6 Classification of residential aged care expenditure

6.1 Background

In previous editions of the Institute's *Health expenditure Australia* and *Welfare expenditure Australia* reports, expenditure for high-level care services in residential aged care facilities was classified to health and expenditure for low-level care services was classified to welfare services. All expenditure on residential aged care facilities is now classified to welfare services in accordance with the classification practices of the Department of Finance and Administration (DoFA), the ABS, the DoHA, Productivity Commission and Department of Treasury. This chapter provides:

- some historical background on aged care policy that relates to the classification of aged care expenditure between health and welfare services
- an explanation as to why all residential aged care expenditure is now being classified as welfare services.

The DoFA classifies all Australian Government residential aged care expenditure under Government Purpose Classification (GPC) 2622 'Welfare services for the aged', and therefore all residential aged care expenditure is included under the social security and welfare function for reporting in the annual Final Budget Outcome papers and other Budget papers produced by the Treasury. These data are passed to the ABS which reports residential aged care expenditure under 'Welfare services for the aged'.

The DoHA reports residential aged care subsidies under Outcome 3 Aged Care and Population Ageing in its annual reports. It does not split these subsidies between 'health' and 'welfare' services.

The Productivity Commission publishes information on aged care expenditure in a number of contexts. In the *Report on Government Services* (SCRGSP 2007), the Productivity Commission reports all residential aged care expenditure under the Community services category, not the Health category. In its report *Economic implications of an ageing Australia* (Productivity Commission 2005), projection of aged care expenditure (including all residential aged care expenditure) was separate from health expenditure.

In the Intergenerational Reports (Treasury 2002, 2007), the Department of Treasury provides information on the impact of an ageing population on the long-term sustainability of government finances. It includes projections for spending and revenue. Information on Australian Government aged care spending and revenue is included in a section titled 'Health and aged care' with information on aged care (including residential aged care) reported separately to health.

The AIHW has been splitting residential aged care expenditure into health and welfare based on the Resident Classification Scale (RCS) categories. That is, expenditure for residents classified as RCS 1 to 4 (high level care needs) was allocated to health expenditure and expenditure for those classified as RCS 5 to 8 (low level care) was allocated to welfare services expenditure.

Table 59: Classification of residential aged care expenditure by various Australian Government agencies

Australian Government agencies	Classification	Publication
DoFA	GPC2622—Welfare services for the aged	Final Budget Outcome, Treasury (annual)
ABS	Same as DoFA	Government Finance Statistics (annual)
DoHA	Not split between health and welfare	Annual report: Outcome 3 Aged Care and Population ageing
Productivity Commission	Community services category	*Report on Government Services (annual)*
	Non-health	*Economic Implications of an Ageing Australia* (Productivity Commission 2005)
Treasury	Aged care	Intergenerational Report (Treasury 2002 & 2007)
AIHW	Part health and part welfare	'*Health expenditure Australia*', and '*Welfare expenditure Australia*'

Except for the AIHW, in recent times Australian Government agencies have been reporting residential aged care expenditure in community services/welfare services or aged care categories. Section 6.2 provides a summary of history from 1974 to the present on changes in aged care policy and its influence on classification. Section 6.3 provides a summary of the results obtained from more recent evidence on the nature of care provided to the aged in residential care facilities which inform discussion on the classification of residential aged care expenditure to welfare services.

6.2 History

Up to 1996, there were two separate Acts underpinning funding on nursing homes and hostels for the aged or people with disabilities. Payment of nursing home benefits was provided for under the *National Health Act 1953* (AGD 1953) and was allowed under the hospital benefits provision of section 51 (xxiiiA) of the Constitution. These were benefits paid by the government to individual patients in nursing homes (under section 49B of the National Health Act 1953). The fact that the hospital benefits provision of the constitution was used was an indication that nursing home benefits were seen as having a health purpose. On the other hand, the deficit funding arrangements under the *Nursing Homes Assistance Act 1974* (AGD 1974) authorise assistance to particular categories of nursing homes, rather than to individuals. It is likely, however, that it too came under Section 51 (xxiiiA).

