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Productivity Commission

Caring for Older Australians

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The Productivity Commission

The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long term interest of the Australian community.

The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

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28 June 2011

The Hon Bill Shorten MP
Assistant Treasurer
Parliament House
CANBERRA ACT 2600
Dear Assistant Treasurer

In accordance with Section 11 of the *Productivity Commission Act 1998*, we have pleasure in submitting to you the Commission's final report into Caring for Older Australians.

Yours sincerely

Handwritten signature of Mike Woods in cursive.

Mike Woods
Presiding Commissioner

Handwritten signature of Robert Fitzgerald in cursive.

Robert Fitzgerald AM
Commissioner

Handwritten signature of Sue Macri in cursive.

Sue Macri AM
Associate Commissioner

Terms of reference

PRODUCTIVITY COMMISSION INQUIRY INTO AGED CARE

I, NICK SHERRY, Assistant Treasurer, pursuant to Parts 2 and 3 of the *Productivity Commission Act 1998*, hereby refer aged care to the Commission for inquiry and report by April 2011. The Commission is to hold hearings for the purpose of the inquiry and produce a draft report by December 2010.

Background

Aged care is an important component of Australia's health system. The National Health and Hospitals Reform Commission (NHHRC) considered that significant reform is needed to the aged care system, including its relationship to the rest of the health system, if it is to meet the challenges of an older and increasingly diverse population. These challenges include:

- a significant increase in demand with the ageing of Australia's population;
- significant shifts in the type of care demanded, with:
 - : an increased preference for independent living arrangements and choice in aged care services,
 - : greater levels of affluence among older people, recognising that income and asset levels vary widely;
 - : changing patterns of disease among the aged, including the increasing incidence of chronic disease such as dementia, severe arthritis and serious visual and hearing impairments, and the costs associated with care;
 - : reduced access to carers and family support due to changes in social and economic circumstances;
 - : the diverse geographic spread of the Australian population; and
 - : an increasing need for psycho geriatric care and for skilled palliative care;
- the need to secure a significant expansion in the aged care workforce at a time of 'age induced' tightening of the labour market and wage differentials with other comparable sectors.

Taking into account the findings of the NHHRC, the Government's proposition for a National Health and Hospitals Network, other recent reviews, including the Senate Standing Committee on Finance and Public Administration's *Inquiry into residential and community aged care in Australia*, and the Productivity Commission's 2009 *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services* as well as the relevant conclusions of the forthcoming *Australia's Future Tax System* review, the Productivity Commission is requested to develop detailed options for redesigning Australia's aged care system to ensure it can meet the challenges facing it in coming decades.

The inquiry should also have regard to the Government's social inclusion agenda as it relates to older Australians.

Scope of the Inquiry

The Commission is requested to:

1. Systematically examine the social, clinical and institutional aspects of aged care in Australia, building on the substantial base of existing reviews into this sector.
2. Develop regulatory and funding options for residential and community aged care (including services currently delivered under the Home and Community Care program for older people) that:
 - ensure access (in terms of availability and affordability) to an appropriate standard of aged care for all older people in need, with particular attention given to the means of achieving this in specific needs groups including people living in rural and remote locations, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, and veterans;
 - : The Commission is specifically requested to examine how well the mainstream service system is meeting the needs of specific needs groups.
 - include appropriate planning mechanisms for the provision of aged care services across rural, remote and metropolitan areas and the mix between residential and community care services;
 - support independence, social participation and social inclusion, including examination of policy, services and infrastructure that support older people remaining in their own homes for longer, participating in the community, and which reduce pressure on the aged care system;
 - are based on business models that reflect the forms of care that older people need and want, and that allow providers to generate alternative revenue streams by diversifying their business models into the delivery of other service modalities;
 - are consistent with reforms occurring in other health services and take into account technical and allocative efficiency issues, recognising that aged care is an integral part of the health system and that changes in the aged care system have the potential to adversely or positively impact upon demand for other care modalities;
 - are financially sustainable for Government and individuals with appropriate levels of private contributions, with transparent financing for services, that reflect the cost of care and provide sufficient revenue to meet quality standards, provide an appropriately skilled and adequately remunerated workforce, and earn a return that will attract the investment, including capital investment, needed to meet future demand. This should take into consideration the separate costs associated with residential services, which include but are not limited to the costs of accommodation and direct care, and services delivered in community settings;

-
- consider the regulatory framework, including options to allow service providers greater flexibility to respond to increasing diversity among older people in terms of their care needs, preferences and financial circumstances, whilst ensuring that care is of an appropriate quality and taking into account the information and market asymmetries that may exist between aged care providers and their frail older clients;
 - minimise the complexity of the aged care system for clients, their families and providers and provide appropriate financial protections and quality assurance for consumers; and
 - allow smooth transitions for consumers between different types and levels of aged care, and between aged, primary, acute, sub-acute, disability services and palliative care services, as need determines.
3. Systematically examine the future workforce requirements of the aged care sector, taking into account factors influencing both the supply of and demand for the aged care workforce, and develop options to ensure that the sector has access to a sufficient and appropriately trained workforce.
 4. Recommend a path for transitioning from the current regulatory arrangements to a new system that ensures continuity of care and allows the sector time to adjust.
 - In developing the transitional arrangements, the Commission should take into account the Government’s medium term fiscal strategy.
 5. Examine whether the regulation of retirement specific living options, including out-of-home services, retirement villages such as independent living units and serviced apartments should be aligned more closely with the rest of the aged care sector, and if so, how this should be achieved.
 6. Assess the medium and long-term fiscal implications of any change in aged care roles and responsibilities

NICK SHERRY

Dated 21 April 2010

Disclosure of interests

The *Productivity Commission Act 1998* specifies that where a Commissioner has or acquires an interest, pecuniary or otherwise, that could conflict with the proper performance of their function during an inquiry he/she must disclose the interests.

Mr Robert Fitzgerald AM has advised the Chairman of the Commission that he holds an interest in the following organisation:

- The Benevolent Society — Vice President (voluntary position)

Ms Susanne Macri AM has advised the Chairman of the Commission that she holds an interest in the following organisations:

- RSL LifeCare — Director (honorary)
- The Royal District Nursing Service (Director)

Current consultancy clients:

- Guild Accountants Pty Ltd
- Simavita Pty Ltd

Acknowledgments

This paper uses unit record data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey. The HILDA Project was initiated and is funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and is managed by the Melbourne Institute of Applied Economic and Social Research (Melbourne Institute). The findings and views reported in this paper, however, are those of the author and should not be attributed to either FaHCSIA or the Melbourne Institute.

Contents

The Commission's report is in two volumes. **This volume 1 contains the Overview, Recommendations, Summary of proposals, and chapters 1 to 5.** Volume 2 contains chapters 6 to 17, appendix A and references. Below is the table of contents for both volumes. Appendices B–H are referred to in the chapters but not included in this report. They are available on the Commission's website (www.pc.gov.au)

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Abbreviations and explanations

AAT	Administrative Appeals Tribunal
ABS	Australian Bureau of Statistics
ACC	Aged Care Commissioner
AACC	Australian Aged Care Commission
ACAR	Aged Care Approval Round
ACAT	Aged Care Assessment Team
ACCC	Australian Competition and Consumer Commission
ACD	Advance Care Directive
ACAA	Aged Care Association of Australia
ACFI	Aged Care Funding Instrument
ACSA	Aged and Community Services Australia
ACSAA	Aged Care Standards and Accreditation Agency
ADL	Activities of daily living
AHURI	Australian Housing and Urban Research Institute
AIHW	Australian Institute of Health and Welfare
ALGA	Australian Local Government Association
AMA	Australian Medical Association
ANAO	Australian National Audit Office
ANF	Australian Nursing Federation
ASIC	Australian Securities and Investments Commission
BCA	Building Code of Australia
CACP	Community Aged Care Package
CALD	Culturally and linguistically diverse
CCIP	Community Care Intermediate Package
CDC	Consumer-directed care
CEDA	Committee for the Economic Development of Australia
CIS	Complaints Investigation Scheme
COAG	Council of Australian Governments
COPO	Commonwealth Own-Purpose Outlays
COTA	Council on the Ageing
CQC	Care Quality Commission

CSIRO	Commonwealth Scientific and Industrial Research Organisation
DoHA	Department of Health and Ageing
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
EACH-D	Extended Aged Care at Home Dementia
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
FPA	Financial Planning Association of Australia
Gateway	Australian Seniors Gateway Agency
GDP	Gross domestic product
GLBTI	Gay, lesbian, bi-sexual, transgender and intersex
GP	General Practitioner
HACC	Home and Community Care
HILDA	Household, Income and Labour Dynamics in Australia
HMM	Home maintenance and modification
IADL	Instrumental activities of daily living
ICT	Information and communications technology
IGR	Intergenerational Report
ILU	Independent living unit
LHMU	Liquor, Hospitality and Miscellaneous Union (United Voice)
LTC	Long term care
LTCI	Long term care insurance
MDS	Minimum Data Set
MPS	Multi-purpose Services
NACA	National Aged Care Alliance
NCAC	National Childcare Accreditation Council
NCS	National Carer Strategy
NDIS	National Disability Insurance Scheme
NESB	Non-English speaking backgrounds
NFP	Not-for-profit
NHHRC	National Health and Hospitals Reform Commission
NHSC	National Housing Supply Council
NQRF	National Quality Reporting Framework
NRCP	National Respite for Carers Program
NSA	National Seniors Australia
OACC	Office of the Aged Care Commissioner
OACQC	Office of Aged Care Quality and Compliance

OECD	Organisation for Economic Co-operation and Development
OHS	Occupational health and safety
PAYG	Pay-as-you-go
PC	Productivity Commission
PCA	Palliative Care Australia
RACF	Residential aged care facility
RCS	Resident Classification Scale
RTO	Registered Training Organisation
RVA	Retirement Village Association
RVRA	Retirement Village Residents Association
SCARC	Senate Community Affairs References Committee
SCRGSP	Steering Committee for the Review of Government Service Provision
SEQUAL	Senior Australians Equity Release Association of Lenders
SSAT	Social Security Appeals Tribunal
UK	United Kingdom
UN	United Nations
US	United States of America
UTS	University of Technology Sydney
VCEC	Victorian Competition and Efficiency Commission
VHC	Veterans' Home Care
WHO	World Health Organization

Explanations

Billion	The convention used for a billion is a thousand million (10 ⁹).
Key points of emphasis	<i>Key points of emphasis in the body of the report are highlighted using italics, as this is.</i>
Recommendations	<i>Recommendations in the body of the report are highlighted using bold italics with an outside border, as this is.</i>

Glossary

Activities of daily living (ADLs)	ADLs are a core set of self-care or personal care activities that include bathing and washing, dressing, feeding, getting in and out of bed, getting to and from the toilet and continence management.
Aged care	A range of services required by older persons (generally 65 years and over (or 50 years and over for Indigenous Australians)) with a reduced degree of functional capacity (physical or cognitive) and who are consequently dependent for an extended period of time on help with basic ADLs. Aged care is frequently provided in combination with basic medical services (such as help with wound dressing, pain management, medication, health monitoring), prevention, reablement or palliative care services.
Aged Care Assessment Team (ACAT)	A multidisciplinary team of health professionals responsible for determining the care needs and services an individual may require. ACATs are known as Aged Care Assessment Services in Victoria.
Aged Care Funding Instrument (ACFI)	The ACFI is a resource allocation instrument which focuses on three domains that differentials care needs among residents. The ACFI assesses core needs as a basis for allocating funding.
Aged Care Planning Region	The geographical region used by the Department of Health and Ageing in its Aged Care Approvals Round.
Aged care recipient	People receiving aged care services in institutions or at home.
Ageing in place	The provision of care which allows a person to remain in their home or in the same residential care facility even if their care needs change.
Ambulatory care	Care on a non-admitted or outpatient basis; patients usually 'walk in and walk out'.
Approved Provider	Approved Providers are organisations approved by the Australian Government, to receive subsidies for the provision of aged care services and accommodation to residents within an aged care home, or for the provision of care and services to people in the community.
Australian Aged Care System	The aged care system that is proposed by the Commission in this report. Services provided under this system would require an entitlement and includes personal care, nursing care, reablement services, home modification services and planned respite. It does not include Community and Carer support services.
Baby boomer	A baby boomer is someone born during the demographic birth boom immediately following World War II to around the early 1960s.
Care coordination	The coordination of services, provided with the aim of enhancing care delivery and transitions, and including preliminary care plans and identification of the need for more intensive case management.

Care leaver	A person brought up in care away from their family as state wards or home children raised in Children’s Homes, orphanages or other institutions, or in foster care.
Care recipient	A person who is receiving care and support, either in the community, in their own home or in a residential aged care facility.
Care setting	Means the place where recipients of care services live.
Case management	An essential aspect of care delivery provided to individuals and including ongoing monitoring of support, detailed planning of clinical care and other aspects of delivery. Provided in part by residential aged care facilities and community care providers to people receiving care.
Clearinghouse	A central access point which serves the needs of users of a specific field and body of knowledge. Similar to a repository, clearinghouses often receive, organise and disseminate information, which can range from broad research and information provision to more specific data networks.
Commonwealth own purpose outlays (COPO)	Outlays made directly by the Commonwealth (Australian Government) in providing a service or function to the community. These outlays are made solely by the Commonwealth for their own purpose and therefore do not pass ‘to’ or ‘through’ the States and Territories.
Community and carers support services	Community and carers support services are low intensity services which can be accessed either directly or through entitlements or referrals. Services would include meal preparation, community transport, day therapy and carer support services.
Community Aged Care Package (CACP)	Individually planned and coordinated packages of care tailored to help older Australians with low-level care needs to remain living in their homes. They are funded by the Australian Government.
Community care	Is provided to people with functional restrictions who mainly reside in their own home. It also applies to the use of institutions on a temporary basis to support continued living at home — such as community care centres and respite. Community care also includes specially designed, ‘assisted or adapted living arrangements’ for people who require help on a regular basis while guaranteeing a high degree of autonomy and self-control.
Community care services	Home and Community Care (HACC) services, Community Aged Care Packages (CACPs), Extended Aged Care at Home packages (EACH), Extended Aged Care at Home Dementia packages (EACH-D), Veterans’ Home Care (VHC), Community Nursing and respite services.
Consumer	Someone that uses aged care services and products.
Consumer-directed care (CDC)	An approach to care that allows people to have greater choice and control over the care and support services they receive, to the extent that they are capable and wish to do so. The concept of ‘choice’ in CDC varies, and can include allowing people to make choices about the types of care services and benefits they access, the delivery of those services and benefits, or choice of service provider.
Everyday living expenses	Includes food, laundry, heating and cooling and social activities.

Extended Aged Care at Home (EACH) packages	Individually planned and coordinated packages of care, tailored to help frail older Australians with high levels of care needs to remain at home. They are funded by the Australian Government.
Extended Aged Care at Home Dementia (EACH-D) packages	An EACH package with a higher level of funding to provide additional care at home for people with dementia. They are funded by the Australian Government.
Extra service	Extra service status allows residential aged care facilities to offer a higher standard of accommodation, services and food and charge extra fees for these. Extra services may be provided throughout the facility or in a specific wing or section. The level of care provided is the same as that provided generally in residential aged care facilities.
Forgotten Australian	See Care leaver
Formal care	Includes all care services that are provided in the context of formal employment regulations, such as through contracted services, by contracted paid care workers.
Grandfathering	The continued application of the status quo to existing users of a system in order to protect against disruptive change.
Home and Community Care (HACC)	A program which provides a broad range of low-level care and support services to help people maintain their independence at home and in the community. HACC is a joint Australian, state and territory government initiative.
High care	The care which is provided for people who have been assessed by an ACAT (or Aged Care Assessment Services in Victoria) and need a high level of assistance with most activities of daily living (ADL). It may include accommodation services as well as personal care.
Informal carers	Are individuals providing aged care on a regular basis (often on an unpaid basis and without contract), for example, spouses/partners, family members, as well as neighbours or friends.
Inpatient	An individual who has been admitted to a hospital or other facility for diagnosis and/or treatment that requires at least an overnight stay.
Instrumental activities of daily living (IADL)	Domestic tasks such as shopping, laundry, vacuuming, cooking a main meal and handling personal affairs.
Low care	The care which is provided for people who have been assessed by an ACAT (or Aged Care Assessment Services in Victoria) and need a low level of assistance with activities such as meals, laundry and cleaning as well as additional help with personal care.
Market failure	Occurs when the allocation of services or goods by a free market is not efficient. Market failure can be caused by information asymmetries, externalities and public goods.
Multidisciplinary care	Where health professionals from multiple disciplines work together to provide team-based care.
Not-for-profit	An organisation that does not distribute profits or surpluses to personal owners or shareholders.
Outpatient	A person treated or seen in a hospital clinic without being admitted.
Palliative care	Care provided for people of all ages who have a life-limiting illness, with little or no prospect of cure and for whom the primary, treatment goals is quality of life. It focuses on 'living well' until death.

