Embedded Incentives in the Funding Arrangements for Residential Aged Care in Australia\textsuperscript{1}

STEVEN D. HAMILTON* 
and 
FLAVIO M. MENEZES**

We examine the Australian Government’s role in the market for residential aged care in Australia and consider its impact on the incentives of market participants. We find that, due to the structure of the funding arrangements, providers are likely to have an incentive to discriminate against high-care residents, in favour of low-care residents. Since high-care residents, unlike low-care residents, face few viable alternatives, many are forced into public hospital beds as a result. This has placed pressure on the broader health system. In providing lessons from our analysis for reform, we stress the importance of fostering proper incentives in policy design and infer the implications for health reform more broadly.

JEL:I18
Key-words: Aged care; incentives; health reform.

1 Introduction

It is well known that the Australian population is ageing. Based on current projections the proportion of Australians aged 70 years and older will increase by half in the next decade, and by mid-century one in five Australians will be aged 70 years or older (Australian Bureau of Statistics, 2006). Similarly, the Australian Bureau of Statistics (2006) predicts that by mid-century the proportion of Australians aged 80 years and older will more than double. This is due to three factors: firstly, the ageing of the baby boomers, secondly, a reduction in fertility rates, and thirdly, a sustained increase in life expectancy. Similar trends have been observed in nations all across the world.

While this will have important implications for health care generally, its effects will be most acutely felt in aged care. Given a rapid expansion of the group of individuals in need of care and a similarly rapid dwindling of the number of individuals able to either fund this care or directly provide it, it is inevitable that the aged care sector will come under increased pressure in the decades ahead. Given this, it is prudent to ensure that the existing system is up to the task. The concern is that it appears, at least anecdotally, that the system as it currently exists in Australia is not functioning optimally (Parliament of Australia, 2009). It follows that if the system is unable to adequately perform as it is, then it will have little chance managing the kind of significant, sustained pressure anticipated. Examining the current conditions of demand and supply as well as the existing regulatory arrangements is an important precursor to developing policies that address the problems at hand.

Elderly people face a variety of circumstances, necessitating a range of alternative methods of care. The care needs and preferences of some individuals are such that they can remain in their own homes. Such individuals may receive what is known in Australia as community (or in-home) care. The services and care provided to them—many of which are supported by the Australian Government—are limited. At some point it may become necessary for an individual to seek a greater and more continuous level of care. Residential aged care providers satisfy this demand, offering a range of services depending mostly on the needs of the resident. While some residents require only minimal monitoring and support,
others require considerable assistance. In Australia, residents are categorised as either low- or high-care, depending on their requirements.

The focus of this paper is the Australian market for residential aged care services. We begin with a description of the current arrangements. The Australian Government intervenes in a number of ways; the interventions are complex and are likely to interact with one another to influence market outcomes. We then describe the incentives embedded in these arrangements. We consider the incentives of providers, residents, and the Government in light of the current policy framework. Some of these incentives are likely to lead to unintended consequences that ought to be of interest to policymakers. We conclude the paper by laying out the lessons of our analysis for reform. While we offer recommendations for the reform of the aged care sector in Australia, we also infer implications for the broader health reform agenda.

2 The Government’s Role

The Australian Government is involved in all aspects of the provision of residential care for the elderly: it regulates entry into the sector; it limits the number of beds that it funds and the level of this funding; it regulates the standard of care provision, and health and safety (which are also regulated by state and local governments); and it provides grants to aged care homes. Many of the measures’ origins can be traced back decades, while some have arisen from more recent reforms. They are an attempt by the Government to overcome a range of perceived market failures, and to provide services on an equitable basis. We describe each of the Government’s roles in turn.²

The Government restricts entry into the subsidised portion of the market firstly on the basis of care quality. Firms must be accredited in order to receive subsidies on behalf of residents, the criteria for which mostly relate to care quality.³ This function is performed by an independent body (Aged Care Standards and Accreditation Agency, 2009). The Australian Department of Health and Ageing must also certify providers before they may receive subsidies. The standards of the provider’s equipment and buildings, the standard of care provision, and the provider’s past conduct are all considered. In Australia, state and local governments play a role in quality regulation through the enforcement of health and safety guidelines.

While the Government does not explicitly restrict the quantity of residential aged care places provided, it does limit the number of subsidised places. Each year, following community consultation, the Department determines the number of subsidised places to be provided in local areas. Once the total number of places is determined, providers are invited to apply for part of the allocation. This is a competitive process, with places allocated to providers on the basis of numerous criteria.⁴ Successful providers are then free to provide places to the number of residents for whom they have been allocated a subsidy.

The Government provides a range of subsidies, all of which are, for practical reasons, distributed to providers. The Government provides funding and subsidised loans to aged care providers for investments in capital works. Subsidies are also allocated to providers on behalf of the residents for whom they care. The eligibility of residents to receive a subsidy and the level of that subsidy depend on the level of care required by the resident and their financial situation.