The government's involvement in respect of hostels was under the *Aged or Disabled Persons Care Act 1954* (AGD1954). This legislation was probably enacted pursuant to the provisions of section xxiii of the Constitution, which gives the Parliament of the Commonwealth power to legislate with respect to Invalid and old-age pensions. It took the form of capital and recurrent funding to institutions that provided care to aged and/or disabled people.

The classification to health and welfare services in relation to the Australian Government's expenditure on services to the aged and the frail has changed over time. The Australian Government viewpoint on nursing homes during the earlier period, particularly 1974 to 1984 was that nursing homes were clearly 'health' institutions. This was evident both from the admissions procedures adopted in respect of patients and the nature of the type of care that was required to be delivered to patients. However, this view has gradually changed when

new evidence on the nature of care provided to older people living in residential care facilities that it is more 'welfare services'. The change became more evident after the *1986 Nursing Homes and Hostels Review* (DCSH 1986).

The *Aged Care Act 1997* (AGD 1997), which replaced the two Acts above, unified nursing home and hostel sectors. The Australian Government's new residential aged care facilities funding arrangements enabled a single form of funding in respect of care provided to all people cared for in residential aged care facilities (formerly hostels and nursing homes). Funding varied according to each resident's assessed need. The instrument used in assessing needs is called the Resident Classification Scale (RCS). There are 8 RCS categories from RCS 1 to RCS 8. These are ranked progressively in terms of intensity of need. RCS 1 to 4 are described as high-level care, and RCS 5 to 8 are low-level care. Funding for residents assessed in category 1 was the highest. Residents classified in category 8 do not attract any funding.

Table 60: Changes in aged care arrangements and policy since 1974

Year	Committee/Department/Act	Review	Changes
1974	Hospitals and Allied Services Advisory Committee (HASAC)	Nursing home staffing levels and physical standards	Eligibility certified by a registered medical practitioner
			Minimum three hours care by registered nurse per week, and seven hours care by unregistered nurses
1982	The House of Representative Standing Committee on Expenditure	Accommodation and home care for the aged	Recommendations of uniform standard 'nursing hours'
1985	The Senate Select Committee on Private Hospitals and Nursing Homes	Accommodation and home care for the aged	Recommendations of uniform standard 'nursing hours'
1986	Department of Community Services and Health	Nursing Homes and Hostels Review	Home and Community Care (HACC) extended through community housing for the elderly, self-contained units and hostels to nursing home care
			Various programs supporting residential facilities for the aged and disabled were amalgamated into a single 'Residential Care Program'
			The differential between 'personal care subsidy' for residents in hostels, and 'ordinary nursing home benefit' provided to moderately dependent patients in nursing homes, was narrowed
			'Ordinary nursing care' and 'extensive nursing care' categories were differentiated. This allowed ordinary care beds to be progressively absorbed into providing 'extensive nursing care'
1997	Aged Care Act 1997	Structure of aged care services	Nursing home and hostel sectors were unified
			Providers offered both high and low care
			Single funding to all people cared for in residential aged care facilities, through the 8 Residential Classification Scale (RCS)
Current	The Australian Government 2004 Budget announcement	Implementation of changes over four years	Replacement of the 8 RCS funding classifications with the 3 Aged Care Funding Instruments (ACFI)—low, medium and high

Some have associated higher level care categories with higher needs for health services. However, just because illness is the cause of the need for care does not mean that the provided type of care has a health purpose. A service has a health purpose if the service is actively aiming to improve a person's health or to prevent illness or injury. Most residential aged care services have a care focus rather than a cure focus. Most of the services are to cater

for needs for personal care that have developed because of declines in health status in the past, but are not directly attempting to reverse that health status decline.

