

Funding the future of aged care

A Deloitte and Aged Care Association perspective



Background:

The Productivity Commission established a public inquiry into Caring for Older Australians and invited a variety of stakeholders to prepare submissions for them to consider. In early August 2010, Deloitte and Aged Care Association Australia (ACAA) provided a joint submission to the Productivity Commission about funding strategies for the future of an aging population. The submission was based on a national strategic workshop hosted by Deloitte and the ACAA, and attended by providers, financiers, operators and other key stakeholders.

Introduction:

While long-term demographic projections contain an unavoidable element of uncertainty, it is widely accepted that the number of elderly people in the Australian population will rise rapidly in coming decades. Much of that increase will involve a rise in the number of people who are very elderly, including centenarians. However, what is less certain is how the health status of that elderly and very elderly population will evolve over time. Even if the average health status of the elderly and very elderly population were to improve greatly relative to earlier decades, the sheer numbers surviving to very high age brackets would result in a very large increase in the population requiring care because of frailty or other conditions for prolonged periods of time. An expansion must occur in the formal care sector if care needs of a changing population are to be met.

Financing future aged care:

Ensuring that older Australians can help finance their care costs requires a carefully designed, long-term transition path, which will assist planning by consumers, care providers and care financiers such as banks and super funds. Measures will also need to be put in place which can help consumers set aside and then access the financial resources they require.

One of the main issues in aged care is how an expansion can be financed, as the current financing arrangements are not capable of supporting the increase in supply that is needed. At present aged care funding is financed from current tax payments and changing demographics will result in a significantly lower percentage of current tax payers compared with elderly people requiring financing. Also problems arise from the inability to charge entry bonds into high care. This has made the availability of funding for expansion of the accommodation stock in high care dependent on the level of other, regulated, charges.

The level of those charges has proven inadequate to finance that expansion. This means that a rising share of the growth in high places has occurred in the extra service segment (where bonds can be charged), but the decision to implement the policy cap on extra service places at local area level has now closed off that option in many of the places where capacity expansion is most needed.

The problems this creates are compounded by the differential trends in demand between high and low care. The Aging in Place policy, as well as minimising the disruption to clients, has also allowed providers to cover at least some part of the common costs of high care places through entry bonds charged in low care. However, while low care continues to expand, it may not expand as rapidly as the required growth in high care places. As a result, the needed growth in high care places will not be able to be financed through bond payments in low care.

There are also issues of financial adequacy in community care. Transport costs have a major impact on the costs of providing community care; so also do staff costs. Both of these have been rising more rapidly than the community care payments and are likely to continue doing so. While there is some potential for new technology to reduce costs in community care (for instance, through improved remote monitoring), those reductions are not likely to be sufficient to offset other sources of cost increase, including rising levels of acuity in the population being served. As those cost pressures play themselves out, providers will have little choice but to reduce the hours of care they provide for each package.

Further difficulties with the financing of community care are likely to arise from the move to consumer-directed care. This involves shifting some or all of budget control into the hands of the consumer, which can have many benefits. However, it also means that providers can no longer subsidise high cost to serve cases from low cost. The result will be to erode the ability of providers to bridge the acuity gap noted above through cross-subsidisation within the pool of consumers.

The primary financial role of the Commonwealth should be to finance care for those elderly Australians who are not in a position to themselves cover its costs

Many elderly Australians have limited assets and income, and a substantial share of what assets they own involve the family home. While that home can be sold at the time of entry into residential care, it may not be so readily sold if only one member of a couple is going into care. Moreover, domiciliary care provided in the family home obviously cannot be funded through the sale of that home, though there may be ways other than selling or unlocking the consumer's equity in his or her home.

We note that many Australians who retire in the future will also have pools of superannuation available to them built up through the compulsory superannuation levy. There are however, concerns that the amounts of super available to retirees will not fund their retirement needs, let alone their aged care needs.

Combined, these factors mean that meeting the growing demand for care will require a significant increase in the flow of funding to the sector. The issue is determining the appropriate balance that is needed in that increased funding as between consumer contributions and payments from the Commonwealth.

