder of the paper is not flawed in the same way.

Anderson GF and Hussey PS 2000 *Population Ageing: A Comparison Among Industrialized Countries*, Health Affairs Vol. 19, No. 3, May/June

Increasing longevity and declining fertility rates are shifting the age distribution of populations in industrialised countries toward older age groups. Some countries will experience this demographic shift before others will. The effect of population ageing on health spending, retirement policies, long-term care services, workforce composition, and income is compared across eight countries: Australia, Canada, France, Germany, Japan, New Zealand, the United Kingdom and the United States. The data on the different countries are interesting and put Australia's population ageing into a wider context. The paper is written however, for American policy-makers, to identify how well the US is positioned to cope with population ageing and to identify areas for on-going monitoring.

Jacobzone S 2000 *Coping with Ageing: International Challenges*, Health Affairs Vol. 19, No. 3, May/June

This paper discusses trends in functional health status among the elderly in several countries. Life expectancy at an advanced age has increased and there is some evidence of lower prevalence of severe disability and a trend toward de-institutionalisation. These changes may result in fewer severely disabled persons, but the impact is less clear from the perspective of public finances, because of the increased need for formal home care and the relative subsidisation of institutions. The implications for health care need further research but also may point to increased expenditures (author's Abstract).

Donelan K, Blendon RJ, Schoen C, Binns K, Osborn R and Davis K 2000 *The Elderly in Five Nations: The Importance of Universal Coverage*, Health Affairs Vol. 19, No. 3, May/June

This paper reports 1999 survey results on the population aged sixty five years and older in five nations – Australia, Canada, New Zealand, the United Kingdom and the United States. The majority of respondents were generally satisfied with the quality, affordability, and availability of health services in their nations. In many measures of access to and cost of care, the United States looks like the other nations surveyed. However, as the elderly view their health systems, the direction they have taken in recent years with respect to caring for the elderly, and the future affordability of care in old age, US respondents tended to be more pessimistic than were those in other nations (author's abstract).

A Report by the Royal Commission on Long Term Care 1999 *With Respect to Old Age Long Term Care – Rights and Responsibilities*, UK

The Royal Commission was appointed in 1997 to review long term care in the United Kingdom. With respect to financing long term care, the Commission sought to recommend a way of paying for long-term care which would bring improvements in the short term and which would be affordable and sustainable. Three key principles informed the approach taken:

- Responsibility for provision now and in the future should be shared between the state and individuals – the aim is to find a division affordable for both and one which people can understand and accept as fair and logical;
- Any new system of state support should be fair and equitable;
- Any new system of state support should be transparent in respect of the resources underpinning it, the entitlement of individuals under it and what it leaves to personal responsibility (adapted from the Executive Summary of the Report).

Paper 2
Options for Financing Long-Term Care for the Aged in Australia

1. Introduction

The origins of this paper were originally described in its introduction.

In brief, following consideration of the first paper it had commissioned, the Alliance requested a second paper to summarise and report on a number of Government and research reports and on developments in the area of long-term aged care in the UK and Germany. This paper is the response to that request.

2. Structure and content of the paper

The first paper developed for the NACA was conceptual and complex. The identified papers were reviewed to develop a base for thinking through the issues regarding financing long-term care. The purpose of the current paper is to provide more background for consideration of the issues identified in that paper.

In preparing the summaries of the various papers, it was decided to provide sufficient information for readers to really understand the relevant material in the paper. Where possible, this was provided in dot point form, in the hope that this would make them easier to skim and later recall. Although the Alliance requested information only on the outcomes of the 1994 German aged care reforms, it was felt that more detail on the German reforms would be very interesting, at least for some members of the Alliance.

The authors of the papers covered in this project have been reasonably economical in their use of words and it has quite often proved difficult to think of a way of paraphrasing their comments in a way that did not either use more words or affect the meaning. Where this has been the case, direct quotes have been provided. Direct quotes from the papers are in italics.

The content of each summary is intended to accurately reflect the paper it has summarised. There is only limited editorial comment where it seemed necessary to clarify a point, or to draw attention to the relevance of a point in relation to this project. Editorial judgement has, of course, been applied to the

selection of the material to be included, and of that to be left out. The content of the summaries does not necessarily reflect the views of the author of this paper.

It has been decided to provide the summaries as appendices to this paper – to emphasise the fact that they are there for reference, rather than all having to be read right through before the reader can move to the Discussion.

3. Discussion

Members of the National Aged Care Alliance will recall that in the first paper prepared for the Alliance, a number of issues were identified for consideration in developing options for financing long-term care in Australia. Section 1.2 of Part 3 (page 12) read:

Important matters to be considered include the relative merits, in the Australian context, of:

- *Pay-as-you-go and pre-funded or advance funded schemes;*
- *Whether a new scheme should aim to fund the program totally or partially;*
- *If a pillars approach is considered appropriate, what those pillars might be and what components of the system they should fund;*
- *Whether or not a new scheme should be linked to other components of the existing health and welfare system, such as Medicare or the superannuation system.*

The papers reviewed provide us with new information that is important to the first of these questions – whether a PAYG or pre-funded scheme, or a combination of both would be most appropriate in Australian conditions.

The last three of these questions can be combined into one question – and that relates to the structure of a long-term aged care program.

3.1 Pay-as-you-go or pre-funded

One of the key arguments against PAYG schemes is that they require the current working population to pay for the needs of those who are no longer working. Where the working population is relatively small and the retired group relatively large (as will happen in Australia from about 2010 onwards), this would be expected to constitute a significant burden for employed people. It would also reflect an inter-generational transfer of resources which may be considered unacceptable.

The National Commission of Audit saw this as inequitable and a potentially serious and increasing problem. It considered that it demonstrated *a major structural deficiency in national saving*. A pre-funded scheme for long-term care would, to some extent address this concern.

The size of the problem was identified by the National Institute of Actuaries, (Somogyi et al 2000). With straight line projections of supply and demand at current rates of support for the aged, the size of the aged population in 50 years time would require governments to provide an additional $45 billion of funding and individuals an additional $14 billion each year. (This is for all aspects of support for people aged 65 and over – age pension, health care and long-term care). This scenario would seem to demand some form of pre-funding and the Superannuation Guarantee Charge scheme is an example of that.

By contrast with these views the National Productivity Commission (Madge A 2000) attempts to identify whether old and oldest old people in 10, 20 and 30 years time will have the same level of need as older people do today. It does seem possible that they may not, and that older people in coming decades may be healthier and suffer less disability than older people today. What this paper is saying about demand for long-term aged care in the future, in summary, seems to be that it is possible that pro rata demand may decline over time, it seems unlikely that it will increase, but that we just don't know yet.

What seems more certain from the paper is that there will be a continuing growth in GDP over the years and that cost as a proportion of GDP is a more important indicator of affordability than is the size of the working population. The Institute of Actuaries paper also recognises the importance of productivity and makes the point that our continuing ability to fund social welfare programs is dependent on continuing improvements in productivity and economic growth.

Madge's work projects that, even with quite conservative projections of growth in GDP, expenditure for long-term care in 2031 will have risen by only about 25% when expressed as a share of GDP (Madge A 2000).

Another important factor in considering the issue of PAYG versus pre-funding is what is happening to incomes and wealth. Over time the SGC will deliver better retirement incomes to older people, and productivity increases will deliver better incomes for working age people. A number of the papers make the point that overall, there should be an increase in incomes and wealth over the coming decades.

It may be possible to continue to fund a part of long-term aged care on a PAYG basis with little difficulty. In considering the problem of inter-generational transfers (one of the main arguments for pre-funding), it is interesting to note that it was precisely because of the burden on young people in the current generation, of a pre-funded scheme, that the UK Royal Commission decided to fund long-term care on a PAYG basis. This was because the burden for young people of having to contribute to their own long term care through a pre-funded scheme while they continued to pay 2.17% of income for current aged care services and to pay for other things such as pensions and their own education would be too great.

It also seems possible that, in the future many older people may be able to afford to contribute more to the cost of their own long-term care, either through increased co-payments for services or through some form of insurance. Retired people in Germany, for instance, continue to pay into the LTC scheme. Ensuring that this approach did not disadvantage people with low incomes would be important as would ensuring that the provisions for low income people did not create perverse incentives for those with higher incomes.

In summary there are arguments in favour of pre-funded schemes and PAYG schemes. There is some evidence that the size of the anticipated increase in expenditure relative to GDP over the next 30 years may not be as severe as most writers have predicted.

