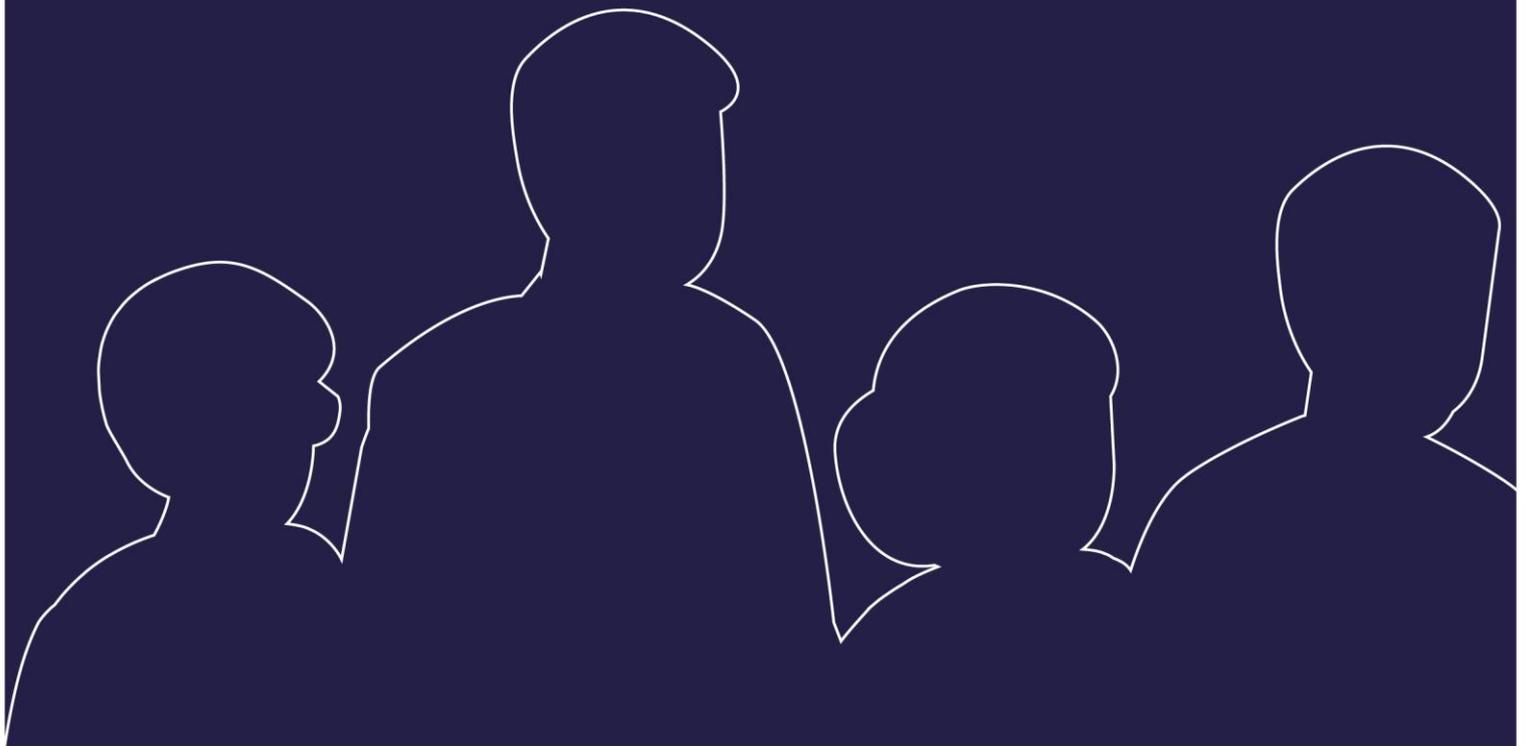




Towards a fairer and more effective approach for financing aged care

Submission responding to Royal Commission into Aged Care Quality and Safety Consultation Paper 2 'Financing Aged Care'



Towards a fairer and more effective approach to financing aged care

Submission responding to Royal Commission into Aged Care Quality and Safety Consultation Paper 2 'Financing Aged Care'

Contents

Purpose and role of the Commissioner 5
Introduction 5
Considerations for designing a new system 6
Complex and special needs – structural deficits and funding gaps 7
Complex care needs 8
Mental illness, severe behaviours and psychological symptoms of dementia 9
Older people with a disability 10
People experiencing or at risk of homelessness 10
Small and more remote rural communities 11
Home Care Packages – limitations in the current model 12
Transparency 13
Affordability 13
Disparity between Home Care and Residential Aged Care Funding 14
Residential Aged Care – inequities in resident contributions 15
Current fee arrangements 15
Low Means Residents 16
Residents with Modest Means 18
High Net Worth Individual 19
Where to next? 21
Conclusion 23
Appendices 24
1. Home Care Packages – Fees paid by recipients 24
2. Home Care Package fee case study 26
3. Residential Aged Care – Combined Income and Assets Test 27
4. Low means residents case studies 28
5. Moderate means residents case study 30
6. Rachel Lane, Aged Care Gurus 31

Acknowledgement

I would like to acknowledge the Department of Health and Human Services and Rachel Lane for their support in preparation of this submission.

Purpose and role of the Commissioner

As Commissioner for Senior Victorians, I provide advice to the Victorian Government on issues relevant to senior Victorians and positive ageing and participation, as well as being an independent public voice to educate the community on seniors' issues, actively promote the positive contribution of seniors and encourage seniors to fully participate in our community.

A key component of my role is to actively advocate for a "seniors' perspective" in government deliberations on issues relevant to senior Victorians including positive ageing, participation, and the needs of vulnerable, at risk and disadvantaged seniors.

I meet regularly with seniors and seniors' organisations from across Victoria to discuss a wide range of matters relevant to people as they age. To inform my contributions to the Royal Commission into Aged Care Quality and Safety, I convened a Carers and Consumers Workshop in May 2019. Quotes from workshop participants are included in this document.

As Commissioner, I also promote community awareness and understanding of other matters such as advance care planning, powers of attorney and loneliness and isolation.

As the Ambassador for Elder Abuse Prevention, I have provided significant policy advice on the prevention of elder abuse and the importance of supporting multicultural and emerging communities.

I have recently been appointed as an adviser to the Victorian Aged Care Response Centre to provide advice and consultation for engaging with families of residents in severely COVID-19 impacted aged care facilities and help connect them to available supports.

Introduction

"We need a system based on values, that gives dignity to older people where they can keep their identity."

"Consumer directed care is not a reality for many older people. Greater assistance is needed for older people to be able to make decisions about their care."

[Quotes from participants at the Consumer and Carer Workshop]

Few older people choose proactively to enter residential aged care. Rather, it is a response to increasing frailty where their primary desire to remain in their own home is no longer possible. However, when they do face entry to residential aged care, often following an incident that led to hospital admission, the options can be very limited, particularly in rural communities. Financial incentives can drive providers to choose one resident over another in decisions divorced from the person's needs. This means that there are times where the person with the greatest need has the greatest difficulty accessing appropriate support.

There is a need at the outset of this submission to acknowledge the limitations of “market” rhetoric. In current form, the aged care system isn’t in reality a market. It is a construct where the Commonwealth exercises substantial control over the supply side, determining the mix and scale of services linked to geographical controls and fiscal considerations irrespective of the level or nature of demand. Not only does the Commonwealth control the supply of aged care, it also exercises regulatory and price control as well as over who may be a service provider.

