



Aged Care Association Australia

Consumer Directed Care

Discussion Paper

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Executive Summary

Vouchers are a common instrument of income support and are regularly used in Australian life. They give consumers a monetary value for certain goods or services, to offset costs with goods and service providers of their choice.

The concept of directing funding to consumers rather than providers is being discussed in the context of the ongoing debate about reforms to Australia's highly regulated aged care system. International experience of consumer-directed care, especially in home care, is broadly positive, but its benefits and costs are highly dependent on policy settings affecting eligibility, type of payment and global budgets.

Since different aged care regulations in Australia are highly interdependent, it is important to note that, all other policy settings remaining unchanged, consumer-directed care's impact on consumers and providers will be muted. Vouchers' potential to change the sector depends on which other reforms, for example, pricing, allocation and funding, are embraced, and the way reforms are implemented.

While resident mix and usage rates in nursing homes would remain largely unchanged in the short term, greater focus on consumer choice in aged care allocations would, over time, place a greater premium on management skills needed to create and communicate offerings aligned with consumer need. Increased competition between providers in larger markets would speed the process of consolidation currently underway in the sector.

Introduction

Consumer-directed care would see a shift in government allocations, from nursing homes and home care providers, to users. This paper discusses the nature of vouchers, their contribution to the Australian aged care reform debate, international experience of their use, and considers some strategic effects of consumer-directed care in Australia.

What is a voucher?

A voucher is a certificate which is worth a certain monetary value to be spent for specific reasons or on specific goods¹. Vouchers give consumers the choice as to the good or service provider; whomever the consumer chooses receives the value of the voucher.

We all use vouchers every day. Many Australians use a petrol discount voucher from Woolworths or Coles to reduce the cost of their petrol by 4 or more cents per litre. While the choice of supplier is limited to Caltex or Shell respectively, we are able to choose the location and timing of the voucher's redemption.

Vouchers are also a popular method of Government assistance and income support, as they ensure targeted support while facilitating consumer choice. Drought assistance recipients use vouchers provided by government to offset the cost of farm, business and private electricity and other services. Older Australians' heating services are supported by Government paid vouchers. Refugees receive food vouchers.

Perhaps the most widely used type of voucher is Medicare. Excepting emergencies, consumers choose their doctors and other health service providers. Wherever Australians go, the Government contributes to their health costs through the Medicare rebate. The levels of the rebate may (if a general practitioner "bulk bills", for example) or may not cover the full fee for any particular health service. However, wherever we go, we use our Medicare voucher, with the Government paying or reimbursing its value.

¹ Wikipedia, <http://en.wikipedia.org/wiki/Voucher>, accessed 5 January, 2006.

Not that Medicare is often referred to as a voucher. The word “voucher” is regarded as politically unsaleable despite its widespread use in various forms. The debate over vouchers in education (secondary and tertiary) has seen them effectively demonised at home and abroad; alternative terms are thus sought and used. Nevertheless, vouchers simply give consumers the choice about where to access services while contributing to cost.

Vouchers in aged care

Australian discussion

Professor Warren Hogan listed vouchers as one of his longer term options for increasing choice in aged care. The goal would be to attach funding to consumers rather than attaching it to beds. Rather than prospective residents seeking out funded beds, providers would seek out funded consumers².

The Federal Government agreed to consider Hogan’s longer term options³, and that process continues. Former Minister Bishop recently foreshadowed support the development of ‘consumer-directed care’ options, funding consumers for their “long term care”, including home care⁴. At the time of writing, the Government’s much-awaited discussion paper, focussing on Hogan’s longer term options, remains to have cleared every political and Cabinet hurdle.

Industry observers have also witnessed some movement, however tentative, on the principle of consumer-directed care by players with a record of opposition to reform. Francis Sullivan, writing in a ‘personal’ capacity, has advocated a “comprehensive benefit schedule ... which provides consumers with a level of public subsidy for their care costs

² Hogan, W., 2004, *Review of Pricing Arrangements in Residential Aged Care*, Department of Health and Ageing, pp.296-297, <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-investinginagedcare-report-index.htm>.

³ Commonwealth Government, 2004, *Australian Government’s Response to the Review of Pricing Arrangements in Residential Aged Care*, <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-investinginagedcare-response-index.htm>

⁴ Bishop, J., 2005, “Consumer-driven aged care”, *The PartyRoom*, No. 2, Spring, p.25, <http://www.andrewrobb.com.au/ArchivedPublications/Default.asp>.

regardless of where they receive that care”⁵ Perhaps this refers more to the *level* of funding than the form in which it is provided.

The Australian Labor Party (ALP) has a consistent record of opposing vouchers, especially in the area of education. However, leading ALP backbencher Craig Emerson has supported the idea of funding consumers rather than providers, suggesting that “difficulties [with vouchers] could be overcome by allocating different amounts of money to different people depending upon their wealth”⁶.

International programmes

Consumer-directed care programmes in Europe and the United States (US) are like vouchers in that they allocate public funding for care to users rather than through nursing homes and community care providers. Consumers and their families have the choice over who receives public funding as the care-giver.