In principle, the primary financial role of the Commonwealth should be to finance care for those elderly Australians who are not in a position to themselves cover its costs. In that sense, the Commonwealth has, and must retain, a primary responsibility to ensure an adequate social safety net is in place. Conversely, those consumers who are in a position to cover their own care costs should do so, thus minimising the call on public expenditure and hence also minimising the need to impose distorting taxes so as to fund that expenditure.

Possible models to ensure sufficient savings are available to fund future aged care needs:

The options below are not mutually exclusive and a combination of these ideas could be considered:

1) Use of Superannuation or other long-term saving products

Our first conceptual idea is to open up superannuation or other long-term saving products e.g. savings account, long-term care insurance. This would require a system whereby care and services would be separated from accommodation and each funded differently which would provide flexibility for both the provider and the resident.

Residents' individual superannuation funds would be used to pay for care and services, whereas the cost of capital would be funded by the superannuation industry as a whole. We believe that incentives would be required for this to occur (possibly tax incentives) or government legislation to ensure minimum investment of the funds into the industry.

The system would operate under a similar funding model to that used to fund private medical insurance.

At a particular age (e.g. 40–45) a portion of superannuation contributions would be set aside for aged care needs.

If these funds were not all used to provide for a person's aged care needs, then either the entire balance would be forfeited to the larger fund or alternatively, the employer portion would remain in the fund and the voluntary contributions would be released to the family.

The aged care operator would benefit through user pays for care and services and should benefit from gaining access to capital. The model would be similar to a private hospital, with options based care and services, therefore the operator would be able to fund debt from loans out of superannuation funds.

This model could potentially lead to a reduction in the government burden for care cost if used as an incentive for younger ageing and wellness. It also moves the burden of funding to the consumer through superannuation payments during their working life, although the government would still be required to provide a safety net level of funding and would still have a vital role in ensuring that quality of service was maintained. This model could also have further benefits if the superannuation system was opened up to allow children to contribute for the aged care needs of their parents.

2) User pays system

Our second conceptual idea is also based on separating the care and accommodation aspects of aged care and then allowing the resident to pay for the care and accommodation based on the quality of the service provided.

As opposed to the current system where the basic level of service is underpinned by the resident, under the resident pays system, the basic level of service would be underpinned by some level of government support.

The monthly retention of the accommodation bond would need to be changed from a cap to a floor arrangement and could be used by the resident to fund care and accommodation.

Removing regulatory burdens, which create inefficiencies in the industry, should allow the operator to derive a reasonable rate of return and provide greater transparency in charging – it would result in an increased ability to attract capital market funding.

This model would ensure that the government could focus regulation on the level and quality of care and would involve the provision of a safety net for basic care for those who cannot afford it and a guarantee in the case of 'resident default'.



This would benefit the resident through greater transparency in charging and the ability to choose service and accommodation levels to their liking and their affordability. It would also result in access to better quality facilities and care given greater investment by the industry.

This model could result in the wealth and income of the family being used to fund the resident care and accommodation needs of their parents/grandparents, although we note that the removal of the government funded place may create some initial uncertainty in funding and prompt a pull back on bank lending guidelines which would need to be addressed.

3) Use of insurance products

Our third conceptual model involves the use of different forms of insurance to fund aged care e.g. public (e.g. Medicare), private, and/or social.

In our view, insurance would not be for base level aged care needs. This is a method whereby the costs of care above base level would be prepaid for users of the aged care system.

The system would be deregulated and the Government would provide a minimum underwritten level of accommodation (e.g. four-bed ward services) and services/care with existing co-payment arrangements. On top of that insurance would provide funds for levels of accommodation and food above base levels (and possibly care above base levels).

This model would encourage a deregulated environment with opportunities for product differentiation. Government would still be responsible for base care.

Insurance products could be acquired by individuals and used either by the individual or their carers/relatives. The method is cheaper for individuals than the alternative of pure savings schemes where everyone has to save enough to meet the costs even if they end up not using the system.

In order to ensure that the pool of funds was sufficiently large, the government could make the scheme mandatory or make it an opt out scheme or incentivise individuals in a way akin to the current private health insurance arrangements.