---

² The Commonwealth Government’s various roles are governed by the Aged Care Act 1997 and the various accompanying legislative instruments. Our overview is derived from the relevant legislation, except where we indicate otherwise.

³ A number of factors are considered: the suitability of key personnel; the ability and experience of the provider in providing aged care services; the ability of the provider to meet relevant standards of care provision; the provider’s commitment to the rights of care recipients; and the provider’s financial management record and methods to ensure sound financial management.

⁴ The following attributes are considered: the expertise and experience of management; the planning and location of the premises; the appropriateness of the level of care provided; past conduct; the measures to be implemented to protect residents’ rights; and the level of care to be provided to those with special needs.
The Aged Care Funding Instrument (ACFI) is used by the Department to determine the level of care required by residents and thus the maximum subsidy that they will receive. Residents are assessed according to numerous criteria (refer to Table 1). Scores for each of the characteristics within a domain are aggregated to form a total score for each domain. These scores place the resident in either a low, medium, or high category for each domain. This classification process is intended to determine, as accurately as possible, the care requirements (and thus care costs) applicable to each individual. A daily amount is paid to homes, depending on the classification level of the resident in each domain. The daily subsidies for the 2009-2010 financial year are summarised in Table 2. The subsidy is calculated using the following formula:

\[
\text{Subsidy} = \min\{(\text{ADL} + \text{BEH} + \text{CHC}), 150.54\}.
\]

Aside from depending on the level of care, the subsidy is means-tested (refer to Figure 1). The means test operates as follows (Department of Health and Ageing, 2009b). Take a resident currently receiving the maximum daily care subsidy of $150.54. The resident continues to receive the full subsidy, provided that her income is below $58.04 per day. For every dollar that her income exceeds $58.04 per day, the daily subsidy is reduced by $0.416. As her income increases, the subsidy continues to reduce at this rate, until her income reaches $207.10 per day, at which point the daily subsidy remains steady at $88.43, regardless of any further increases in income. This scenario will vary depending on the amount of the subsidy for which the resident is eligible.

**TABLE 1**

**ACFI DOMAINS AND THEIR CONSTITUENT CHARACTERISTICS**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities of Daily Living (ADL)</td>
<td>Nutrition, Mobility, Personal hygiene, Toileting, Continence</td>
</tr>
<tr>
<td>Behaviour (BEH)</td>
<td>Cognitive skills, Wandering, Verbal behaviour, Physical behaviour, Depression</td>
</tr>
<tr>
<td>Complex Health Care (CHC)</td>
<td>Medication, Complex health care</td>
</tr>
</tbody>
</table>

**TABLE 2**

**DAILY ACFI SUBSIDY RATES ($) (01/07/09 – 20/06/10)**

<table>
<thead>
<tr>
<th>Level</th>
<th>ADL</th>
<th>BEH</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Low</td>
<td>29.78</td>
<td>6.81</td>
<td>13.40</td>
</tr>
<tr>
<td>Medium</td>
<td>64.86</td>
<td>14.11</td>
<td>38.17</td>
</tr>
<tr>
<td>High</td>
<td>89.85</td>
<td>29.72</td>
<td>55.12</td>
</tr>
</tbody>
</table>
In addition to subsidising residents' care costs, the Government subsidises some residents' accommodation costs through the Accommodation Supplement. The maximum rate of the subsidy, as at May 2010, is $26.88 per day (Department of Health and Ageing, 2009b). The amount of the subsidy depends on the resident's assets (refer to Figure 2). The means test operates as follows. Take any resident currently receiving a daily Accommodation Supplement of $26.88. The resident continues to receive the full subsidy, provided that the value of her assets does not exceed $37,500. For every one thousand dollars that the value of her assets exceeds $37,500, the daily subsidy is reduced by $0.481. As the value of her assets increases, the subsidy continues to reduce until it is eliminated. The value of her assets at this point is $93,410.40.

As well as providing subsidies, the Government regulates the price of residential aged care services. While it is not illegal for providers to set charges above the mandated levels, a provider’s accreditation (upon which the payment of the aforementioned subsidies is contingent) is dependent on its adherence to the guidelines. In practice, the regulations amount to price controls. The Government stipulates a number of allowable charges covering

\[ \text{Daily subsidy ($)} \]

\[ \begin{array}{c}
\text{Daily income ($)} \\
\hline
0 & 58.04 & 207.10 \\
\end{array} \]

\[ \text{Figure 1: ACFI subsidy means test}\]

\[ \begin{array}{c}
\text{Asset value ($)} \\
\hline
0 & 37,500 & 93,410.40 \\
\end{array} \]

\[ \text{Figure 2: Accommodation Supplement means test}\]
the costs of care (basic daily care fees and income-tested fees) and accommodation (Accommodation Bonds and Charges).