A system which was built on the aspirations and desires of older people would ensure that the unmet demand for home care was immediately responded to and would ensure that residential aged care is viewed as an essential safety net. As we have repeatedly heard, a different approach to what we currently have is desired.^{1 2}

This is not a market with empowered consumers able to wield their purchasing power to obtain the services they need at competitive prices. Until this is recognised, we will continue to fail to address the imbalance in power between the providers and users and fail to ensure fee structures are fair and that access to high quality supports is needs based and equitable.

This submission will detail some of the key challenges confronting the system, including:

- Insufficient funding to drive development of services in some locations or to meet the needs of complex or special needs, leading to thin markets.
- Inefficient use of funding that is available, leading to poor outcomes for service users.
- Affordability issues for people of limited or modest means.
- Poor financial outcomes for many providers within the sector.

These issues affect the capacity of individuals to access care in their community or that meets their needs and are directly related to how the system is financed. This submission looks at these issues in the context of the home care packages and residential aged care services programs, before proposing principles that should guide funding reforms and next steps.

Considerations for designing a new system

As well as highlighting key challenges, it must be acknowledged that the question of how to finance an aged care system that better meets the needs of people that use it can only be properly answered once other key questions are answered.

- **What is the vision for the aged care system?** The system must be designed to be agile and responsive to advances in healthcare and assistive technologies. More importantly, it must address the needs and wishes of older people. The context for many discussions regarding cost is the large number of Australians estimated to require aged care, particularly residential care, by 2050. There needs to be investment to

¹ Royal Commission into Aged Care Quality and Safety Interim Report: Neglect Volume 1 pp 9-10
<https://agedcare.royalcommission.gov.au/sites/default/files/2020-02/interim-report-volume-1.pdf> - accessed 31/8/20

² <https://unitingcare.org.au/download/aged-care-program-redesign-services-for-the-future/> - Accessed 31/8/20

develop alternative strategies to support people at home. Of particular importance is the need for investment in early intervention and prevention strategies.

- **What is the system we are trying to pay for?** We cannot design a financing approach for an aged care system that is fairer, meets people's needs and is sustainable if we have not yet settled on what that system itself looks like.
- **What do we mean by high quality?** Quality means different things to different people so what one person considers to be a satisfactory or a high-quality standard can vary markedly from the views of someone else. It should already be clear from Royal Commission hearings and submissions to date that service providers and older people and their advocates define quality quite differently. Until there are clearly defined standards with objective and quantifiable measures, identifying the quality of a system will remain a problem.
- **What are the responsibilities of providers to meet the assessed needs of older people?** We need to acknowledge that rarely do people choose to enter the aged care system, rather it is because they are no longer able to meet their own needs without assistance. The Specified Care and Services³ need to be updated with a focus on clarifying responsibilities of providers to meet all the needs of residents. This needs to be done in conjunction with clarification of the respective roles of the aged care, health and disability systems. The lack of clarity with respect to these arrangements delays access to the care and supports needed by some of our most vulnerable Australians.

Complex and special needs – structural deficits and funding gaps

“The funding model needs a lot of work and funding doesn't match need.”

[Quote from participants at the Consumer and Carer Workshop]

In Victoria, many public sector residential aged care services, including specialist aged persons' mental health facilities, play a critical role in addressing failures of the current 'market style' model to provide access to and meet the needs of vulnerable older people with complex physical and/or mental health needs. This includes both those specifically mentioned in the *Aged Care Act 1997's* list of special needs groups as well as others not listed such as people who are refugees (issues of torture and trauma); and people who have experienced alcohol or other drug related dependence.

This role has provided extensive insights and learnings into the inadequacy of current arrangements and the lack of capacity in the system to provide the necessary care. This is related to the existing level and structure of the system of funding, with these structural deficits

³ Australian Government *Quality of Care Principles 2014*. <https://www.legislation.gov.au/Details/F2020C00096> - accessed 31/8/20

impacting the ability of people to access appropriate support. The following section details some specific issues in relation to various groups.

Complex care needs

It is recognised that in designing a system that is administratively simpler and focussed on average needs, people with care needs outside the norm may not have their needs met if not adequately funded.

Structural disincentives that prevent people with complex care needs from accessing appropriate services in their community and push them towards the health system or specialist and public sector residential aged care services need to be addressed. For example, there are many residents in Victoria's public sector and some specialist aged care providers, who would experience difficulty accessing appropriate care with many mainstream providers and would be at risk of long-term hospital admission with concomitant impacts on individual outcomes and hospital patient flow.

Commonwealth care subsidies for residential aged care providers are calculated under the Aged Care Funding Instrument (ACFI). This funding model is designed around the resource needs of an average resident and does not reflect all care needs with funding capped, irrespective of the complexity or cost of providing care and supports to a resident with very complex needs. This means the incentives to drive development of capacity within the system to meet the needs of people with complex needs are minimal.

While residents with complex needs constitute a small minority of all residents, the intensive nature of their care needs and the requirement for a skilled clinical workforce significantly impacts on the cost of care. Given the rise in chronic disease and number of people living with dementia, it is anticipated that this resident cohort will increase as the population grows and ages.

Work commissioned by the Victorian Department of Health and Human Services to understand trends around increasing complexity of resident care needs and the refusal of a number of providers to accept certain types of residents indicated that:

- A pattern of failed placements in mainstream services with residents either unable to secure a place, or, if they did, they could not remain due to the service not being able to effectively manage their specific care needs.
- Residents with complex medical and/or mental health needs require more intensive support and a range of specialist clinical services.
- Case studies were characterised by care needs that exceed what is provided for through the ACFI care subsidies.
- Many of these residents would be unable to access appropriate residential aged care outside the public sector.

- At present, non-government services cannot appropriately support the cohort with very severe mental illness or responsive behaviours, even with intensive support from the State's specialist mental health service.

The funding attached to a resident who has any of these conditions needs to recognise the resource intensiveness of these to ensure it provides for appropriately qualified and skilled staff and the management and support needed. Considerations include:

- Higher level cognitive functions such as communication, problem solving, ability to follow instructions and task planning are associated with a range of conditions such as stroke, acquired brain injury, memory loss, dysphasia or dyspraxia etc.
- Emotional support as an essential part of wellbeing. Residents may experience fear and anxiety following admission or as a manifestation of some health and disease progression. Residents experiencing loneliness, depression or other behavioural issues around not wanting to engage in personal care, or other activities of daily living.
- People with severe behaviours associated with their mental illness or dementia, particularly those who are mobile and represent a greater safety risk to themselves and others require frequent monitoring and multiple appropriately trained staff to deescalate behaviours when triggered, in addition to specialist psychiatric supports.
- Residents with dysphagia, who require constant monitoring and supervision, including one-on-one assistance with drinking and eating to manage the risk of choking.
- Residents with a tracheostomy, who require intensive support to maintain suctioning and airway patency.

The Australian National Aged Care Classification (AN-ACC) is under consideration as a replacement for the existing system, the ACFI, for determining Commonwealth care subsidies to providers. It is noted that the Victorian Government submitted a detailed submission on aspects of the AN-ACC that require attention and improvement to ameliorate existing inequities and perverse consequences that currently limit the capacity of people to access appropriate care. Like ACFI, the AN-ACC is a capped funding model and, although underpinned by a different approach, it is unlikely that it will address these issues and may create some new challenges unless modified.