Personal care services	Includes assistance with bathing, toileting, eating, dressing, mobility, managing incontinence, community rehabilitation support, assistance in obtaining health and therapy services and support for people with cognitive impairments.
Person-centred care	An approach to care that consciously adopts a person's perspective. This perspective can be characterised around dimensions such as respect for a person's values, preferences and expressed needs; coordination and integration of care; involvement of family and friends; and transition and continuity.
Primary carer	A person who provides the most assistance, in terms of help or supervision, to a person with one or more disabilities on an ongoing basis.
Principal residence	Meaning the principal home as defined in section 11.A of the <i>Social Security Act 1991</i> .
Protected person	A 'protected person' exclusion applies if, at the time of the assets assessment or the date of entry into care (whichever is earlier): <ul style="list-style-type: none"> • the partner or dependent child is living in the resident's former principal residence • a carer eligible for an income support payment has lived in the resident's former principal residence for at least two years • a close relative who is eligible for an income support payment has been living in the resident's former principal residence for at least five years.
Reablement	Intensive and generally time-limited programs aimed at restoring function. Services included as part a reablement approach can include physiotherapy, psychosocial and other education programs, environmental modification and linkages to social activities.
Residential aged care	Refers to facilities (other than hospitals) which provide accommodation and aged care as a package to people requiring ongoing health and nursing care due to chronic impairments and a reduced degree of independence in activities of daily living (ADL). These facilities provide residential aged care combined with either nursing, supervision or other types of personal care required by the residents. Aged care institutions include specially designed institutions where the predominant service component is long-term care and services are provided to people with moderate to severe functional restrictions.
Respite care	Care given as an alternative care arrangement with the primary purpose of giving the carer or a care recipient a short-term break from their usual care arrangement.
Sub-acute services	May include rehabilitation, geriatric evaluation and care management. Some sub-acute services are colloquially referred to as 'low dependency' or 'step up' and 'step down' care, meaning that it can either precede (and potentially avoid) a hospital admission or follow an acute hospital admission. Most sub-acute services can be provided on either an inpatient or ambulatory basis.
Supported residents	A person who qualifies for subsidised aged care accommodation costs because they have total assets below a certain level.

Teaching aged care services	Formalised partnership arrangement between universities and residential aged care facilities which aim to increase the scope for collaborative research, evidence-based practice and ongoing education for nursing staff and allied health students.
Transition care	Short-term care that seeks to optimise the functioning and independence of older people after a hospital stay. It seeks to enable more people to return home after a hospital stay rather than enter a residential aged care facility.
Veterans' Home Care (VHC)	Provides low level home care services to eligible veterans and war widows and widowers.

OVERVIEW

Key points

- Over one million older Australians receive aged care services. The range and quality of these services have improved over past decades, but more needs to be done.
- Future challenges include the increasing numbers and expectations of older people, a relative fall in the number of informal carers, and the need for more workers. By 2050, over 3.5 million Australians are expected to use aged care services each year.
- The aged care system suffers key weaknesses. It is difficult to navigate. Services are limited, as is consumer choice. Quality is variable. Coverage of needs, pricing, subsidies and user co-contributions are inconsistent or inequitable. Workforce shortages are exacerbated by low wages and some workers have insufficient skills.
- The Commission's proposals address these weaknesses and challenges and aim to deliver higher quality care. The focus is on the wellbeing of older Australians — promoting their independence, giving them choice and retaining their community engagement. Under this integrated package of reforms, older Australians would:
 - be able to contact a simplified 'gateway' for: easily understood information; an assessment of their care needs and their financial capacity to contribute to the cost of their care; an entitlement to approved aged care services; and for care coordination — all in their region
 - receive aged care services that address their individual needs, with an emphasis on reablement where feasible
 - choose whether to receive care at home, and choose their approved provider
 - contribute, in part, to their costs of care (with a maximum lifetime limit) and meet their accommodation and living expenses (with safety nets for those of limited means)
 - have access to a government-sponsored line of credit (the Australian Aged Care Home Credit scheme), to help meet their care and accommodation expenses without having to sell their home. A person's spouse, or other 'protected person' would be able to continue living in that home when an older person moved into residential care
 - choose to pay either a periodic charge or a bond for residential care accommodation
 - if they wish to sell their home, retain their Age Pension by investing the sale proceeds in an Australian Age Pensioners Savings Account
 - have direct access to low intensity community support services
 - be able to choose whether to purchase additional services and higher quality accommodation.
- Limits on the number of residential places and care packages would be phased out, while distinctions between residential low and high care and between ordinary and extra service status would be removed.
- Safety and quality standards would be retained. An Australian Aged Care Commission would be responsible for quality and accreditation; and would transparently recommend efficient prices to the Government.

Overview

Older Australians generally want to remain independent and in control of how and where they live; to stay connected and relevant to their families and communities; and be able to exercise some measure of choice over their care.

While changes to the aged care system over past decades have increased the range and quality of care and support available to older Australians, there are significant variations in the quality of services. However, fundamental reform is required to overcome the delays, discontinuities, constraints and shortages that currently exist, and to respond to future challenges. The challenges include:

- a significant increase in the number of older people
- an increasing incidence of age-related disability and disease, especially dementia
- rising expectations about the type and flexibility of care that is received
- community concerns about variability in the quality of care
- a relative decline in the number of informal carers
- a need for significantly more nurses and personal care workers with enhanced skills.

Aged care can be greatly improved. Government policies, programs and regulations, and the services offered by community groups and businesses, need to be redesigned around the wellbeing of older people and be delivered in ways that respect their dignity and support their independence. Services need to be affordable for older people and for society in general.

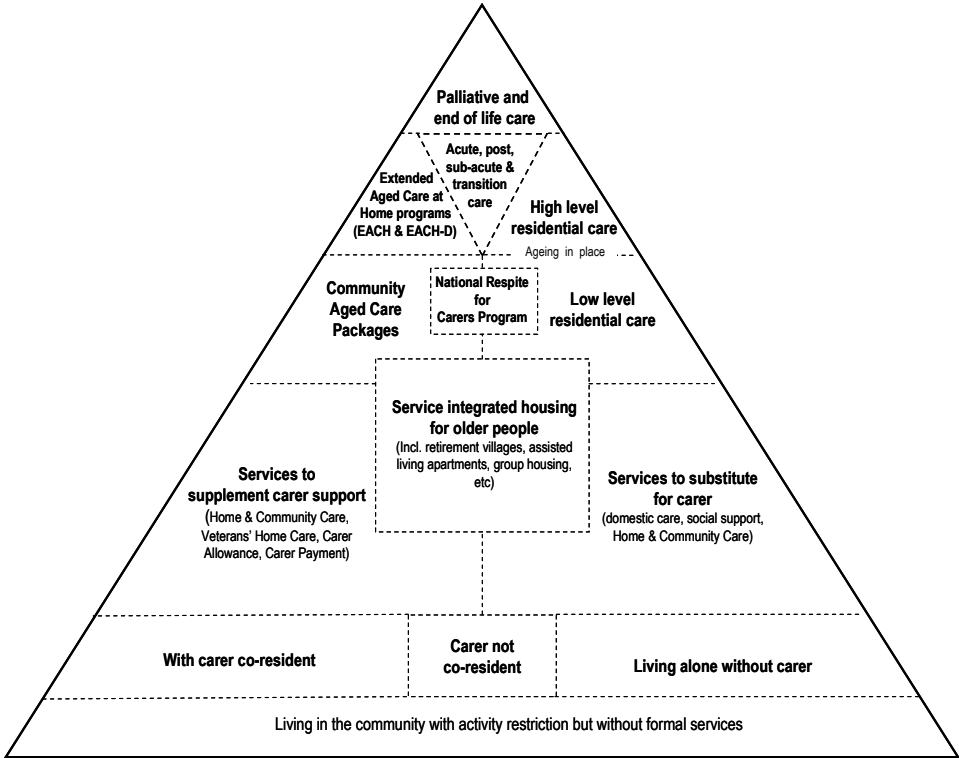
The Productivity Commission has been asked to develop detailed options to redesign and reform Australia's aged care system and to recommend a transition path to a new system.

Australia's current aged care system

Most Australians who reach old age can expect to need aged care services. Within limits, the types of services, their intensity, and their duration, are provided according to each older person's assessed needs. The aged care service continuum is represented in figure 1.

Care and support is mainly provided by partners, family, friends and neighbours — of those older Australians receiving assistance in the community, about 80 per cent receive it from informal carers.

Figure 1. **Current modes of care in the aged care system**



In addition, government-subsidised services are provided to over one million older Australians (and their carers) each year, with more than half receiving low intensity support through the Home and Community Care (HACC) program. The number of higher level community care packages and residential care places in each region is limited by needs-based planning ratios — 25 places per 1000 people aged 70 or over for community care packages and 88 places for residential care. However, not all approved places in each region are being used.

As at 30 June 2010, more than 160 000 Australians received permanent residential care, with the majority receiving high level care. In recent years, around 70 per cent of residents were female and around 55 per cent of residents were aged 85 years or older.

In 2009-10, Australian, state and territory government expenditure on aged care was around \$11 billion, with two-thirds of that expenditure directed to residential aged care.

Strengths and weaknesses of the current system

The strengths and weaknesses of the system are well known.

In terms of the former, the range and quality of care and support available to older people has been increasing, with quality and safety standards continuing to improve. The workforce is generally appropriately skilled and dedicated to caring. However, due to the variable quality of training, some workers have insufficient skills.

But, there are many weaknesses. The need for fundamental and wide-ranging reform has been identified in the 2004 Hogan Review, the 2009 National Health and Hospitals Reform Commission Report, the 2010 Henry Review, the Commission's previous reports, the analysis it has undertaken for this inquiry, and in the many submissions from inquiry participants. Concerns about the current system include:

- delays in care assessments and limits on the number of bed licences and care packages — older people may suffer excessive waiting times and have limited choice of care providers, while providers have reduced incentives to become more efficient, improve quality, innovate, or respond to consumer demand
- discontinuous care across the packages of community-based services — changes in an older person's care needs can lead to a change in their 'care package', care provider, and personal carer
- constrained pricing — concerns include the low level of charges for high care accommodation, declining hours of service within the care package funding levels, the rate of indexation for subsidies, and the need for a 'temporary' Conditional Adjustment Payment
- difficulties in obtaining finance, in particular, to build high care residential facilities
- financial inequities — the levels of user co-contributions are inconsistent and inequitable within and between community and residential care
- insufficient and inadequate funding for restorative and reablement care; and for palliative and end-of-life care
- variable care quality across the system, which older Australians and their carers also find complex and difficult to navigate
- uncertainty about care availability — there is limited confidence among those needing care that they can leave their care package during periods of greater wellness and independence and re-engage readily should their circumstances change

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- workforce shortages — due in part to low wages, high administrative loads arising from the burden of regulation, strenuous work environments and limitations on scopes of practice
 - complex, overlapping and costly regulations — with an embedded culture in governments of excessive risk aversion and a lack of independence of some regulatory activities
 - insufficient independence of the complaints handling process from the Department of Health and Ageing (DoHA) — with policy development and the administration of regulation being combined, contrary to best practice
 - incomplete and overlapping interfaces — within and between jurisdictions, and also with health, disability, mental health, housing and income support.

Future challenges

The dimensions of the challenges facing aged care are well known, but worthy of a brief review.

- The number of Australians aged 85 and over is projected to increase from 0.4 million in 2010 to 1.8 million (5.1 per cent of the population) by 2050.
- By 2050, it is expected that over 3.5 million older Australians will access aged care services each year, with around 80 per cent of services delivered in the community.
- There is increasing diversity among older Australians in their preferences and expectations (which continue to increase), including a greater desire for independent living and culturally relevant care. This is particularly relevant for many culturally and linguistically diverse, sexually diverse, and Indigenous communities.
- The *Intergenerational Report 2010* estimated that Australian Government spending on aged care would increase from 0.8 per cent of GDP in 2010 to 1.8 per cent of GDP by 2050.
- While further advances in the management of some diseases are expected, more people will require complex care for dementia, diabetes and other morbidities associated with longevity, as well as palliative and end-of-life care.
- Many older Australians with low income have substantial wealth, which gives them the capacity to meet their lifetime accommodation costs and to make a modest contribution to the costs of their care, subject to a reasonable safety net.
- The relative availability of informal carers will decline, reducing the ability of some older people to receive home-based care.

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- The aged care workforce will need to expand considerably at a time of ‘age induced’ tightening of the overall labour market, an expected relative decline in family support and informal carers, and strong demand for workers from other parts of the health and disability systems. It will need to adopt new models of care and scopes of practice.
 - There is a need to harness new, cost-effective assistive and information technologies that offer opportunities for productivity gains and higher quality care.

The system, as currently configured, cannot withstand these challenges. Fundamental reforms are needed and the new arrangements should be built on a clear statement of the Government’s policy objectives for the caring of older Australians.

Policy objectives

There are strong rationales for government involvement in aged care, including equity of access to appropriate care, the protection of vulnerable consumers and the correction of market failures such as gaps in the provision of information. The Australian Government has principal responsibility for aged care planning, funding and regulation, and for supporting informal carers. The Government states that it:

... aims to ensure that all frail older Australians have timely access to appropriate care and support services as they age ... through a safe and secure aged care system. (DoHA 2009, p. xi)

A number of participants presented their visions of a future system of care and support for older Australians. While the visions varied, they had many common themes, including that: the focus should be on wellbeing; services should promote independence; and people should be able to make their own life choices, even if it means they accept higher levels of risk. Older people should be treated with dignity and respect and should be able to die well. Carers of older people should be adequately supported.

The overriding objective of public policy is to improve the wellbeing of the community as a whole. In the context of aged care policy, the focus for older people should be on their physical and emotional needs, connectedness to others, ability to exert influence over their environment, and their safety — within their expressed life choices. At a broader level, the wellbeing of family members, friends and neighbours who provide care to older people, and people who provide formal care also need to be considered. The effects of policies on current and future taxpayers who fund care subsidies should also be taken into account.

To guide future policy change, the aged care system should aim to:

- promote the independence and wellness of older Australians and their continuing contribution to society*
- ensure that all older Australians needing care and support have access to person-centred services that can change as their needs change*
- be consumer-directed, allowing older Australians to have choice and control over their lives and to die well*
- treat older Australians receiving care and support with dignity and respect*
- be easy to navigate, with older Australians knowing what care and support is available and how to access those services*
- assist informal carers to perform their caring role*
- be affordable for those requiring care and for society more generally*
- provide incentives to ensure the efficient use of resources devoted to caring for older Australians and broadly equitable contributions between generations.*

While the distinction between the various components of aged care costs are not always clear, unpacking aged care (into accommodation, everyday living, health and personal care costs) is important for designing future funding principles for aged care and for ensuring consistent subsidies and user contributions across care settings.

The Australian Government should adopt separate policy settings (including for subsidies and co-contributions) for the major cost components of aged care, namely care (including personal and health care), everyday living expenses and accommodation.

This report offers a detailed plan for implementing a new policy framework which encapsulates the Commission's proposed objectives and approaches to policy settings.

Consumer-directed care

Older Australians told the Commission that they did not want to be passive recipients of services, dependent on funded providers. Rather, they wanted to be independent and be able to choose where they live, which provider they would use, the way in which services are delivered, and whether to purchase additional services and/or a higher standard of accommodation.

There is strong empirical evidence that consumer choice improves wellbeing, including higher life satisfaction, greater life expectancy, independence and better continuity of care. In addition, competition amongst providers in a system where consumers can exercise choice leads to a more dynamic system, with enhanced incentives for greater efficiency, innovation and quality. A more flexible system would also enable providers to increase the range and scope of their services, freeing them from the current highly regulated, risk-averse regime. Regulations should revert to a more appropriate role of ensuring safety and quality, protecting the vulnerable and addressing market failures.

A simplified gateway to the aged care system

The current system is complex and difficult to navigate. For older people to be able to exercise choice, they need relevant, current and accurate information that they can easily understand.