3.2 Structures for financing long-term aged care

3.2.1 Residential care

Readers will recall that one of the models discussed in the earlier paper was what was referred to as a mixed model, developed by Howe and Sarjeant (Howe A L and Sarjeant H 1999). In this model responsibility for funding different components of residential care was proposed to occur in different ways:

- Individual consumers would pay at the point of consumption for their board and lodging, as they would if they were living in the community;
- The cost of basic care and the capital cost of residential care would be pre-funded through a social insurance scheme;
- The variable costs of care – could be covered by public funding as an annual budget expenditure item funded by taxation (PAYG).

Individual responsibility for payment of basic living costs is reflected in both the new German long-term care scheme and the recommendations of the UK Royal Commission.

In Germany the state pays for basic care, medical care and therapeutic social activities to a capped amount for nursing home residents. The resident pays for board and lodging to at least 25% of the total cost. Where the nursing home fee is greater than the flat fee paid by the sickness fund and the resident's 25% contribution, the resident must pay the additional cost.

The UK Royal Commission recommended that in order to be consistent with the NHS, the nursing component of long-term care should be provided free of charge. It also recommended that personal care in residential or community based care, which is defined relatively narrowly, should be the responsibility of the state, funded on a PAYG basis from general taxation.

Capital for the development and maintenance of accommodation for residential care is referred to specifically in the paper on the German long-term care scheme, where it is stated that the cover provided for nursing home residents does not cover capital. The UK Royal Commission states that *the elements of care which relate to living costs and housing should be met from people's income and savings, subject to means testing.*

3.2.2 Community based services

In most of the papers reviewed it is recognised that there is a need to continue to improve access to appropriate services in the home and the community and to support carers. The reasons for this are that we should enable people to remain in their homes for as long as possible, where that is the best option for them, and because, in most cases, it is less costly than residential care.

In considering a structure for financing aged care, it is important that community care should be recognised as an important component of a long-term aged care program. This is particularly important because the residential care and community based care programs care for the same target group. There are real opportunities for substitution between the different strands of long-term care. There are also opportunities for integration of services and for coordination of activity as with respite care and day care.

If a pillars approach to funding long-term care is being considered, it is important to consider which pillar should fund community based services. Clearly, it ought to be the pillar that funds the care for which community services can be a substitute. If we were considering the Howe and Sarjeant model, this would be the pillar which funds the variable costs of care – the tax-payer funded PAYG component.

3.2.3 Rehabilitation

In its findings, the UK Royal Commission referred to the importance of rehabilitation. The Commission found that nursing homes were being used by the acute health sector to reduce length of stay for elderly people, and thus save money. As a result older people were not being offered rehabilitation. Many people admitted from hospitals to nursing homes eventually recovered sufficiently to be able to return to their homes, but were unable to do so because their homes had been sold to fund their nursing home care.

Similar problems arose with the introduction of the German reforms to long-term care. An explicit goal of the reforms had been to favour rehabilitation over long-term care. This was not achieved because the availability of long-term care benefits made it possible for the acute care services to shift the costs of disability to another program.

Although none of the papers reviewed considered rehabilitation as a component of long-term care, the National Aged Care Alliance may care to consider its importance and how programs might be structured to ensure that people who need rehabilitation receive it.

3.3 Other issues

3.3.1 Targeted or universal benefits

The paper developed by the Institute of Actuaries addresses a number of matters for consideration in any future scheme for long-term care. Of particular interest are the comments that a universal scheme would create certainty for Government about the size of the group to receive benefits, which would not be altered by fluctuations in the economy. This would support more accurate long-term planning. It is also argued that individuals would understand what their future needs would be and that this could be an incentive for long-term saving.

The UK Royal Commission reported that the means test for long-term care benefits had been an incentive for people to divest themselves of assets and was a disincentive for saving. Despite this, the recommendations of the Royal Commission include requirements for individual contribution to care, subject to a means test.

An important driver of reform in Germany was the sense that the means test for long-term care undermined social solidarity and was demeaning. An important goal of the German reforms was thus to create a program that delivered universal benefits.

3.3.2 Voluntary or compulsory participation, private or public funding?

The Institute of Actuaries proposes, as one option, a three tier approach to financing aged care (p.15). The base tier would be publicly funded and provide a basic set and level of benefits. It points out that, when funded from general taxation, the first tier is re-distributive. The second and third tiers would probably be voluntary, with support and/or incentives provided by Government. The second tier would probably be established in the private sector as is the Superannuation Guarantee scheme. The third tier would be private.

The National Commission of Audit proposed that long-term care could be provided for through a private insurance scheme. However the idea was not developed, and the impression gained in reading this paper is that long-term care was not a high priority for the Commission at that time. The Institute of Actuaries notes that private insurance schemes for long-term care in the US were not particularly successful, but considers that with incentives provided by Government, they could be successful in Australia. None of the other papers reviewed regarded private insurance for long-term care as a realistic option. The arguments for this position are the same as those set out in the first paper.

4. Conclusion

The papers reviewed do provide more information on which to base consideration of options for financing long-term aged care. The Institute of Actuaries sets out four possible options for financing long-term aged care, commencing on p.15 of this paper.

Another very helpful paper is that prepared by the National Productivity Commission (Madge A 2000). It presents a reasonably optimistic picture about future needs for long-term care and our capacity to fund them.

The Report of the UK Royal Commission on Long-Term Care for the Ageing is helpful to considerations of possible funding structures. The German experience is also enlightening. Both of these reports prompt the reader to reflect on the considerable strengths in our own system of long-term aged care.

There are some themes that are common to most of the papers and probably reflect changing values in society. One of these is the need for individuals to take more responsibility for their own lives and to rely less on Government to support them in their old age. Encouraging people to save more is seen as very important. The introduction of a compulsory pre-funded scheme for at least part of long-term care would improve levels of saving.

Another theme is that our ability to afford social programs such as long-term care is dependent on the state of the economy, which is dependent on productivity. This, in turn, is said to be dependent on micro-economic reform.

If we are to protect and build on the strengths of our aged care program we do need to consider financing options that would give it greater security and stability. It is hoped that this paper will help the National Aged Care Alliance and other readers in consideration of this important matter.

Jan Webster, February 2001

Appendix 1
Australia's Ageing Society, January 1994

Ross C and Ashok T *Economic Planning Advisory Council, Background Paper No. 37*, Office of EPAC

> *The Economic Planning Advisory Council (EPAC) was established in 1983 to provide independent and broadly based advice on the medium and longer term economic outlook, and on policies which might assist the achievement of sustained economic growth. The membership of the Council is drawn from Government, business, union, professional, consumer and welfare sectors and is chaired by the Prime Minister.* (Description provided on the reverse side of the cover sheet)

Introduction

The purpose of the paper is consistent with this statement and is defined thus:

> *to highlight the ageing of the population structure, and the variety of the economic and social pressures and opportunities this will bring. It both extends and refines earlier EPAC analysis on this topic in a number of important areas.* (p.i)

The paper, published in January 1994, is relatively old at this point in time and we have equally high quality and more up to date data in some of the other papers reviewed (eg Somogyi et al 2000; Madge A 2000). The years since 1993 have seen many changes in Australia's long-term aged care program, which also make some aspects of the paper less relevant than they would have been when it was initially published. The paper covers all of the implications for expenditure associated with the ageing of the Australian society – in particular, the age pension, health care and aged care or long-term care. Long-term care is a much smaller budget program than either of the other two and is not really the main focus of the paper.

What follows are the key issues with some relevance for the consideration of financing long-term care.

Findings of relevance to financing long-term aged care

The paper provides data on population projections, on the effects of migration and on the projected workforce to 2051. In addition projections are provided of growth in GDP and in expenditure on retirement incomes as well as health and other social expenditures.

It argues that, even though the ageing of the population would be gradual, it was important that action to address the anticipated age related expenditure growth should commence *now* (ie in 1994), *given the lags involved in social policies becoming fully effective in a number of areas.* (p.i)

There is an emphasis on the need for people to move away from reliance on government as a provider of income to government as a partner supporting individual initiative and greater self reliance.

The EPAC paper makes the point, which is made in other papers reviewed for this project, that *Productivity growth and income distribution even more than population policy are keys to dealing with the ageing population. The ageing of the population makes enhanced investment and microeconomic reform an even greater priority* (p.iii).

Other key issues

- Prior to the SGC delivering higher retirement incomes, there would be a reduction in the tax base due to the low incomes of most older people – however this would be redressed to some extent with the broadening of the tax base with indirect taxes. Once the SGC program has reached maturity, taxation revenue should increase modestly;
- Older people need a wide range of services but they are also providers of services to members of their own generation as well as to their children and grandchildren;
- Older people have control of significant financial resources. The Retirement Income Modelling Taskforce has estimated that retired people, including people between aged 55 and 65, have assets worth over $200 billion (in 1993);
- A national insurance scheme for long-term care has been suggested, but the implementation of such a scheme in the near future seems unlikely. The reasons given for this include:

  The National Health Act effectively prohibits the marketing of indemnity insurance against costs of aged care or disability (p.82).