Beyond this general principle (funding users rather than institutions), there are wide variations as to amounts and administration⁷.

Vouchers versus cash payments

In Austria, Finland and Germany, users receive cash and may spend it on whatever they want, including aids for the home, or even household groceries. This very flexible assistance is closer to income support rather than a voucher. In France, benefits may be either channelled to a residential home or used for hiring a personal assistant. In the Netherlands, there is greater government control over how money is spent, with regional public agencies formally approving how users spend their ‘personal budgets’. As in Holland, the US organises

⁵ Sullivan, F., 2005, “Consumer centred aged care”, *Progressive Essays*, 26 November, http://www.craigemersonmp.com/progressive_essays.html.

⁶ Emerson, C., 2005, “Providing aged care in a fair society”, *Progressive Essays*, 26 November, http://www.craigemersonmp.com/progressive_essays.html.

⁷ This section is based on Tilly, J., Wiener, J.M. and Cuellar, A.E., 2000, *Consumer-Directed Home and Community Services in Five Countries: Policy Issues for Older People and Government*, The Urban Institute, October, <http://www.independentliving.org/docs4/urbani2000.html>, and Lundsgaard, J., 2002, “Competition and Efficiency in Publicly Funded Services”, *OECD Economic Studies*, No.35, <http://www.oecd.org/dataoecd/42/36/22027701.pdf>.

payment of workers through agencies, though users have the power to hire and fire.

In almost every country, relatives may be hired as personal care workers (except spouses in France and the US). The United Kingdom disallows benefits being spent on any relative.

Universal versus means tested

Austria, Germany and the Netherlands provide benefits irrespective of citizens' wealth, unlike France and the United States where benefits are limited to lower-income groups. Funding is either sourced from general revenue, or insurance programmes, some with mandatory premia (for example, Germany and the Netherlands).

Controlling costs

Demand-driven services, especially those with a flexible cash component, can easily blow out fiscally. Thus most countries have strict eligibility criteria (such as Austria and Germany limiting support to severe disability or higher care needs) and/or limits on expenditure growth (such as setting global budgets for home care, not indexing for inflation, or the Netherlands' caps on consumer-directed sub-programmes). France's complex and bureaucratic means-testing process is considered an effective deterrent against applications for assistance.

Residential versus home care

As in Australia, foreign governments are attracted to less expensive home care services, especially as it accords with users' desire to remain in their homes. Thus payments for home care can be quite generous. Three years ago in Austria, Denmark, Finland, France, Germany and Sweden payments of over 500 euros per month⁸ were well under the cost of alternative formal institutional care services⁹.

⁸ About \$A800 per month at today's exchange rate of €1=\$A1.60.

⁹ Lundsgaard, 2002, p. 106.

Implications of vouchers for Australia's aged care sector

International experiences

Tilly *et al* interviewed participants in consumer-directed home care programmes in Europe and the US. The following insights, focussed on consumer-directed home care, were reported:

- Assertive consumers with broad support networks are more likely to want to direct their own care;
- Consumers with cognitive impairment need significant support in managing services. Hogan also noted this point in his report¹⁰;
- In setting regulations, a balance needs to be struck between care agencies' inflexibility, and consumers' burden of management which can mitigate against the benefits of choice;
- Cash payments may simply be supplementing household income rather than providing quality care;
- Unsurprisingly, family members who act as carers face higher emotional stress and burdens. Paying family members for their care could lead to greater stresses;
- Close carer-consumer relationships can lead to overwork, unpaid overtime and exploitation;
- Monitoring quality is challenging. Limited supervision compounds the greater challenges of quality control when consumers direct their care (especially challenging for consumers with cognitive impairment); and
- Issues relating to the tax and social security system, and growing "grey markets" (i.e. growing black economies in home help) to avoid taxes, other on-costs and regulation.

Responses to the challenges of consumer-directed care invariably involve greater government oversight and regulation, such as, in the case of Tilly *et al*, worker registries and monitoring of client satisfaction¹¹. Australia's strong public role in aged care, typified by blaming governments for substandard care (real and perceived), could invite the threat of greater regulation in any consideration of consumer-directed care.

¹⁰ Hogan, *op. cit.*.

¹¹ Tilly *et al*, *op. cit.*, p. 10.

Consumer-directed aged care in Australia

The following discussion outlines issues which could arise from a shift to a consumer-directed allocation of government aged care funding. The effects of consumer-directed care would differ in conjunction with other reforms, for example, changes to funding levels, private contribution rates or pricing deregulation.

Today, Aged Care Assessment Team (ACAT) approval for care services permits application to fill a funded residential care bed or community care place (package). The government funds beds and community places through centralised, tightly controlled allocation processes, paying heed to flexible global targets for different types of aged care places and geographical need. Aged care places are only funded when they are filled by a resident or client.