Whatever the funding model chosen, there needs to be sufficient resources so that aged care providers have the capacity to employ a workforce with the necessary range of competencies and specialist skills to cater for the needs of older people, including those with the most complex needs.

Mental illness, severe behaviours and psychological symptoms of dementia

To be in the business of aged care includes being in the business of supporting people living with dementia. However, a lack of capacity within the system to support people living with dementia has been highlighted by the Royal Commission. In Victoria, the public sector provides

dedicated aged persons' mental health services to support people with severe psychological symptoms associated with their dementia or mental illness.

Current funding levels are insufficient to cover the cost of intensive and specialist supports and are insufficient to drive development of system capacity to meet the needs of these people. This is most notable in the case of people experiencing severe behavioural symptoms associated with their dementia.

The Commonwealth's Special Dementia Care Units (SDCU) initiative, will provide a welcome addition to the supports available for people experiencing more severe symptoms associated with dementia, however, it is limited in scale and excludes residents whose behaviours are linked to other diagnoses so some people will continue to have difficulty accessing care due inadequate funding.

As the population grows and ages, there will be a corresponding increase in the proportion of people experiencing severe behavioural symptoms associated with their dementia or mental illness. A corresponding increase in funding is required along with a change in eligibility to ensure Australians do not fall through the cracks.

Older people with a disability

Aged care facilities are designed to meet the needs of frail older people and are often not designed or equipped to meet the needs of people aged over 65 with a disability. This group has additional support requirements and services also need the capacity to flexibly meet the changing personal care support, therapy and equipment needs of people with degenerative conditions, such as multiple sclerosis, in a timely manner. At present, services are not required to provide customised aids and equipment that can assist the person to remain as independent and active as possible.

Older residents with a disability will be a growing cohort as the baby boomers reach the age where late onset disability such as Motor Neurone and Parkinson's disease will manifest. The appropriate physical environment and customised equipment are an essential element of maintaining independence and quality of life and should be funded accordingly.

These issues need to be addressed to respond to existing issues where people with complex care needs are at risk of falling through the gaps.

People experiencing or at risk of homelessness

The complex history surrounding those experiencing, or at risk of, homelessness, means that people experiencing, or at risk of experiencing, homelessness have difficulty accessing care. Consequently, mechanisms are needed to encourage services to more readily accept these residents and the funding needs to be sufficient to provide the additional supports they require.

The homeless supplement is an additional payment that is made available to eligible providers when more than 50 per cent of residents meet certain criteria, in order to assist them meet the additional needs of those who are, or are at risk of, homelessness.

It is critical that the current supplement remains in place irrespective of any changes that may arise from the consideration of the AN-ACC funding model.

Small and more remote rural communities

Current funding models do not properly recognise the higher costs associated with operating small-scale services in smaller or more remote communities. Demand in many smaller communities is often too low to attract private providers who may consider facilities of 90-beds or more as necessary for viability. As a result, in rural Victoria, the public sector accounts for around 30 per cent of sector capacity overall; increasing to more than 40 per cent in outer regional locations and 100 per cent for remote locations. In smaller communities, the public sector and not-for-profit organisations committed to servicing local communities are the key service system.

The Viability Supplement is intended to assist services to survive in smaller or more remote communities. However, as the evidence indicates, rural services are significantly over-represented among services generating an operating loss. This suggests that existing funding mechanisms are inadequate to support services operating in these locations and need an overhaul with increased funding to better reflect the higher cost structures associated with small scale services and remoteness.

According to the Aged Care Financing Authority (ACFA), the proportion of residential service providers reporting an operating loss has been steadily increasing over recent years.⁴ In 2018-19, 42 per cent reported a loss and in 2019-20 noting a one-off \$320 million increase in the ACFI without which, performance would have deteriorated more significantly and that data from other sources such as the StewartBrown Aged Care Financial Performance Survey,⁵ indicate that financial performance continues to deteriorate.

ACFA data also indicates the trend towards consolidation of places or services and fewer providers is continuing. Nationally, State and Territory governments account for 4 per cent of service system capacity and around 11 per cent of providers⁶ noting these smaller scale services are predominantly in rural locations and these will be increasingly important to maintain continued access to services for rural communities given financial pressures on the sector and for smaller services in particular.

The proposed AN-ACC, if combined with rolling the Viability Supplement into the Fixed Tariff, will result in a redistribution of funding away from many services currently reliant upon the Viability Supplement. This may impact their viability. While a component of funding under the AN-ACC is proportionally higher for services in the most remote locations, for many others it will result in a loss of revenue. In Victoria, most services will be classified as a single facility type with the fixed payment being the same for a small 18-bed service in Edenhope being the same as for a 150-bed service in Melbourne.

Rural services play an important role in supporting access to residential aged care for those requiring it as well as drivers of local economies as employers and purchasers of services. Loss of service capacity will have ramifications beyond those for the people using these services and may result in people, and their families, leaving the community in order to access care.

⁴ Aged Care Financing Authority. July 2020. Eighth report on the Funding and Financing of the Aged Care Industry.

⁵ https://www.stewartbrown.com.au/news-articles/26-aged-care-_-accessed_31/8/20

⁶ Aged Care Financing Authority. July 2020. Eighth report on the Funding and Financing of the Aged Care Industry.

It is critical that the rural Viability Supplement remains in place irrespective of any changes that may arise from the consideration of the AN-ACC funding model.

Home Care Packages – limitations in the current model

“Not being able to get a home care package means access is often then from a crisis after a hospital admission.”

“There is a disconnect between the assessment of needs and the support available through the care package when one finally becomes available.”

[Quotes from participants at the Consumer and Carer Workshop]

As the Royal Commission has heard, in 12 months more than 16,000 people died waiting for a home care package.⁷ For others, a lack of access to supports has resulted in premature entry into residential aged care. Rationing of supply of packages is out of step with demand and with community preferences, denying people access to supports that may allow them to stay home. This impacts quality of life, particularly for those without family or friends to help fill the gap.

For those who are allocated a package, there are differences in the type and level of care people can access across providers and depending where they live. The system is overly complex, lacks transparency and is not designed in a way that protects the older person or to encourage consistent high quality and value for money. In addition, there are broader questions about whether funding is equitable when compared to residential aged care.

⁷ Royal Commission into Aged Care Quality and Safety Interim Report: Neglect Volume 1 p 154
<https://agedcare.royalcommission.gov.au/sites/default/files/2020-02/interim-report-volume-1.pdf> - accessed 31/8/20

Transparency

For many the expectation of home care is that you simply “order in” the care you need. In reality accessing a home care package is a test of patience, resourcefulness and forensic accounting. You need patience during the long waits for assessment and then for care to start; resourcefulness in finding services, volunteers and family members to fill in the gaps; and forensic accounting to determine whether or not you are getting a good deal.

Administration and case management are services that providers must deliver; without them the package doesn't operate. But they are tasks that are largely invisible, making it difficult to know what is really involved and easy for unscrupulous operators to gouge their customers. I have seen a Level 4 home package provided by a not for profit organisation which had an administration fee of 52%. That equated to more than \$28,000 per year to co-ordinate \$26,000 of care.