Voluntary schemes for insurance against the costs of long-term care have had very little uptake either due to lack of demand or because of the difficulty for private insurers to develop viable schemes. *Individuals are not very interested in buying coverage for something that may or may not occur some decades into the future, and for which a degree of public funding is available* (p.82).

Insurance companies are not very interested in *marketing disability insurance to the main group which would be interested, that is, the frail or disabled aged* (p.82);

- While there had been calls for a national, compulsory scheme, they had received little support. This was probably because the frail elderly were not seen as a politically powerful group, and because the general population was probably reluctant to support a proposal which would require additional taxation;
- An integrated approach to housing for the elderly and urban planning was proposed, with a reduction in the usual taxes and charges to make sale of houses by older people easier and to promote greater housing choices for the older owner occupiers.

Appendix 2
National Commission of Audit – Report to the Commonwealth Government, June 1996

Establishment and Terms of Reference

The National Commission of Audit was established in March 1996 by the Commonwealth Government in accordance with its pre-election commitment.

A summary of its task is set out at the commencement of its Terms of Reference:

> *The Commission of Audit will investigate and report on the financial position of the Commonwealth Government with a view to advising the Government on the future management of its finances consistent with a medium to long term goal of improving the Government's fiscal position* (National Commission of Audit 1996, p.1).

It had a number of specific Terms of Reference relating to the state of the Commonwealth's finances at that time, including risk exposure, the compilation and publication of a whole of Government balance sheet, Commonwealth sector infrastructure, financial performance targets for Commonwealth departments and agencies and service delivery arrangements between the States and Commonwealth and their efficiency and effectiveness.

The references of specific relevance to the subject of this paper are at Terms of Reference 2 (iii) and 3:

> 2. The Commission will report on:
>
> *(iii) The impact of demographic change on Commonwealth finances, with the intention of making recommendations as to how emerging pressures could be provisioned*; and
>
> *3. The Commission, in undertaking its investigations and reporting on the above issues, will have regard to areas of expenditure which warrant closer examination with the objective of restraining growth of total outlays and improving the quality of public expenditure. These could include (but not necessarily be limited to) ...examining the cost implications of demographic changes* ((National Commission of Audit 1996 p.1).

Key findings relevant to long-term care of the aged

Prior to discussing the Commission's findings, it should be said that long-term care for the aged was not the matter of greatest concern in terms of increased expenditure resulting from demographic change. Although it was certainly recognised as an important issue, the Commission's main concerns for Government finances related to the rising cost of health care and increased Social Security payments, predominantly for the age pension.

The Commission found that decreased fertility and improved longevity arising out of better health care and higher living standards would have a major impact on the structure of Australia's population over the following 45 to 50 years and that this impact would be permanent. It also reported that the ageing of the baby boom generation (those born between 1945 and 1965) would strongly influence the speed of this change. The baby boomers will progress into retirement from about 2010 onwards.

The consequences of demographic change for Commonwealth finances would include:

- Significantly increased pressure on Commonwealth outlays for social security (mainly age pensions), health care and long-term care, if the prevailing arrangements and community expectations regarding public and private expenditure are not changed;
- An increase in Commonwealth outlays for health care of approximately 3.9% of GDP for the period to 2041, (although the Commission acknowledges that only a small part of this increase is related to the ageing of the population);
- A reduced working age population with a significant increase in the aged/ working population dependency ratio (the ratio of people over 65 to the working population) which would not be offset by the reduction in the young dependency ratio (the ratio of people under 18 or 22 – depending on the source – to the working age population). The Commission also notes that, overall older people *impose a much larger burden on Commonwealth outlays than the young;*
- The net increase in Commonwealth expenditure would not be matched by increases in revenue collection on the basis of current taxation policies.

The Commission saw the major pressures on Commonwealth finances resulting from demographic change as coming mainly through health and social security programs and policies. It notes that the over 65 population has considerable wealth, although the largest part of this is related to home ownership.

The Commission also states that a large proportion of people currently working could prepare for their future health and care needs but do not have the incentives to do so. The Report does not contain a discussion of the options for financing long-term care for the aged, but Recommendation 6.3 (below) relates to private long term care insurance. It is probable that a detailed exploration of this topic was not within the scope of this inquiry.

Although a private long-term care insurance scheme is proposed, the Commission does recognise that this approach would have to differ from private health insurance which provides cover against current risks rather than long term future risks. It also notes that private long term care insurance could not be bound by the same regulations as is private health insurance in which the pricing of health insurance is regulated and health insurers are not able to discriminate between people on the basis of risk. If it were, it would only be attractive to those with the highest risks and would be prohibitively expensive.

The Report contains a discussion of intergenerational equity. It points out that this is a potential problem where most programs for the aged (health, aged care and age pension) are funded by current taxpayers on a pay-as-you-go basis. The projected demographic changes will make the problems particularly clear.

It is argued that *the overwhelming message (from a consideration of intergenerational equity) is one of a major structural deficiency in national saving* (p.145). It is particularly important also that a budget such as Australia's, which is dominated by current outlays, should be in balance or have a small surplus. Budget deficits mean that current expenditure has to be paid off over time by future generations.

Key recommendations relevant to long-term care

The Commission's key recommendations concerning demographic change of relevance to this project include the following:

- The Government should urgently *reduce the potential for longer term age related funding increases, or make allowances now in budget figuring to provide for them;*
- Action should be taken now to *change the expectations of reliance on government assistance, by reducing aged and health related outlays.* Such measures could include *maintaining universal access to nursing homes for those in need* but introducing measures to ensure that those who can afford to pay (either because of their income or their assets) do so;

- The Government should comprehensively review the impact of current tax and social security arrangements on the incentives for household saving.

These concepts are reflected in the Commission's specific recommendations:

- There is a need for urgent action, although *the major part of demographic change is still almost 20 years away* (Recommendation 6.1);
- Nursing home benefits should be better targeted – funding arrangements for nursing homes should be changed so that those able to contribute more to their own care do so. Means testing for nursing home benefits could achieve this. Consideration should be given to the cost of nursing home care for income poor but asset rich people being recovered from their estates (Recommendation 6.2);
- To encourage those able to contribute to their own long term care needs, the Government should explore the potential for private insurers to develop long term care insurance products along the lines of a life policy (Recommendation 6.3).

Appendix 3
Financing the Ageing Now Is The Time To Act – A Discussion Paper

Somogyi S, Gale AP, Helenius CO, Knox DM, Sarjeant HB and Stevens RJ 2000 *Prepared by the Financing the Ageing Committee of the Institute of Actuaries, www.actuaries.asn.au*

Introduction

This discussion paper was first published on the Internet and publicised in the media towards the end of 2000. It would, no doubt, have been forwarded to the relevant Ministers and areas of Government.

The purpose of the paper is set out in its Conclusion:

> *Our aim in this paper has been to raise some issues with respect to the retirement income, health care and aged care needs of Australia's population over the first half of the 21st century;* and
>
> *We have suggested several options to consider, each targeted to solve the future problems of having sufficient funds to support individuals' needs of retirement income support, health care and aged care. We do not claim to have covered every option. However, we hope there is a sufficient smorgasbord of potential options to cover the range of possible approaches. We look forward to a lively discussion on these and other possible solutions* (p.65).

Defining the problem

A summary of the nature and size of the coming changes in Australia's demography has been provided for readers of this Alliance publication in the overview section.

Like the National Commission of Audit, the Institute of Actuaries recognises three main areas where these changes will have a major financial impact if nothing is done. These are the areas of age pension, health care for older people and aged care – by which the Institute means long-term care for older people.

Projected increased costs of health care are a major factor in the total increase in costs predicted to occur over the next 50 years. This increase is predicted to be from about 8.5% of GDP currently to around 16.3% of GDP by 2051. Like the National Commission of Audit, the Institute recognises that the ageing of the population is only one of the factors driving the increase in the cost of health care, other key factors being increased patterns of utilisation and technological change. It has been calculated that the ageing of the population alone will account for an increase in the costs of health care of about 0.6% per annum.

Despite the fact that there are other more important drivers of health cost escalation, this paper also includes the total increases in health costs in its consideration of the effects of population ageing.

The paper presents the impact of demographic change on the financial system quite graphically as follows:

> *the strain on the economy (from the ageing of the population over the next 50 years) could be in the order of 8.5% of GDP;* and
>
> *To put this in today's context, if we faced having to find this extra cost in 1998/99 without being able to call on other resources, it would result in Governments in Australia needing to find an additional $45 billion and individuals needing to find an additional $14 billion of funding in the year in question, and every year thereafter. Such a sum represents $3,150 per capita. In the context of the Federal budget it would mean expenditure would have to increase by 32% to be matched by a similar revenue increase to maintain current Budget balance. In the context of tax revenue from individuals, if all of this shortfall were to be raised by lifting taxes paid by the Australian public they would have to increase by 79% in 1998/99* (p.10).