The Commission proposes that this information be delivered by a new national platform that integrates, simplifies and enhances the current disparate information networks (including the National Carelink and Respite Centres and DoHA sites). A single Australian Seniors Gateway Agency (the Gateway) would be responsible for the information platform. Older Australians would be able to access the Gateway's information directly both centrally and through its regional outlets, or through general practitioners (GPs), health clinics, Centrelink or other entry points. There are significant advantages to enabling a plurality of information sources, with all of those services founded on the one coherent and integrated source of information.

The Gateway would consolidate the many assessment processes currently undertaken by HACC providers and Aged Care Assessment Teams (ACATs). For older people to receive an entitlement to approved aged care services, they would first need to be assessed by (or on behalf of) the Gateway, by a local team of professionals.

Similarly, an assessment of the capacity of informal carers, and any support they may require, would also be part of the Gateway's functions but carers could also separately approach Carer Support Centres for a wide range of assistance, including emergency respite.

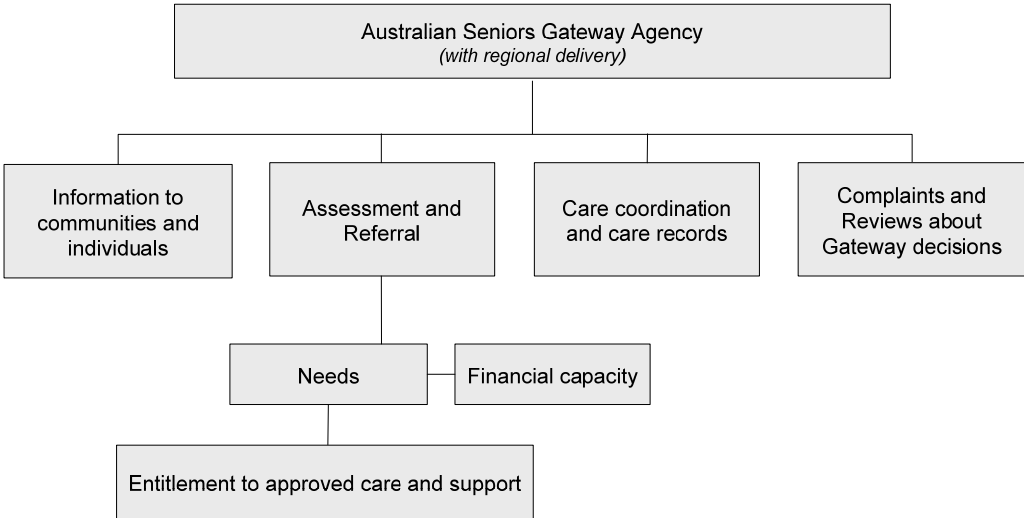
Assessors would use a set of criteria that would apply for all levels of care and support in both community and residential settings. The Gateway would arrange for Centrelink to undertake a separate assessment of the older person's financial capacity to make co-contributions, where required.

Other, lower-intensity community and carers support services outside of the formal Aged Care System (figures 3 and 5) would continue to be accessed directly, or be provided as part of a Gateway-assessed entitlement or referral.

Coordination of aged and health care, and of the providers of that care, becomes increasingly important for older people as the scope and complexity of their needs increase. This role is already performed by a number of general and nurse practitioners, community health clinics and Community Options Program providers. The Gateway would offer a default care coordination service and assess a person’s need for more complex case management, as appropriate, the latter being available as an entitlement.

The Commission proposes the establishment of an Australian Seniors Gateway Agency which would be responsible for maintaining the national aged care information database, and for delivering assessment and care coordination services (figure 2). Older Australians assessed as needing care would receive an entitlement to services through the Agency.

Figure 2 Australian Seniors Gateway Agency



An electronic record of assessments, entitlements, co-contributions and use of approved services would overcome the need for older people to repeatedly tell their story to different agencies and providers. It should also reduce errors and inconsistencies in care records and enhance coordination across the various providers of care, support, health and accommodation. The record would assist with administering lifetime limits to personal care expenditure as set out below. Such records would be protected under the *Privacy Act 1988*.

Care that meets the needs of older Australians

The care needs of older Australians vary from person to person and over time, as ageing is a unique experience. Care needs depend on people's functional capacities, physical and mental health, culture and language, and the environment within which they live. Accordingly, older Australians need access to a flexible range of care and support services that address their specific current needs and, to the extent possible, restore their independence and wellness.

Under the current system, some care needs are not being met because of inflexibilities within the system. While the HACC program has some ability to deliver a variety of services to meet the individual needs of its clients, community care packages are less flexible bundles of services. There are limits to their supply and funding, and there are large gaps between packages.

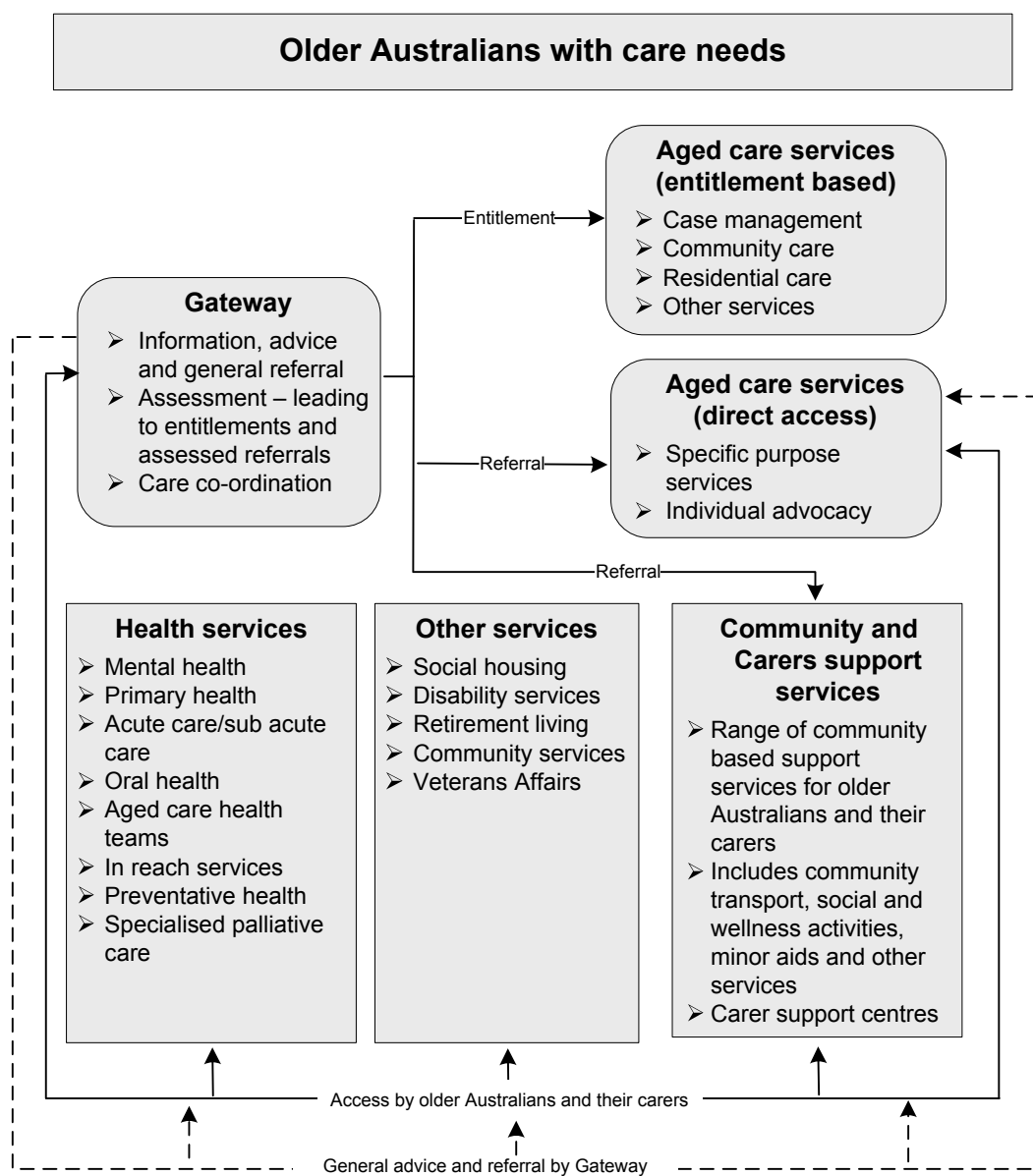
The Commission proposes a model of care and support that offers a flexible range of services to meet older people's individual needs using a mixed approach to access. This combines an entitlement-based approach with direct access for some services (figure 3).

Older Australians who experience an increase in frailty might require personal care services such as daily showering and dressing, assistance with eating, toileting, oral hygiene and health monitoring. The number and/or intensity of care services that older people need can increase — but this might be temporary rather than permanent — or decrease.

Older Australians might also increasingly require specialised care, such as for wound management, and other health (including dental) and nursing care, including dementia and challenging behaviour, incontinence, palliative and end-of-life care, and restorative care and rehabilitation, including transitional and sub-acute care.

Under the Commission's proposed model, older Australians would receive an entitlement to approved aged care services upon assessment by the Gateway. The entitlement would cover care services including personal and nursing care as well as more specialised services. This could also include case management as well as access to high level aids and home modifications. Care recipients would receive a detailed care assessment outlining care objectives, the type and intensity of services to meet the objectives, and the total value and timeframe of the entitlement.

Figure 3 Accessing aged care and support



Older Australians would also have access to lower intensity community support services (such as home maintenance and meal preparation). These services could either be accessed directly or through the Gateway as a referral, or as an entitlement where those services are assessed as being essential to the delivery of higher or more complex levels of service. The full range of aged care services and community supports are set out in figure 5.

Assistance would also be provided to informal carers, and include ongoing planned and emergency respite, either through aged care providers or specialised carer support services.

Providers of aged care services (in the community or as operators of residential aged care facilities) and community and carers support services would need to be approved, with many requiring accreditation and appropriate regulatory oversight.

Where appropriate, services would be modified to meet the particular needs of special needs groups. And, importantly, as needs change, consumers or providers would be able to initiate a reassessment by the Gateway, which could result in increased or decreased levels of support or a change in service mix. In residential care facilities, the provider could undertake such ongoing reassessments, subject to validation and audit processes.

Opening up the supply of care and accommodation to enhance choice

Current trends in service use underline the mismatch between what is offered by the system and what older people want. There is a high and unmet demand for the limited number of community care packages and a decline in demand for residential low care. Many, especially those not suffering from dementia, are deferring entry into residential high care until they reach greater frailty. However, providers are presently constructing very little new residential high care unless it is for ‘extra service’ places, which allows them to charge accommodation bonds.

The current limits on the supply of services often preclude older people, who have an ACAT approval for services, from choosing between competing approved providers. In the Commission’s view, competition would be a powerful incentive for providers to improve quality and efficiency, and to offer care solutions that best address the needs of individuals.

Crucially, by opening up supply in the aged care system, the Commission’s recommendations are designed so that older Australians can be confident about getting the care they need when they need it, including in situations where their condition has deteriorated.

As part of the new consumer-directed arrangements, the Commission proposes the progressive relaxation and eventual removal of supply-side limits on bed licences, community care packages and other services, while maintaining quality standards and provider accreditation. As a temporary measure, to improve service responsiveness, an additional service level should be added between community aged care packages (CACPs) and extended aged care at home (EACH).

To improve the flexibility of supply in residential care, the Commission is proposing to overturn the alignment between intensity of care and type of accommodation (low care in hostel settings and high care in nursing homes), noting that the more recent policy of ‘ageing in place’ has already blurred the boundaries.

Also in need of reform are the current methods of charging for accommodation which similarly differentiate between high care (daily charges) and low care and extra service (accommodation bonds). For high care at the present time, the one daily rate applies equally to old three-bed rooms and to newly constructed single rooms with ensuites and is also set at a level which is insufficient to ensure investment in new residential high care facilities.

The Commission proposes that the current distinctions between residential low and high care and between ordinary and extra service status be removed.

To enable older Australians to exercise informed choice when deciding on their community or residential care provider, all providers should be required to publish up-to-date information about their approved services in terms of availability, quality and price in each local area, and the cost of any additional services they choose to offer. Quality and accreditation assessments for residential and community care should be published by the proposed Australian Aged Care Commission (AACC) (see below).

This opening up of supply, and creation of a responsive and competitive market, will require providers to change their business models and will test the management skills of some. However, the transition must be orderly, to ensure the ongoing delivery of safe, quality care to older people and the viability of the aged care industry, while not protecting individual providers.

The Commission recognises that being able to choose between competing providers is not always feasible. In some situations, the pricing recommendations of the proposed AACC would include supplements (or block funding) to providers of specialised services (such as specific aged care services for homeless people) and to those operating in rural and remote areas (including Indigenous-specific flexible aged care services). The report provides commentary on testing the further use of market-based instruments, block funding and multipurpose services in thin markets.

Funding aged care

Increases in the public costs of aged care are inevitable, given the greater longevity of older people and the lifetime risk of requiring aged care (table 1), the ageing of the baby boomers, and increased expectations as to the quality of services. The costs of public health and the Age Pension are also expected to increase. Although currently each Australian aged 65 years or older is supported by five people of working age, by 2050 this ratio is expected to fall to 2.7. Thus, service delivery must become more effective and efficient, but this will not, in itself, sufficiently reduce the rate of growth of public expenditure.

Table 1 Lifetime risk of requiring aged care, 2006–08

<i>Remaining lifetime risk of requiring care (%)</i>	<i>At birth</i>	<i>At age 65</i>	<i>At age 75</i>	<i>At age 85</i>	<i>At age 95</i>	<i>At age 100 or over</i>
Females	62	68	72	80	83	65
Males	42	48	53	62	67	41

The relaxation of supply-side constraints is essential to improving choice and competition, but it will add to the risk of even greater public expenditure unless there are also changes to funding arrangements. The Commission aims to contain the fiscal risks associated with aged care, while recognising that, even under the current system, the public costs to the Australian Government are projected by the *2010 Intergenerational Report* to rise significantly.

Many participants to the inquiry, including consumer organisations, recognised that if aged care were to be greatly improved, there would need to be higher aged care contributions from those older Australians who have the financial capacity to pay, provided that those with limited means were protected. Co-contributions were also seen as a way of encouraging people to more closely assess the value of the care and support they were receiving, to better appreciate the value of those services and in turn to increase pressure on providers to improve the range and quality of their services.

Providers' concerns with the funding arrangements centred on the residential high care accommodation charge and the indexation rates applying to care payments. They claimed that the former no longer provides an adequate return on capital, and drew attention to the reduction in the construction of residential high care facilities. Providers who have both low and high care licences are cross subsidising from the escalating values of low care and extra service accommodation bonds and from the carry forward of bonds into high care through 'ageing in place'. The average bond paid by new residents has risen from \$58 000 in 1997-98 to over \$230 000 in 2009-10. Thus, whereas the average bond exceeds the cost of new construction for basic residential accommodation, the accommodation charge in non-extra service high care is insufficient to meet a reasonable return on equity for investment in new construction.

A further significant funding issue is the complex and distortionary interaction between the income and assets tests for the Age Pension and for co-contributions for aged care. Incoming residents have an incentive to pay large accommodation bonds so as to retain their Age Pension and reduce their care co-contributions. Providers have an incentive to ask for high bonds as they are an interest-free source of debt financing, and their ability to get them has been reinforced by artificial supply constraints.

A new care co-contribution regime

Under current arrangements, there is considerable discontinuity between the levels of private co-contributions paid for HACC services, for CACP and EACH packages, and for care delivered in residential aged care facilities. This has led to inequities between older people with the same needs and the same financial capacity, and to an inefficient allocation of resources within and between the different forms of community and residential care.

The Commission proposes that the current arrangements be replaced by a single national care co-contribution regime which would apply across the Aged Care System, whether services are delivered in the community or in a residential aged care facility. The rate of the private co-contribution would be set according to a person's financial circumstances, with the amount paid varying according to the underlying price (which would reflect both the complexity and extent of care). The Government, on the transparent advice of the proposed AACC, would set care prices. Co-contributions for services delivered under the Aged Care System would be treated separately from user charges for community support services.

To reinforce the transfer of choice and control to older people, they would be responsible for paying their co-contribution directly to the provider, or providers, from whom they selected to purchase services. They would also assign their Government subsidy to the selected approved provider(s). Older people could change providers at their discretion, with the Government subsidy then flowing to the newly selected approved provider(s).

The design of the co-contribution regime needs to take into account the variability of the financial capacity of older people to make a co-contribution. While the majority of older Australians receive either a full or part Age Pension, even by 2050, a large proportion of these pensioners are expected to have considerable wealth, with the principal residence making up most of this wealth. Currently, the median household of those aged 65 to 74 holds around 79 per cent of their net worth in their principal residence, rising to 90 per cent for the median household of those aged 75 and over.