How much care the person can receive with the net funding will depend on where they live, the type of care and services they receive and who provides it.

Care providers who employ care staff have a vested interest in using their own staff to provide care and services which in theory has the potential to offer economies of scale. In practice, consumer choice is often restricted to the services (and rostering availability) of the employed carers with an hourly rate for the services that is far greater than the cost of wages (and on costs) to the provider. It is not uncommon for wages (and on costs) to be around \$30/hr while the cost charged to the consumer is \$55/hour or more.

Rachel Lane, Principal, Aged Care Gurus

Affordability

A significant concern is the home care package fee structure. Older people are expected to contribute towards the cost of their package which includes a Basic Daily Fee based on the level of package and an income-tested care fee which is calculated by Centrelink.

The application of the income test and resulting fees can result in affordability issues for low income pensioners. As the case study of Jill at appendix 2 shows, the basic daily fee can amount to 15 per cent of annual income, even without considering expenses associated with daily living or any other supports older people might require but cannot access through their home care package. It is possible that older people may not be able to afford the fee contribution which in turn may become a barrier to accepting a package.

At the time people are seeking additional supports, daily living is becoming more challenging. It should not be assumed that people have capacity, or advocates to assist them, to actively seek and understand the choices available to them. If an expert is required to assist someone to successfully navigate the system, then by definition, it is failing to meet the needs of all. A simpler and more user-friendly system together with a higher standard of accountability and transparency is required to safeguard the interests of the most vulnerable older people.

Disparity between Home Care and Residential Aged Care Funding

In home care the amount of funding provided for someone's care is based on the level of package they receive. There are 4 levels of package with level one receiving the lowest level of funding at \$8,928/year and level 4 receiving the highest at \$51,808/year

In residential aged care the funding model is more complicated with the resident's care needs classified as either nil, low medium or high in 3 care domains: activities of daily living, behaviours and complex healthcare creating up to 64 different funding outcomes. Under this model the lowest level of funding for a resident is \$0 per year and the highest is \$81,446 per year.

In home care there is a supplement for people with dementia/cognitive care needs and in both home care and residential aged care there are supplements for people who require oxygen and enteral feeding.

When you crunch the numbers on the funding models it becomes clear that people living in residential aged care receive more funding than those receiving home care.

At the ultimate amount the funding for someone receiving a home care package is just over \$192/day while the care funding for someone (potentially the very same person) in residential aged care is around \$256, that's more than 34 per cent additional funding for your care based on where you live.

Similarly the converse can also occur, a person with dementia may receive a higher amount of funding through a level 4 package (with the dementia supplement) than an aged care facility can receive through the Aged Care Funding Instrument (ACFI).

These disparities in funding raise a number of questions, including why the funding arrangements are different, whether it creates a necessity for some people to enter residential aged care when if the funding was the same they could afford to stay at home and whether the funding, particularly as it relates to dementia behaviours restricts access to residential aged care for some.

Rachel Lane, Principal, Aged Care Gurus

Residential Aged Care – inequities in resident contributions

The design of the current system for determining the contributions of individuals to residential aged care costs at times results in differing and sometimes perverse outcomes. Current settings may at times disadvantage low means residents, while simultaneously protecting higher net worth individuals.

As the following discussion will show, accommodation contribution or payments required of a low means resident, or one with modest means who just scrapes over the threshold, can be significantly greater than their total assets. The only real difference is the way in which the price they pay for accommodation is set. Due to the way the daily price and lump sums are calculated, and maximum permissible interest rates that apply at the time, one type of resident may be more valuable to a provider than another. This in turn may impact their capacity to access care. If affordability is an issue, they may decide to delay entry to the services they need.

An individual with modest means and a high net worth individual are subject to the same annual and lifetime caps and they may even negotiate the same accommodation price. The difference is that the person with modest means cannot afford a full lump sum so their daily contributions will erode their asset. For the high net worth individual, the accommodation deposits are likely to be refunded in full when they leave the service.

Current fee arrangements

All residents pay the Basic Daily Fee for hotel services, which is set at 85 per cent of the single aged pension. This charge is the same for all residents, irrespective of their means.

To be eligible for Commonwealth support, residents must undergo a combined income and assets test that determines their liability for a means tested care fee (subject to annual and lifetime caps) and whether they qualify for assistance with their accommodation charges, provided through the Accommodation Supplement paid to the service.⁸

It is not compulsory for people to disclose their income and assets, but if they choose not to they can pay the market price for their accommodation and a means tested care fee equal to the cost of care (capped at the \$28,087 annual and \$67,410 lifetime caps).

People who exceed the upper income and assets test limits pay the accommodation price set by the service. People below these thresholds may be asked to pay an accommodation contribution which is pegged against the applicable rate of Accommodation Supplement.

All residents assessed as having to pay a contribution towards the cost of their accommodation have the option of paying these fees through a:

⁸ Aged Care Act 1997 Division 44 Subdivision 22

- Daily payment – (Daily Accommodation Payment (DAP) is paid by unsupported residents and Daily Accommodation Contribution (DAC) is paid by partially supported or low-means residents).
- Refundable lump sum (Refundable Accommodation Deposit (RAD) paid by unsupported residents and Refundable Accommodation Contribution (RAC) paid by partially supported or low-means residents).
- Combination of daily payment and lump sum.

Detail regarding the calculation of these amounts is provided in the Appendices.

The lump sum (RAD or RAC) is calculated by dividing the daily accommodation contribution (annual) by the Maximum Permissible Interest Rate (MPIR). Due to the nature of this formula, a reduction in the MPIR results in the equivalent lump sum increasing. Changes to the MPIR don't affect existing residents as the rate is fixed on the day they move in.

Low Means Residents

A low means resident is a supported or concessional resident, whose income and assets fall below a threshold to qualify for full or partial subsidisation from the Commonwealth in meeting the costs of their accommodation and care. Partially supported or concessional residents may pay their accommodation contribution through a DAC, RAC or combination.

Changes in the financial position of supported residents will cause their accommodation contribution to be recalculated. If their assets and/or income reduce, then their contribution reduces. Similarly, if their assets and/or income increase, their accommodation contribution will increase, and they may be subject to a means tested care fee. While they remain living in that aged care home, they remain classified as a supported or concessional resident which means their accommodation fee remains capped at the rate of Commonwealth Accommodation Supplement applicable to the facility.

The means testing arrangements include a number of anomalies for low means people:

- The income test is the same as that used for home care with the addition of an assets test with the outcome of each test added together.
- For assets between \$50,500 and \$171,535 low means residents need to contribute towards the cost of their accommodation at a rate of 17.5 per cent p.a.
- The daily accommodation contribution calculation is converted to an equivalent lump sum payment at a government set interest rate: the MPIR, which is currently 4.10 per cent p.a.⁹

⁹ Schedule of Fees and Charges for Residential and Home Care, 20 March 2020, Department of Health

- The net effect of the combined income and assets test and formula used in calculation of the accommodation charge is to make it mathematically impossible for the resident to be able to afford the cost.

As the case studies at appendix 4 demonstrate, the fees for two low means residents can differ drastically. Importantly, proportional increases in fees are not necessarily associated with a proportional increase in assets. Fully supported and partially supported residents may be expected to pay very different fees as a result of the way the combined income and assets test operates. This may leave some residents in the position of never being able to afford to pay their residential aged care service in full and create a liability beyond what some older people can afford.