For these reasons the Institute considers that something needs to be done and that action should be taken sooner rather than later.

Fundamental structural issues

It is important to remember that this paper is discussing all of the costs of Australia's ageing population over the next 50 years, and not just long-term care. The paper discusses the different approaches to the financing of future benefits including health and retirement incomes and long-term care. It does not separate these three areas out.

The paper recognises four key structural issues to be considered in developing models for financing ageing. They are:

- PAYG or advance funding;
- Targeted or universal benefits;
- Voluntary or compulsory participation;
- Public or private funding.

PAYG or advance funding?

The primary distinction is between the current funding approach or *pay-as-you-go* (PAYG) and advance funding or pre-funding, often referred to simply as *funding*. These were discussed in some detail in the first paper prepared for the National Aged Care Alliance.

An important issue discussed in the paper, which was not addressed in the earlier paper for the NACA is the close relationship between the state of the economy and the capacity of a society to provide an adequate level of benefits for its people. This is an important consideration in both PAYG and pre-funded schemes, and it is why it is so important to consider the impact of possible models for financing aged care on the economy. Two selected comments on this issue follow:

> *Brown (1997) makes the valid point that the living standards of pensioners are directly related to the production of the next generation of workers under either system. Therefore the critical issue is output. Output can be improved by increased productivity, increased labor force or overseas investments* (p.19).
>
> *(Brown) notes that a move to advance funding assumes that the real rate of return is greater than the growth in national income* (p.20).

Targeted or universal benefits?

The question to be addressed here is whether the age pension, health care and aged care should be provided by the Government for all Australians or whether some or all of these services should be targeted at those with the least ability to pay and/or the greatest need. Arguments for targeted benefits focus on ensuring that those most in need and with the least resources receive the services and support they need, while those who could provide for themselves do so.

Arguments against targeting benefits centre on its encouragement of individual behaviour considered to be inefficient and undesirable from the perspective of the economy, and its discouragement of *good* behaviours such as part time

work. Other problems include the cost of administering the means test and stigma.

The arguments for universal benefits are, in many cases, simply the reverse of those for targeted benefits. There are however, other issues to be considered. Important arguments for the universal provision of benefits for older people include:

- Universal benefits would provide a stable and known base in terms of retirement income and health care for individual long-term planning for retirement and old age. This could be an incentive for long term saving.
- Government is able to plan its long term expenditures more accurately because the size of the group to receive benefits is not affected by fluctuations in the economy such as interest rates or employment levels.

The Institute's paper is neutral on the question of universal or targeted benefits.

Voluntary or compulsory participation?

While most mandatory schemes involve public financing support and mainly provide universal benefits, Governments currently prefer to provide rewards for voluntary membership rather than to introduce compulsory arrangements.

The main advantage of voluntary financing schemes is said to be that they provide scope for individual choice. The main disadvantage is the lack of total coverage with all of the consequences of that.

The main advantage of compulsory schemes is that, with universal participation, they are efficient and effective. The main disadvantages are said to be the lack of individual incentive and choice, and the possibility that some people's needs may not be adequately met because of the lack of targeting.

In summary, the Institute says *Compulsory arrangements, with the Superannuation Guarantee being a possible exception, most often occur if most or all of the funding is publicly financed. In recent times, Governments seem more attracted to compulsory schemes where benefits are targeted or at a basic level, with voluntary additions perhaps with some form of incentive* (p.27).

Public or private funding?

The final structural question addressed relates to who is providing the funding. This question is closely linked to the voluntary versus compulsory and PAYG versus pre-funded questions. The paper notes *Compulsory and pay-as-you-go*

systems almost always require significant public funding, as they are difficult to justify in a privately financed environment (p.28).

The main advantage of publicly funded schemes is the ability to support compulsory and pay-as-you-go schemes and to gain the required level of coverage or benefits. The main disadvantage lies in the limitations on the system related to available funding and other constraints imposed by Government. The paper summarises this issue as follows:

Governments are increasingly looking for ways to reduce the cost of publicly financed schemes by shifting towards encouragement of privately financed provision by those who can afford it. The most likely acceptable model is a mixed one with a publicly funded base level with privately funded additions encouraged by incentives. Such a model will be driven by constraints on Government finances which prohibit totally publicly funded models, different living standards and the desire for some elements of choice and individual responsibility (p.29).

Structural options

The Institute proposes that *the funding and provision of benefits over the longer term for retirement income, health care and aged care can be broadly grouped into three tiers* (p.30). The model proposed is a triangle divided into 3 horizontally, with the first tier being the base of the triangle.

The first tier forms the base of the pyramid – is funded by the public sector and provides a basic set and level of benefits. Funding would usually be from general taxation on a pay-as-you-go basis. When funded from general taxation the first tier is re-distributive.

The second tier is *normally strongly supported by Government and in some cases this means mandatory involvement for those in employment. In many cases, particularly for retirement income, this tier is funded in advance, often through the private sector, or as a combination of both the private and public sectors. The SGC system in Australia is a good example of this tier with full funding in the private sector with some taxation support and associated legislation. Private health insurance is another example* (p.30).

The second tier would, in most cases, complement the first tier, although it could substitute for it in some cases. There is limited capacity for re-distribution.

The third tier is a voluntary arrangement where individuals choose to fund their future needs. There may be some limited Government taxation or policy support, but if so, it would be associated with a limit on the level of support. This tier will always exist regardless of the availability of Government support.

Development of policy options for long-term care

The fourth section of the paper develops a series of policy options for each of the three areas under discussion – retirement incomes, health and long-term care for older people. Although it is important that these three areas should be considered as an integrated whole package, the remainder of this summary will focus on options for financing long term care for older people.

By long term care, the Institute means the accommodation and residential care of *those elderly persons who are unable to adequately care for themselves* (p.54). It notes that *the provision of services to the elderly in their own homes is of growing importance, but is not of the same magnitude of cost as residential care.* In other words, community based services such as Home and Community Care services and Community Aged Care Packages are not taken into account.

Supply and demand

In considering options for reform to financing long-term care, the paper notes that proposed approaches can seek to influence demand for aged care products – funding or pricing considerations; or they can seek to influence supply of aged care products by encouraging or discouraging the suppliers of aged care. Recent Governments have explored both approaches.

It is stated that solutions to the funding of aged care must recognise that the impact on both demand and supply are equally important. *For example, a fully funded aged care scheme will only be successful if there are sufficient providers of aged care to satisfy demand at the required time* (p.56).

PAYG and pre-funding

PAYG funding for long term care is usually publicly provided from general revenue however, it could be privately provided by consumers at the point of consumption.

Pre-funding could be arranged by Governments establishing a central fund similar to an accumulation fund, or setting up a social insurance scheme. More commonly pre-funding is arranged through the private sector.

The paper notes *It is possible for an aged care scheme to feature components of government funding and private sector funding, PAYG and pre-funding or benefits, but also insured and uninsured risks from the individual's perspective* (p.58).

Tiers of funding

Discussion of possible financing options for long-term care makes use of the three tiered funding model described above.

Tier 1 would be a compulsorily funded base level of care. This is described in the paper as *Those unable to look after themselves would be adequately fed, securely housed, and provided with such assistance as is required to cope with daily living.*

Such an arrangement would not necessarily cover options on the location of that accommodation, and would be limited in additional facilities such as entertainment. The ratio of staff to residents would imply a lower response time to requests for assistance than would be obtained at present in the better run facilities.

Funding is presumed to be compulsory, either as at present by deduction from government revenue, or with some pre-funding. However, that funding level could be based on a presumption of means-testing of users (pp.58–59).

Tier 2 would be a voluntary scheme for people prepared to fund their own aged care requirements, rather than to participate in a *one size fits all* government scheme. Encouragement for this would be provided by government with tax relief or rebates of some sort. This description implies that Tier 2 would be a substitution for Tier 1, rather than an optional enhancement of Tier 1. The paper notes that pre-funding of Tier 2 care could be undertaken through private Aged Care Insurance schemes.

Tier 3 would comprise individual voluntary provision for aged care with no Government incentives. The paper states *It seems unlikely that individuals will willingly spend significant sums in times of youth and good health to provide for an unknown and possibly unlikely benefit, without a financial incentive to do so (eg some form of tax relief)* (p.59). The paper also notes that Tier 3 services are only likely to be available if they can produce adequate profits for the providers.