The Commission proposes that a person's capacity to contribute to aged care be based on an assessment of both their income and their assets, and that this assessment be undertaken on behalf of the Gateway by Centrelink. For the income assessment, the Age Pension's income test would be used — for ease of understanding by older people and for efficiency of administration. However, to promote equity, the assets test needs to overcome the exclusion of the principal residence and accommodation bonds from the Age Pension assets test. A further

complexity of the current Age Pension assets test is that lump sums arising from the sale of the principal residence, but invested in instruments other than housing or accommodation bonds of similar value, are not exempt assets. The Commission therefore proposes that all people be subject to an assets test on those assets exempt from the Age Pension assets test (such as the principal residence and accommodation bonds). The income test would include interest deemed to accrue from assets included in the Age Pension assets test. Such an approach would retain the familiarity with, and efficiency of, a Centrelink social security assessment. It would not affect the person's ongoing eligibility for the Age Pension.

The Commission proposes that the assessment of financial capacity to pay care co-contributions use a 'comprehensive aged care means test'. For income, the Age Pension income test would apply, including interest deemed to accrue from assets that are included in the Age Pension assets test. The assets test would apply to those assets exempt from the Age Pension assets test (such as the principal residence and accommodation bonds).

The Commission recognises that the new arrangement will require some older people, whose wealth is in assets rather than income, to draw down on those assets. An existing scheme, the Pension Loans Scheme administered by Centrelink, enables people of Age Pension age (or their partners) to receive, or top up, their pension payments to the level of a full Age Pension by accessing capital tied up in their assets. The 'loan' is secured against Australian real estate owned by the person — primarily their principal residence. A similar arrangement could be attractive where an older person moves into residential care and their partner or dependent remains in the principal residence, or to help them fund their care co-contributions while living at home.

The Commission proposes that older Australians should not be required to sell their home to meet their aged care co-contributions or accommodation costs. For older Australians whose financial capacity is mainly in the form of their principal residence, there be a Government-backed Australian Aged Care Home Credit scheme, which they could flexibly draw against for their care co-contribution and other aged care accommodation costs up to a specified limit. The scheme would be designed to protect those remaining in the former principal residence, such as a spouse, partner or dependent child with a disability (and other protected persons). The scheme would charge interest on the outstanding balance at a rate equal to the consumer price index, but, as a safeguard, there would be a minimum asset floor below which no further funds could be drawn, and interest would be no longer charged.

Protection against very high costs of care

The costs of aged care (not including accommodation and everyday living costs) vary considerably. They can range from less than \$1000 per annum for basic home support to around \$50 000 for people with dementia on an intensive package in the community, and to around \$65 000 per annum for the highest cost of care services in a residential facility.

The starting point for the Commission is to ensure that care co-contributions are reasonable and affordable, that they are comparable with current arrangements for those of limited means, and that they do not place any group in a position of hardship. Hence, the Commission recognises that some people would not be able to contribute. The report illustrates the effects of an upper limit of co-contributions of 25 per cent of the cost of care, for people with the greatest income and assets, and also illustrates the effect of other upper limits. The final decision as to the appropriate level of co-contributions is one for the Government in balancing the relative proportion of private co-contributions and taxpayer funding. For the purposes of this report and the illustrative cameos, an indicative range of co-contributions of zero (for those with least means) to 25 per cent (for the wealthiest) of the cost of care services was chosen. On this basis, the Commission estimates that two-thirds of community care recipients and three-quarters of residential care recipients would pay a care co-contribution of 15 per cent or less in 2013.

A further source of variability is the probability of needing very costly care. Lifetime estimates show that 68 per cent of women and 48 per cent of men at age 65 will require at least one intensive aged care service at some time in their remaining life (table 1). Less predictable is whether an individual will require such services for an extended period. Many who suffer dementia and need long term residential care fall into this category, and so can others such as those with acquired brain injury or long term chronic health care conditions.

The Commission proposes that, as a safeguard, there would be an upper limit — a lifetime stop-loss limit — to the value of care co-contributions for approved aged care services that any one person pays over their lifetime, irrespective of their financial circumstances. The report illustrates the effect of an indicative lifetime limit of \$60 000, but also examines other limits that the Government might choose.

The lifetime stop-loss limit should be subject to annual indexation at a rate announced by the Government on the transparent advice of the AACC.

The price paid to providers for care services (by way of the user co-contribution and the relevant public subsidy) should be set by the Australian Government at a level

which meets the cost of efficiently delivering approved aged care services. The service payment amounts should be updated annually based on transparent recommendations from the AACC. The level of payment would continue to recognise, as appropriate, any different costs of providing care to special needs groups, including Indigenous Australians and older people living in rural and remote areas. There would be some form of block funding of specialised services, such as for the homeless.

Funding accommodation

The Commission, and many participants in this inquiry, consider that accommodation expenses are a personal responsibility throughout life, while recognising that there are accommodation subsidies (including the availability of public housing and rental assistance) for those in need.

As noted earlier, there are many distortions in the present residential aged care funding arrangements. In terms of high care, providers receive a standard daily accommodation payment, irrespective of the number of beds per room, age of facility or quality of fittings. There is evidence that the present daily charge for high care accommodation does not provide an adequate return on the cost of new supply. Some allocated beds have not been made operational, new rounds of allocations have not been fully subscribed, and some bed licences are being handed back.

In low care and extra service high care, escalating accommodation bond values are a consequence of their attraction to providers and to pensioners. A number of participants argued for the extension of bonds to high care, but if bonds were left uncapped, this could burden many more older people.

In designing its proposals, the Commission focussed on the following considerations. The need to:

- provide a sustainable funding regime to allow for long term investment in aged care residential accommodation
- design a comprehensive but fair co-contribution regime to assist older Australians to access the equity in their principal residence and so contribute to their care costs but be protected from catastrophic costs of care and from having to sell their home
- remove incentives for the payment of very high accommodation bonds that are disproportionate to the value of the accommodation.

Under the Commission's proposals, accommodation providers would receive a sufficient payment from all residents to meet a reasonable return on equity to

maintain and build new facilities, irrespective of whether they receive periodic payments or accommodation bonds. The proposals also remove the incentive for intending residents to pay excessive accommodation bonds by providing an Australian Age Pensioners Savings Account, (which preserves their access to the Age Pension should they choose to sell their home) and by ensuring that care co-contributions are not affected by the size of any accommodation bonds. By removing supply constraints, providers will be less able to use their market power to demand excessive bonds.

The Commission proposes the establishment of an Australian Age Pensioners Savings Account scheme, for those on a full or part-rate Age Pension who wish to deposit all or some of the proceeds of the sale of their principal residence. The real value of the savings account would be maintained by consumer price indexation, and be excluded from the Age Pension assets and income tests. The savings account could be drawn down flexibly by the account owner for any purpose.

The Commission proposes that residential care providers be required to offer a periodic accommodation charge, and, where offered, an accommodation bond of an equivalent (or lower) value, and for both to be published.

In the face of actual or potential competition, the Commission expects that the price of accommodation would be reflective of its value, rather than of the wealth of the consumer. To guard against temporary opportunities for price exploitation, however, the Commission proposes price monitoring during the transition period.

For those in rural and remote localities, where market forces are likely to be weak, the Commission proposes that residential services be provided by the most appropriate local means, whether through a competitive tender or through block funding.

Unlike the current aged care system where older Australians are often forced to sell their home to pay an accommodation bond, the Commission's proposals provide them with the alternatives of an Australian Age Pensioners Savings Account scheme and Australian Aged Care Home Credit scheme.

These reforms, together with the lifting of supply constraints, would enable competing providers to offer a range of accommodation, from a basic standard to very high quality. Older people would be able to choose the standard of accommodation that they want and could afford, just as they have done when living in the community. Those with limited means would, however, be supported through an adequately funded supported residents subsidy.

The Commission proposes that the Australian Government set a supported resident ratio (or quota) in each region, to be met by residential care providers. In setting regional ratios, the Government should assess the potential social impact within regions and, where appropriate, set ratios for subregions that exhibit a degree of homogeneity in the demographic mix. A pilot scheme to test the viability and efficacy of trading supported resident ratio obligations within the same region (or subregion) should be undertaken. If successful, the scheme should be extended to all regions to increase flexibility in the delivery of services.

The Commission suggests that the approved basic standard of accommodation for supported residents should be funded at the prevailing applicable standard of 1.5 beds per room per facility on average, with the funding amount to be transparently assessed by the AACC.

Financing the costs of aged care

The Commission examined a range of options for broadening the funding base to meet the costs of caring for older Australians.

Voluntary personal insurance would allow risk-averse individuals to insure against the possibility of high care costs but it is unlikely to work in anything but a very modest way because of problems on both the supply and demand side of the insurance market. Under the lifetime stop-loss co-contribution model proposed by the Commission, where the Government covers all approved costs above a nominated cap, there could be a role for voluntary personal insurance as the Government would be taking on the ‘long risk’ that individuals and insurers are less willing to accept. Accordingly, the Commission does not support restrictions to voluntary personal insurance being offered by the private sector.

Compulsory aged care savings accounts were rejected as they would reduce choice over savings vehicles and it is essentially too late for this strategy to effectively fund the aged care costs of the baby boomers. Two other broad options have been analysed: compulsory insurance, and the continuation of pay-as-you-go funding from annual government budgets and co-contributions.

The benefits and costs of a compulsory insurance model are explored in the Commission’s parallel inquiry into a national disability long term care and support scheme. Suggested benefits include greater intergenerational equity and certainty of the availability of funds. This option is, in practice, similar to the mandatory taxpayer funded component of the current funding arrangements. That is, to the extent that government ultimately bears the risk of any unfunded care, the notion of strict risk-pooling within a defined benefit fund loses much of its meaning. Indeed,

government-owned insurance schemes have, in the past, returned surpluses to, and requested funding (to offset shortfalls) from, general revenue respectively.

Under a compulsory insurance model, there are also uncertainties relating to the actual premiums that should be set for future care, as well as administration and fund management costs. Under some schemes, premium payments to a compulsory insurance pool represent little more than the hypothecation of taxes, or some sub-set of the taxes, such as a levy on income. Any move to a compulsory insurance model raises significant design and transitional issues.

A key difference between the aged care and disability sectors is that the probability of needing to receive care and support in old age is much higher than the probability of acquiring a non age-related disability. Many older Australians needing aged care services have generally had the opportunity to purchase a home and to accumulate other wealth such as retirement savings, and therefore have the financial capacity to contribute to the costs of their care. Care co-contributions by older Australians, and ongoing responsibility for providing their own accommodation, achieve a measure of intergenerational equity. Also, as the boomers are moving into their retirement years, their scope to contribute to an insurance pool is limited.

Overall, in terms of meeting the costs of aged care, the Commission proposes a pay-as-you-go tax financed system supplemented by higher co-contributions from those with the financial capacity to make them, and a lifetime stop-loss mechanism (to achieve risk pooling) for the high costs of care. Cameos illustrating the effects on various cohorts of care recipients are at schedule C.

The Commission's projections suggests that the Australian Government's outlays under the reformed arrangements could represent in the order of 2.0 per cent of GDP by 2050, compared to the *Intergenerational Report's* projection of 1.8 per cent for the existing system on a comparable basis. Under the Commission's proposals, the Australian Government would meet around two-thirds of the costs of the proposed scheme, with one-third being paid for by, or on behalf of, care recipients.

An estimate of the cost to the Australian Government of the Commission's proposals over the forward estimates period is illustrated in table 2.¹ For the first few years, the cost to government is lower than in the current forward estimates because of the relatively early introduction of the proposed co-contribution regime, while the expansion of residential and community places is gradual over a number of years.

¹ This table is for illustrative purposes only, and assumes that the co-contribution regime commences from 1 July 2012.

Table 2 Aged care expenditure by the Australian Government — forward estimates and Commission’s proposals

Millions of dollars (nominal)

	2012-13	2013-14	2014-15
Forward estimates	12 390	13 180	14 090
Commission’s proposals	11 077	12 084	13 310

To ensure comparability, the Commission has not included the assessment component, labour force initiatives and information provisions in both the forward estimates and in the Commission’s proposals. While the forward estimates are only available to 2014-15, the Commission estimates that the public cost of its proposals would exceed the cost of the current arrangements by 2016-17.

The Commission has not included potential savings from its proposals in its estimates, in particular through the more efficient use of hospitals and the provision of sub-acute services in residential care facilities at a lower cost.

The Commission is conscious that the removal of limits on aged care supply represents the removal of a significant constraint on the Australian Government’s potential expenditure over time. However, current supply limits restrict the ready availability of services and the exercise of choice by older people and the degree of competition between providers. Their repeal is essential to the success of the reforms. As the Australian Government could manage its fiscal exposure by setting the criteria for needs assessments, the resource levels for approved services, the co-contribution schedules and the standard for basic accommodation, the Commission considers that the removal of restrictions on supply is warranted and appropriate.

Care delivery by informal carers and the formal workforce

Older people want to be cared for by someone who cherishes them, who has time for them, and who respects their right to make their own decisions. Most older people also want to continue to be relevant and connected to their families and communities. Informal carers and the formal care workforce play important roles in providing care and support. Volunteers also contribute to the wellbeing of older people, with many providing highly valued social engagement and spiritual support, and should be appropriately supported in these roles.

Informal carers

Family members and other informal carers, such as friends and neighbours, provide most of the care for older people. They assist with personal and health care, and coordinate the various formal services that the older person might be using.

Demographic trends indicate there will be a decline in the relative availability of informal carers, coinciding with an increased demand for aged care services. There are important implications of these opposing trends — most notably, the potential for greater reliance on formal care services for those with dementia — which will place increasing pressure on care resources and public expenditure.

The significant value to society from the care delivered by informal carers has been recognised by governments through carer payments and other support measures.

To further support carers of older Australians, the Commission proposes that the assessment of the needs of older people by the Gateway acknowledge the role of carers and provide entitlements for the older person to planned respite and other services where appropriate. Carers can also have an assessment of their needs undertaken by a Carer Support Centre. As proposed in this report, these carer services may be accessed either directly or through a referral from the Gateway. Carer supports should include carer education and training, carer counselling and peer group support, and advocacy services. Services specifically for supporting carers should be coordinated and undertaken, where appropriate, by a network of Carer Support Centres, which could also provide services to carers of people with disabilities. Most emergency respite services would also be organised and administered through these Carer Support Centres.

Broader reforms to the aged care system will also be of assistance to carers. These include the replacement of a variety of information sources with a single, easily understood and navigable information platform, and the availability of more flexible care options which are designed to meet the individual needs of those for whom they are caring.

The formal workforce

The high standards of aged care are due, in large part, to the skill and dedication of Australia's health and personal care workforce. In this inquiry, the Commission has focused mainly on the contribution of nurses and personal carers whose roles and skill sets are directly concerned with providing care to older Australians. However, the Commission also recognises the important contributions made by support workers in residential facilities and in home maintenance services for the elderly,

allied health professionals and medical specialists, and the primary and acute health care workforce more generally.

As the number of older Australians rises and the demand for aged care services increases, there will be a commensurate increase in demand for a well-trained aged care workforce. The Commission anticipates that the aged care workforce will need to more than quadruple by 2050, at a time when the overall employment to population ratio will be declining. Aged care employers will be under pressure to offer terms and conditions which will attract sufficient numbers of workers.

Opportunities to ameliorate this rising level of demand for aged care services are canvassed in the report, such as through the promotion of older people's independence and wellness, and the greater provision of reablement care services.

Improved employment terms and conditions are the foundation for building a larger supply of workers in the aged care sector. The most notable shortcoming is the low wage rates for personal carers and the long standing disparity between the wages paid to nurses employed in the aged care sector compared to those employed in comparable settings, such as the public health system. The fiscal impact of increases in wage rates would be felt equally on the current system or the reformed system as proposed by the Commission.

But wage increases alone will not be enough to set the industry on a sustainable path. A coordinated approach to improving the attractiveness of the aged care sector is necessary and will involve paying fair and competitive wages, improving access to high quality education and training, developing well-articulated career paths, improved management, extending scopes of practice, reducing the regulatory burden, and better use of technology. While some of these initiatives may improve productivity, aged care will remain a labour intensive service.

The Commission proposes that scheduled care prices take into account the need to pay fair and competitive wages to nursing and other care staff. The Commission is also supporting the development of more attractive career paths, opportunities for professional development, improved managerial expertise and a review of registered training organisations to ensure the quality of delivery of accredited courses.