4) Use of capital markets for funding requirements

Our fourth conceptual idea involves the wider use of capital markets for funding requirements. Current bonding and debt arrangements lack flexibility and are a limited source of capital, so aged care businesses will need to attract other sources of capital.

Capital market funding would include:

- Superannuation funds
- Stock markets
- Private capital
- Private health funds.

The funding of accommodation costs (capital markets/superannuation/private capital) should be separated from the funding of care costs (supported by government) to allow a greater diversity in the mix of the accommodation.

The current level of regulations would need to be reduced to make the industry more attractive for investment. The cap on the rate of return would need to be lifted to make it appealing to the capital markets. The rate of return could be assisted by reducing the tax burden on aged care businesses – i.e. state/federal, direct and indirect taxes. Owners could also get relief through a ‘negative gearing’ type model.

The Government would still need to provide a safety net for base levels of accommodation and base this on individual or family means tests. However as the levels of investment and return increased over time this might reduce.

Residents would benefit through access to more diverse accommodation as well as more choice.

Strategies for effective funds dispersal

1) The current position

The key components of funding for care recipients are:

- Care and personal services
- Accommodation and hotel services.

Currently Government provides approximately 80% of aged care funding.

Means tests and regulations discriminate for and against many care recipients in accessing their care and accommodation needs. Numerous anomalies, inconsistencies and imbalances have grown out of a system focused on management of demand for aged care, services and accommodation within the government appropriation system. This is entirely understandable as good Government must be held accountable for its expenditure.

However, what we now have is a system where Government is the price setter, price taker and price controller with complex regulation and controls to protect its interest in the process.

The current rigid and inflexible system exists in a changing environment and where higher and more complex levels of care will be required by many and where Care Recipients will seek more choice over their care needs than the current one size fits all model.

A better mix of acute and long-term services can help make expenditure more effective and sustainable

2) A suitable pricing mechanism

It is vital that an independent mechanism for calculating an appropriate economic cost of care and personal services and levels of hotel and accommodation services is established. The task of undertaking this cost assessment should be allocated to an independent authority or commission (i.e. consider the possibility that that function be undertaken by the new Hospital Pricing Authority) for the ongoing evaluation, calculation and administration of this cost mechanism.

This can then serve to be the price setter, whereby Government as purchaser, can determine the level of services it will fund and to who it will fund into the aged care system. It can also be the price setting mechanism for care recipients in choosing the services they wish to access and the type or quality of accommodation and hotel services they procure.

Government will then have a much simpler task ahead of it, deciding which services/accommodation it purchases and which is left to the care recipient to fund.

3) Effective disbursement of aged care funding

It is important we address the issue of dispersing aged care funding effectively. We need to consider how we convert the savings of care recipients to disbursements on to the care providers and how does Government facilitate a disbursement structure efficiently?

Currently recipients are converting their savings, mainly from the family home, to buy their aged care accommodation through payment of bonds/charges.

A few options could be considered to disperse aged care funding;

- *Savings options*

An introduction of a supplementary national aged savings scheme could be made through the extension of the superannuation guarantee scheme. This would generate a pool of funds which can be preserved for procuring health and aged care services for citizens older than 75

- Insurance
 - Health savings accounts which are Government approved tax effective savings accounts that are preserved for health and aged care service funding
- Long-term care insurance
 - This involves Government approving a tax effective long-term care insurance product that could be offered through the Private Insurance Industry or general insurers
- Private Health Insurance
 - Private health insurance providers are either obligated or provided with incentives to expand their product offering to include a range of aged care specific services and products that can be delivered in either the home or residential care
- Public Insurance
 - This involves Medicare being required to extend the range of options that it would offer customers to cover long-term care and home based service provision.

These options above mean that recipients can access their savings to fund the balance of care, services and accommodation or access another long-term funding option.

Conclusion

Rigorous debate will continue around sustainability of financing long-term care services ensuring more responsive aged care services, increased consumer choice and better quality services. The current government inquiry provides an opportunity for the industry to work with government in ensuring the future of aged care funding is more effective and sustainable.

For further information



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