

Consumer centred aged care

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Consumers deserve better value for their money in aged care. The market favours providers and leaves consumers with a 'take it or leave it' conundrum. If consumers are to pay more, they need more choice and better quality services.

In a deliberate strategy to shift financial risk off the public purse, the Howard Government in 1997 expanded the contribution of user fees in residential aged care. Now the onus for paying accommodation costs and providing the investment for capital development falls to the residents. Entry contributions, daily charges and up front loans, (known as accommodation bonds)¹ are levied on all but financially disadvantaged residents². The upshot is that consumers now contribute around 30 per cent to the costs of their care and can provide a refundable upfront loan to a value considerably higher than the capital cost of the bed.

But the system still lacks consumer choice, equity and guarantees of quality. The only certainty is that consumers pay more without gaining more. Some residents now pay up to 300 per cent more than others for similar, if not identical, care services.

The Government has before it a blueprint designed to improve the prospects for consumers and the financial sustainability of the industry. The results of the Government's commissioned review into the pricing of residential aged care³ herald a cultural shift in the financing of the aged care program. Not only does it confirm that more private money will come into the service, it signals a greater bearing of commercial risk by providers. In turn this means that the industry will need to be even more professionalised and consolidated.

These features go hand in hand with a market approach to aged care provision. This is not something to be resisted, rather it needs to be encouraged. The alternative, a constrained public funding program, only shackles industry development and hinders strategic investment.

Even before the 1997 reforms it was apparent that the Commonwealth was retreating from the primary responsibility to fund the capital and accommodation costs in residential care. Such had been the shift that the capital investment shortfall had been estimated in excess of

¹ Under the bond scheme residents are asset tested and charged a bond whereby the facility can retain up to \$3,186 per year for five years. The remainder of the capital is returned to the resident or their estate when they leave the facility. The bonds apply only in low care homes.

² These are concessional residents in the residential program. A concessional resident must not have owned their home two years prior to admission and have assets less than 2.5 times the single basic pension.

³ This was conducted by Emeritus Professor Warren Hogan and delivered to the federal government in early 2004. A \$2.2 billion package of measures based on the immediate term recommendations of Hogan was announced in the 2004-2005 federal budget.

\$1 billion⁴. Enormous capacity constraints have resulted. The supply of beds had been heavily regulated and in turn geographically restricted. Families were at the mercy of bureaucratic rationing. Nursing homes were full, frailer and sicker people turned to hostels for assistance and the elderly were caught in the hospital system with little or no after care options. Change was necessary. The Howard Government reforms did ease some of this pressure but still more is needed.

More critically a change is important if consumer choice is important. Giving consumers greater commercial power is crucial. There are always downsides to market approaches if the market created is not consumer friendly. But moving from a highly regulated program into a more sophisticated competitive environment requires a market structure. If it is done in a measured manner, people without financial means can be safeguarded whilst services can be expanded and access for the elderly markedly improved.

The role of markets in human service delivery must be placed in context. The political debate can easily demonise markets. But market critics often confuse market failure with what they perceive to be a pro business even pro profit agenda.

In reality, many philosophers of the left⁵ have readily acknowledged the usefulness of markets. The key is to make the markets in human services work for consumers, not providers in the first instance.

Since 1997, consumers have used their assets to help finance the capital costs of residential aged care. Over that period the average accommodation bond has increased by over 100 per cent, from \$54,500 to \$112,613.

The irony is that residents can be charged relatively high bonds to live in relatively old facilities, whilst others pay less for recently built homes.

Those consumers not on a pension now contribute up to \$31,339 for their care alone. This contribution has doubled since the introduction of the reforms.

Yet for all this, consumers still don't have the guarantee of their own room with an ensuite. They still pay the same fees regardless of whether the aged care home in which they reside has passed a three year accreditation or just fallen over the line with a one year reprieve.

In reality, consumers have little if any commercial power.

⁴ This estimate was arrived at through a review by Professor Bob Gregory commissioned by the Commonwealth in the early 1990s.

⁵ Most notably Amartya Sen, winner of the Nobel Prize in Economics. He makes this case in a number of publications e.g. 'Development As Freedom', Anchor Books, 1999.

Moreover the Commonwealth Government continues to adopt a policy whereby it applies uniform subsidies to aged care homes regardless of their quality, long term investment strategies or record of consumer complaints.

In effect the Government fails to place any serious competitive tension in the system in the interests of consumers.

One such inequity exists in the application of accommodation bonds.

These bonds, or consumer loans, are designed to capitalise the construction of the homes but their availability is limited to low care facilities. This in part is a historical factor since up front fees were not imposed on nursing homes (high care) but were permitted in hostels (low care). Now this distinction is being superseded by the changing nature of residents across low and high care facilities.