The Commission has highlighted the need for workers who have a close connection with the cultural backgrounds of their clients. Attracting Aboriginal and Torres Strait Islander workers and workers from specific cultural and linguistic backgrounds will be especially important in the provision of appropriate care.

Reform of the regulatory framework

This inquiry confirmed the findings of previous reports that the current aged care system contains a plethora of unnecessary, complex and burdensome regulations. Many of them relate to quantity and price restrictions and over-reaction to specific incidents. Problematic governance arrangements have also inhibited best practice regulation. That said, regulation plays an essential role in how the Government manages the risks to the wellbeing of older Australians and the fiscal risks to taxpayers.

Many of the reforms proposed in this report will require the removal of existing regulation and, in some cases, amendments to reflect the new arrangements. The most important changes involve restructuring Australian Government governance arrangements.

The Commission proposes to simplify and streamline the front end of the aged care system through the establishment of the Gateway. This reform would consolidate a number of functions currently carried out by DoHA and by state and territory agencies and funded services.

The Commission also proposes that the policy functions of DoHA be separated from the regulation of aged care, with the latter to be undertaken by an independent commission: the Australian Aged Care Commission (AACC).

The main functions of the AACC (figure 4) would include:

- administering regulations covering the quality of community and residential care, prudential requirements and supported resident ratios, and assisting and educating providers in relation to compliance and continuous improvement
- assessing, reporting, and transparently recommending and monitoring service prices
- providing information, including collecting and disseminating data
- determining and referring complaints and handling reviews.

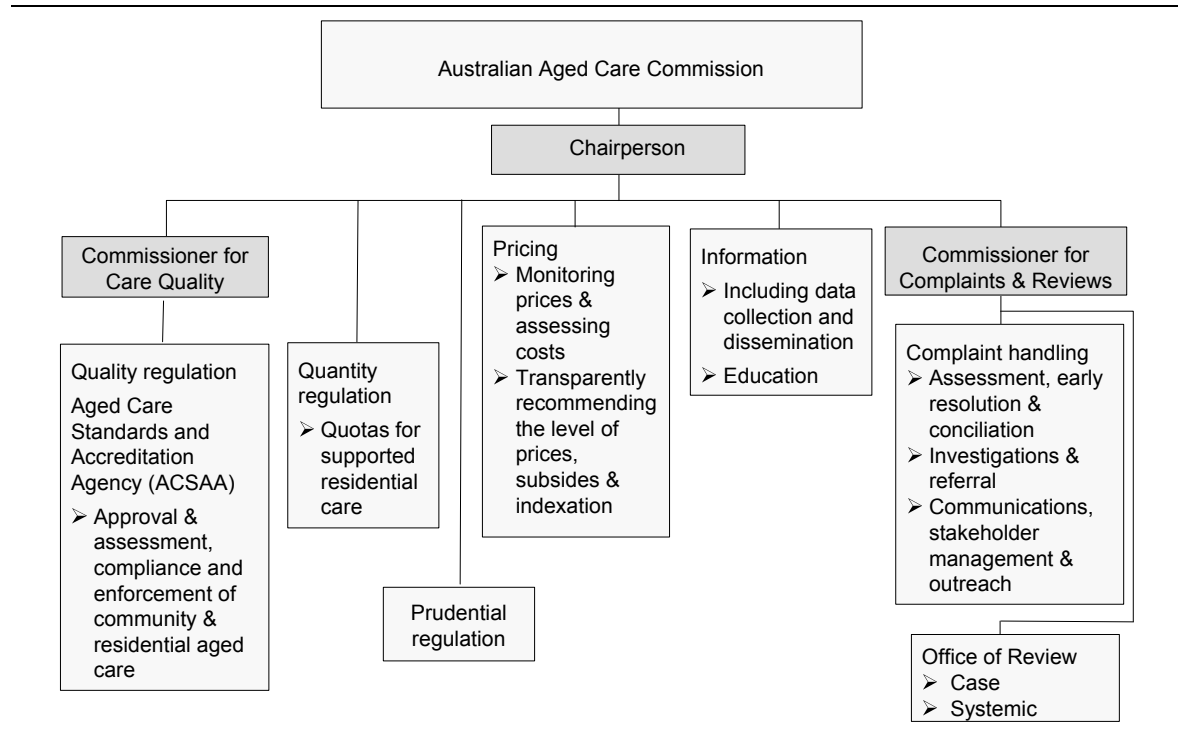
The AACC would have three full-time, statutory Commissioners: a Chairperson; a Commissioner for Care Quality (including standards and accreditation); and a Commissioner for Complaints and Reviews.

The Commission proposes that the Aged Care Standards and Accreditation Agency operate as a statutory office within the AACC and undertake the quality assessment, accreditation and approval of community and residential care providers. Alongside the AACC's education and compliance checking activities it would also determine

enforcement sanctions, drawing from a broad range of enforcement tools (to ensure that penalties are proportional to the severity of non-compliance).

In order to facilitate feedback loops between complaints and the AACC's compliance and enforcement activities, complaints handling and review should be handled by a division of the AACC. It is envisaged that this division be structured along the lines recommended by the Walton Review (2009), with the addition of conciliation, referrals and outreach. Individuals and providers, who do not agree with the decisions of the AACC, would also be able to request an independent review of the decision. This reform, together with the referral of all appeals against the decisions of the AACC and the Gateway to the Administrative Appeals Tribunal, means that the Office of the Aged Care Commissioner would become redundant.

Figure 4 Proposed functions of the Australian Aged Care Commission



The need for better data and 'evidence' in aged care

Many participants to this inquiry complained that aged care data is difficult to access, there is limited reporting and public availability of analysis and evaluations, and there are 'gaps' in research on ageing. There are also potential conflicts of interest arising from DoHA's role as policymaker, evaluator and main repository for aged care data.

To promote greater transparency and accountability, the Commission proposes that the AACC ensure the provision of a national aged care data clearinghouse.

The clearinghouse's functions will include coordinating, storing and distributing aged care data and facilitating greater access to datasets for researchers, policymakers and the community at large. These will assist decision-makers in the sector (particularly under a more market-based and consumer-directed regime), facilitate more (and more timely) research in aged care, and — through a stronger evidence base — help ensure that aged care policies are soundly based.

Enhancing quality

Participants expressed views about variability in the quality of care provided within the aged care sector, with that quality being seen predominantly in terms of the skills and attitudes of staff, as well as the personal contact time they are able to offer. The amenity of the accommodation and standards of everyday living services are also seen as important. One of the reasons for the quality variation is the design of the current system which allows operators who only meet the minimum standards to survive, but who in a more competitive market might otherwise fail.

The Commission believes that the reforms proposed in this report will promote high quality care through:

- greater consumer choice, more competition and more responsive service providers
- improved funding and, as a result, improved working conditions
- improved regulation and regulatory oversight
- making standardised performance information available to further facilitate the decisions by care recipients and their families on care options and to make providers more accountable for quality outcomes
- greater recognition by providers, staff and trainers of the needs of culturally diverse groups and those with special needs
- increased access to consumer advocates, including through a statutory Community Visitors Program to promote and protect the rights and wellbeing of residents.

Technology

As noted in many submissions, technology has a vital role in improving the quality and range of care available to older Australians, reducing the strain on care workers and improving labour and capital productivity for aged care providers. The Commission's reforms will remove barriers in the aged care system to adopting cost-effective technologies and will provide systemic incentives to improve technology use in aged care.

The Gateway assessment process will assist older people to identify where assistive/enabling technologies are the best fit to meet their care needs. More funds for advocacy services will improve their ability to inform care recipients about the benefits of technologies. These changes, coupled with older people's control over their entitlements to care services and choice of care provider(s), will allow them to select providers who can deliver that best fit.

The national clearinghouse for aged care data will also facilitate the collection and dissemination of information on the cost-effectiveness of technologies in achieving care outcomes. This will benefit care recipients, providers and policy makers by supporting informed decisions on the most appropriate care services.

The proposal to phase-out supply restrictions will mean that providers that offer services (embodying technologies) preferred by care recipients will now benefit from any increase in demand for those services. Further, the AACC will take into account the contribution of technologies in delivering cost-effective services in its recommendations on efficient prices for approved aged care services. This will reinforce the incentives for providers to adopt that technology.

More generally, the Commission's proposal for prices and subsidies to reflect the efficient cost of delivering services should overcome concerns by providers that, under the current system, they cannot find the capital and recurrent funding to introduce new technologies.

Diversity and special needs

The increasing diversity of older people's needs presents an additional level of complexity in the aged care system. Older Australians are increasingly of different ethnic and cultural backgrounds, and have differing preferences. Some live in rural and remote locations. A number have long term disabilities. Sexual diversity also needs to be recognised.

The Commission believes that the systemic reforms proposed will assist all users of aged care services. To ensure better outcomes for those with special needs, the Commission's proposals have placed additional emphasis on the need for improved funding, better skills training of staff, flexible service delivery models, culturally appropriate assessment tools, and enhanced recognition of diversity and special needs in standards and care practices. Successful providers of specialist care will not be constrained from expanding their services. The Commission also proposes that the Gateway operate a range of access hubs for older people from culturally and linguistically diverse backgrounds. Where there is a demonstrated need, block funding should be available to services dedicated to delivering aged care to specific groups, such as homeless people or people from Indigenous communities in remote locations.

Interfaces with disability care and health systems

The Commission is conducting a concurrent inquiry into disability care and support and the draft report of that inquiry has recommended the establishment of a National Disability Insurance Scheme (NDIS) for eligible individuals. The Commission strongly advocates that adequate care and support should be available in both the disability care and aged care systems.

The Commission notes the agreement by the Council of Australian Governments that under the National Health and Hospital Network Agreement (NHHNA), the Australian Government agreed to funding specialist disability services provided under the National Disability Agreement for people aged 65 years and over (50 years and over for Indigenous Australians). Funding for this agreement is already factored into the Australian Government's budget commitments.

Should the Government accept the recommendations of the forthcoming disability care and support inquiry to establish an NDIS, those persons who have been assessed as eligible for the NDIS would, once they reached 65, have a choice of remaining in the NDIS or to transfer to the aged care system. Funding under the NHHNA would follow the person to the system chosen.

Where the person elects to transfer to the aged care system, that system's assessment, care services entitlement, and funding rules would apply. This does not require the person to change provider. Should a person with a disability move into a residential age care facility on a permanent basis, he or she will be deemed to have transferred to the aged care system.

For younger people with disabilities who receive services through the aged care system, the disability care system (including the NDIS where applicable) will meet those costs.

Problems with the interface between the aged care and health care systems are a key factor in preventing older Australians from receiving appropriate and seamless care. The Commission has therefore recommended several specific reforms to assist. These include increased use of visiting multi-disciplinary aged care health teams and measures to allow some sub-acute services to be provided in residential facilities where cost-effective and appropriate. Further, the Commission proposes that for regional aged care planning and service delivery the regions should be aligned to the proposed Medicare locals or, where not appropriate, the Local Hospital networks. For certain purposes, subregions may need to be used.

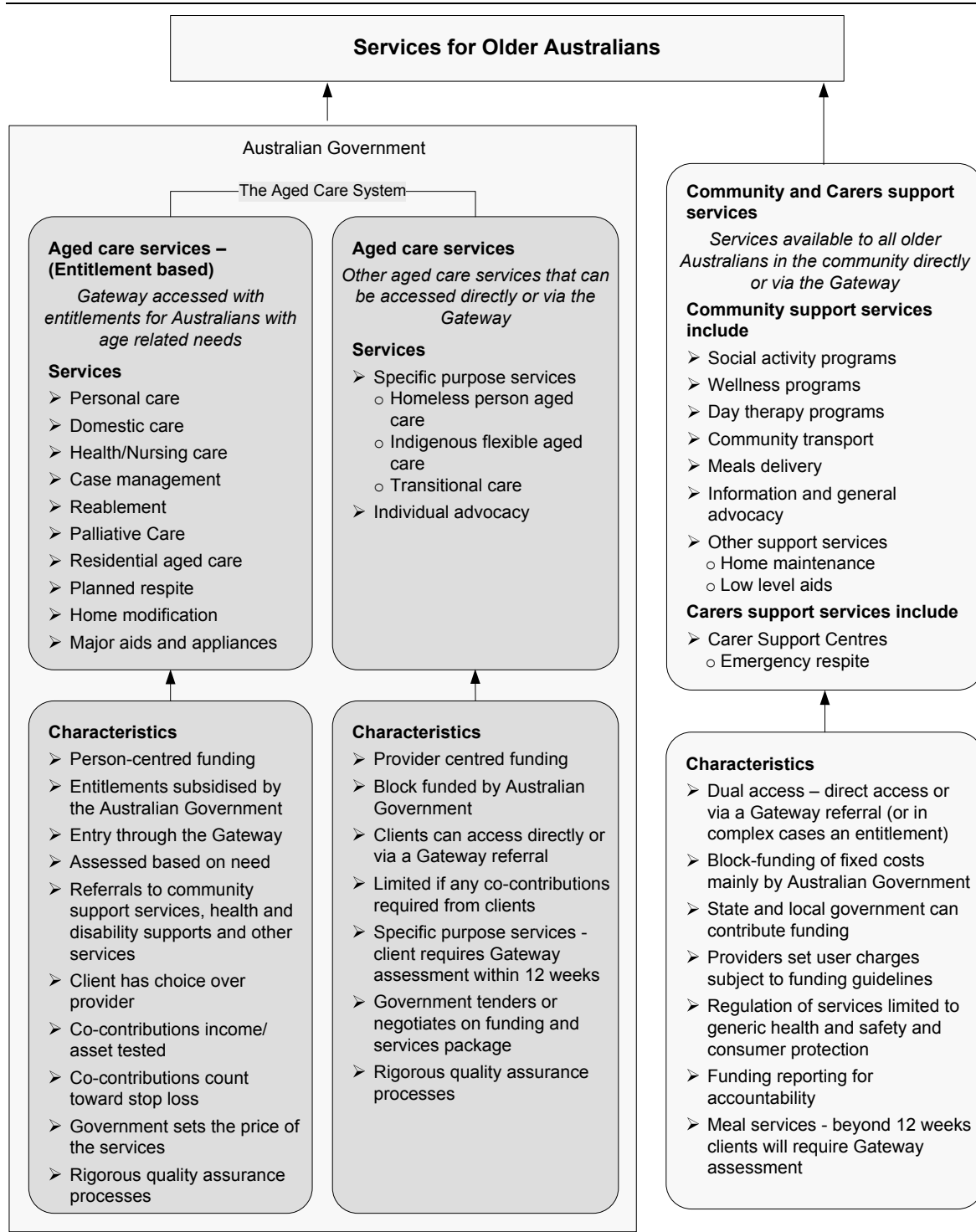
The implementation pathway

The reforms proposed in this report will lead to a new system of aged care services supported by a range of community and carers support services as set out in figure 5. To be credible, these reforms need a strong commitment to change from the Australian Government and from state and territory governments. There is also a need for a properly empowered implementation body that is separate from, but consults with, the key stakeholders; and an implementation plan that is signalled in advance and has clear and measurable milestones. Older Australians, their carers, providers and aged care workers all need certainty about the reform plan and confidence that it will be implemented. The proposed implementation plan includes provisions to protect existing consumers and certain providers of aged care services from disruptive changes and provides a sequenced approach over a five-year period to facilitate a smooth transition to the new arrangements.

The Commission proposes that there be an Aged Care Implementation Taskforce which would drive the reform agenda in consultation with an Aged Care Advisory Group.

An implementation plan, involving three broad stages of reform, is set out in schedule A. In addition, a profile of the impact of the proposals from the perspective of older Australians, their carers and providers is at schedule B.