Under consumer-directed care, ACAT approval would lead to an amount of (eligible) care funding from the government. If consumers chose a particular provider, and there was a vacancy, the dollars would flow to that provider, along with whatever additional consumer fees might apply. The Government could retain regional caps of particular types of places (low/high/extra//community) but would no longer licence beds or community packages as they do today. In a fully devolved, consumer-driven sector, aged care providers would be free to have as many or as few beds or packages as they wished based on local market and investment conditions.

The Government could use vouchers to *speed the move from residential to community care*, either through different voucher values for different types of care or different eligibility or conditions for each. Cash payments versus directly funding providers and means-testing are regulatory instruments which the government can choose from to make some types of care more attractive than others.

The Government could retain responsibility for *concessional consumers* through agency-directed programs with state governments (HACC), while deregulating its own community care programs (CACP) while moving to consumer-directed policy settings.

Of course, the Government would be held responsible for any quality problems, as it is now in a residential setting. Indeed, a move to consumer-directed care could be expected to be accompanied by a much tighter *oversight of standards* in community care.

As noted by Hogan, without greater *information about aged care services*, consumers will be confused and even agitated if given greater choice¹². Companies which effectively understand and deliver marketing communications, and ensure their business systems and services are aligned to these, will capture greater market share. The Government will also need to shepherd the industry and consumers through reform with public campaigns and industry information.

Hogan also noted the more limited benefits of consumer-driven care if consumers' cognitive abilities are limited. In the case of dementia sufferers, in the absence of a close support network, additional assistance and/or regulation would need to be considered to safeguard consumer rights and avoid exploitation.

So what effects might such a change bring to the aged care sector?

Minimal short-term residential care *profile effects*

Any Government move to consumer-directed care would likely be implemented over many years and in a way that grandfathered existing and perhaps some prospective residents, due to the breadth of the change and the need to manage voter uncertainty and concern.

In addition, if the Government decided to take full responsibility for concessional and assisted residents, this would include the vast majority of residents who are pensioners, both now and into the future¹³.

Vouchers alone are unlikely to change resident profiles, especially in high care, as co-morbidity rates are not correlated to aged care funding method or level. Physical dependence will continue to grow as the

¹² See Hogan, 2004, pp.79-80, and 297.

¹³ Although the proportion will fall, by 2031 around 65% of aged care residents will be pensioners. Sullivan, *op.cit.*, p. 4.

population ages, irrespective of how Governments and consumers share the cost.

For these reasons, the residential care sector's existing client base and usage rates are unlikely to significantly change, especially in the short term.

Younger disabled residents may take up more community care

Depending on funding levels, younger disabled residents could take the opportunity offered by vouchers to take up home-based care. American experience suggests that younger people are more confident in exercising choice of care, and about moving out of institutional care to a community¹⁴. Such preferences may be furthered by state and federal government moves to improve the care of younger disabled people. Overall, therefore, consumer-directed care could assist in providing better more appropriate care for younger disabled people, thereby freeing some places for older consumers.

Greater substitution of community for low care in longer term

Consumer-directed care could, over time, encourage less dependent consumers to substitute care services, from nursing homes to community care. The extent and speed of this shift would naturally depend on the level and nature of funding arrangements. It could also encourage an amalgamation of state and commonwealth community care programmes, though the political complexity of such a reform might limit any consideration and/or change.

Increased competition in larger markets

If a consumer has a voucher but there are only one or two providers with fixed capacity in his or her search area, consumer choice will have little practical effect. However, if there are many providers with capacity, providers will have to compete for business, seeking out and enticing consumers to their services.

¹⁴ Tilly *et al*, *op. cit.*, p. 4.

With consumer choice, larger markets such as capital cities and retirement communities in regional areas will attract more providers who will be able to build capacity without requiring departmental allocations. In the absence of guaranteed funding and tightly controlled and limited supply, securing finance and business success will require proactive and flexible management practices.

In regional areas with smaller populations, changes associated with consumer-driven care would be far less dramatic. Nevertheless, Governments may need to consider supplemental assistance to ensure stability and continuity of service.

Increased competition will drive *sectoral consolidation*

Understanding market conditions, forecasting future demand and closely monitoring changes in the community will be even more important to secure business success. Providers will succeed if they have business practices more closely attuned to consumer demands, such as finding new ways to switch resources from residential to community places easily. Superior human resources practices will be a keenly fought and guarded competitive advantage, as will professional marketing capabilities to understand consumer preferences and effectively communicate offerings, and business systems to flexibly deliver on these needs.

Conversely, aged care providers in larger markets who have small operations or who are unprofitable, or lack management skills to flexibly serve consumers, will find it even more difficult to remain in the industry.

Consumer-directed care will put an even greater premium on management skills and innovation, and will so speed the process of consolidation in the aged care sector. Greater competition will suit larger firms' balance sheets and financing capabilities, as well as management flexibility that comes with multiple operations.

Conclusion

Consumer-directed care would speed consolidation and change in Australia's aged care sector by placing consumers' needs and choices above government allocations. However, the effects of this change of philosophy in aged care funding would differ wildly depending on other reforms the Government makes. For example, the use of vouchers in a sector with a greater degree of pricing freedom would be more significant than if consumer choice was simply "tacked on" to current pricing settings.