The Australian

Aged-care package buys time but tsunami ahead

- by: Henry Ergas
- From: The Australian
- April 23, 2012 12:00AM

IT is nonsense to talk of population ageing as a problem. Rather, its main cause -- the immense rise in human life expectancy -- is perhaps society's greatest achievement. But it does create challenges, and providing aged care is central among them.

The government's reforms help address that challenge, but fall far short of resolving our aged-care system's difficulties.

The demographic facts are stark. For most of human history, life expectancy was in the order of 25 years. By 1700, it had increased to 37 years in England and The Netherlands. Then, in about 1820, a steep rise in longevity began that has increased life expectancy in high-longevity countries to about age 82.

Initially, longevity increases were almost entirely because of reductions in infant mortality. Indeed, even taking a period as late as 1921 to 1971, 60 per cent of the substantial rise in Australian male life expectancy came from reductions in death rates under the age of five. Mortality reductions at ages five to 50 accounted for the remainder. There was, in other words, virtually no increase in male life expectancy from reductions in death rates past age 50.

That changed completely in the late 1970s. Since then, about half of the still rapid gains in life expectancy have been due to falling mortality rates at ages over 80.

The result is a marked rise in the numbers surviving to very high ages, with nonagenarians and centenarians being the most quickly growing groups in the Australian population.

Nor is there any sign of those trends abating. Rather, leading bio-demographer James Vaupel estimates 50 per cent of today's babies will reach the age of 102 in Germany, 104 in France and the US, and 107 in Japan. Australia will not be far behind.

But survival to old age does not eliminate normal processes of pathogenesis. Despite medical advances, ageing continues to bring declines in the functional integrity and homeostasis of the body.

Especially in the "older old", those changes lead to ongoing, often substantial, requirements for aged-care services. However, the nature of those requirements is changing.

Traditionally, aged care was used by a small share of the population. Few made it to old age, and those who did had a few healthy years followed by a short, sharp decline. Their care needs were met by relatives, until collapsing health led to hospitalisation and death.

That pattern was especially true for men, who generally predeceased their wives.

The wives, on the other hand, faced lengthy widowhood, and it was typically a deterioration in health during that period that precipitated entry into care. Aged-care facilities therefore generally cared for single women, who suffered mainly from frailty, and whose remaining lifespan was in the order of two to three years.

Recently, however, the life expectancy gap between men and women has shrunk dramatically. In fact, among the high-longevity countries, Australia now has the smallest gender gap in life expectancy, and so has an unusually low number of years of widowhood.

Unprecedented numbers of couples consequently survive to very old age, and they naturally seek to remain at home. Moreover, their health is such that they can cope, so long as they have help with more onerous activities. The demand for home care has therefore expanded rapidly, while that for hostels, providing "low-care" services largely to widows, has almost disappeared.

At the same time, however, there has been a sustained increase in the numbers suffering from severe neurodegenerative conditions, whose incidence rises rapidly with age. Those conditions greatly reduce capability, requiring continuous assistance in special accommodation.

But they have little effect on mortality, so assistance may be needed for a decade or more. The result is rising demand for "high-care" services that are increasingly oriented to patients with dementia.

Our aged-care system has struggled to cope with those changes. Regulations restricting the number and location of places, and fixing their distribution as between types of care, have prevented adaptation to the changing level and structure of demand.

Restrictions on charges have worsened the problems, making providers' viability dependent on attracting entrants into residential low care, where entry bonds can be charged, and then migrating them into high care, where bonds are prohibited but daily payments higher. And even then, the entry bond arrangement assumes most residents will die within five years, as that is how long the bonds can be retained, and so is ever less useful as care durations rise.

Adding to the inefficiencies, the commonwealth has forced providers to subsidise full pensioners through charges on residents who pay means-tested fees. As for those fees, the exclusion of the family home from the means tests narrows the base on which they are assessed, creating inequities and encouraging avoidance.

The government's reforms remove some of these inefficiencies, including by eliminating the outdated distinction between high and low care. They also expand the services providers can offer and give consumers greater say over home-care services.

But while the Productivity Commission recommended dismantling entry restrictions and price controls, the government has shied away from liberalisation. Regulations that have impeded competition and adjustment will therefore remain.

Nor has long-run fiscal sustainability been assured. Shifting more of the financing burden on to care recipients can make sense, but exposes older Australians to significant financial risk, especially as proposed caps on outlays cover care costs but not accommodation. The Productivity Commission sought to cushion the blow by broadening the base for means testing to the family home while facilitating access to reverse mortgages. Such a wider base would increase the numbers contributing to aged-care costs and allow sustainability to be achieved with lower, less distorting, co-payment rates. It could also ease eventual inclusion of homes in the pension means test, reducing that distortion too.

Instead, by excluding family homes, the government has opted for higher rates on a narrow base, compromising sustainability, increasing incentives for avoidance and distorting decisions between aged care and healthcare, where co-payments are lower.

The proposed reforms are therefore only a useful first step. Yes, they buy time. But they leave the sector's structural problems largely unaddressed. And they do too little to enhance flexibility and competition. Until those issues are tackled, our aged-care system will remain incapable of coping with the demographic tsunami ahead.

Have your say