Figure 5 The structure of the wider system of support for older Australians



Community and Carers support services

Services available to all older Australians in the community directly or via the Gateway

Community support services include

- Social activity programs
- Wellness programs
- Day therapy programs
- Community transport
- Meals delivery
- Information and general advocacy
- Other support services
 - Home maintenance
 - Low level aids

Carers support services include

- Carer Support Centres
 - Emergency respite

Characteristics

- Dual access – direct access or via a Gateway referral (or in complex cases an entitlement)
- Block-funding of fixed costs mainly by Australian Government
- State and local government can contribute funding
- Providers set user charges subject to funding guidelines
- Regulation of services limited to generic health and safety and consumer protection
- Funding reporting for accountability
- Meal services - beyond 12 weeks clients will require Gateway assessment

Schedule A Implementation Plan

<i>Stage 1: expedited measures within two years</i>	<i>Stage 2: within two to five years</i>	<i>Stage 3: five years and beyond</i>
<ul style="list-style-type: none"> Establish the Aged Care Implementation Taskforce and Aged Care Advisory Group Establish the Australian Aged Care Commission (AACC) and Australian Seniors Gateway Agency (the Gateway) Transfer the Aged Care Standards and Accreditation Agency to a statutory office in the AACC Remove the distinctions between low and high care, and between ordinary and extra service Require residential aged care facilities to offer and publish periodic accommodation charges and, optionally, equivalent (or discounted) accommodation bonds. Remove regulated accommodation bond retention amounts Introduce price monitoring for residential accommodation Increase the number of community care places by 20 per cent above the baseline established by the Aged Care Approvals Round, including the introduction of a temporary intermediate community care level between Community Aged Care Packages and Extended Aged Care at Home 	<ul style="list-style-type: none"> Introduce the new model of care assessments and services entitlements Create the formal entitlement based aged care system, together with the block funded community support services Finalise the major regulatory changes Introduce the new co-contribution and lifetime stop-loss funding arrangements Introduce the Australian Aged Care Home Credit scheme Set care prices and the accommodation charge for supported residents based on transparent advice and recommendations from the AACC Review the pilot scheme for trading the supported residents ratio obligations Undertake an assessment of the appropriate total assets test thresholds for the supported resident accommodation supplement Gradually increase the quantity of residential places by 10 to 20 per cent above the baseline established by the Aged Care Approvals Round Introduce measures to improve the quality of aged care services, including the promotion of transparency and accountability 	<ul style="list-style-type: none"> After five years, remove supply restrictions in both residential and community care Commission a public review which would analyse and recommend: <ul style="list-style-type: none"> whether the consumer-directed system had developed sufficiently so that care and supported accommodation prices could be liberalised in certain markets whether any changes to the Accreditation Grant Principles, the Quality of Care Standards, and the Community Care Common Standards were required any changes that may be needed to maintain fiscal sustainability any changes that may be needed to ensure access for special needs groups whether supported residents should receive funding directly from an entitlement and the need for a mandatory ratio applying to residential facilities the efficacy and cost of the reablement service any changes to the financing arrangements, arising from a thorough examination of the operation of the new financial arrangements

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Schedule A (continued)

<i>Stage 1: expedited measures within two years</i>	<i>Stage 2: within two to five years</i>	<i>Stage 3: five years and beyond</i>
<ul style="list-style-type: none">• Set region specific supported resident ratios for all new and existing residential providers (except those subject to explicit grandfathering arrangements) and introduce a pilot scheme for trading supported resident ratio obligations• Increase the supported resident accommodation supplement progressively to a level commensurate with the cost of an approved supported resident place• Introduce the Australian Age Pensioners Savings Account scheme• Conduct a public benchmarking study of aged care costs to initially set the scheduled prices• Provide protection to existing recipients of aged care services through appropriate grandfathering• Increase the release of data, information and research findings with the AACC having the responsibility for the dissemination of data as a national clearing house• Introduce a temporary assistance package for small residential providers.	<ul style="list-style-type: none">• Continuing the increase in the number of community care places that commenced in stage 1• Implement the Commission's remaining recommendations relating to care, quality, catering for diversity, age-friendly housing and retirement villages, carers, the workforce and regulation.	<ul style="list-style-type: none">– an appropriate timeframe for a subsequent public review of the aged care system– re-evaluate workforce sustainability.

Schedule B What do the proposed reforms mean?

Older Australians and their carers

The Commission's recommendations will significantly improve the quality and quantity of aged care services for older Australians. As a result of the reforms, older Australians would:

- have ready access to general advice on ageing issues, as well as specific information about their local aged care services. This advice and information would be available from a range of sources that all draw from a national information platform run by the Australian Seniors Gateway Agency (the Gateway)
- be assessed for their care and support needs by the Gateway. They could also go directly to community-support services (such as meals delivery and community transport) which would continue to be block funded (or receive a Gateway referral to them)
- receive an entitlement to services that matched their needs, and be advised of the price of those services and the details of approved providers in their local area
- be offered a care coordination service run by the Gateway and a case management service when needed
- have a single, updated, aged care electronic record that means that they do not have to keep repeating their history and personal circumstances
- benefit from a new intermediate community care package between CACP and EACH as part of the transitional arrangements
- choose their preferred provider (quantity limits on providers having been lifted), having regard to the quality of services being offered, including the professional and relationship skills of the personal carers, the cultural awareness and languages spoken and the ability to negotiate timing of service delivery
- seek a reassessment of their needs if there is a material change in their circumstances
- be subject to a fair and comprehensive financial means test — based on income and assets — to determine their level of co-contribution for approved care and support services (whether in their home or in residential care), with a safety net for those of limited means and with a lifetime stop-loss for care co-contributions

Aged care providers

The Commission's reforms will involve significant changes for community and residential aged care providers, overcome current financial pressure points and create scope for individual providers to grow within an emerging competitive market. Good managers who meet the needs of empowered older people will have significantly more opportunities to be successful contributors to the caring of older Australians. Providers would:

- be subject to quality accreditation, but be free of any quantity limitations such as bed licences and numbers of care packages (with a five year transition to an open market)
- compete with other providers for clients who had entitlements to care and support services, subject to being approved providers of those services
- receive a price set by the Government for those approved care and support services determined through the assessment process by the Gateway (comprising a care co-contribution from the client and a subsidy from the Government)
- while meeting the approved quality and safety standards, and operating within the price set for the entitlement, compete on a range of dimensions such as the professional and relationship skills of their workforce, the cultural awareness and languages on offer, the quality of food and other services and their responsiveness to the particular requests of individual clients
- offer a range of additional services, at a quality and price set by the provider
- liaise with the Gateway on matters of initial assessments of client needs and entitlements, and be able to undertake subsequent assessments in response to a material change in a client's needs, subject to a risk management audit process
- liaise with the Australian Aged Care Commission on matters of quality standards and assessments, complaints handling and costs of service delivery

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Schedule B (continued)

Older Australians and their carers

- have access to a government-backed Australian Aged Care Home Credit scheme with a no negative equity guarantee to meet their care and accommodation costs if their wealth is held mostly in the form of their house while protecting the share of the equity held by a spouse/partner
- be able to retain their house and be confident that their spouse, dependent child or other 'protected persons' would continue to be able to live in that house, rather than be forced to sell their home in order to go into residential care, as is the case for some at present
- if in residential care, pay a basic daily fee (currently set at 84 per cent of the single age pension), pay their care co-contribution, and pay a daily periodic accommodation charge or equivalent bond, with a safety net for those of limited means
- retain their Age Pension if they sell their home to move to alternative accommodation (such as a retirement village, serviced apartment, or a residential care facility) and pay a lower capital sum or daily charge by investing the excess proceeds from the sale in a Government-guaranteed Australian Age Pensioners Savings Account scheme
- benefit from measures to improve the quality of aged care services, including through a quality assurance framework, better evidence and information, and a more competitive environment facing approved providers
- receive enhanced access to general practitioners at residential aged care facilities through an increased Medicare rebate
- be given every opportunity to maintain or regain functional independence (including reablement)
- be free to choose whether to purchase additional aged care services (including accommodation) beyond the minimum approved entitlement and meet the associated costs themselves
- be confident that the Australian Aged Care Commission is monitoring the quality of care by providers and the price of residential accommodation during the transition period to protect against providers exploiting supply shortages and is an independent avenue for examining consumer complaints
- receive improved access to information about advance care directives, with a link to the proposed electronic records
- get better palliative and end-of-life care through an assessed entitlement from the Gateway.

Aged care providers

- be able to access information from the proposed Australian Aged Care Commission regarding projections of future demand trends and ways to improve the quality of services.
- In addition, providers of residential care would:**
- be able to seek approved provider status for all levels of care and support delivered in a residential setting (with inability to meet the demands of specific residents being dealt with on a strict exception basis), with the distinction between low, high and extra service care being removed
 - receive care payments for community and residential care set by the Government on the transparent advice and recommendation of the Australian Aged Care Commission
 - charge all residents for their everyday living costs by way of a basic daily fee (currently set at 84 per cent of the single age pension)
 - set their own periodic accommodation charge for all new residents and, if desired, offer an accommodation bond of up to the equivalent amount, and publish those charges and bonds (with current bonds being grandfathered)
 - receive a set daily accommodation fee for supported residents, based on the average cost of 1.5 beds per room per facility at a level designed to meet the value of that standard of accommodation
 - be required to provide for a minimum quota of supported residents with a pilot scheme on a tradeable ratio obligation within the relevant region
 - be able to offer a range of other services in their facilities, such as respite care, transition care, reablement, sub-acute care, rehabilitative and restorative care, behaviour management stabilisation, palliative pain management and end-of-life care, subject to meeting the relevant quality and safety requirements, and reaching agreement on prices and other terms and conditions
 - access a transitional assistance package for small residential providers.
-

Schedule C — Illustrative cameos

The recommendations in this report will change the way in which consumers of aged care engage with the sector. In particular, the recommendations will result in consumers:

- being assessed by the Gateway for eligibility for an entitlement to aged care services in the community or in a residential aged care facility
- having their capacity to contribute to the cost of care assessed by Centrelink on behalf of the Gateway
- paying a co-contribution for their care costs (a possible indicative range from 0 to 25 per cent of the cost of their care based on the means test)
- being protected against catastrophic care costs by a lifetime (indexed) stop-loss limit (a possible indicative cap of \$60 000)
- paying for residential accommodation via a periodic charge or an accommodation bond of equal (or lower) value, or some combination thereof
- having access to the Government-backed Australian Aged Care Home Credit scheme which would help unlock their home equity so they could contribute to their care and accommodation costs while not having to sell their home. The scheme would protect a spouse, partner, dependent child with a disability or other ‘protected person’ still living in the principal residence
- having access to the Australian Age Pensioners Savings Account scheme if they wish to sell their principal residence and remain an age pensioner.

This schedule examines, for illustrative purposes only, the possible implications of the Commission’s recommendations for various cohorts of persons who may be subject to the new co-contribution regime.

The comprehensive aged care means test will ensure that those with insufficient resources to make any contribution to their aged care costs will be protected.

Assumptions

The cameos in this section are based on the following assumptions.

- Total care costs in community care of \$25 000 per year (\$961.40 per fortnight), expected to be around the cost of the intermediate package proposed in the transition period.

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- Total care costs in residential care of \$35 000 per year (\$1346.15 per fortnight), which approximates the average care cost in residential care.
 - House prices of \$500 000 and \$1 million.² Where only one member of a couple needs care, only that person's share of the equity (generally 50 per cent) is taken into account for the means test.
 - Indicative residential accommodation charges of \$50 per day (\$700 a fortnight).
 - The following categories of older people:
 - a full-rate age pensioner (both a home owner and non-home owner) and partnered and single
 - a single part-rate age pensioner (home owning) with an income of \$1500 per fortnight (inclusive of the Age Pension)
 - a part-rate age pensioner couple (home owning) with a combined income of \$2000 per fortnight (\$1000 per fortnight each, inclusive of the Age Pension)
 - a single self-funded retiree (home owning) with an income of \$2500 per fortnight
 - a self-funded retiree couple (home owning) with a combined income of \$3000 per fortnight (\$1500 per fortnight each).
 - The cameos examined cover single persons and couples in community care and couples in residential care where one person remains in the principal residence.

Community care

Under the Commission's proposals, older people assessed as eligible for community care services by the Gateway would be able to choose their provider(s) and would also be assessed (by Centrelink on behalf of the Gateway) for the co-contribution they would be required to pay based on their assets and income. Based on indicative figures, the proportion of approved care costs payable would range from 0 to 25 per cent, subject to the indicative lifetime stop-loss limit for care co-contributions of \$60 000.

The relevant cameos for a single person with total care costs in the community of \$25 000 per year are shown at table C.1 and for a couple (with one person requiring care) at table C.2.

² The median price of established house transfers (ABS Cat. No. 6416.0) ranged from \$345 000 (Hobart) to \$595 000 (Sydney) in the September quarter 2010 (most recent estimates available).

Table C.1 Community care cameos — single persons
(dollars)

<i>Person</i>	<i>Home</i>	<i>Total care cost per fortnight</i>	<i>Care co-contribution per fortnight</i>
Full-age pensioner	No	961.40	40.00
Full-age pensioner	500 000	961.40	195.13
Full-age pensioner	1 million	961.40	240.38
Part-age pensioner	500 000	961.40	240.38
Part-age pensioner	1 million	961.40	240.38
Self-funded retiree	500 000	961.40	240.38
Self-funded retiree	1 million	961.40	240.38

Table C.2 Community care cameos — couple, one person receiving care
(dollars)

<i>Person</i>	<i>Home 50% of equity for means test</i>	<i>Total care cost per fortnight</i>	<i>Care co-contribution per fortnight</i>
Full-age pensioner	No	961.40	40.00
Full-age pensioner	500 000	961.40	115.38
Full-age pensioner	1 million	961.40	195.13
Part-age pensioner	500 000	961.40	139.15
Part-age pensioner	1 million	961.40	218.90
Self-funded retiree	500 000	961.40	175.16
Self-funded retiree	1 million	961.40	240.38

Residential care

The following cameos are based on a couple where one person needs to enter residential care for a service involving an annual total care cost of \$35 000, the other remaining in the home. The assessed co-contribution for care could be obtained through the Commission's proposed Australian Aged Care Home Credit scheme to access the person's share of their home equity (which excludes the share of a spouse or other 'protected person'). The relevant care co-contributions for the cameos are shown at table C.3.

Table C.3 Residential care cameos — care co-contributions for a couple, one person in residential care
(dollars)

<i>Person</i>	<i>Home 50% of equity for means test</i>	<i>Total care cost per fortnight</i>	<i>Care co-contribution per fortnight</i>
Full-age pensioner	No	1346.15	0
Full-age pensioner	500 000	1346.15	94.23
Full-age pensioner	1 million	1346.15	205.88
Part-age pensioner	500 000	1346.15	127.50
Part-age pensioner	1 million	1346.15	239.15
Self-funded retiree	500 000	1346.15	177.92
Self-funded retiree	1 million	1346.15	289.56

In addition, the resident would be required to pay for his or her accommodation and everyday living expenses.

Accommodation charges (or bonds) would be paid according to the price published by the relevant residential care provider. For illustrative purposes, an accommodation charge of \$50 per day, or \$700 per fortnight, has been used.

All residents (including supported residents) pay the everyday living expense of \$553.05 per fortnight (84 per cent of the basic single rate Age Pension).

The total cost of residential care, including accommodation, care and everyday living expenses, is illustrated in table C.4.

Table C.4 Residential care cameos — total cost covering one person in residential care, partner remaining at home
(dollars)

<i>Person</i>	<i>Home 50% of equity for means test</i>	<i>Accommodation per fortnight</i>	<i>Everyday living expenses per fortnight (84% of the Age Pension)</i>	<i>Care co-contribution per fortnight</i>	<i>Total per fortnight</i>
Full-age pensioner	No	0	553.05	0	553.05
Full-age pensioner	500 000	700	553.05	94.23	1347.28
Full-age pensioner	1 million	700	553.05	205.88	1458.93
Part-age pensioner	500 000	700	553.05	127.50	1380.55
Part-age pensioner	1 million	700	553.05	239.15	1492.20
Self-funded retiree	500 000	700	553.05	177.92	1430.97
Self-funded retiree	1 million	700	553.05	289.56	1542.61

A person entering residential care would be protected in several ways under the Commission's proposals. First, by the care lifetime stop-loss limit, which takes account of co-contributions for care in community and residential settings. Second, where a person retains a principal residence and uses the Australian Aged Care Home Credit scheme to draw upon his or her share of the home's equity, there would be both a maximum drawdown on that share of the home equity and a no negative equity guarantee. When a person reached that limit, he or she would become a supported resident and be liable only for paying everyday living expenses (currently \$553.05 per fortnight).

A spouse (or other 'protected person') would also be able to remain in the principal residence when the older person moved into residential care.

Why a comparison with the current aged care system is not practical

The Commission has not included a comparison of the proposed new co-contribution regime to that which applies under the present aged care system.

While DoHA has issued a policy indicating what co-contributions providers can charge for community care packages, the actual amount individuals pay is determined through a negotiation between the care recipient and provider. Recent information from the Community Care Census highlights that the actual fees charged are well below the maximum permitted. In the case of residential care, the widely varying amounts deposited in accommodation bonds preclude any meaningful comparison.