The deficits in the current approach are clear yet it is worth noting that only some of the costs were taken into account in the case studies. When it is considered that medical expenses, personal expenses and mandatory additional services charges imposed by many services were not taken into account, it is clear that some older people will be in considerable financial distress. The inability to afford basic necessities has a significant impact on a person's dignity and wellbeing.

Considering the case studies at appendix 4, as well as broader anomalies, the impacts on low means people may include:

- People of low means who have assets or income above the lower threshold can be required to pay an accommodation contribution that significantly exceeds their means.
- The Market Price of the bed does not cap what a supported resident can pay, meaning it is possible that their fee may be above the market price for that bed.
- If the proportion of supported or concessional residents in the home increases from less than 40 per cent to greater than 40 per cent, then their fee may also rise as it is linked to the applicable rate of Accommodation Supplement.
- The fee paid by partially supported residents will increase if the service obtains a Significant Refurbishment determination to qualify for the higher rate of Accommodation Supplement.
- Partially supported residents can be left with no resources to pay for other aspects of their care such as medications, customised aids or equipment, let alone buy new clothes, or maintain a phone so they can remain connected with friends or family, nor are they able to buy a small gift for a grandchild, for example.
- Under the current system, it is the people with limited means that have the least certainty regarding their fees.
- Protections designed to leave all residents with a minimum amount of assets are transitory at best, being limited to 28 days.

- Measures intended to incentivise providers to accept low means residents have perverse outcomes on the fees paid by these same residents due to the way the combined income and assets test operates, and incentives created by the lower MPIR.

Incentives to accept low means residents

While many people believe “if I don’t have any money, I won’t get into residential aged care” this is simply not true. There are funding incentives for providers to accept low means residents. These include the requirement to meet a minimum ratio of “low means” residents and a 25 per cent funding incentive for having 40 per cent or more low means residents.¹

It is counterintuitive, but a low means resident paying nothing towards the cost of their accommodation can be more valuable to an aged care home than a resident paying \$1 million, depending on where the facility sits with their ratio.

Since the introduction of the Living Longer, Living Better (LLLBB) reforms we have seen the Maximum Permissible Interest Rate (MPIR) reduce from 6.69 per cent p.a to the current historical low of 4.10 per cent p.a. As the MPIR has reduced we have seen a growing number of people whose cost of aged care accommodation would be less as a market price payer than as a low means resident.

The reducing MPIR provides a greater incentive for aged care homes to change the ratio of low means residents. If the home meets the new or refurbished building standards but has a ratio less than 40 per cent low means residents, the most they can receive (on the current MPIR) is \$43.64/day or \$388,502 as a lump sum from a low means resident. If they can meet the 40 per cent ratio they can receive \$58.19/day or \$518,033 as an equivalent lump sum. This may be very attractive, especially if their market price is below \$518,000.

Such a change in the home’s funding doesn’t just impact what new residents can pay, it can also impact on existing residents. A resident who moved in June 2018 and is currently paying a DAC of \$43.64/day could find that their cost jumps up to \$58.19 per day – as a lump sum their cost would increase by just over \$92,000 from \$276,059 to \$368,100.

Rachel Lane, Principal, Aged Care Gurus

Residents with Modest Means

For a person to be liable for the market price for their aged care accommodation, they only need to have assets of \$171,535 (including the value of the former home) to be ineligible for Commonwealth assistance with their accommodation costs. That is, once a person reaches the income and asset test threshold, they pay the market price. It is a common scenario for people exiting a retirement village.

While the market price of their property maybe \$350,000 or more their exit entitlement is typically 50 to 70 per cent of that value, making them a market price payer that cannot afford the market price. The \$50,500 minimum assets amount that they must be left with restricts the amount they can pay towards their RAD in the first 28 days, but it doesn’t reduce their liability to meet the full market price.

As the case study at appendix 5 demonstrates, it is possible for the means test to at times determine that an older person can pay market price when they cannot in reality do so. Older people may be ineligible for Commonwealth assistance with the cost of accommodation, yet it may still be far more than they can afford. The only option residents in this position may have is to a partial RAD and deduct the DAP for the remainder from the RAD. Over time, this will erode their RAD and may impact their capacity to access care elsewhere if they have to move services.

In this way, residents on moderate means may end up in a worse position than those with lesser means. In the right combination of market conditions, the market price may be lower than a lump sum equivalent to the Accommodation Supplement. This may incentivise providers to choose supported residents, making it more difficult for residents expected to pay market price to access services. In effect, their choices may shrink along with their capacity to access appropriate care in their community.

High Net Worth Individual

Approximately 60 per cent of all residents are ineligible for assistance with their accommodation charges (noting that as above this may include people with modest means). However, while this group may be asked to pay a means tested care fee towards subject to annual and lifetime caps, once the caps are reached, the Commonwealth pays the difference and if the person has reached their caps, the Commonwealth pays the full amount.

The following points are relevant to high net worth residents:

- All residents, irrespective of their means, pay the same Basic Daily Fee.
- While the market price can vary widely for accommodation, they may be able to negotiate a fee that is less than what a partially supported resident may pay.
- The rate at which they contribute is much lower, being 1 per cent on assets between \$171,535 and \$413,605 and 2 per cent on assets above, but the means tested care fee is not unlimited.
- Assuming their means are high enough (and care needs great enough) to have a means tested care fee of \$200 per day they won't pay \$200 day for the whole year. There is an annual limit of \$28,087 and a lifetime limit of \$67,410¹⁰ – which includes any Income tested fee paid towards a home care package. In effect, a high net worth individual is subject to the same lifetime cap as people with much more modest means.
- The means tested care fee is used to offset the government funding on a dollar for dollar basis. This adds administrative burden and costs for providers but provides no additional revenue. (Total care subsidies, including a person's mean tested care fee as assessed through the ACFI, is the same for any other person of similar needs.)

¹⁰ Schedule of Fees and Charges for Residential and Home Care, 20 March 2020, Department of Health

So what would Australia's richest person pay?

She wouldn't qualify for funding for accommodation so she would need to pay the market price which could be as low as \$99,000 or as high as almost \$2.9 million. Like all residents she could choose to pay this by RAD, DAP or a combination.

She would pay the basic daily fee of \$52 per day and a means tested care fee based on her cost of care. If we assume her cost of care is \$200 per day then she would pay that for 140 days at which point she would reach the annual limit and revert to paying just \$52 per day.

For the remaining 225 days of the year the government would pay the \$45,000 for her care.

At the start of the next year she could start paying a means tested care fee of \$200 per day again until she reached the annual limit or the lifetime limit. If we assume that she didn't receive a Home Care Package prior to entering residential aged care she would reach her lifetime limit in 2 years and 2 months. Once her lifetime limit is reached no further means tested fee would be payable, from this point the government would fund all of her \$200/day cost of care.

Rachel Lane, Principal, Aged Care Gurus

Where to next?

If a role of Government is to provide a safety net for vulnerable members of our society, then interventions should contribute to equitable outcomes and ensure older people are not worse off. From this perspective, the combined income and assets test does not appear to be fit for purpose and a drastic revamp is required.