These days nearly two thirds of all residents are assessed as needing high care. This far outstrips the Commonwealth's planning which assumes the provision of only 44 per cent of beds for high care. Demand on the system is overwhelming the Commonwealth's management of public resources. The squeeze for beds will only intensify unless providers can build with more certainty and have access to better finance.

Far from being just an investment issue, this goes to the heart of improving access to care for an ageing population.

Recent reports indicate that over half of all high care beds are filled by people with dementia. Often the distinctions between high and low care classifications are somewhat arbitrary. People with dementia can be classified as needing high or low care based on a series of indicators which range in degree rather than in substance. High care residents are not charged bonds, yet people in low care homes do pay bonds. Most aged care organizations use low care bonds to cross subsidise the capital costs of high care beds. Thus a perverse inequity has developed. People on reasonable assets with dementia in high care are having their accommodation costs subsidised by people with similar conditions with modest assets in low care. Again this distinction is outdated, inequitable and holding back the injection of private capital into a hamstrung industry.

The opposite is the case for people in the upper reaches of high care. Where residents are admitted to the intensive end of high care for what essentially is a palliative care service, it seems reasonable to quarantine them from the bond scheme. As high as 40 per cent of residents die or return to hospital in the first year of admission to an aged care home. In these cases the resident is receiving a health care service which in other circumstances would be delivered in a hospital or hospice setting where accommodation bonds don't apply.

Keeping the application of bonds out of the admission requirements for residents in the upper reaches of high care is a rational policy decision.

At the same time it seems logical to extend the use of accommodation bonds into the lower reaches of high care in order to address the present inequities and provide more private capital for refurbishment and expansion.

This change to the present regulated program should be accompanied with the separation of the responsibility for accommodation costs from the remainder of the service. In essence this would leave consumers to meet their accommodation costs on a capacity to pay basis, whilst the Government remains primarily responsible for meeting the cost of care. With the appropriate safeguards in place for pensioners, this change is reasonable as long as consumers get more if they pay more.

That is not the case at present. Some consumers are paying higher bonds than others even though they reside in homes that are not as recently built as others, or have achieved as higher quality assessment as others.

Granted that a change like this may be unsettling, the Government could consider introducing differential application of the bonds. That is, capping the amount charged to consumers in accordance with the level of accommodation, its age and relative market cost. This should give a high degree of comfort to consumers that they are paying no more than is necessary to meet their accommodation costs.

The policy of splitting the accommodation costs from the care service costs will free the Government to better fund the care of the aged (even though consumers pay up to 30 per cent of these costs now). This is a vital point. Projections indicate that even by 2031 close to 65 per cent of aged care residents will be pensioners. They may have their own homes to help fund accommodation costs, but they will be very short on extra money for their care costs. A public subsidy scheme will be essential. One that promotes flexibility and consumer commercial power will be important.

To this end a comprehensive benefit schedule should be established which provides consumers with a level of public subsidy for their care costs regardless of where they receive that care. This enables consumers to receive the appropriate level of care in their own home, in the community or in the residential program.

At the same time it is too near sighted to leave the equation to just the Government and the consumer. With an ageing population, there should be a more flexible health insurance regulatory environment which will permit insurance companies to cover for aged care in the community.

Not only will this encourage new providers to bring services into the homes of the elderly, it will also open up opportunities for residential aged care organizations to build other than residential beds to cater for the transitional and short stay respite needs of the elderly.

And it is this last area where the Government still has the potential to make significant changes in the interests of older people.

The dysfunctional arrangement between hospitals and community care is desperate for frail, dependent elderly people.

Older patients are either trapped in hospitals, still waiting on surgery lists or stranded in their own homes. All because governments restrict their role to specific health programs rather than conduct more integrated services.

As the Commonwealth's aged care program begins to de-regulate, there should be a more concerted effort on the part of the Commonwealth to take full responsibility for the over 75 aged group.

A Commonwealth program which seeks to accelerate the hospitalisation and after care of the over 75s is more than justified. A program of this kind is already in place for veterans.

In the first instance the program could be restricted to low income elderly people or for those with specific conditions.

Something that encourages private investment to deliver a public good is very much in keeping with the goals of the Commonwealth's aged care program.

The Federal Treasury has earmarked the cost pressures of an ageing Australia as a strategic issue. In an essential area such as aged care services, a shift to market solutions seems inevitable. The challenge is not to stone wall the change, but to ensure that equity and consumer benefits drive the solution. It will require a new balance between community responsibility and individual participation.