While information is available on the distribution of co-contributions that are currently charged, it is not possible to determine how these fees relate to the income and assets of care recipients. As such, it is not possible to compare what people would pay under the proposed arrangements with the current co-contributions they make.

Effectively, the current system has an arbitrary application of fees and charges: two people of identical financial means using the same aged care services could pay significantly different fees and charges. A key advantage of the proposed new co-contribution regime is that it is coherent, transparent and equitable.

Caring for Older Australians

Recommendations

Assessing the current system

RECOMMENDATION 4.1

To guide future policy change, the aged care system should aim to:

- *promote the independence and wellness of older Australians and their continuing contribution to society*
- *ensure that all older Australians needing care and support have access to person-centred services that can change as their needs change*
- *be consumer-directed, allowing older Australians to have choice and control over their lives and to die well*
- *treat older Australians receiving care and support with dignity and respect*
- *be easy to navigate, with older Australians knowing what care and support is available and how to access those services*
- *assist informal carers to perform their caring role*
- *be affordable for those requiring care and for society more generally*
- *provide incentives to ensure the efficient use of resources devoted to caring for older Australians and broadly equitable contributions between generations.*

Principles of funding

RECOMMENDATION 6.1

The Australian Government should adopt separate policy settings (including for subsidies and co-contributions) for the major cost components of aged care, namely care (including personal and nursing care), everyday living expenses and accommodation.

Paying for aged care

RECOMMENDATION 7.1

The Australian Government should remove regulatory restrictions on the number of community care packages and residential bed licences. It should also remove the distinction between residential high care and low care places.

RECOMMENDATION 7.2

The Australian Government should remove regulatory restrictions on accommodation payments, including the cap on accommodation charges in high care. It should also abolish the charging of regulated retention amounts on accommodation bonds. The Government should mandate that residential aged care providers:

- *offer and publish periodic accommodation charges*
- *where offered, publish accommodation bonds and any combinations of periodic charges and bonds.*

The Australian Government should require that, when a provider offers an accommodation bond, the bond does not exceed the equivalent of the relevant periodic accommodation charge. The paying of interest on accommodation bonds should be prohibited.

RECOMMENDATION 7.3

The Australian Government should establish an Australian Age Pensioners Savings Account scheme to allow recipients of the age and service-related pensions to establish an account with the Government (or its agent) with some or all of the proceeds of the sale of their principal residence.

- *The account would be exempt from both the Age Pension assets and income tests and would pay interest equal to the prevailing consumer price index to maintain its real value. All accounts would be free of entry, exit and management fees.*
- *Apart from the proceeds from the sale of a principal residence (including the sale of any subsequent principal residences), no other amounts should be able to be deposited into the account.*
- *Account holders would be able to flexibly draw upon the balance in the account.*

RECOMMENDATION 7.4

The Australian Government should charge residential providers a fee to reflect the costs of providing the Government guarantee on accommodation bonds.

RECOMMENDATION 7.5

To ensure sufficient provision of the approved basic standard of residential aged care accommodation for those with limited financial means, providers should continue to be obliged to make available a proportion of their accommodation to supported residents. The Australian Government should set the level of the obligation on a regional basis.

Where providers do not meet the supported resident ratio obligation in their region, a sliding scale of penalties should be levied, where the size of the penalty would depend on the severity of the non-compliance. The current pricing arrangements (which apply a 25 per cent discount to the full rate of the accommodation supplement when facilities do not have more than 40 per cent supported residents) should be abolished.

RECOMMENDATION 7.6

For supported residents, the Australian Government should set a subsidy level for the approved basic accommodation standard of residential care which reflects the average cost of providing such accommodation. The subsidy should be set regionally and on the basis of the July 1999 building standard (an average of 1.5 beds per room). A lower subsidy level should be paid to those facilities which do not meet the July 1999 building standard. The Australian Aged Care Commission should be empowered to consider exceptional circumstances for those facilities which do not meet the July 1999 building standard and make an appropriate recommendation to the Australian Government to increase the level of the supported resident accommodation subsidy for these facilities.

RECOMMENDATION 7.7

To better target the supported resident accommodation subsidy, the relevant share of a person’s former principal residence should be included in the total assets test and the exemption of the principal residence when there is a ‘protected person’ remaining in the former principal residence should be abolished. To allow an existing ‘protected person’ to continue to remain in the former principal residence, there should be guaranteed access of the resident to the Government-backed Australian Aged Care Home Credit scheme and the existing option of deferred payments. Further research and modelling should be undertaken to consider the scope for assessing the total assets test thresholds for supported resident accommodation payments.

RECOMMENDATION 7.8

The Australian Government should remove the regulatory restrictions on supplying additional services in all residential aged care facilities, discontinue the issuing of extra service bed licences and remove the distinction between ordinary and extra service bed licences.

RECOMMENDATION 7.9

The Australian Government should:

- *prescribe the scale of care recipients’ co-contributions for approved aged care services which would be applied through the Australian Seniors Gateway Agency*
- *set a comprehensive means test for care recipients’ co-contributions for approved aged care services. This test should apply the Age Pension income test. The test should also apply an assets test to the relevant share of a person’s assets which are excluded from the age pension means test (such as the principal residence, accommodation bonds and the proposed Australian Age Pensioners Savings Account).*

To facilitate greater consistency in co-contributions across community and residential care, comprehensive aged care means testing to determine care recipient co-contributions to care costs in both settings should be undertaken through the Australian Seniors Gateway Agency by Centrelink.

The care recipients’ co-contributions scale should be regularly reviewed by the Australian Government based on transparent recommendations from the Australian Aged Care Commission.

The Australian Government should set a lifetime stop-loss limit comprising the care recipients' co-contributions towards the cost of approved aged care services (excluding accommodation and everyday living expenses). Once the limit has been reached, no further care recipients' co-contributions would be required for those services.

With a stop-loss limit in place, the Australian Government should exclude aged care costs from the net medical expenses tax offset.

Broadening the funding base

The Australian Government should establish a Government-backed Australian Aged Care Home Credit scheme to assist older Australians to make a co-contribution to the costs of their aged care and support.

- *Under the scheme, eligible individuals would receive a Government-backed line of credit secured against their principal residence, or their share of that residence.*
- *In establishing the line of credit, the Australian Seniors Gateway Agency would arrange a valuation of the principal residence and specify a minimum level of equity for the person's share of the home. The individual could draw progressively down to that minimum to fund their aged care costs. The drawdown on the line of credit would be subject to interest charged at the consumer price index. If the outstanding balance and accumulated interest reached the minimum limit set by the Australian Seniors Gateway Agency, the interest rate would fall to zero, and no further draw down would be permitted under the scheme.*
- *The outstanding balance of the line of credit would become repayable upon the disposition of the former principal residence including upon the death of the individual, except where there is a protected person permanently residing in the former principal residence.*
- *In the latter circumstances, the outstanding balance of the line of credit would be repayable when the protected person ceases to permanently reside in that former principal residence, or ceases to be a protected person. (Protected person is defined in the Aged Care Act 1997 and includes, for example, a partner, dependent child or a carer.)*

Access to aged care

RECOMMENDATION 9.1

The Australian Government should establish an Australian Seniors Gateway Agency to provide information, needs assessment, care coordination and carer referral services. The Gateway would deliver services via a regional structure.

- *A platform within the Gateway would provide information on healthy ageing, social inclusion and participation, age-friendly accommodation, and information on the availability, quality and costs of care services from approved providers, and how to access those services.*
- *Assessments of the needs of older people would be undertaken for their potential entitlement to approved care services. The level of assessment resourcing would vary according to anticipated need.*
- *Assessments of financial capacity to make care co-contributions toward the cost of services would be undertaken by Centrelink on behalf of the Gateway.*
- *The assessment of the individual could lead to an entitlement to a set of aged care services which the older person and their carer may access from approved aged care providers of their choice.*
- *The assessment could lead to a referral or an entitlement to community support services and carer support services where such services form an essential part of a set of services to meet complex needs.*
- *Initial care coordination services would be provided, where appropriate and requested, as part of the Gateway. Further care coordination and case management, which may form part of the entitlement, would be provided in the community or in residential aged care facilities by an individual's approved provider of choice.*

The Gateway would:

- *have a separate Australian Government Budget appropriation for the entitlement-based services that it approves*
- *be a Prescribed Agency under the Financial Management and Accountability Act 1997.*

The Gateway would operate via a network of regional centres to enhance local responsiveness, with operational regions defined with reference to those for Medicare Locals and/or Local Hospital Networks. These regional centres would offer the full range of information, needs assessment and care coordination services and their operation may be subcontracted to third party operators including other government agencies or non government or private entities.

RECOMMENDATION 9.2

An intensive reablement service should be introduced to give greater focus on independence, rehabilitation and restorative care. Eligibility and entitlement for this service should be assessed by the Australian Seniors Gateway Agency.

RECOMMENDATION 9.3

A trial of more flexible arrangements for respite care, such as cashing out for respite services and extending the range of registered individuals who can be approved to provide respite, should be conducted as part of a broader introduction of an entitlement based approach to care services.

RECOMMENDATION 9.4

The Australian Government should replace the current system of discrete care packages across community and residential care with a single integrated, and flexible, system of care entitlements (the Aged Care System). The System would have the following features:

- it would cover services including residential care, community care (domestic, personal, nursing), reablement, planned respite, home modification, palliative care, high level aids and equipment, and care coordination*
- the Australian Government should approve a schedule of aged care services to be provided to individuals on an entitlement basis, according to the Gateway's assessment of their need. Individuals should be given an option to choose an approved provider or providers*
- the entitlement provided to consumers as part of the Gateway assessment process should include a detailed statement of the care assessment, the care objectives, the type and intensity of services to meet those objectives, the total value of the entitlement, and the period of the entitlement. In addition the consumer would receive a statement of their co-contribution obligation*
- the Australian Government would set the scheduled price of approved services based on a transparent recommendation by the Australian Aged Care Commission*
- the Australian Government should fund an expanded system of aged care individual advocacy by initially expanding funding and access to advocacy under the National Aged Care Advocacy Program.*

The Australian Government should also support a range of community support services which would be directly accessible by older Australians and their carers and through the Gateway. Such community support services would include funding from the Australian Government (including, for example, block funding for infrastructure and overheads) as well as user charges and financial and in-kind support from state, territory and local governments and the community. For some community services, where a person requires long term support, an assessment from the Gateway may be required.

RECOMMENDATION 9.5

The Australian, state and territory governments should promote the expanded use of in-reach services to residential aged care facilities and the development of regionally or locally-based visiting multi-disciplinary health care teams (including from oral and mental health disciplines and dementia care specialists as appropriate).

RECOMMENDATION 9.6

The Australian Government should set scheduled fees for the delivery of certain sub-acute services that are delivered in a residential aged care facility. These fees should be cost reflective and, in general, lower than the scheduled fee for the equivalent service provided in a hospital.

RECOMMENDATION 9.7

The Commission notes that the Australian Government has agreed to assume funding responsibilities for specialist disability services delivered under the National Disability Agreement for people over the age threshold.

In that context, the Australian Government should ensure that:

- a person with a disability eligible for and being supported within the disability care system prior to reaching the aged threshold should be able to be continue to be supported by services best able to meet their needs including through the disability care system*
- such a person may at any time after reaching the age threshold elect to be supported through the aged care system and be subject to that system's arrangements and shall be deemed to have done so upon permanent entry into a residential aged care facility.*

Quality of aged care

RECOMMENDATION 10.1

The quality assurance framework for aged care should be expanded to include published quality indicators at the service provider level to help care recipients and their families make informed choices about care and to enhance transparency and accountability about funds spent on care. The Australian Aged Care Commission should develop a Quality and Outcomes Data Set for use by care recipients and bring together evidence on best practice care, with the information openly accessible via the Gateway.

RECOMMENDATION 10.2

The Medicare rebate for medical services provided by general practitioners visiting residential aged care facilities and people in their homes should be independently reviewed to ensure that it covers the cost of providing the service.

RECOMMENDATION 10.3

The Australian Government should ensure that residential and community care providers receive appropriate payments for delivering palliative and end-of-life care. These payments should form part of the assessed entitlement determined by the Gateway assessment process. The appropriate payment for palliative and end-of-life care should be determined by the Government on the transparent advice of the Australian Aged Care Commission and in consultation with the National Hospital Pricing Authority.

RECOMMENDATION 10.4

Providers of aged care services should have staff trained to be able to discuss and put in place advance care directives.

Funding should be made available for community awareness education about advance care planning.

Advance care directives should be included in the proposed electronic records.

Catering for diversity

RECOMMENDATION 11.1

The Australian Government should ensure the accreditation standards for residential and community care are sufficient and robust enough to deliver services which cater to the needs and rights of people from diverse backgrounds including culturally and linguistically diverse, Indigenous and sexually diverse communities.

RECOMMENDATION 11.2

The Australian Seniors Gateway Agency should cater for diversity by:

- *ensuring all older people have access to appropriate information and assessment services*
- *facilitating access for people with language and cultural needs through the development of specific hubs for older people from diverse backgrounds that have limited English skills and require access to bi-lingual staff*
- *ensuring that diagnostic tools are culturally appropriate for the assessment of care needs.*

RECOMMENDATION 11.3

The Australian Aged Care Commission, in transparently recommending the scheduled set of prices for care services, should take into account costs associated with catering for diversity, including:

- *providing ongoing and comprehensive language services for clients from non-English speaking backgrounds*
- *ensuring staff undertake appropriate professional development activities to increase their capacity to deliver care with dignity and respect to all older people.*

RECOMMENDATION 11.4

The Australian Government should ensure that rural and remote, and Indigenous aged care services be actively supported before remedial intervention is required. This support would include but not be limited to:

- *the construction, replacement and maintenance of appropriate building stock*
- *meeting quality standards for service delivery*
- *clinical and managerial staff development, including locally delivered programs and enhanced use of technology assisted training*

-
- *applying funding models that ensure service sustainability and support the development of service capabilities at a local level.*

RECOMMENDATION 11.5

The Australian Government should partially or fully block fund services where there is a demonstrated need to do so based on detailed consideration of specific service needs and concerns about timely and appropriate access. Such services might include:

- *dedicated aged care services for homeless older Australians*
- *Indigenous specific, flexible aged care services.*

Direct access to these services would be available immediately but care recipients would be required to undergo an Australian Seniors Gateway Agency assessment within three months of entering such care services and, where appropriate, pay relevant co-contributions.

Accommodation

RECOMMENDATION 12.1

The Australian, state and territory governments should develop a coordinated and integrated national policy approach to the provision of home maintenance and modification services, with a nominated lead agency in each jurisdiction.

To support this national approach, all governments should develop benchmarks for the levels of services to be provided, terms of eligibility and co-contributions, and the development of professional and technical expertise.

RECOMMENDATION 12.2

The Australian Government should develop building design standards for residential housing that meet the access and mobility needs of older people.

RECOMMENDATION 12.3

The Council of Australian Governments, within the context of its agreed housing supply and affordability reform agenda, should develop a strategic policy framework for ensuring that an adequate level of affordable housing is available to cost effectively meet the demands of an ageing population.

RECOMMENDATION 12.4

The regulation of retirement villages and other retirement specific living options should remain the responsibility of state and territory governments, and should not be aligned with the regulation of aged care services.

RECOMMENDATION 12.5

State and territory governments should pursue nationally consistent retirement village legislation under the aegis of the Council of Australian Governments.

Carers

RECOMMENDATION 13.1

The Australian Seniors Gateway Agency, when assessing the care needs of older people, should also assess the capacity of informal carers to provide ongoing support. Where appropriate, this may lead to approving entitlements to services for planned respite and other essential services.

Carers Support Centres should be developed from the existing specialist carer support service programs to undertake a comprehensive and consistent assessment of carer needs. Such centres should be directly accessible to carers as well as through the Gateway and would also deliver carer support services, including:

- *carer education and training*
- *emergency respite*
- *carer counselling and peer group support*
- *carer advocacy services.*

RECOMMENDATION 13.2

Funding for services which engage volunteers in service delivery should take into account the costs associated with:

- *volunteer administration and regulation*
- *appropriate training and support for volunteers.*

Workforce

RECOMMENDATION 14.1

The Australian Aged Care Commission, when assessing and recommending scheduled care prices, should take into account the need to pay fair and competitive wages to nursing and other care staff delivering approved aged care services and the appropriate mix of skills and staffing levels for the delivery of those services.