Options for financing long-term care for the aged

Four options for financing long-term care for older people are provided. While the authors of the paper say that they do not claim to have described every possible option, they hope that they have provided *a sufficient smorgasbord of potential options to cover the range of possible approaches* (p.65).

Option A. Maintenance of the status quo

While the current PAYG approach would make for very large intergenerational transfers over time, there would also be problems with an advance funding approach.

As more people need aged care however, the current system will come under real strain. This would result in the need to raise more revenue either from the public or from consumers, or the need to restrict access to services more severely. None of these would be easy to implement or politically popular. Recent administrative decisions to require sale of the family home, if necessary, to enable consumers to contribute more to the cost of their care, proved very unpopular.

The paper proposes that if the current arrangements for financing aged care are to remain over the coming decades the most urgent need would be to revise the government contribution. It may be necessary to do this with a Medicare style addition to tax as a temporary solution. It concludes however, that *Eventually, if current trends continue, the total cost and the obvious intergenerational transfer may make this arrangement (ie the status quo) politically impossible* (p.60).

Option B. Pre-funding by the government

There are problems associated with pre-funding. These particularly arise out of the difficulty of predicting need over such a long time period. The kinds of services needed, or demanded, will be dependent in part on how successful the health care system is in preventing disability and maintaining good health in old and very old people, in particular in preventing or delaying the onset of dementia. Demand will also be driven by the standards of care that prevail when future services are needed. Neither of these is easily predicted.

It is proposed that a specific levy rate could be determined once it was decided how much of the expected costs should be pre-funded. It is recognised however, that despite experience with the Medicare levy, *there seems no attraction in having a specific levy to meet an unspecified part of the current cost* (p.61).

Major advantages of this option relate to affordable costs earlier in life replacing unaffordable costs later in life, there is less inter-generational inequity and government and the public would be very aware of the emerging problem.

The major disadvantages include the need to increase taxes or raise significant revenue in some other way and the need for administrative arrangements to be developed for the receipt, investment and payment of funds.

Option C. Private pre-funding of aged care costs

In the US some States offer private long-term care insurance to complement or substitute for government provided schemes. The paper notes that this approach would seem to be a Tier 3 type scheme as it has little or no government support.

Insurance schemes, it is asserted, offer the benefits of pooling risk. The pool of funds is made up of contributions from people who die before reaching the age of 65, people who are aged 65 or over and who do not need long term care and people aged 65 or over who do, plus returns on investment. Benefits would be available to members of the scheme who meet the eligibility criteria for aged care.

While there has been poor uptake for such schemes in the US, the Institute of Actuaries of Australia considers that this approach could prove more successful in Australia if it were supported by government with tax deductible premiums or concessional rates applied to insurer investment returns.

The main advantages would be that it offers individual choice, its introduction would not be politically sensitive, and it would *encourage efficiencies in the system through competition and the profit motive* (p.62). It would also enhance the level of savings in the private sector, and could encompass all forms of long-term care.

The evidence is that for many people, the need for residential care is for only a very short period prior to death. A major disadvantage of a voluntary private insurance scheme is that there may be a low uptake due to a general reluctance of people to make provision where there seems little likelihood of a need for the benefit and the level of benefit is uncertain. Another disadvantage is that the benefits provided by the scheme may be less than anticipated due to fraud, mis-management or profit taking by the insurer.

Option D. PAYG Government funded scheme

This approach is similar to the schemes currently operating in the Netherlands, Germany, Israel and Japan. Compulsory contributions would be made by working people, either over the working life-time or from a specific age (eg 45 years). The coverage would be universal. The premium would be a hypothecated tax for the provision of long term care for the aged and it would be reviewed and the new premium determined regularly.

The scheme could have the capacity to pay cash instead of benefits, which could encourage more care by relatives and act as a buffer against under-supply of services. However, it is noted that, as a PAYG scheme, it may be unsustainable over the long term with a rapidly ageing population.

The main advantages of a PAYG Government funded scheme would be that there would not be adverse selection as the entire population would be included, there would be relatively low administration costs and it has proved to be politically acceptable in countries where it is in use.

The main disadvantages of this option are that, to maintain political acceptability, there would be restrictions on contribution levels and thus on benefit levels. Where government finds it necessary to improve benefit levels contributions may be forced to rise unacceptably. It is also argued that the scheme, of itself, would not create incentives for suppliers to provide sufficient levels of service.

Appendix 4
Long-term Aged Care: Expenditure Trends and Projections

Madge A 2000 *Productivity Commission Staff Research Paper*, Canberra, *www.pc.gov.au/research/staffers/LTAC/LTAC.pdf*

Introduction

> *The Productivity Commission is an independent Commonwealth agency and is the Government's principal review and advisory body on microeconomic policy and regulation. It conducts public inquiries and research into a broad range of economic and social issues affecting the welfare of Australians.*

The ageing of Australia's population, and, in particular, the increase in numbers of people aged over 80 and in the proportion of the population that they represent, raises significant social policy issues. Health and long-term care of the aged are two such issues. At present Australia spends about 1% of GDP, or $6 billion, on long-term aged care[1].

The purpose of this paper is to try to project the changes that are likely to occur over the coming decades until 2031, due to demographic change and other factors, and what that may mean in terms of Government programs for the aged. It also analyses past government expenditure trends in the areas of long-term aged care.

This paper does not discuss how long-term care might be financed in the future, but its contents are absolutely critical to an understanding of the kinds of change that will occur and the magnitude of that change. In particular it projects the costs for long-term aged care until 2031. This, in turn, has to be the foundation upon which any policy development concerning financing long-term aged care must be based. And so this paper provides very important data for any consideration of the options for financing long-term care of the aged.

[1] In this document long-term aged care refers to residential care (nursing homes and hostels) and community services delivered in the home or some other community setting. Community services include both Community Aged Care Packages (CACPs) and the Home and Community Care (HACC) services delivered to older people.

The paper uses data produced by other organisations such as ABS, AIHW and by academics, and applies sophisticated calculation and modelling techniques to develop projections. It is clear that considerable expertise has been applied to this issue, however it is important to recognise the limitations of projections over such a long time frame. As the author of the paper says *(The economic projections) are, at best, only as good as their base year data. While the 1996–97 data used in the long-term aged care projections are as comprehensive and accurate as possible, there are gaps – most especially in relation to home and community services. Second, the further projections are from the base year the more unreliable they are. ...it would seem prudent to regard projections presented ...as being no more than broadly indicative of likely long-term aged care cost trends beyond 2011* (p.77).

Findings

In addition to the questions concerning population numbers and population structure, this paper has attempted to answer some important questions about the likely need for services and the types of services that might be required as the population ages. While there can be no clear answers to these, it is important to recognise that we cannot assume that current aged care utilisation patterns will continue unchanged over the next thirty years. Other important questions relate to the unit cost of services, to the incomes and wealth of older people and to Australia's ability to afford any possible increases in the costs of long-term care over the years.

Demand for long-term care services

With respect to demand for long-term care services the key findings of the study are:

Population

Australia's population will age over the next 30 years, particularly after 2011. *Sensitivity analysis using different ABS demographic projections incorporating, amongst other things, different net migration assumptions, does not change this conclusion* (p.78).

The numbers of people aged 65 years and over, will increase by about 140% from 1997 to 2031. More importantly, the oldest old (people aged 80 years or more) will increase by 200%. People over 65 years currently make up about 12% of the population, but by 2031 this figure will be about 22%.

Unit cost of long-term care services

There will be upward pressure on aged care expenditure resulting from demographic change and, almost certainly, also from increased costs of services. It is probable that the increase in unit cost of long-term care services will be greater than the general cost rise in the economy. The increasing costs will arise out of expected increases in real wages and continuing expectations of improvements in the quality of services. The fact that these costs exceed general cost rises in the economy is because long-term care services are very labour intensive with limited opportunity to improve productivity through capital substitution.

Aged disability rates

While it is clear that there will be an increasing need for long-term care services relating to the increasing number of older people, the size of the demand is not so clear. Severity of disability is the most important indicator of need for long-term care but it is not clear what impact improved health and longevity will have on levels and severity of disability.

There is some evidence of reducing age-specific disability rates in many OECD countries. The Australian data on this are ambiguous – although the paper points out that this could result from the nature of the surveys on which these findings are based.

If there is a reduction in age specific disability rates in Australia over the coming years, this would partly offset the impact of the increasing numbers of older people, and particularly of *oldest old* people (those aged 80 years and over).

In addition we can envisage that there would be major reductions in the need for long-term care if there were new effective treatments to prevent or lessen the severity of diseases of the aged such as osteoporosis or dementia. On the other hand, there could be a greater risk of disability as people are treated effectively for conditions which would previously have caused premature death (such as cardio-vascular disease), and subsequently develop other disabling conditions.

