18 May 2011

Highlights from *Help Wanted? Providing and Paying for Long-Term Care*, OECD Publishing, 2011.

- Australia expenditure on long-term care as a share of GDP is expected to at least double, and could even triple, by 2050.

- The demand for LTC workers as a share of the working population is set to increase by 140%, over the same period.

- Carers in Australia are 30% more likely to hold a temporary job and have nearly three years shorter working career than non-carers. Measures such as flexible working time can help work-care reconciliation. As in the case of the United Kingdom, the use of flexible working time is found to increase carers' working hours in Australia. On the other hand, cash benefits to the carer can raise policy trade-offs. While Australia is one of the few countries with a carer allowance, means-tested allowances generate incentives for carers to reduce hours of work (as in the United Kingdom). Low-skilled women are especially at risk.

- Working-age carers are at a higher risk of poverty. Caregiving is associated with a higher probability of experiencing poverty in Australia as in most other OECD countries, except in southern Europe. Women carer appear to be especially vulnerable to poverty risks.

- Australia, the United Kingdom and Canada are among the few countries with immigration programmes that can apply to long-term care workers. Good initiatives to attract and retain care workers should be continued, such as measures related to skill upgrading, public funding streams for care workers interested in further qualifying into a nursing profession, and efforts to re-recruit workers that left the LTC sector.

- Avoiding inappropriate use of acute health care services for LTC needs helps foster cost-efficiency. Some OECD countries have implemented policies in this direction. Like Hungary, Israel, the United Kingdom and Sweden, Australia arranges support of care outside the hospital. The average length of stay for acute care in hospitals for conditions linked to dementia nearly halved between in the past 15 years.

- With rising future expenditure for long-term care, it is unthinkable for governments to shoulder all cost linked to care for frail elderly, especially those related to board and lodging in LTC institutions. However, there is a potential role for the Australia government to facilitate the mobilisation of non-financial assets – such as a residence – towards some of the private costs associated with LTC.

- The experience of some OECD countries can be relevant to Australia. The New Zealand government providers interest-free residential care loans to assist those ineligible to a residential care subsidy. Under the 2009 Irish Fair Deal Scheme, residents in an institution are required to contribute towards cost, based on their income and assets of the resident, but the private contribution can be deferred until after the death of the resident, providing flexibility about not having to sell the resident's assets during the lifetime.

OECD (2011), *Help Wanted? Providing and Paying for Long-Term Care*, Paris,
www.oecd.org/health/longtermcare and www.oecd.org/health/longtermcare/helpwanted

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Key Facts

- In 2008, approximately 13.3% of the Australian population was over the age of 65 (OECD average 15%) while 3.7% of the population was over the age of 80.
- Australian public expenditure for long term care was 0.8% of GDP in 2005.
- In 2009, around 263,000 people aged under 65 had a profound core activity limitation and 417,000 others a severe core activity limitation (Ministry of Health, 2011).
- In 2009, 7.2% of the population over the age of 65 received long term care in institutions or medical settings with 8.6% of this population receiving care at home.
- In 2009, Just over 265,000 people used a range of specialist services and around 200,000 used Home and Community Care services (Ministry of Health, 2011).
- In 2008, there were 59,6 beds in institutions per 1000 population aged 65 years old and over (OECD Health Data 2010).
- There are 70 formal long term care nurses and personal carers per 1000 population over the age of 65 in Australia according to data available for 2007 (OECD Health Data 2010).

Background

Australia is a federation comprised of six states and two territories. The federal government has primary responsibility in financing and designing LTC for those aged 65 or more while the states and territories exercise planning and service delivery oversight of LTC for those with disabilities and aged under 65 (except in relation to employment services) and contribute most of the funding under the National Disability Agreement (over AUD 5 billion, USD 4 billion, of total government funding in 2009). The National Disability Agreement is an agreement between the Australian Government and each Australian State and Territory Government designed to improve and increase services for people with disability, their families and carers.