Much discussion has occurred in relation to the exclusion of the home from the means test if a protected person is living in it.^{11 12} It is proposed that in considering options to improve the operation of the means test that this exemption remains. In most instances, the person remaining in the home has played a significant role as carer, it is essential that their contribution as carer, and to the economy as a whole, is recognised and their interests are also protected to ensure they have ongoing housing security.

All older people need to be able to access a home care package from the point at which they are assessed as needing care and/or support. The financing of the home care system then needs to be based on either a 'care continuum model' or an 'NDIS model'. That is, under a proper care continuum model there would be a substantial increase in the number of levels, so that older people can automatically progress to a higher-level package as their needs increase.

Alternately, the NDIS model would be a far more 'open ended' approach to the provision of services where an older person receives a package that meets their actual needs rather than being forced into one of the available 'home care packages'. The design of the current system is more about controlling financial liability of the Commonwealth.

Principles to underpin the design of a fairer system

To support development of a better aged care system that is appropriate to the needs and wishes of all Australians, it is proposed that the following principles should underpin the design of a new financing approach for aged care:

- **High quality** means people accessing aged care receive services that are person-centred, appropriate to their needs, promote their health and wellbeing, including supporting them to maintain their social relationships and community connections, and are delivered by appropriately skilled and trained staff. Most importantly, quality needs to be judged from the perspective of the person utilising those services.
- **Respect and dignity** means that people are supported to make their own decisions about the care and services they receive, can exercise choice even where this entails a level of risk (or are afforded the dignity of risk), are able to make their own choices and

¹¹ <https://www.servicesaustralia.gov.au/organisations/health-professionals/services/aged-care-entry-requirements-providers/residential-care/residential-aged-care-means-assessment> - accessed 31/8/20

¹² <https://probonoaustralia.com.au/news/2020/07/reintroducing-the-liquid-asset-test-is-mean-spirited-and-unfair-in-the-midst-of-a-recession/> - accessed 1/9/20

are actively consulted so their views and experiences are considered in the design and delivery of services.

- **Equity** means that services are targeted towards the people with the greatest needs for those services and that access to services is facilitated for those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location to help those recipients to enjoy the same rights as all other people in Australia.
- **Transparency and accountability** means that people accessing aged care services receive information regarding their rights, mechanisms for making complaints, the fees and costs as well as the standard of care of services they receive in a format that is understandable and accessible to them. Service providers are responsible for the outcomes of people utilising the service and they must act with integrity and openness, respond to concerns raised by or on behalf of the people using the services and, most importantly, protect the health and wellbeing of the recipients of aged care services.
- **Sustainability** means that services are affordable and appropriate to the needs of people that require them, that resourcing is sufficient to achieve desirable outcomes and funding is enough to incentivise development of diverse aged care services that are efficient, and avoid duplication and waste while maintaining a high quality standard of care and support.
- **Responsive and innovative** means that the system is flexible and able to respond to the wishes of older people regarding the setting, location and types of services they receive through integrated approaches to care and support services that incorporate innovative approaches and technologies.
- **Streamlined and accessible** means the system is seamless and simpler to navigate, without barriers that prevent people from accessing the services appropriate to their needs when they require them.

Overall, the system that is required is one in which people can access the services they need without delay, with costs and quality standards that are transparent and providers that are accountable and responsive to the needs of people using these services and who will work with them to innovate and drive efficiencies that will enhance sustainability without compromising agreed standards. To achieve these goals fundamentally the system needs to be less complex. The role of the Commonwealth Government is to provide the environment in which that can occur and to ensure the system is fair and equitable.

Conclusion

In considering how the aged care system may be financed in the future, this submission has highlighted issues with the existing system that need to be addressed. These include the lack of financial incentives to drive the development of services to address thin markets, to encourage high quality standards and to sustain the system with a substantial number of providers reporting an operating loss. This in turn impacts the capacity of some people to access services that meet their needs assuming that they can afford the price as, perversely, means testing arrangements appear to be better at protecting the assets of those most able to afford services while disproportionately charging those of limited or very modest means.

A financing system that is based on the relative capacity of a person to pay is consistent with the Australian view of a fair go but it also must contain a relevant safety net that protects the interests of the most vulnerable when they need support. This includes retaining both the Homeless and Rural Viability supplements in residential aged care irrespective of which funding model is set in place.

However, we first need to complete the important debate about what the system should look like and aspire to achieve in terms of the quality standards and individual goals, as judged from the perspective of the people who use the system. Only then are we in a position to engage with the Australian community about how we can collectively finance high-quality service models that are sustainable, targeted towards those with the greatest needs and that are responsive and innovative. The system also needs to be transparent and accountable and needs to simultaneously protect the interests of people using aged care as well as respecting their rights to make their own decisions. The current complexity of the system is a major impediment to these goals.

As the structure of financial arrangements shape a system and can incentivise and discourage particular outcomes, we need to be sure that we have addressed the issues identified and that any new approach will be better and less complex than what went before it.

Appendices

1. Home Care Packages – Fees paid by recipients

Everyone who receives a Home Care Package can be asked to pay the Basic Daily Fee, based on the level of their package.

Home Care Level 1	\$9.63/day
Home Care Level 2	\$10.19/day
Home Care Level 3	\$10.48/day
Home Care Level 4	\$10.75/day

The liability to contribute beyond the basic daily fee is based solely on assessable income, through what is called an Income tested care fee. People who receive the Full Age pension (or have the equivalent income) do not pay an income tested care fee. People with income in excess of the threshold pay an income tested care fee at 50 cents per dollar of income above the threshold.

	Income Free Area (annual)
Single	\$27,840.80
Couple	\$21,606.00
Illness Separated Couple	\$27,320.80

The income tested fee is capped at \$15.43/day and \$5,617/year for part-pensioners (and people with the equivalent income) and \$30.86/day and \$11,235/year for self-funded retirees (and people with equivalent income). There is also a lifetime cap of \$67,410 which applies across both home care and residential aged care.

Annual and Lifetime Caps

	Daily Cap	Annual Cap
Home Care ITCF - Pensioner	\$15.43	\$5,617.47
Home Care ITCF	\$30.86	\$11,234.96
Residential Care MTCF	\$252.92	\$28,087.41
Lifetime Limit across Home Care and Residential Aged Care \$67,409.85		

Home Care Package Subsidy Rates (Daily)

Package Level	Basic Subsidy	Temporary Subsidy 1 March-31 August	Dementia Supplement	Temporary Subsidy 1 March-31 August
Level 1	\$24.46	\$0.29	\$2.81	\$0.03
Level 2	\$43.03	\$0.51	\$4.95	\$0.06
Level 3	\$93.63	\$1.11	\$10.77	\$0.13
Level 4	\$141.94	\$1.68	\$16.32	\$0.19

Level	Activities of daily living (ADL)	Behaviour (BEH)	Complex Health Care (CHC)
Nil	\$0.00	\$0.00	\$0.00
Low	\$38.28	\$8.75	\$16.98
Medium	\$83.36	\$18.14	\$48.37
High	\$115.49	\$37.81	\$69.84

Residential Aged Care – Aged Care Funding Instrument (ACFI) (Daily)

Temporary additional daily amount – 1 March 2020 to 31 August 2020			
Level	Activities of daily living (ADL)	Behaviour (BEH)	Complex Health Care (CHC)
Nil	\$0.00	\$0.00	\$0.00
Low	\$0.46	\$0.11	\$0.21
Medium	\$1.01	\$0.22	\$0.59
High	\$1.40	\$0.46	\$0.85

Home Care and Residential Care Daily Supplements

Oxygen Supplement	\$11.98
Enteral Feeding Supplement - Bolus	\$18.98
Enteral Feeding Supplement – Non Bolus	\$21.32

2. Home Care Package fee case study

Case Study – Affordability of home care package fees for full pensioners

Jill has a home worth \$500,000, \$50,000 in the bank and \$10,000 in personal assets. She receives the full age pension. Jill is receiving a Level 3 Home Care Package.