The questions used to determine the resident's intensity of care needs, and thus the amount of funding paid, cover the areas listed below (Table 61). The majority of these activities (excluding 17 to 19) fall under the category of personal care assistance rather than health care. These activities can be performed by people without health qualifications, and this is another indication that the activities do not primarily have a health purpose. For funding purposes, each resident is classified according to the answers given to the RCS questionnaire. Each answer has a different weight applied and the sum of these weights gives an overall score for the resident.

Table 61: RCS question set and weightings for residential aged care population June 2003

RCS question	Description	A	B	C	D
1	Communication	0.00	0.28	0.36	0.83
2	Mobility	0.00	1.19	1.54	1.82
3	Meals and drinks	0.00	0.67	0.75	2.65
4	Personal hygiene	0.00	5.34	14.17	14.61
5	Toileting	0.00	5.98	10.65	13.70
6	Bladder management	0.00	2.22	3.82	4.19
7	Bowel management	0.00	3.32	5.72	6.30
8	Understanding and undertaking living activities	0.00	0.79	1.11	3.40
9	Problem wandering and intrusive behaviour	0.00	0.80	1.58	4.00
10	Verbally disruptive or noisy	0.00	1.19	1.75	4.60
11	Physically aggressive	0.00	2.34	2.69	3.05
12	Emotional dependence	0.00	0.28	1.50	3.84
13	Danger to self or others	0.00	1.11	1.54	1.98
14	Other behaviour	0.00	0.91	1.82	2.61
15	Social and human need—care recipient	0.00	0.95	1.98	3.01
16	Social and human need—families and friends	0.00	0.28	0.55	0.91
17	Medication	0.00	0.79	8.55	11.40
18	Technical and complex nursing procedures	0.00	1.54	5.54	11.16
19	Therapy	0.00	3.64	6.10	7.01
20	Other services	0.00	0.71	1.46	2.93

Source: DoHA 2005b. Those residents classified in category D need more assistance with that particular area as compared in those classified in the lower need A, B and C categories. And A is lower need than B, and B lower need than C.

In the 2004 Budget, the Australian Government announced a number of further changes to the residential aged care system. These changes are being implemented progressively over four years and have implications for data reporting from 2004–05 onwards. The changes with data implications are:

- replacement of the eight RCS funding classifications with Aged Care Funding Instrument (ACFI) categories:
  - –low
  - –medium
  - –high, and
- two new supplements, each paid at three levels (low, medium and high) for:
  - –mental and behavioural conditions, including dementia, and
  - –the other for complex health care needs, including palliative care.

From 20 March 2008 a new assessment instrument, the ACFI, which uses a different question set (12 questions) to the RCS classifications, will be introduced (DoHA 2007). From the date

of ACFI's introduction for the foreseeable future, the residential data set will be a mix of reporting based on a new question set (the ACFI) and reporting based on the previous question set (the 20 RCS questions) (Table 61).

6.3 Residential aged care expenditures: estimating the distribution of expenditure across different service needs

The AIHW has estimated the funding that is allocated for each RCS question for the residential aged care population as at June 2003. The 20 questions used as the basis for these calculations and details of the methodology used are available in *Welfare expenditure Australia 2005–06* (AIHW in press).

The following three areas could be considered health services: medication; technical and complex nursing procedures; and therapy. The other 17 areas, which mostly involve assistance with activities of daily living, could be considered welfare services. On that basis, the three areas allocated to health (RCS questions 17 to 19) accounted for 28% of the total government basic subsidy for residential aged care (Table 62). The other 17 areas accounted for 72% of the government basic subsidy.

This approach contrasts with the method of allocation used in previous *Health expenditure Australia* reports based on the RCS1–8 scale where RCS care need categories 1–4 were allocated to high level care and therefore to health, and RCS 5–8 categories were allocated to low level care and therefore to welfare services. This method resulted in a split of approximately 78% to health and 22% to welfare services.