If disability rates in Australia remain unchanged, the number of residents in long-term aged care institutions would rise by about 150% between 1998 and 2031. If Australia experiences a similar decline in age-specific disability rates to that experienced in other major OECD countries, this rise would be in the order of 70%.

Longevity

Increasing longevity, particularly of males, will be an important factor contributing to the increased number of old people over the coming decades. The impact of increasing longevity on levels of disability is not clear. However *the weight of international evidence is that the disability-free years of older people increase along with life expectancy. In particular, severe disability (the type most likely to require intensive long-term aged care services) tends to be concentrated in the last 2 to 4 years of life, regardless of how long a person lives. This suggests that the relevant age-specific disability rates will fall – at least up to some threshold age* (p.25).

Wealth and income

It is likely that incomes and wealth will increase in the future. The impact of this on demand for long-term care services is unclear. On the one hand higher income and wealth is associated with better health, but on the other, the increased purchasing power of older people could increase the demand for these services.

Institutional factors

Access to subsidised long-term care services is regulated by government decisions concerning the numbers of places and services (residential places and community care services) to be made available, and by the eligibility criteria for those places and services. Madge (2000) argues that *these rationing mechanisms, combined with potential constraints on public funding, imply that the future usage of long-term care services may not be as great as the outlook for underlying demand might suggest* (p.ix).

He also notes however, that the constraints on future demand are dependent on community expectations and government policy and are difficult to predict. For this reason the paper has assumed unchanged policy settings in its projections.

Recent trends in government expenditure on long-term aged care

The study analysed real government long-term care expenditure over the period from 1989–90 to 1999–00. Included in the analysis was expenditure on nursing home and hostel care together with expenditure on CACPs and HACC services provided for people 65 years and over. The HACC data were not as complete as data on the other services. The analysis shows that:

- Real government expenditure on all long-term aged care increased;

- Much of the increase reflected increases in the target population which grew steadily over the period;
- The proportion of the older population receiving any aged care services fell over the earlier years of the period but was recovering towards its end;
- Real expenditure per person increased for people in long-term aged residential care or in receipt of CACPs, but appears to have fallen for aged people receiving HACC services;
- There have been changes in the long-term aged care service mix, with the importance of nursing homes declining in favour of increases in hostel places and community care. The report warns however, that *any capacity for further gains [in terms of cost savings] from such a shift may be limited* (p.ix).

Long-term aged care expenditure in the future

The projections of expenditure on long-term care for the aged have been undertaken using a *base case* which holds all factors constant at 1996–97 levels except population growth and levels of GDP.

An important difference between the projections contained in this paper and those in others relating to the future costs of long-term aged care, is that where other papers judge the affordability of the expected increase in costs to the size of the working age population, the Productivity Commission paper uses the ratio of long-term age care expenditure to projected GDP to assess this.

Using the 1996–97 base case, it is projected that long-term aged care expenditure will more than double in real terms between 1997 and 2031. It is expected however, that productivity will continue to grow over this period. Thus:

> *even with relatively conservative GDP projections, expenditure grows by only about 25 per cent when expressed as a share of GDP. It also appears likely that the wealth and incomes of the aged 'baby boomer' generation will be significantly higher than those of the current aged – also increasing the capacity of society to meet the needs of this group* (p.x).
>
> *The financial burden associated with increased long-term aged care expenditure, whether borne by taxpayers or by the aged and their families, will depend on GDP growth. If Australia's GDP growth (and its underlying determinant, productivity growth) is similar to that of recent years, it is less likely that increased provision of long-term aged care services will be a financial strain* (p.xi).

If the factors influencing demand such as disability and institutional rates for each age group were to be lower than has been projected, for example through new and effective treatments for key health problems of older people, it is possible that the rise in expenditure on long-term aged care may be quite modest and even fall as a proportion of GDP.

Appendix 5
With Respect to Old Age: Long Term Care – Rights and Responsibilities

A Report by the (UK) Royal Commission on Long Term Care 1999, *www.official-documents.co.uk/document/cm41/4192/4192-01.htm*

Introduction

The establishment of the Royal Commission on Long Term Care in the United Kingdom resulted from the fact that the UK had very serious problems with its provision of care for its ageing population. Some of these problems and their impact on older people and their families are described below.

The National Aged Care Alliance has asked for a summary of the findings of the Royal Commission, but a number of the findings and recommendations only make sense in the context of the problems they are seeking to correct. As a result it seems important to provide a brief description of the long-term care situation in the UK at the time the Royal Commission was conducting its Inquiry.

Funding long-term care in the UK – prior to the Royal Commission

The following brief description is taken from Chapter 4 of the Report. Reference to the *current system* or *current situation* is a reference to the situation at the time of the Royal Commission.

The current long-term aged care system:

- is characterised by complexity and unfairness in the way it operates;
- is haphazard – having grown up in a piecemeal fashion.

The Royal Commission received many representations from members of the public expressing bewilderment and frustration with the system *how it works, what individuals should expect from it and how they can get anything worthwhile out of it. We have heard countless stories of people feeling trapped and overwhelmed by the system, and being passed from one budget to another, the consequences sometimes being catastrophic for the individuals concerned* (Chapter 4, p.3).

Features of the UK long-term aged care system pre Royal Commission

- There is no single long-term aged care program funded and administered by one Department and one level of Government;
- Public funding for long-term care is provided through a number of programs including programs run by Social Security, the National Health Service and the Local Authorities;
- Aged care assessment and placement, where appropriate, is undertaken at the local level by the Local Authorities, which all have different approaches to service provision and consumer charges;
- Publicly funded benefits are based on a means test which takes both income and assets into account;
- In assessing people's ability to pay for services, both income and assets are regarded as income. For instance, for a person with capital between £10,000 and £16,000, an income of £1 per week is assumed for every £250 of that capital over £10,000, and added to actual income for the purpose of the means test. The aim of this process is that a person should contribute some of their capital towards the fees.

  If a person is in residential care for up to three years, and owns a house worth say, £40,000, over those three years the system (by assuming that the house is sold and the proceeds are used to pay for care) will bring him or her to a level where it judges there is sufficient impoverishment to warrant state help. Someone with more assets is less likely to become impoverished in this way. The system at the moment helps people who are poor, demands that people of modest means make themselves poor before it will help. and affects people to a lesser degree the richer they are... (Chapter 4, p.6).

There were perverse incentives in the system. For instance, it was often cheaper for the Local Authorities to send someone to a nursing home rather than to provide community based services for them. This was because some Social Security funding was available for Nursing Home accommodation, but the Local Authority had to fund community based services. In addition the National Health Service (NHS), concerned about its budget, and attempting to target only acute care, closed 38% of its long stay beds (21,300 beds). The need to move patients rapidly through beds in the NHS was not supportive of the rehabilitation of older people and, the number of nursing home beds that had become available made it much easier to institutionalise someone than to rehabilitate them.

As a result, very large numbers of older people were placed in nursing homes and the numbers of private nursing homes in the UK grew by 900% between

1983 and 1999. This was an increase of 141,000 beds. Only 8% of these additional private nursing home beds are paid for by Health Authorities and Health Boards. The rest are paid for by individuals and Local Authorities. The quality of care in many of these nursing homes was a matter of concern for the Commission.

Fundamental principles and key recommendations

The Royal Commission had an underlying philosophy about old age, stated thus:

The Commission have begun from the point of view that old age should not be seen as a problem, but a time of life with fulfilments of its own. To provide security in old age and proper care for those that need it our main recommendations are that:

- *The costs of long-term care should be split between living costs, housing costs and personal care. Personal care should be available after assessment, according to need and paid for from general taxation: the rest should be subject to a co-payment according to means;*
- *The Government should establish a National Care Commission to monitor trends, including demography and spending, ensure transparency and accountability in the system, represent the interests of consumers, and set national benchmarks, now and in the future* (Executive Summary and Summary of Recommendations, p.1).

In seeking to identify a way of paying for long-term care that could bring improvements to the system in the short term and which was affordable and sustainable, the Commission recognised three key principles. They were:

- Responsibility for the cost of long-term care should be shared by the state and individuals. The challenge is to find the best balance – one which can be afforded by both parties and which is comprehensible to people and is considered fair;
- A new approach to state support must be fair and equitable;
- A new system of state support should be transparent with regard to the sources of funding, the entitlement of individuals, the benefits to be provided and the responsibility of individuals.

The Commission's overall conclusions

The findings of the Commission are clearly and succinctly set out in the Executive Summary. After some consideration, it has been decided to reproduce the key findings or key parts of the findings as they are presented in the Report, rather than trying to paraphrase them. The text that is directly taken

from the Report is in italics. Where it seem important to provide some explanation from other parts of the Report that is provided in normal text.