The Government allows providers to charge a basic daily care fee, as a contribution to care costs and living expenses. While the level of the fee may be negotiated between residents and providers, it may not exceed 85% of the annual single basic aged pension. As at May 2010, the maximum basic daily care fee is $38.65 (Department of Health and Ageing, 2010). Recall that the ACFI subsidy is means-tested according to residents’ incomes. The Government allows providers to recover any means-tested reduction in the subsidy from residents, so that the amount providers receive is constant, regardless of residents’ incomes. Therefore, the maximum fee that a resident may be levied is calculated in the same way as the subsidy is reduced, and the amount of the income-tested fee may not exceed the reduction in the ACFI subsidy (refer to Figure 3).

In addition to fees covering care costs, the Government allows providers to charge for the cost of residents’ accommodation. The two forms of fees are an Accommodation Charge and an Accommodation Bond. A resident may only be asked to make an accommodation payment to a provider if her assets are worth more than 2.25 times the annual single basic pension, which, as of May 2010, is $37,500. The type of accommodation payment levied depends on the type of care received by the resident. Providers may request the payment of an Accommodation Bond if a resident is receiving a low level of care. Residents receiving a high level of care may not be asked to pay an Accommodation Bond, and may instead—if their assets are above the aforementioned threshold—be levied an Accommodation Charge.

The Accommodation Bond levied by firms must leave residents with at least $37,500, as at May 2010. The provider may ask the resident to pay any proportion of the value of her assets that exceed this amount. The provider may invest this sum and retain a proportion of the interest earned. The maximum permissible interest rate is currently 8.16% per annum. They may also retain an amount of the principal for a maximum period of five years. The maximum retention amount is set by the Government at $154.50 for bonds of no more than $18,540 and $299 per month for bonds of greater than $35,880 (Department of Health and Ageing, 2009a). Retention rates for bonds between these amounts are calculated as a linear combination of the two. In lieu of an Accommodation Bond, the Government allows residents

![Figure 3: Daily means-tested care fees](image-url)
to make regular payments to providers equivalent to the retention amount and interest payments forgone (refer to Figure 4).\(^5\)

The Accommodation Charge may be levied by firms, in place of an Accommodation Bond, on residents receiving high-care services. The level of the charge may be negotiated between the resident and provider, though the maximum level a provider may charge is means-tested (refer to Figure 5). As at May 2010, a provider may not charge (per week) more than \(\frac{1}{2080}\) of the value of the resident's assets that exceed $37,500, up to a maximum of $26.88 per day for residents with assets of $93,410.40 or more (Department of Health and Ageing, 2010).

In summary, the Government plays a role in all areas of the sector. The Government regulates the quality of services supplied by providers. If providers do not meet the specified standards of care provision, then they are ineligible to receive subsidies on behalf of their residents. The Government also limits the number of subsidised places, and these are allocated by geography. A range of subsidies are awarded to providers to fund capital works, and residents’ care and accommodation costs are subsidised. These subsidies are provided on the basis of residents’ care requirements and income and asset levels. The prices providers are permitted to charge are capped; providers’ eligibility to receive subsidies is contingent on their adherence to these price limits. The maximum allowable charges are means-tested on the basis of assets and income. These measures interact with one another to impact market outcomes. In combination, the interventions are complex and the net effects are impossible to determine precisely. In the following section we infer a range of broad consequences that might be expected.

\[\text{Daily accommodation bond fees ($)}\]
\[\begin{align*}
\text{0} & \rightarrow 5.08 \\
\text{37,500} & \rightarrow 9.83 \\
\text{56,040} & \rightarrow 9.83 \\
\text{73,380} & \rightarrow 17.85
\end{align*}\]

\[\text{Asset value ($)}\]

**Figure 4: Accommodation Bond means test**

- - - Retention amount

- - - - With interest

\(^5\) It is worth noting that we have ignored two features for the sake of simplicity. Firstly, firms are only permitted to hold a bond for a period of 5 years; our analysis therefore only applies to individuals with fewer than 5 years of residence. In Australia, as at 30 June 2008, 21% of existing residents had had a length of stay of 5 or more years (Australian Institute of Health and Welfare, 2009). Of those who had completed their stay, only 18% had stayed for 5 or more years, while the average length of stay was 147.8 weeks. Secondly, a provider’s retention of a proportion of the bond principal reduces the return derived from the bond through interest over time. This effect is more dramatic for large bonds than for small ones. Given this (and in addition to the fact that the key part of our analysis in this case relates to bonds of over $75,000), the fact that firms might be assumed to earn some return on the retained principal, and the simplicity resulting from the disregard of time in our analysis, this exclusion is a reasonable one.
3 Embedded Incentives

We now focus on the incentives embedded in the funding model described above. We have established that the Australian Government both provides a subsidy for residents’ care and accommodation costs and caps the maximum price they may be charged for services. Though the intention of these policies may be to support residents and constrain providers, they provide incentives for the various agents to alter their behaviour. This could have unintended consequences for the functioning of the market and social welfare more broadly.