Jill's Financial Position	
Assets	
Home	\$500,000
Bank Account	\$50,000
Personal Assets	\$10,000
Total	\$560,000
Income	
Interest @2 per cent p.a	\$1,000 p.a
Age Pension	\$24,552 p.a
Total	\$25,552 p.a
Home Care Package	
Basic Daily Fee	\$3,825 p.a
Income Tested Care Fee	\$0
Total Cost of Aged Care	\$3,825 p.a
Cash Flow	\$21,727 p.a

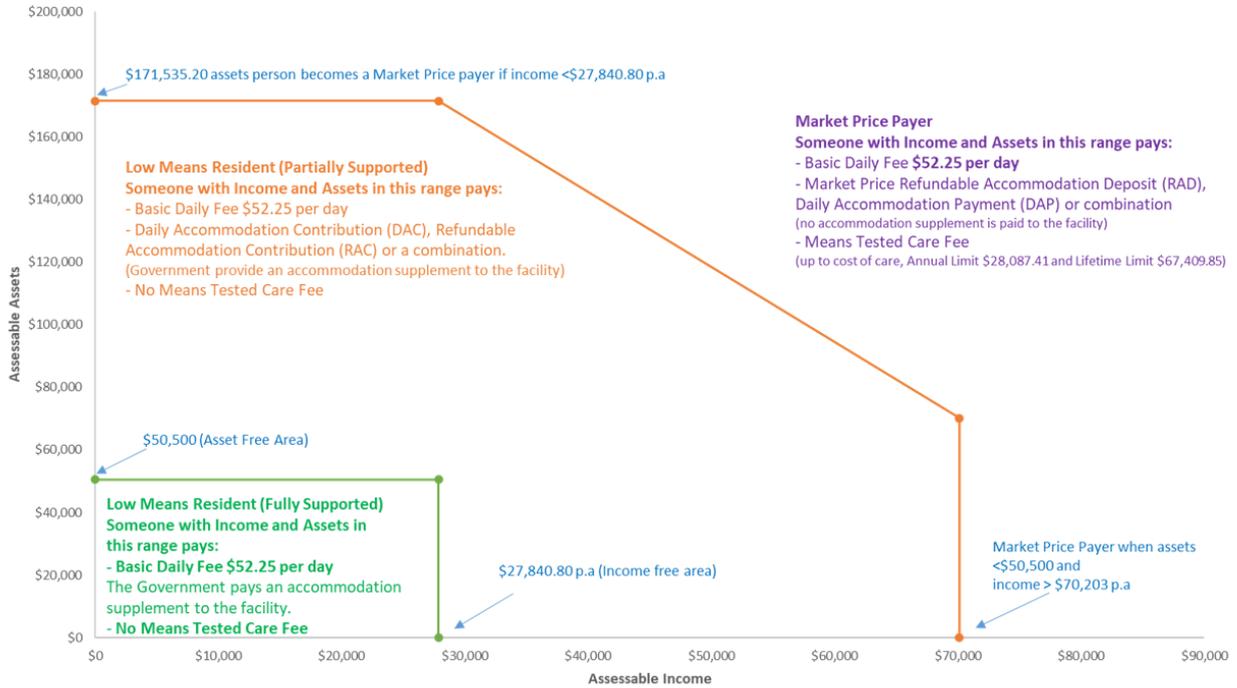
The cost of the home care package is around 15 per cent of Jill's total annual income, depending on her living expenses she may not be able to afford this contribution.

While the means testing arrangements often refer to the amount of income tested care fee someone will pay towards their home care package based on whether they are a pensioner or self-funded retiree, the assessment is solely based on income so it is possible for a pensioner to pay a higher income tested care fee than a self-funded retiree with substantial assets if the self-funded retiree does not have a higher level of assessable income.

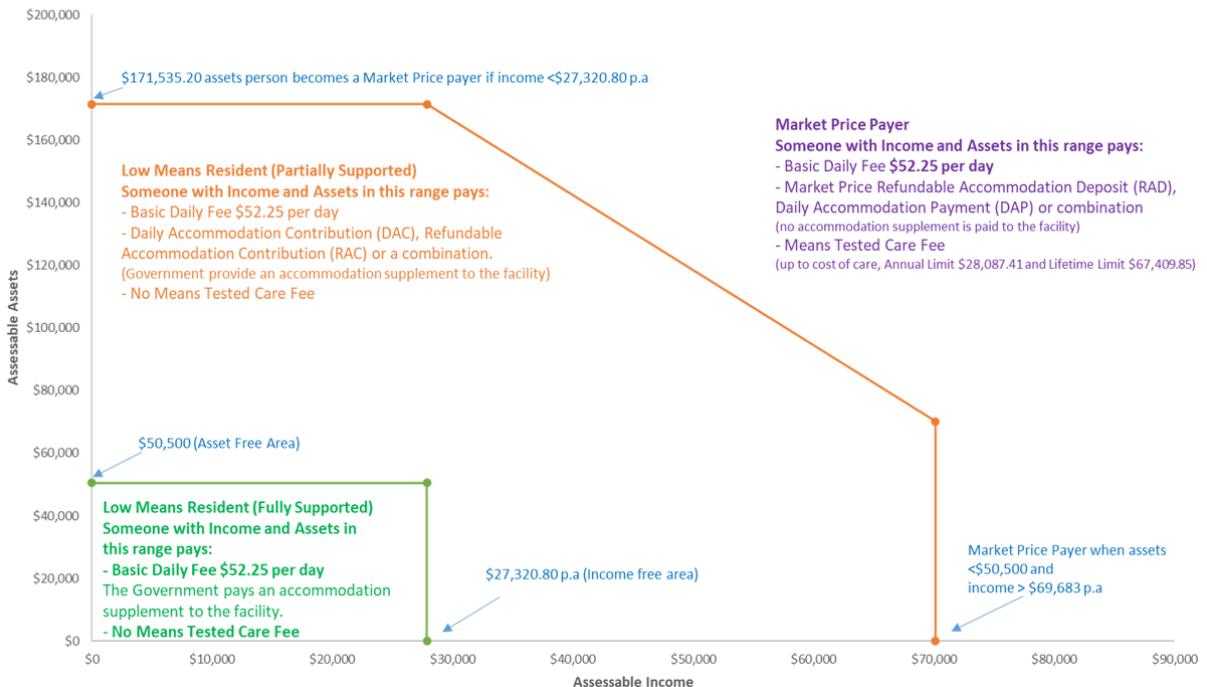
Rachel Lane, Principal, Aged Care Gurus

3. Residential Aged Care – Combined Income and Assets Test

Residential Aged Care Means Testing – Single



Residential Aged Care Means Testing – Member of a Couple



4. Low means residents case studies

Case Study – Low Means Resident (fully subsidised)

Shirley's Financial Position		
Assets		
Bank	\$10,000	
Personal Assets	\$500	
Total	\$10,500	
Income		
Interest @2 per cent p.a	\$200 p.a	
Age Pension	\$24,552 p.a	
Total	\$24,752 p.a	
Accommodation Contribution		
	DAC (Annual)	RAC (Lump Sum)
	\$0	\$0
Basic Daily Fee	\$19,071 p.a	
Personal Expenses	\$3,650 p.a	
Total Cost	\$22,721 p.a	
Cash Flow	\$2,031 p.a	

Shirley is moving into aged care on 4/8/2020.