The broad outline of the Commission's conclusions is as follows:

- For the UK there is no *demographic timebomb* as far as long-term care is concerned and as a result of this, the costs of care will be affordable;
- Long-term care is a risk that is best covered by some kind of risk pooling – to rely on income or savings, as most people effectively have to do now, is not efficient or fair due to the nature of the risk and the size of the sums required;
- *Private insurance will not deliver what is required at an acceptable cost, nor does the (private insurance) industry want to provide that degree of coverage.* The first paper prepared for the Alliance contained a brief discussion of the advantages and disadvantages of private long term care insurance;
- The most efficient way of pooling risk, giving the best value to the nation as a whole, across all generations, is through services underwritten by general taxation, based on need rather than wealth. This will ensure that the care needs of those who, for example, suffer from Alzheimer's disease – which might be therapeutic or personal care – are recognised and met just as much as of those who suffer from cancer;
- A hypothecated unfunded social insurance fund would not be appropriate for the UK system. A *pre-funded* scheme would constitute a significant lifetime burden for young people and could create an uncertain and inappropriate call on future consumption:
  - a hypothecated tax or levy was rejected on the grounds that it was inconsistent with the approach of successive Governments to funding public services and that it would reduce flexibility and set priorities in stone. It was also argued that hypothecation might make it a target for cuts if, for example, a Government was seeking to reduce the tax burden;
  - pre-funding or advance funding was also rejected. The arguments against this were that the contribution rate if contributions started at age 20 would be 1.6%, 2.3% for a 30 year old, 3.9% for a 40 year old, and 10.1% for a 50 year old. Throughout the transition period (that is while the fund is building up to the point when it can begin to deliver benefits) each working person would continue to pay the 2.17% of income they are currently paying for people receiving long-term care services now. *Given the burdens on young people to make provision*

for pensions, to fund their own education, and the uncertainty of employment patterns, pre-funding of long-term care would arguably place an unacceptable burden on them (Chapter 6, p.17);

- The answer lies in improvement of state provision, but the state cannot meet all the costs of *long-term care* in the broad sense. The elements of care which relate to living costs and housing should be met from people's income and savings, subject to means testing, as now, while the special costs of what we call *personal care* should be met by the state;
- Although people will still need to meet their living and housing costs should they need care, it will be clear what they will need to make provision for – and such provision will be affordable by more people;
- *Other options are available at less cost to make specific improvements to the current system. They include disregarding the value of the house in the means test for three months, changing the limits of the means test, and making nursing care wherever it is provided, free.* The reason for disregarding the value of the house in the means test for 3 months is to allow for the possibility of rehabilitation. The Commission found that a number of people who had recovered sufficiently, after a period of time, to live independently were unable to leave the nursing home because their houses had already been sold;
- *Because of the uncertainty of the data, the lack of trust in the present system among older people, and the cynicism as to Government's future intentions which exists amongst younger people, a new body, the National Care Commission, should be established. Its task would be to look at trends, monitor spending, ensure standards, and visibly represent the voice of the silent majority of consumers now and in the future;* Interestingly, its role does not appear to be to strategically plan, integrate or co-ordinate an aged care program;
- The system needs more effective pooling of budgets, including bringing the budgets for housing aids and adaptations into a single pot;
- The Commission recommends that more care is given to people in their own homes. Therefore the role of housing will be increasingly important in the provision of long-term care;
- *More services should be offered to people who have an informal carer.* The Commission had found that where there was an informal carer, people were much less likely to be offered any services in the home.

Key recommendations

The Royal Commission's two key recommendations are identified at the beginning of this section – ie that the state should be responsible for the cost of personal care and individuals for board and accommodation; and that the Government should establish a National Care Commission.

Because of the distinction in funding between personal care, living costs and housing costs it is important to set down the Commission's definition of *personal care:*

Personal care would cover all direct care related to:

- *personal toilet (washing, bathing, skin care, personal presentation, dressing and undressing);*
- *eating and drinking (as opposed to obtaining and preparing food and drink);*
- *managing urinary and bowel functions (including maintaining continence and managing incontinence);*
- *managing problems associated with immobility;*
- *management of prescribed treatment (eg administration and monitoring medication);*
- behaviour management and ensuring personal safety (for example, for those with cognitive impairment – minimising stress and risk).

We acknowledge that this definition could be regarded as on the tight side. It would, for example, exclude costs attributable to:

- cleaning and housework;
- laundry;
- shopping services;
- specialist transport services (eg dial-a-ride);
- *sitting services where the purpose is company or companionship* (Chapter 6, p.13).

The Report contains a number of more detailed and specific recommendations. Some are relevant only within the UK system because they deal with problems specific to that system. All of the recommendations of more general application or interest are set out below.

Funding

- The Government should ascertain the total amount of money that is provided for supporting older people in residential care and their own homes by all of the Departments, agencies and authorities involved;

- The value of the house should be disregarded for up to three months after admission to care in a residential setting (with appropriate safeguards to prevent abuse) and the opportunity for rehabilitation should be included as an integral and initial part of any care assessment before any irreversible decisions on long-term care are taken;
- Measures should be taken to bring about increased efficiency and improved quality in the system, including a more client centred approach, a single point of contact for the client with devolved budgeting, budgets shared between health, social services and other statutory bodies and greater integration of budgets for aids and adaptations;
- The Commission set out a number of other changes to the current system, such as changing the limits of the means-test, or making nursing care free, which would be of value in themselves, but which would be subsumed by our main recommendation.

Provision of services

- *Further research on the cost effectiveness of rehabilitation should be treated as a priority, but that this should not prevent the development of a national strategy on rehabilitation led by the Government to be emphasised in the performance framework for the NHS and Social Services;*
- *Further longitudinal research is required to track the process and outcomes of preventive interventions and to assess the impact both on quality of life and long-term costs;*
- *It should be a priority for Government to improve cultural awareness in services offered to black and ethnic minority elders;*
- *The role of advocacy should be developed locally, with backing from central Government.*

Help for carers

- Better services should be offered to those people who already have a carer;
- The Government should consider a national carer support package.

Information and projections

- The National Care Commission should be made responsible for making and publishing projections about the overall cost of long-term care at least every five years;
- The Government should set up a national survey to provide reliable data to monitor trends in health expectancy.

- *The Government should conduct a scrutiny of the shift in resources between various sectors since the early 1980s, and should consider whether there should be a transfer of resources between the NHS and social service budgets given changes in relative responsibilities.* This relates particularly to the NHS having shed 38% of its long stay beds, which is seen as a shifting of costs into the long-term care system which is subsidised by Social Security. The argument is that the NHS should, perhaps, transfer the recurrent funds relating to those beds to the Department of Social Security.

Appendix 6
Financing Long Term Care in Germany – A Social Insurance Model

Cuellar AE and Wiener JM 2000 *Can Social Insurance for Long-Term Care Work? The Experience of Germany*, Health Affairs, Vol. 19, No. 3, May/June

Background

Until 1994 Germany's long term care for the aged was administered and financed by the individual German states. Support for long-term care was a social assistance program only for the most needy as assessed by a means test. It differed significantly from Germany's acute health care system which was covered by universal health insurance.

As a result of growing financial pressure on the states and public discomfort at the adverse effect of the policy on social solidarity – which is an important value in German social policy – it was decided to reform long-term care financing. This was at a difficult time for Germany as it was having to cope with two challenging and costly issues – re-unification and high levels of unemployment.

Acute health care in Germany is financed primarily through the sickness funds which are *quasi public quasi private insurers heavily regulated by the national government* (p.10).

Cuellar and Wiener (2000) report that, in considering options for long-term care, Germany rejected the idea of targeting or means testing because it was seen as demeaning. They also state that the private insurers rejected the idea of subsidised private insurance because their target market had always been in the high income groups and because their premiums were set independently of income.

Financing

In 1994 a mandatory, universal coverage social insurance program for long-term care was introduced by Chancellor Helmut Kohl's conservative government. The program would provide benefits for both nursing home care and community based services. Initially the program was to cover only the needs of the older

people, but following concerns about equity and younger disabled people it was expanded to provide cover for people of all ages.

The program is financed by a premium set at 1.7% of salary of employed people. Employees pay half of the premium and employers pay the other half. In order to overcome employers' objections to the proposal for an employment based premium one mandatory annual paid public holiday was abolished.

Retirees also contribute, paying half of the premium and the pension funds paying the other half.

This is a pay-as-you-go scheme, although there was a period of four months between the commencement of premium collection and the commencement of payment of benefits. There was also a period of 15 months between benefits for home care becoming available in April 1995 and nursing home benefits being introduced in July 1996. As a result the fund built up some reserves which have been added to by the surplus in the fund in each year since then.