3.1 The Provider’s Incentives

Providers derive a number of revenue streams from the funding arrangements. Some depend on residents’ incomes, others depend on the value of residents’ assets, while others still depend on residents’ care levels. We begin with an examination of the accommodation arrangements. We first characterise a typical firm’s situation when servicing low-care residents whom the firm is permitted to charge an Accommodation Bond. We can determine the total revenue the firm receives for the accommodation of a typical low-care resident; this consists of the bond fees paid by the resident plus the government subsidy (refer to Figure 6). At asset values below $136,485.77 the firm maximises revenue by accepting residents whose assets are valued at just over $37,500. This is because, at this asset value, the firm is receiving almost the full subsidy and can charge the same retention fee as for a resident with $56,040 in assets. At the value of assets increases from just over $37,500, the subsidy is withdrawn more quickly than the bond fee increases, with the net effect negative virtually all the way to an asset value of $93,410.40 (revenue increases by 29 cents per day between $56,040 and $73,380 of assets), at which point the subsidy is exhausted. From here, as the asset value increases the net effect is positive since bond fees are increasing. At an asset value of $136,485.77 the revenue derived is roughly equivalent to that at just over $37,500 in assets. At higher asset values revenue increases indefinitely with the value of assets.

![Figure 5: Accommodation Charge means test](image)
Ultimately, if its goal is to maximise profit, the firm would like to attract residents with the highest possible asset values. This is the case provided that accommodation costs are homogeneous across potential residents and that any differences in care costs are fully subsidised. In this event, maximising revenue is equivalent to maximising profit; the firm’s selection of the resident from which it can extract the greatest level of revenue is a profit-maximising decision.

Whether a firm could secure residents with the highest possible asset values would depend on the level of competition, the extent to which the firm behaves in a profit-maximising manner, and the ability of the firm to price-discriminate (which may be restricted by non-competitive factors). On the first condition, while it is unlikely that any provider is a pure monopolist, a degree of market concentration is probable, certainly on a local level. In Australia, aged care facilities tend to be geographically dispersed, leaving many firms as the sole provider of services to a local community. While it may be possible for residents to seek alternative accommodation in other areas, this may involve significant costs (living in an unfamiliar location, living a long distance from friends and family, etc.). This is likely to limit, at least to some extent, the level of competitive pressure on firms. On the second condition, while there are a number of profit-seeking aged care providers in Australia, many services are provided on a not-for-profit basis. However, even though many such services are run by registered charities, they are often operated to cross-subsidise an organisations’ other charitable functions, like providing food and shelter to the homeless, for example. As a result, it is not clear that such firms would be willing to forego additional revenue for the sake of alternative considerations.

Nevertheless, there are likely to be a number of firms for whom profit maximisation is at most a second-order consideration. The prevalence of firms with alternative objectives in the residential aged care sector has implications for how one should approach it. Our analysis and recommendations apply only to those firms with a certain set of objectives. Firms with different objectives, like some not-for-profit firms, might not conform to our inferences. In 2007-2008, only 28% of aged care services in Australia were provided by private organisations (Australian Institute of Health and Welfare, 2009). The rest were provided by religious organisations, community-based providers, and charitable organisations. As mentioned, many such organisations pursue similar objectives to private, profit-seeking firms. However, it is likely that many do not. The existence of such firms in the industry might have
implications for the appropriate role of regulation or the merits of competition in producing optimal market outcomes. These alternative motivations are worthy of further consideration.

The firm's situation when providing high-care services is comparatively simple. Recall that a high-care resident may not be levied an Accommodation Bond, but instead may be levied an Accommodation Charge. This charge is means-tested, as is the Accommodation Supplement that the firm receives from the Government. While the net effect of the accommodation payment and the Accommodation Supplement was somewhat haphazard in the case of a low-care resident, the net effect for high-care residents is constant (refer to Figure 7). As asset values rise the reduction in the subsidy is exactly offset by an increase in the fee, yielding an amount of total revenue invariant to the value of residents' assets. As a result, the firm is indifferent between high-care residents with differing asset values. Thus there should be no incentive, on the basis of potential accommodation-related revenue, for the firm to discriminate between high-care residents.

While we have established how firms might discriminate within care types, we are yet to determine the extent to which firms might discriminate between care types. The choice that firms face is simple. If costs are the same (we assume that all relevant costs are fully subsidised by the Government), given two residents with the same level of assets but who differ in terms of care requirements, from which resident can the firm extract the most revenue? The answer to this question depends on the value of the residents' assets (refer to Figure 8). The choices made by firms in practice depend on their motivations. If firms are motivated by profit, then their choices should align with those specified here. However, we know that many firms are endowed with alternative objectives. In the case of a not-for-profit firm, for example, such behaviour might not be optimal.