The Productivity Commission, the Australian Government's independent research and advisory body on a range of issues affecting the welfare of Australians, has been directed to inquire into disability service needs and provision, and during 2011, to suggest options for longer-term reform relating to both disability at birth and catastrophic injury in the course of life. The final report is due to the government on 31 July 2011.
As part of the general endeavour to better integrate the provision of care for older Australians, each year Australia creates new aged care places for the growing aged population in accordance with demonstrated regional needs within overall provision ratio targets based on numbers of people aged 70 or over.

Benefits and eligibility criteria
Benefits for those in need of care

The *Aged Care Funding Instrument* has components measuring activities of daily living, behaviour and complex health care needs, and determines the level of federal government subsidy for care providers based on the overall individual needs of clients in residential aged care either in *High level* care (24-7) or *Low level* care.

Residential care: Aged Care Assessment Teams (ACATs), comprising or with access to a range of health professionals, independently assess eligibility of individuals for residential care or home-based support packages based on their needs. Once found eligible after application of a means-test, clients can receive a federal subsidy for residential care or one of the home care package(s) for which they have been approved. As of 2010, the maximum co-payments for those in residential care have been reduced from 85% to 84% of a significantly-increased single-person base age pension, so that a pensioner had at least AUD 64.12 (USD 59) of available income per week (20% increase from the previous situation). In 2009, the average subsidy for each residential care recipient was around AUD 20 000 (USD 15 855) for those in low care and nearly AUD 52 000 (USD 41 222) for those in high care.

Non-residential care: The *Home and Community Care (HACC) program* is currently a joint federal-state program. HACC services are available to all whose needs attract sufficient priority within the funding that individual service providers still have available to assist new clients. HACC includes services such as meals, transport, community nursing, domestic assistance, personal care, home modification and community-based respite care. In 2008, when the relatively-small proportions with extensive needs are excluded, clients on average received services worth around AUD1 400 (USD 1 194) for the full year.

Community Aged Care Packages (CACPs) consist of tailored home-care services as an alternative to low level residential care for frail elderly people who have been assessed and approved by an ACAT. In 2010, 57 751 individuals benefited from federal funding for such packages. The average subsidy was around AUD12 000 (USD 9 513) in the previous year. Typically, 5-6 hours of direct assistance are provided to recipients each week.

Extended Aged Care at Home (EACH) packages are alternatives for those assessed as requiring high level residential care and are funded federally. These provide high level care to people living at home who require assistance beyond the ambit of a CACP. In 2010, 7 996 individuals were assisted this way. The average subsidy was around AUD39 000 (USD 30 917) in the previous year.

Extended Aged Care at Home Dementia (EACHD): packages are similar to EACH but extend specialised services to people with dementia. EACHD seeks to help frail older people with high level care needs and dementia that leads to behaviours of concern to stay at home. In 2010, 3 848 individuals benefited from the operational packages. The average subsidy was around AUD 45 000 (USD 35 673) in the previous year. EACH and EACHD recipients typically receive 15 to 20 hours of direct assistance each week. In the case of all three non-residential packages, the federal government sets the level of maximum daily co-payment that service providers can ask for.

Benefits for LTC-providers

In general, the capital costs of aged care are met by care recipients through the fees and charges that they pay, on which service providers earn interest and from which they may make small monthly deductions. Commonwealth recurrent subsidies, such as accommodation supplements in residential care, assist care recipients who do not have sufficient means.

The majority of funding for providers of residential care or care packages comes through the basic federal government subsidies for individuals being cared for. Residential care providers can also receive a Conditional Adjustment Payment supplement (8.75% in 2009) for participating in improvements in corporate governance and financial management practices, including in relation to staff training and provision of survey information, as well as a variety of primary care supplements for making specific services available to individuals.

A viability supplement assists aged care services in rural and remote areas to meet the additional costs of delivering services in their areas. An ongoing program of targeted capital assistance, in the form of annual capital grants, assists service providers unable to attract sufficient residents who can make accommodation payments. Since 2008, the *Zero Real Interest Loans* initiative has provided low-cost finance for building or expansion of residential and respite care facilities in areas of high need. In both cases, successful applicants are determined during each annual aged care approvals round to establish the allocation of new packages or places in residential homes.