Shirley has \$10,000 in the bank, \$500 personal assets and receives the full Age Pension of \$944.30 per fortnight.

The cost of Shirley's aged care accommodation contribution is \$0 as her assets are below \$50,500 and her income is below \$27,840.80/year.

**Rachel Lane, Principal,
Aged Care Gurus**

Low means case studies continued over page.

Case Study – Low Means Resident (partially subsidised) who cannot afford his liability

Jack is moving into residential aged care on 4/8/2020.

Jack has \$95,000 in the bank earning 2 per cent p.a. and \$5,000 in personal assets, he receives the full Age pension of \$24,552/year.

Jack has a number of options regarding how he pays for his aged care.

Pay by DAC: If Jack meets his cost of care by daily payment, then his cost of aged care will be \$76.05 per day (\$23.80 DAC + \$52.25 Basic Daily Fee).

Pay by RAC: Jack must be left with \$50,500 in the first 28 days of entering aged care, meaning he could pay up to \$49,500 as a lump sum when he enters aged care, effectively offsetting the 4.10 per cent interest on this amount. Jack's daily accommodation contribution would be adjusted to \$18.24/day.

Top up RAC: After the initial 28-day period Jack could pay as much as he wishes towards his Refundable Accommodation Contribution (RAC). If Jack paid an additional \$30,000 towards his RAC, his DAC would further reduce to \$14.87/day.

	Pay by DAC	Pay Max RAC on entry	Top up RAC (after 28 days)
Assets			
Bank Account	\$95,000	\$45,500	\$15,500
Personal Assets	\$5,000	\$5,000	\$5,000
Total Assets	\$100,000	\$50,000	\$20,500
Cost of Aged Care			
RAC Paid	\$0	\$49,500	\$79,500
RAC Outstanding	\$211,861	\$162,361	\$132,361
Basic Daily Fee	\$19,071	\$19,071	\$19,071
DAC Paid	\$8,687	\$6,657	\$5,428
Means Tested Care Fee	\$0	\$0	\$0
Personal Expenses	\$3,650	\$3,650	\$3,650
Total Cost	\$31,408 p.a	\$29,378 p.a	\$28,149 p.a
Income			
Age Pension	\$24,552	\$24,552	\$24,552
Interest @2 per cent p.a	\$1,900	\$910	\$310
Total Income	\$26,452	\$25,462	\$24,862
Cash Flow	-\$4,956 p.a	-\$3,916 p.a	-\$3,287 p.a

Under the Income test Jack's liability is \$0/day. Under the Asset test his liability is \$23.80/day, with an equivalent lump sum **more than double his assets** at **\$211,861**

Jack's cost of aged care regardless of his chosen method of payment is **greater than his income** and this is before he has met any of his personal living expenses like medications, haircuts, clothing, etc.

Jack **will never be in a position to pay his RAC in full** and nor will he be able to meet his cost of care from his cash flow. While the means assessment recognises that Jack is of limited means, the formula creates a liability for him to pay beyond what he can afford.

Rachel Lane, Principal, Aged Care Gurus

5. Moderate means residents case study

Case Study – Market Price Resident

Betty is moving into residential aged care from a retirement village on 4/8/2020.

Betty's exit entitlement from the village is \$180,000 (different State based laws will determine how much of this and when Betty can access these funds if her unit has not sold). Betty has \$25,000 in bank accounts and \$5,000 in personal assets and receives the full Age Pension of \$24,552/year.

The Market Price at the facility Betty wants to move to is \$500,000 (RAD). Betty can pay by Daily Accommodation Payment (DAP), Refundable Accommodation Deposit (RAD) or a combination, including deducting her DAP from her RAD.

Betty's aged care costs vary with the Payment Option			
	Pay by DAP	Pay RAD	Deduct DAP from RAD
Assets			
RAD Paid	\$0	\$180,000	\$180,000
Bank Account	\$25,000	\$25,000	\$25,000
Personal Assets	\$5,000	\$5,000	\$5,000
RV Exit Entitlement	\$180,000	\$0	\$0
Total Assets	\$210,000	\$30,000	\$30,000
Cost of Aged Care			
RAD Paid	\$0	\$180,000	\$180,000*
RAD Outstanding	\$500,000	\$320,000	\$320,000
DAP Paid	\$20,500	\$13,120	\$0
Basic Daily Fee	\$19,071	\$19,071	\$19,071
Means Tested Care Fee	\$0	\$387	\$387
Personal Expenses	\$3,650	\$3,650	\$3,650
Total Cost	\$43,221 p.a	\$36,228 p.a	\$23,108 p.a
Income			
Age Pension	\$24,552	\$24,552	\$24,552
Interest @2 per cent p.a	\$500	\$500	\$500
Total Income	\$25,052	\$25,052	\$25,052
Cash Flow	-\$18,169 p.a	-\$11,176 p.a	\$1,944 p.a

*If Betty elects to deduct her DAP from her RAD, each month as the RAD reduces her DAP increases. The table below shows the effect of this strategy over time.

Betty's DAP/RAD	DAP (Daily)	RAD Balance (Lump Sum)
Month 1	\$35.95	\$178,907
Month 12	\$37.32	\$166,631
Month 24	\$38.88	\$152,703
Month 36	\$40.50	\$138,193
Month 48	\$42.20	\$123,077
Month 60	\$43.96	\$107,329

Betty is a common example of someone who the means test determines can pay the market price but cannot afford to do so.

Rachel Lane, Principal, Aged Care Gurus

6. Rachel Lane, Aged Care Gurus

Rachel is the Principal of Aged Care Gurus where she oversees a national network of advisers dedicated to providing quality advice to older Australians and their families. Rachel and her team have grown the company to become leading experts within the financial planning industry, offering a comprehensive suite of tools, leading edge software and educational programs (including a Masters of Financial Planning subject in at University of Technology Sydney) to professional advisers.

Regularly consulting to industry and government, Rachel and her team have participated in a number of taskforces, inquiries, projects and discussions on a range of financial matters relating to retirement living and aged care.

A columnist for both industry and consumer publications including Fairfax Money, Rachel has co-authored several books including the best-seller *Aged Care, Who Cares?* with Noel Whittaker, their latest book *Downsizing Made Simple* and industry text *Retirement and Aged Care Living in Australia*.

Rachel has over 20 years' experience in financial services, specialising in retirement living and aged care since 2004. She holds a Masters in Financial Planning which included a research paper titled *Aged Care; The struggle to provide Quality, Equity, Efficiency, Sustainability and Choice*.