Figure 7: Revenue from Accommodation Charge and Accommodation Supplement

---

Total revenue
Accommodation Supplement
Accommodation Charge
For a profit-maximising firm, the ultimate effects of the policy depend on the asset values of prospective residents (refer to Table 3). According to the Australian Bureau of Statistics (2007), in 2005-2006, of couple households in Australia with the reference individual aged 65 or over, half had a net worth in excess of $480,000, while the average net worth was $868,000. Of single households in Australia, with the occupant aged 65 and over, half had a net worth in excess of $334,000, while the average net worth was $468,000. Of the pool of potential residents, then, a considerable majority have assets that far exceed the $113,771.54 threshold at which low-care residents yield a greater level of revenue than high-care residents. This could indicate a preference by providers for higher-yielding low-care residents over lower-yielding high-care residents. This is supported by aggregate data on the size of bonds collected by providers. For the 2008-2009 financial year, the average accommodation bond collected in Australia was estimated to be $212,958, while half of bond-paying residents paid a bond in excess of $200,000 (Department of Health and Ageing, 2009c). In 13.5% of Australian homes that received new bonds, the average bond amount was $100,000 or less, while in 26% of Australian homes, the average bond amount was between $100,000 and $150,000. Without more disaggregated data, however, it is impossible to determine for certain in which asset band the bulk of potential aged care residents lie. This makes it difficult to determine providers’ true (care) preferences. We can say, though, that a great many potential residents hold assets in excess of $113,771.54, and that such residents make up the vast bulk of the bond-payers whom firms are able to attract.

The only remaining detail is the nature of the revenue that firms receive for the cost of care. Firms receive the ACFI subsidy from the Government and an income-tested fee from residents. The Government has structured the ACFI in such a way that the means-tested reduction of the subsidy is exactly offset by the means-tested increase in fees, so that the amount that the provider receives is constant irrespective of income (refer to Figure 9). Thus, provided that care costs are fully subsidised by the Government, firms will be indifferent, on the basis of revenue received for care costs, between residents with different incomes. Overall, in the absence of an insufficient subsidisation of care costs, the irregular low-care funding arrangements produce the only obvious source of distortion that could lead to discrimination between residents.

Figure 8: Revenue comparison between low- and high-care residents

- - - - Revenue from high-care resident
- - - - Revenue from low-care resident

For a profit-maximising firm, the ultimate effects of the policy depend on the asset values of prospective residents (refer to Table 3). According to the Australian Bureau of Statistics (2007), in 2005-2006, of couple households in Australia with the reference individual aged 65 or over, half had a net worth in excess of $480,000, while the average net worth was $868,000. Of single households in Australia, with the occupant aged 65 and over, half had a net worth in excess of $334,000, while the average net worth was $468,000. Of the pool of potential residents, then, a considerable majority have assets that far exceed the $113,771.54 threshold at which low-care residents yield a greater level of revenue than high-care residents. This could indicate a preference by providers for higher-yielding low-care residents over lower-yielding high-care residents. This is supported by aggregate data on the size of bonds collected by providers. For the 2008-2009 financial year, the average accommodation bond collected in Australia was estimated to be $212,958, while half of bond-paying residents paid a bond in excess of $200,000 (Department of Health and Ageing, 2009c). In 13.5% of Australian homes that received new bonds, the average bond amount was $100,000 or less, while in 26% of Australian homes, the average bond amount was between $100,000 and $150,000. Without more disaggregated data, however, it is impossible to determine for certain in which asset band the bulk of potential aged care residents lie. This makes it difficult to determine providers’ true (care) preferences. We can say, though, that a great many potential residents hold assets in excess of $113,771.54, and that such residents make up the vast bulk of the bond-payers whom firms are able to attract.

The only remaining detail is the nature of the revenue that firms receive for the cost of care. Firms receive the ACFI subsidy from the Government and an income-tested fee from residents. The Government has structured the ACFI in such a way that the means-tested reduction of the subsidy is exactly offset by the means-tested increase in fees, so that the amount that the provider receives is constant irrespective of income (refer to Figure 9). Thus, provided that care costs are fully subsidised by the Government, firms will be indifferent, on the basis of revenue received for care costs, between residents with different incomes. Overall, in the absence of an insufficient subsidisation of care costs, the irregular low-care funding arrangements produce the only obvious source of distortion that could lead to discrimination between residents.
TABLE 3

PROVIDERS’ CARE-TYPE PREFERENCES

<table>
<thead>
<tr>
<th>Asset value (AV) ($)</th>
<th>Preferred care type</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 \leq AV \leq 37,500$</td>
<td>Indifferent</td>
</tr>
<tr>
<td>$37,500 &lt; AV &lt; 75,657.69$</td>
<td>Low-care</td>
</tr>
<tr>
<td>$AV = 75,657.69$</td>
<td>Indifferent</td>
</tr>
<tr>
<td>$75,657.69 &lt; AV &lt; 113,771.54$</td>
<td>High-care</td>
</tr>
<tr>
<td>$AV = 113,771.54$</td>
<td>Indifferent</td>
</tr>
<tr>
<td>$113,771.54 &lt; AV$</td>
<td>Low-care</td>
</tr>
</tbody>
</table>