Cuellar and Wiener (2000) report that the scheme was *implemented quickly with surprisingly few difficulties and, after five years, enjoys broad popular and political support. If anything the Labor government of Chancellor Gerhard Schroeder seeks to expand the program slightly* (p.9).

Key features of the program

The program has a number of financial features of relevance to the deliberations of the National Aged Care Alliance. They include:

- The program is administered by the sickness funds, although long-term care is fiscally separate from acute care;
- The decision to use the sickness funds meant that people were dealing with a familiar administrative body;
- Despite the mandatory nature of the contributions, they are not viewed as taxes and thus have greater support than they otherwise would;
- Expenditure on sickness fund programs does not appear on government budgets;
- The 1.7% of salary is seen to be relatively modest when compared with the average 39.6% of income that Germans pay for health, pension and unemployment benefits;
- Cost control mechanisms have been built in to the program. These are:
  - if spending exceeds agreed upon levels deliberate choices must be made by government authorities to balance the funds;

  - both revenues and benefits are capped – revenues by the fixed contribution, and benefits by there being a maximum monthly amount payable by disability level;
  - benefits do not automatically increase with inflation;
- Extensive household sample surveys were undertaken in 1992 from which estimates of the number of beneficiaries were determined. The actual number is quite close to the estimate;
- The program has so far run with a surplus each year, although the size of the surplus has been reducing.

Eligibility and assessment

Eligibility for long-term care benefits is determined solely on functional status. As a result, the assessment of disability is a key issue. Other points concerning eligibility and assessment are:

- The eligibility criteria were developed to fit the estimated funds available and are mandated by federal law;
- Assessments are undertaken by the medical officers of the sickness funds;
- These assessments are the sole mechanism for the allocation of resources;
- The eligibility criteria are the same for home care and for nursing home care;
- People are eligible if they have a mental or physical condition resulting in their needing help with at least two activities of daily living (ADL) and one or more instrumental activities of daily living (IADL), and which is expected to last for at least six months;
- There are 3 eligibility categories, differentiated mainly by the number of ADLs and IADLs with which assistance is needed and the estimated time required;
- It is argued that the assessment and eligibility criteria do not adequately address cognitive impairment and that dementia is thus not appropriately resourced. Cuellar and Wiener (2000) state that the Schroeder government *has made changing the eligibility criteria a high priority;*
- *Changes to eligibility criteria to accommodate more persons with dementia would have to be associated with tighter eligibility criteria for others, to make any change budget-neutral* (p.15);
- Social assessment is not a part of the assessment for eligibility – access to benefits is entirely independent of family or other caregiving and support.

This approach reflects the view that there should be equal treatment for equal levels of disability;

- There is virtually no case management – for instance to advocate for clients or assist them in their choice of services.

Benefits

The main features of the benefits provided by the German long-term care program are:

- The level of benefits is set by the disability level and the individual's choice of institutional or home care – with a capped maximum expenditure for each level and home care or nursing home status;
- People who choose home care can elect to have services paid for by the sickness funds (up to the assessed level) or to receive a cash benefit or a mixture of both;
- Cuellar and Wiener propose that the service option can be thought of as receiving a voucher for approved services and the cash option as an income supplement;
- Persons electing the cash benefit receive less than half the value of the service benefits they are eligible for;
- There are no restrictions on how the cash may be used;
- The program provides for a cap on monthly expenditure for services, institutional care or cash for each eligible person;
- It seems that benefits are not necessarily expected to cover all of the care a person may need, and that what services are used and at what cost is a matter for the individual. It is generally believed however, that most people spend up to the maximum level provided by the benefit and stop at that point;
- Community based services, for those who elect services rather than cash, are provided by service providers with contracts with the sickness funds. The beneficiary may choose from the providers contracted to his/her fund;
- The benefit for nursing home care covers basic care, medical care, and therapeutic social activities but not board and accommodation or capital costs;
- Nursing home residents must pay at least 25% of the costs of nursing home care;
- In addition where the nursing home costs are greater than the flat fee paid by the sickness fund plus the resident's 25% contribution, the resident must pay the additional cost;

- The *excess* payments that residents may have to pay increases with disability level as, according to Cuellar and Wiener, program payments do not increase with disability level to the same extent as nursing home costs do. As a result, people with the highest disability levels may have the greatest incentives not to choose institutional care.

Utilisation

- 74% of beneficiaries in 1998 were receiving care outside of nursing home facilities;
- 76% of the beneficiaries not in institutional care had elected to take cash benefits rather than services;
- There was some variation in the choice of cash or services associated with level of disability but even in the most disabled group 65% chose cash;
- Dementia is not a reason to deny the choice of cash over services, however cash is only granted if the medical officer of the sickness fund has assessed the care of the person as adequate;
- Beneficiaries receiving cash are visited every four to six months, depending on the disability level, to assess the adequacy of care.

Outcomes

The program was established with a number of objectives, many of which it has achieved.

Achievements

- The financial burden of long-term care has been shifted from the states and municipalities;
- There is a reduced dependence on means tested welfare;
- There has been an expansion of home and community based services – with the possibility that there is now an over-supply in some areas due to the unexpectedly high uptake of the cash benefit;
- There has been an increase in the number of nursing homes from 4,300 in 1992 to 8,100 in 1999, although much of this increase has resulted from re-categorisation of residential facilities;
- Spending on long-term care has increased significantly as planned;
- Cover has been expanded to non-institutional settings with half of the program expenditure in 1998 being for non-institutional care and almost three quarters of the beneficiaries being in non-institutional settings;

- Program expenditure has remained within budget;
- Increased support has been provided for informal care givers (through the cash benefit).

Goals not yet achieved

- It had been intended that the program would foster price competition. This has not happened to any extent. As in the acute sector, sickness funds must contract with all providers that meet minimum standards. They cannot selectively contract on the basis of price and quality. The sickness funds do not negotiate with providers individually but rather undertake collective rate negotiations with provider associations as they do in the acute care system. Beneficiaries are free to choose providers from the sickness fund list;
- An explicit goal of the new program was to favour rehabilitation over long-term care. This has not been achieved, because there was an opportunity provided by the existence of long-term care benefits for the acute care services to shift the costs of disability to another program. Rehabilitation is a cost to the acute health services which would deliver cost savings to the long-term care program.

Issues for the future

> *Nearly everyone interviewed for this study regarded the new long-term care insurance program as an immense political and social accomplishment. It had achieved or made substantial progress toward several important goals, including giving security and support to informal caregivers, shifting the balance of long-term care from institutional to home care services, increasing attention to quality of care, providing (the states) with fiscal relief, reducing dependence on social assistance, increasing the supply of providers and increasing choice* (p.22).

The early success of the program has enabled it to focus more intensively on issues that need further work including:

- The eligibility criteria may need to be reviewed with particular reference to the issue of cognitive impairment;
- Quality – considerable work is being done on the development of quality assurance and Total Quality Management programs by and for service providers;
- The issue of quality in home care provided by informal caregivers is interesting with the prevailing view being that care by family members is a personal issue and outside the scope of regulation;

- Consumer input – there has been little or no consumer input at the policy level to the program although there is an increasing use of consumer surveys as part of quality review processes.

The challenges posed for a pay-as-you-go system by the rapidly increasing size of the German population aged over 80 – from 3.6% of the population to 6.3% between 2000 and 2020 are not at this stage being addressed, according to Cuellar and Wiener. They point out however, that the challenges for the long-term care program are nothing compared with the problems that will arise in the health and pension areas.

Lessons from the German experience

Cuellar and Wiener (2000) set out a number of lessons to be learned from Germany. They are:

- It is possible to introduce new, non means tested, social programs for long-term care which operate within their budget;
- A number of features of the program made it politically successful including the fact that an entitlement was established to a set of benefits that people could understand and believed they would receive if they met the eligibility criteria. The provision of a cash alternative was attractive and introduced maximum flexibility;
- Assuring quality of care has been a challenge, particularly in view of the large increase in providers. Achieving an optimal balance between effort and resources dedicated to quality both by providers and the authorities and the additional costs to the program or consumers is a difficult task;
- The relatively inflexible national program has left little room for innovation or programs tailored to meet individual needs;
- It is not easy to define the boundaries between acute care and long-term care. It is important to maintain a separate funding stream for long-term care to prevent it being swallowed by the acute care system, but cost shifting is a problem;
- The option of taking benefits as cash illustrates the conflict between equity and efficiency. *On moral grounds, policymakers want to reward informal caregivers for their sacrifices. But from an efficiency perspective, long-term care funds are spending a great deal of money to accomplish relatively little behavioural change. ...For people receiving the cash benefit, it is not clear that much has changed in the way they receive care, although some observers think it is too early to tell* (Cuellar and Wiener 2000, p.23).

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