Table 62: RCS questions and funding subsidies for residential aged care population June 2003

RCS question	Description	Residential aged care basic subsidy ($m)	Per cent of total expenditure
1	Communication	27	0.6
2	Mobility	99	2.2
3	Meals and drinks	65	1.5
4	Personal hygiene	942	21.2
5	Toileting	618	13.9
6	Bladder management	191	4.3
7	Bowel management	363	8.2
8	Understanding and undertaking living activities	115	2.6
9	Problem wandering and intrusive behaviour	69	1.6
10	Verbally disruptive or noisy	118	2.7
11	Physically aggressive	50	1.1
12	Emotional dependence	132	3.0
13	Danger to self or others	78	1.8
14	Other behaviour	143	3.2
15	Social and human need—care recipient	148	3.3
16	Social and human need—families and friends	33	0.7
17	Medication	493	11.1
18	Technical and complex nursing procedures	376	8.5
19	Therapy	357	8.0
20	Other services	24	0.5
Total		**4,441**	**100.0**

Source: Calculated by AIHW based on data from the DoHA Aged and Community Care Management Information System (ACCMIS) database.

Given that over two-thirds of the expenditure for residential care facilities is of a welfare services nature rather than a health nature, it is no longer appropriate to continue to use the high level care/low level care split whereby 78% of residential aged care expenditure was allocated to health and 22% to welfare services. It has been decided, after consultation with DoHA, the ABS and the Health Expenditure Advisory Committee to classify all expenditure for residential aged care facilities under welfare services, as the majority of this expenditure has a welfare purpose. This is in accord with the classification practice of the DoFA, the ABS and other government agencies.

All data appearing in this report for prior years have been revised accordingly.

There is an argument for splitting residential aged care expenditure about two-thirds to welfare services and one-third to health, but such a split is difficult to estimate technically and is not in accord with existing management and program classifications so is not a practically realistic option.

Full details of expenditure on residential aged care are given in the *Welfare expenditure Australia* reports, but a summary of expenditure for this area is given below.

Table 63: Residential aged care expenditure[(a)], current and constant prices[(b)], 1999–00 to 2005–06

Period	Current prices ($ m)	Constant prices ($ m)
1999–00	5,043	5,979
2000–01	5,273	6,252
2001–02	5,599	6,225
2002–03	6,010	6,461
2003–04	7,018	7,279
2004–05	7,247	7,247
2005–06	7,492	7,185

(a) Residential aged care subsidies from DVA, DoHA, state and territory governments, non-government organisations, injury compensation insurers, and fees from residents. Also includes payments for the Extended Aged Care in the Home program.

(b) Constant price health expenditure for 1999–00 to 2005–06 is expressed in terms of 2004–05 prices.

Source: AIHW health expenditure database.

In 2005–06, recurrent expenditure on residential aged care facilities by the Australian government, state and territory governments, and co-contribution fees paid by residents was estimated at $7,492 million (Table 63). In real terms, there was a 20.2% increase in recurrent expenditure on residential aged care facilities between 1999–00 ($5,979 million in constant prices) and 2005–06 ($7,185 million).

Implications of reclassification

Allocating all residential care subsidies to welfare services has a significant impact on the total amount of expenditure designated to health and to welfare services, and therefore the health expenditure and welfare services expenditure to GDP ratios (Table 64). Compared with the previous allocation method, the health expenditure to GDP ratio in 2004–05 is lower

by 0.65 percentage points and the welfare services expenditure to GDP ratio is higher by 0.65 percentage points (Table 64). However, under both approaches the combined health/welfare services expenditure to GDP ratio remains the same at 12%.

Table 64: Health and welfare services expenditure to GDP ratio based on two classification approaches, 2004–05 and 2005–06 (per cent)

	Based on residential aged care expenditure split between health and welfare by RCS 1-4/5-8		Based on all residential aged care expenditure allocated to welfare services	
	Health to GDP	Welfare services to GDP	Health to GDP	Welfare services to GDP
2004–05	9.7	2.4	9.05	3.0
2005–06	9.6	2.4	9.0	3.0

Source: Calculated by AIHW from the health and welfare expenditure databases and the DoHA ACCMIS database.