3.2 The Resident’s Incentives

Australians considering entering residential aged care face a number of choices. These choices depend, first and foremost, on an individual’s care needs. Residents requiring extensive care have little real choice but to opt for high-care residential services, since low-care services are insufficient and extensive care in the home would likely be prohibitively expensive and, in some cases, inadequate to meet the individual’s needs. An individual with low-care needs, on the other hand, might consider community care to be a viable substitute for a low-care residential place. Indeed, the accommodation payment arrangements are likely to impact this choice.

Recall that when faced with a low-care resident, a provider has an incentive to attract residents with the highest asset values, since the accommodation payments for low-care residents, at some point, increase indefinitely with asset values. Such residents—were they
able to attract them—could serve as ‘cash cows’ for residential aged care providers, potentially cross-subsidising less attractive, higher-care residents. However, faced by a very—and potentially boundlessly—high Accommodation Charge, residents with high asset values would likely seek alternative methods of care. In the absence of other limits on the revenue-maximising behaviour of providers, the existence of substitute services would constrain the ability of firms to extract very large accommodation payments. Consumers with very high asset values might find better value in hiring a carer to assist at home, for example.

Despite being in demand by providers since, unlike high-care residents, their accommodation payments are uncapped, low-care residents (unlike high-care residents) have the luxury of choice. The key question becomes: at the bond values at which low-care residents are more attractive to providers than high-care residents, are alternative methods of care viable substitutes? At moderate asset levels, it is unlikely that residents face considerably less expensive equivalent alternatives. At the $113,771.54 asset level (at which the provider would be indifferent between a low- and high-care resident), a provider may ask a low-care resident to pay a maximum bond equivalent to a weekly charge of $188.16. Given the modesty of this charge, such individuals might be inclined to accept it. As asset values rise, however, the maximum charge becomes less reasonable and, as a result, alternatives would likely become more appealing. At the median wealth level for Australian singles aged over 65 ($334,000), for example, a provider may levy the equivalent of a weekly charge of $532.89, while at the average wealth level for such individuals ($468,000), the equivalent weekly charge is $742.50. For residents with assets worth $1,000,000, a provider is permitted to levy the equivalent of a weekly charge of $1,575.05. This is sure to be unacceptably high for the typical low-care resident with such an asset level. There are likely to be many far less expensive alternatives available (hiring a full-time carer and all of the relevant support equipment, for one). It is difficult, though, to determine the typical asset value at which the alternatives become viable substitutes.

In practice, there appears to have been a switching of individuals from low-residential aged care to (in-home) community care. There have been a number of anecdotal reports of a ‘hollowing-out’ of the lowest of low care services in Australia (Parliament of Australia, 2009), while there has been a considerable decline in the proportion of Australian aged care residents receiving a low level of care (Australian Institute of Health and Welfare, 2009). At the same time there has been a boom in the take-up of community care. There have been widespread reports of aged care facilities facing difficulty in sourcing higher-yielding low-care residents (Parliament of Australia, 2009). At the same time, these firms have been reluctant to take on high-care residents, as they do not consider them to be an attractive source of funds (recall that they may not be levied an Accommodation Bond). The resultant gap is reported to have placed a great deal of pressure on providers across the industry, prompting calls for high-care residents to be charged in a similar way to low-care residents (Parliament of Australia, 2009).

Regarding high-care services, recall that firms are indifferent between residents on the basis of assets. Unlike the potentially limitless Accommodation Bonds that may be extracted from low-care residents, the Accommodation Charge levied on high-care residents is capped. This distinction between care types is likely a response to the lack of choice faced by high-care residents. The view seems to be that, since high-care residents are considered unfortunate and particularly in need (and thus potentially vulnerable), it would be inappropriate for providers to be able to extract an unlimited amount of revenue from them. As a result, the choice faced by the typical high-care resident is simple; her only real option is to seek a high-care place in a residential aged care facility, and the price she pays for her accommodation rises with the value of her assets to a modest, capped level.

Recall, though, that firms have an incentive to discriminate between care types at different asset levels. At some income levels, in the case of a constrained supply of places, high-care residents may be unable to secure a place. The last resort for such an individual is a hospital bed. The occupation of public hospital beds by aged care residents with no alternative is a major point of friction in the Australian public hospital system (National Health and Hospitals Reform Commission, 2009). In 2006 around 2400 Australians eligible
and approved to receive residential aged care services and not requiring hospital care occupied a hospital bed (Australian Government, 2010). Of these individuals, 63% had been waiting in hospital for more than 35 days. Addressing this problem has been identified as a key part of the health reform agenda in Australia.