Funding and coverage

All public LTC programs are tax based, and some require co-payments. Federal funding for residential care is means tested. Co-payments fund approximately 30% of residential care and about 10% of community aged care. The HACC program is funded by both the federal government (around 60%) and local, state and territorial governments (around 40%). Co-payments only make up 5% of HACC costs. Once certain private LTC expenditure forms part of medical expenditure that exceeds an annual threshold it qualifies for a 20% tax offset.

The federal government and state and territory governments have agreed to major reforms to the funding and operational roles and responsibilities of the LTC sector and commenced work on the development of a national aged care system. Under this system, the federal government will become the sole funder and regulator of LTC home and residential services. The federal government has directed the Productivity Commission to examine all aspects of Australia's aged care system and, by June 2011, to develop alternative options.

Delivery

Both federal and state governments are involved in LTC delivery to older Australians which is largely community based, depending on both public and private organisations. Aged care in Australia includes a range of high and

low-level community and residential care services and service-integrated housing for old people. Packaged and residential care providers may come from both the public and private sectors and be non-profit or for-profit. They must satisfy legislative criteria surrounding suitability and meet standards relating to quality, user rights and accountability, and can receive subsidies only in relation to packages or places that have been allocated during an annual competitive aged care approvals round. Residential care providers have two years in which to make new allocated places operational. LTC quality in residential care services is supervised and monitored by the *Aged Care Standards and Accreditation Agency* and there is also a formal complaints investigation scheme. The states and territories manage day-to-day HACC service delivery through a range of public and private sector organisations that meet national service standards and program guidelines.

Caregivers

In 2007, about 1.9 percent of Australia's total labour force worked in residential care and non-residential care settings (OECD Health Data, 2010). In each case the number of full-time equivalent workers was around 60% of the head count. The proportion of personal carers among LTC workers in residential care has continued to rise beyond two-thirds in recent years. About 80% of direct care providers in residential care have a formal post-school qualification, most often a certificate in aged care in the case of personal carers.

In Australia, the majority of LTC is informal. As of 2003, over 83% of LTC recipients received informal care which is usually provided by partners, family and other unpaid carers. The Australian Government provides support for family carers, mainly based on the needs of care recipients. Support mainly consists of two cash allowances:

1. One form of support is the Carer Payment which provides income support for carers whose responsibilities prevent them from undertaking substantial paid employment. As of October 2009, these payments are at pension rates, with some level of pension supplement: in March 2011, they were at least AUD 689.40 (USD 696.3) every 2 weeks for a single person; and AUD 519.70 (USD 524.9) for each eligible member of a couple. Recipients are also issued a Pensioner Concession Card, which entitles them to make a lower co-payment for prescription medicines and concessions on a range of government services, as well as increasing their prospects of 'bulk-billing' for GP appointments and reductions in fees for medical treatment not in public hospitals.

2. Tax-free Carer Allowance is a non-means-tested tax-free income supplement of AUD 110 (USD 111) per 2 weeks (2011) for people who provide daily care and support at home for an adult or child with a disability or severe medical condition. In addition, since 2009, these people are eligible for an annual benefit supplement of AUD 600 (USD 476) for every additional person cared for. Eligibility is based on a standardised needs assessment for care recipients aged over 16 years and based on care needs stemming from disabilities for under-16 care recipients.

There are additional income support schemes for carers of veterans, war widows and widowers. In addition, several respite care programs exist for counselling, education and emergency. They include day care and overnight services targeted to carers of people with severe disability. *The National Respite for Carers Program* provides short term or emergency respite in the community and services include day care, overnight and personal care services, information, and counselling. Over 140,000 carers received assistance in 2009.For those with temporary institutional care needs, the *Residential Respite* program provides short-term care stays in residential aged care facilities. There were nearly 60 000 admissions in 2009, for 23 days on average. This type of care requires approval by an ACAT.

References

OECD (2009-2010) Questionnaire on Long-Term Care Workforce and Financing

OECD (2010) *Health Data 2010*, Paris.

OECD Social and Labour Demographics Database 2010