3.3 Cost-shifting and accountability across different levels of government

So when an individual is unable to locate a high-care residential place, she has little choice but to occupy a public hospital bed. Unlike low-care residents, many of who have the option of either community (in-home) care or low-residential care, high-care residents have special needs that limit the feasibility of alternatives. The substitutability of hospital beds for high-care residential places gives rise to two important connections. The first, which we address later, is between aged care and the broader health care system. The second, which we deal with here, is between the Australian Government (which regulates and provides funding for all residential aged care services) and the various state and territory governments (which have primary responsibility for the funding of public hospitals).

When a high-care individual occupies a public hospital bed, rather than the high-care residential place for which she is eligible, the cost of her care is borne by the responsible state or territory government. As a consequence, until such time as the individual is able to locate and occupy a high-care residential place, the Australian Government avoids paying the subsidies that would normally apply to her. Thus, in the event of a shortage of high-care places, a proportion of the Australian Government’s health care cost burden is shifted onto states’ and territories’ budgets. This suggests that it has an incentive to restrict the availability of high-care places, since doing so would benefit its fiscal position at the cost of the states’ and territories’. This practice, known as ‘cost-shifting’, has been identified as an important area for reform.

In practice, the Australian Government’s propensity to cost-shift is difficult to determine. Budgetary considerations are certain to play some role in determining the number of allocated places. The level of cost-shifting depends on whether nursing homes provide a sufficient number of high-care places. This is a function of both the number of places allocated by the Government and the willingness of firms to offer places to high-care residents. The latter depends on the adequacy of the funding derived from high-care residents, and was addressed earlier. We address the former now.

Each year the Government specifies the number of subsidised low- and high-care places allocated by region. Assuming providers take up all of the allocated places, the occupancy level is an indicator of the sufficiency of the allocation. In the 2008-2009 financial year, the average occupancy rate across all bed types in Australia was 92.9% (Department of Health and Ageing, 2009c). As at 30 June 2009, there were 49.9 low-care places and 49.3 high-care places allocated per 1000 people in the Australian population aged 70 or older (Australian Institute of Health and Welfare, 2009). Of the allocated low-care places, 44.2 (or 88.6%) were operational, while this figure stood at 42.6 (or 86.4%) for high-care places. While the allocation of places seems fairly tight overall, the relative slackness of the high-care allocation casts doubt over the likelihood that the Government restricts the supply of high-care places in a bid to cost-shift. It still remains likely, however, that firms’ unwillingness to service high-care residents forces individuals to enter the hospital system, shifting costs from the Australian Government’s budget to those of the states and territories. Thus the legislated inability of providers to levy high-care residents an Accommodation Bond could benefit the Australian Government’s fiscal position.

---

6 Since a resident’s occupation of a hospital bed allows her to avoid the fees (for both accommodation and care costs) that would apply were she to reside in a nursing home, individuals benefit financially from this scenario. However, since the occupation of a hospital bed may impose additional (non-financial) costs on the individual, it is impossible to determine whether the typical individual would prefer a hospital bed to a residential aged care place. Regardless, since the resident’s placement is out of her control, the effect on her incentives of the substitutability of hospital beds for high-care residential places is irrelevant to this analysis.
In April 2010, the Australian Government announced a range of measures intended to eliminate cost-shifting between itself and the states and territories (Australian Government, 2010). The Australian Government is to provide an additional $300 million over 4 years to support investment in an additional 2500 residential aged care places. Since the underprovision of residential high-care services is likely due to high-care residents’ relatively lower financial value to providers, it is difficult to see how an additional allocation of places will do much to address the incidence of cost-shifting. A more direct response is the Australian Government’s plan to provide $280 million over 4 years to the states and territories to fund the hospital costs of individuals awaiting a high-care residential place. This directly reverses the cost-shift, placing the burden back onto the Australian Government’s budget. However, this does not address the underlying incentives responsible for the problem. The incentive for providers to discriminate against high-care residents appears to be responsible for the occupation of hospital beds by aged care residents, and thereby the shift of costs from the Australian Government to the states and territories. Any attempt to correct the problem must focus on correcting these incentives.

4 Lessons for Reform

Our analysis of the Australian residential aged care sector provides a number of important lessons for reform. Any change to the current arrangements should be considered in light of these lessons. The aged care system is fragmented, with care provided via a number of channels—community (in-home) care, residential low-care, residential high-care, and hospital care—depending on the needs of the individual. If the channels were fully independent, it might be appropriate to manage them individually. However, as we have shown, there are a number of ‘marginal’ individuals who could enter a number of different channels. Many individuals face a choice between community care and low-care residential services, for example, while others who would like to occupy a high-care residential place are forced to occupy a hospital bed instead. As a result, the funding arrangements of any one of the channels affect demand not only for that channel, but also for the other channels. Indeed, this is precisely what we have shown. Reforms of the policy framework must consider the interactions between channels, and the incentives must be geared accordingly.

Furthermore, while three of the channels are (largely) confined to the aged care system, one resides within the mainstream health care system. As we have shown, aged care residents can move between nursing homes and public hospitals depending on the number of high-care residential places available. Given this, policymakers should not consider aged care in isolation, but rather in the context of the broader health care system. To date, the various interactions have not received enough of policymakers’ attention, despite their contribution to much of the dysfunction that currently occurs. Piecemeal approaches have done little to address the problems plaguing the industry; policymakers ought to take a bigger-picture view. We will provide more on this in a moment.

One of the key messages to emerge from our analysis is the importance of incentives. Reform approaches to date have mostly centred on the practical aspects of health care provision, and rightly so; they are clearly an important piece of the puzzle. It is disappointing, however, that the incentives underlying the health care system have not been devoted the attention they deserve. Since incentives are the most common source of unintended policy consequences, policymakers would do well to attend to them. Indeed, in the case of aged care, the perverse incentives embedded in the current policy framework are the source of some of the greatest threats to the sector. By addressing providers’ preferences for low-care residents over high-care residents, much of the pressure facing the sector would be alleviated. The inability to derive an equivalent level of funding from high-care residents as low-care residents is placing pressure on providers’ finances. The resultant restriction of the supply of high-care residential places is making it difficult for individuals to access suitable accommodation, forcing them into public hospital beds. The occupation of public hospital beds by those eligible for a residential aged care place is a major source of pressure on the public hospital system today. While the correction of these incentives is no panacea, it should
play a role in the overall health reform agenda. Plainly, these kinds of perverse incentives are not unique to the Australian situation. Our analysis provides yet more evidence that incentives matter and should be at the forefront of policymakers’ minds.

As is often the case in public policy, the road to perverse incentives is paved with good intentions. While the Australian Government is attempting to assist high-care residents by exempting them from being charged an Accommodation Bond, doing so restricts their access to traditional services, thereby forcing them into public hospital beds. A by-product of this is that the costs of these individuals’ care are shifted from the Australian Government’s budget to those of the states and territories. This makes correcting the current arrangements costly for the Australian Government. But the emergence of a properly-functioning aged care sector relies on getting the underlying incentives right. The Band-Aid approaches taken in the past, which have focused merely on additional funding without altering the underlying incentives, have been inadequate. The challenges facing the sector will only worsen in the decades ahead, heightening the need for reform that delves deeper into the system’s underpinnings.

The lessons we’ve presented reach past the boundaries of the aged care sector and make a broader comment about the wider Australian health reform agenda. The various fields of health care share a range of common features, rooting them in a common context. Problems in one field may have an impact on another and lessons from one field may prove instructive for another. In aged care we have called for an holistic approach to reform and the elevation of incentives within the attention span of policymakers. But these calls apply just as well to the entire health care system. The time has come to embark upon a major microeconomic reform program in which aged care reform represents just one of many reform dimensions. This is no small task, but it is the surest way to produce an optimally-functioning health care system that has the health and wellbeing of all as its cornerstone.

While such an agenda might seem audacious, a reform program of a similar scale has been completed before in Australia. And it has been remarkably successful. The National Competition Policy reforms of the 1990s are proof that a bold and extensive reform agenda, if implemented appropriately, can have a positive effect on the functioning of key markets. At their core, these reforms focused on incentives. They redefined the role of public and private participants in the provision of services. Importantly, they lead to new and innovative mixes of competition and regulation to underpin well-functioning markets.

The reforms to the Australian energy sector serve as a useful illustration. One of the central measures was the unbundling of the chain of production, distribution and retail in electricity and gas, which mitigated or eliminated a raft of adverse firm behaviours. The reforms also included privatisations in some states and corporatisations of government-owned enterprises in others. The mix of competition and regulation changed dramatically in the new energy market framework. Competitive wholesale markets were introduced, since the generation of electricity and production of gas could be optimally provided in competitive markets. For natural monopoly activities newly established regulators set prices. Retail prices were initially set by governments in some jurisdictions and regulators in others, but eventually retail competition was introduced.

Importantly, the markets’ ailments were not cured overnight. While the reform process was well conceived in advance, the implementation of a successful set of arrangements took a decade or more to achieve. To this day, the various policies continue to be fine-tuned in response to an improved understanding of behaviour, changing market conditions, and market experience. The institutions that arose from the reforms took years to establish and integrate into the market landscape. The reforms were a long and costly process, but the benefits have been considerable. The problems faced by the Australian health care sector, like those described earlier in the context of aged care, call for this kind of serious reform. Band-Aids will not be enough. A well-conceived program of microeconomic reform in health care will take time to develop and implement, but the benefits are likely to be substantial.
REFERENCES