RECOMMENDATION 14.2

The Australian Government should promote skill development through an expansion of accredited courses to provide aged care workers at all levels with the skills they need, including:

- *vocational training for care workers entering the sector and looking to upgrade their skills*
- *adequate tertiary nursing places to meet the anticipated demand from the health and aged care sectors*
- *advanced clinical courses for nurses*
- *management courses for health and care workers entering these roles.*

RECOMMENDATION 14.3

The Australian Government, in conjunction with universities and providers, should fund the expansion of ‘teaching aged care services’ to promote the sector and provide appropriate training for medical, nursing and allied health students and professionals.

RECOMMENDATION 14.4

Given industry concerns about the variability in training outcomes for students, the Australian Government should undertake an independent and comprehensive review of aged care-related vocational education and training (VET) courses and their delivery by registered training organisations (RTOs). Among other things, the review should consider:

- *examining current practices that may be leading to variability in student outcomes, including periods of training and practicum*
- *reviewing procedures to ensure that VET trainers and assessors possess required current practice knowledge*

-
- *identifying whether regulators are adequately resourced to monitor and audit RTOs using a risk-based regulatory approach and have appropriate enforcement regimes that allow for appropriate and proportional responses to non-compliance by RTOs*
 - *identifying reforms to ensure students demonstrate pertinent competencies on a more consistent basis.*

Regulation

RECOMMENDATION 15.1

The Australian Government should establish a new independent regulatory agency — the Australian Aged Care Commission (AACC). This would involve:

- *the Department of Health and Ageing ceasing all its regulatory activities, except the provision of policy advice to the Australian Government on regulatory matters, including advice on the setting of quality standards*
- *establishing the Aged Care Standards and Accreditation Agency as a statutory office within the AACC*
- *establishing a statutory office for complaints handling and reviews within the AACC*
- *establishing a stakeholder advisory committee to provide advice to the AACC in relation to consumer and industry interests*
- *establishing it as a Prescribed Agency under the Financial Management and Accountability Act 1997.*

The AACC would have three full time, statutory Commissioners:

- *a Chairperson*
- *a Commissioner for Care Quality*
- *a Commissioner for Complaints and Reviews.*

Key functions of AACC would include:

- *administering the regulation of the quality of community and residential aged care, including compliance and enforcement*
- *promoting quality care through educating providers and assisting them with compliance and continuous improvement*
- *approving community and residential aged care providers for the provision of government subsidised approved aged care services*
- *administering prudential regulation and all other aged care regulation, such as supported resident ratio obligations*

-
- *monitoring, reporting and assessing costs and transparently recommending a scheduled set of prices, subsidies and a rate of indexation for approved aged care services*
 - *handling consumer and provider complaints and reviews*
 - *providing information to stakeholders, including disseminating and collecting data and information.*

RECOMMENDATION 15.2

The Australian Aged Care Commission's (AACC) Commissioner for Complaints and Reviews should determine complaints by consumers and providers in the first instance. Complaints handling should be structured into the three areas: assessment, early resolution and conciliation; investigations and referral; and communication, stakeholder management and outreach (including rural and remote and Indigenous outreach). A separate review office should be developed to hear and determine initial appeals of individual cases as well as to conduct 'own motion' systemic reviews within the AACC.

The Australian Government should abolish the Office of the Aged Care Commissioner.

The Australian Seniors Gateway Agency should establish a separate complaints handling and review office to deal with complaints about its decisions, including assessments and entitlements. These matters would not be subject to complaint handling or review by the Australian Aged Care Commission.

All appeals in respect of decisions of the AACC and the Australian Seniors Gateway Agency should be heard by the Administrative Appeals Tribunal. The allowable time in which to appeal should be increased to 13 weeks from the current 28 days.

RECOMMENDATION 15.3

The Australian Government should implement an independent statutory Community Visitors Program for residential aged care facilities akin to the operation of other types of statutory visitor programs operating in other residential settings (for example, disability and children's residential services) and in other jurisdictions, to promote and protect the rights and wellbeing of residents.

RECOMMENDATION 15.4

The Council of Australian Governments should agree to publish the results of community care quality assessments using the Community Care Common Standards, consistent with the publication of quality of care assessments of residential aged care.

RECOMMENDATION 15.5

The Australian Government should provide a broad range of enforcement tools to the Australian Aged Care Commission to ensure that penalties are proportional to the severity of non-compliance.

RECOMMENDATION 15.6

In the period prior to the implementation of the Commission's new integrated model of aged care, all governments should agree to reforms to aged care services delivered under the Home and Community Care (HACC) program to allow the Australian Government to be the principal funder and regulator. However, in the event that they do not agree, the Victorian and Western Australian Governments should agree to harmonise (from 1 July 2012) the range of enforcement tools in HACC delivered aged care services.

RECOMMENDATION 15.7

The Australian Government should introduce a streamlined reporting mechanism for all aged care service providers (across both community and residential aged care) based on the model used to develop Standard Business Reporting.

RECOMMENDATION 15.8

The Australian Government should amend the residential aged care prudential standards to require residential aged care providers to disclose (to care recipients or prospective care recipients) whether they have met all prudential regulations in the current and previous financial years. At the same time, providers should be required to indicate that the following would be made available on request, rather than automatically:

- *an audit opinion on whether the provider has complied with the prudential standards in the relevant financial year*
- *the provider's most recent audited accounts.*

The Australian Government should amend the missing resident reporting requirements in the Accountability Principles 1998 to allow a longer period for providers to report missing residents to the Australian Aged Care Commission, while continuing to promptly report missing residents to police services.

The Council of Australian Governments should identify and remove, as far as possible, onerous duplicate and inconsistent regulations, including in relation to infectious disease outbreaks, occupational health and safety, food safety, nursing scopes of practice, advance care plans, power of attorney, guardianship and elder abuse.

Policy research and evaluation

To encourage transparency and independence in aged care policy research and evaluation, the Australian Aged Care Commission should be responsible for ensuring the provision of a national ‘clearinghouse’ for aged care data. This would involve:

- *establishing a central repository for aged care data and coordinating data collection from various agencies and departments*
- *making these data sets publicly available in a timely manner for research, evaluation and analysis, subject to conditions that manage confidentiality risks and other concerns about potential data misuse.*

To maximise the usefulness of aged care data sets, reform in the collection and reporting of data should be implemented through:

- *adopting common definitions, measures and collection protocols*
- *linking databases and investing in de-identification of new data sets*
- *developing, where practicable, outcomes based data standards as a better measure of service effectiveness.*

Research findings on aged care and on trial and pilot program evaluations, including those undertaken by the Department of Health and Ageing, should be made public and released in a timely manner.

Transition

RECOMMENDATION 17.1

The Australian Government should establish an Aged Care Implementation Taskforce to coordinate and manage the transition to the new aged care system, chaired by the Department of the Prime Minister and Cabinet.

To assist the Implementation Taskforce, a non-statutory Aged Care Advisory Group should be established comprising representatives from consumers (including carers), providers and the workforce.

RECOMMENDATION 17.2

The Australian Government should negotiate with providers of care services to existing care recipients to harmonise care subsidies and other arrangements. It should reach an agreement within five years that would have the effect of removing grandfathering arrangements for existing and new places while protecting existing recipients of care from changes that would impose a new cost upon them.

The exemption from the supported resident ratio obligation provided to some extra service facilities should be removed at the end of the transition period as part of a negotiated settlement.

RECOMMENDATION 17.3

The Australian Government should provide, during the transition period, capped grants to existing smaller approved residential care providers, on a dollar-for-dollar basis, for financial advice on business planning to assist in assessing their future options.

Subject to an audit to demonstrate solvency, the Australian Government should offer — during the transition period — existing smaller approved residential care providers a loan facility for the repayment of accommodation bonds. The Government should charge an interest rate premium on the facility to discourage its use when private sector options are available.

RECOMMENDATION 17.4

The Australian Aged Care Commission should, during the transition period, formally monitor accommodation prices in residential care. If the price monitoring shows that residential providers are systematically charging excessive accommodation fees, the Australian Aged Care Commission should recommend that the Australian Government consider regulatory measures that might be implemented to reduce this practice.

RECOMMENDATION 17.5

The Australian Government should introduce at the earliest opportunity a temporary intermediate community care package level to reduce the gap between Community Aged Care Packages and Extended Aged Care at Home during the first stage of the transition period.

RECOMMENDATION 17.6

The Australian Government should conduct a pilot whereby providers could transfer (subject to approval by the Australian Aged Care Commission) up to 50 per cent of their supported resident ratio obligation per facility with other providers within the same region (or subregion).

This arrangement should be reviewed within five years with a view to assessing its widespread applicability and to consider the option of introducing a competitive tendering arrangement, or entitlement funding, for the ongoing provision of accommodation to supported residents as an alternative.

RECOMMENDATION 17.7

In implementing reform, the Australian Government should announce a detailed timetable for changes and how the changes are expected to affect consumers (including carers), providers, workers, and the sector in general. In particular, the Australian Government should:

- carefully and fully communicate the design, objectives and implications of the reform measures*
- be guided by the three-stage implementation plan listed in schedule A.*

Summary of proposals

The following table does not include all the Commission’s recommendations and represents only a brief summation of the reforms proposed. The full set of recommendations is provided in a separate section following the Overview.

<i>Current problem</i>	<i>Proposed reform</i>	<i>Main benefits of change</i>
Funding		
<i>The major components of aged care need separate policy settings</i>		
Current arrangements for aged care subsidies and user contributions are ‘ad hoc’ and ‘inconsistent’ and are not well aligned across care settings.	Separate policy settings (including for subsidies and co-contributions) for the major cost components of aged care, namely care, everyday living expenses and accommodation.	Unbundling or separating out the costs of aged care will facilitate a more effective and equitable funding framework for the aged care system and provide more choice for older people.
<i>Regulatory restrictions on community care packages and residential aged care bed licences</i>		
The supply of aged care services is not matched to the level of demand or the geographic incidence of that demand.	Remove restrictions on the number of community care packages and residential bed licences. Remove distinction between residential high care and low care places and discontinue the extra service category.	Providers would be able to better respond to the level of demand and the preferences of a wider range of care recipients. Consumer access to care will be substantially improved, regardless of their type of accommodation.
<i>Regulatory restrictions on residential accommodation payments</i>		
Accommodation charges do not reflect the costs of providing residential accommodation, with accommodation bonds bearing little relation to real costs.	Allow accommodation bonds for all residential care, abolish regulated retention charges and give residents the choice of a periodic charge, or, where offered, an accommodation bond or a combination of these. Limit accommodation bonds to no more than the equivalent of periodic accommodation charges. But uncap such periodic accommodation charges to reflect differing standards of accommodation.	Improves the capacity of the industry to meet the demand for residential high care services and freedom to set accommodation charges. Improves the transparency of accommodation costs for residents, gives them choice and ensures that if a bond is offered it reflects the actual cost of accommodation supplied, allowing for a reasonable return on investment.

<i>Current problem</i>	<i>Proposed reform</i>	<i>Main benefits of change</i>
Funding		
<i>Co-contributions across community and residential care</i>		
Consumer contributions, if allowed, vary and are not always related to cost of supply nor are they related to people's capacity to pay. The system abounds with cross-subsidies.	Rate of co-contributions to be determined by the Australian Government, and based on affordability and capacity to pay. A comprehensive means test for care recipients' co-contributions will apply.	Consumer contributions will better reflect people's capacity to pay based on their wealth, not just income. They will be transparent and fair, not ad hoc and arbitrary.
Excessive or catastrophic costs of care could totally consume older people's accumulated wealth.	A lifetime limit to the care recipients' co-contributions towards the cost of government-subsidised care services.	The stop-loss limit ensures consumers and their families are not exposed to excessive costs of care (but it excludes accommodation costs).
<i>Assisting older Australians to pay for care and support</i>		
Current arrangements provide an incentive for older people to sell their residence and 'over-invest' the proceeds in accommodation bonds which lose value at the rate of inflation.	Establish an Australian Age Pensioners Savings Account scheme to allow age pensioners to deposit proceeds from the sale of their principal residence. The account is exempt from the assets and income tests, and can be drawn on flexibly to fund living expenses and care costs.	Pensioners have more choice in how they use their housing wealth. If they chose to sell, their home, they can retain their pension benefits, and access the savings account to pay for living, accommodation and care costs while maintaining the real value of their asset.
Financial products to access equity in one's home are limited in scope, expensive and not well supported by older Australians.	Establish a Government backed Australian Aged Care Home Credit scheme to assist older Australians meet their aged care costs, including for accommodation, whilst retaining their primary residence. Dependents living in the residence will be protected.	Allows individuals to draw on the equity in their home to contribute to the costs of their aged care and support, in an easy and secure manner with a very low interest rate. Repayment not due until care recipient and all protected persons choose to vacate the residence.
<i>Residential care for those of limited means</i>		
Inadequate supply of residential aged care places for the financially disadvantaged.	Providers obliged to make available a proportion of their accommodation (set on a regional basis) to supported residents. A limited pilot would test the benefits of allowing the trading of the obligation between providers in the same region.	Ensures equitable access to residential care for those unable to pay for their own accommodation costs. This flexibility will allow providers to pursue more efficient and innovative residential business models.

<i>Current problem</i>	<i>Proposed reform</i>	<i>Main benefits of change</i>
The Government subsidy for supported residents is inadequate.	The subsidy for the approved basic standard of residential care accommodation for supported residents should increase to reflect the average cost of providing such accommodation within a region.	The level of subsidy will sustain the commercially viable provision of supported accommodation (based on the 1999 building standard, which is currently 1.5 beds per room).
Current eligibility conditions for a supported resident subsidy are inconsistent with the principle that care recipients with the means to do so should pay for their accommodation.	A person's share of their principal residence should be included in the total assets test for supported resident status, but that person should have guaranteed access to the Australian Aged Care Home Credit scheme.	This will allow subsidies to be better targeted to those most in need, but will remove the need for those moving into residential care to sell their residence in which a 'protected person' remains living.
<i>Scheduled prices, subsidies and co-contributions to reflect actual costs</i>		
Government set prices do not fully reflect the cost of delivering aged care services. As a consequence, the quantity and to some degree quality of services on offer has suffered.	Transparent recommendations from the new independent Australian Aged Care Commission (AACC) on the scheduled set of prices and related indexation.	Realistic prices, subsidies and indexation will support a sustainable aged care industry. Greater industry confidence in the price setting process. Protects consumers from market power of providers and encourages the supply (and choice) of aged care services.
Care and support		
<i>A single gateway into the aged care system</i>		
Consumers face a complex and confusing array of entry points into the aged care system and multiple sources of information about ageing and how they can best manage their own ageing.	Establish an Australian Seniors Gateway Agency to provide information, assessment of needs and entitlement to care and support services, care coordination and carer referral services, to be delivered via a regional network. The Gateway will facilitate the assessment of capacity to pay for the purpose of co contributions.	The Gateway will make the aged care system easier to access and navigate for potential aged care recipients. It will be more efficient because it will remove duplication of some services and provide greater care coordination.

<i>Current problem</i>	<i>Proposed reform</i>	<i>Main benefits of change</i>
<i>Care continuity and consumer choice</i>		
At present, care provided in community and residential settings is provided in discrete care silos, and moving between these is problematic for consumers. Consumers have limited choice about the mix of services they receive and the provider of those services.	Replace current discrete care packages with a single system of integrated and flexible care provision. Government support for a range of community services which older Australians could access through the Gateway. The Gateway will approve a set of services to individuals on an entitlement basis. Individuals may choose an approved provider or providers. To support these arrangements, fund an expanded system of consumer advocacy services and provide care coordination and case management as needed.	Consumers will have better access to services appropriate to their needs as these needs change. Consumers will be able to exercise greater choice about who provides those services.
Some basic community support services for older people need to be supported and easily accessible.	Provide support for a range of basic community support services for older people and their carers.	Expanded consumer advocacy services and other supports will assist informed choice, particularly among vulnerable consumers. Improve access to community support services for the aged.
<i>Greater focus on reablement</i>		
The current system emphasises services to address symptoms of functional decline rather than on halting and reversing the decline.	Introduce an intensive time-limited reablement service, with eligibility and entitlement assessed by the Gateway.	A greater focus on independence for the aged, through providing rehabilitation and restorative care.
<i>More flexible arrangements for respite care</i>		
Current arrangements inhibit the delivery of respite care that is best suited to individual circumstances.	More flexible respite arrangements to be trialled, such as cashing out respite entitlements and extending the range of approved informal respite providers.	Provide more appropriate respite arrangements for carers of older Australians.
<i>Improving the interface with health and disability services</i>		
Limited integration of services between health and aged care service providers leads to inappropriate hospital admissions and care. Current health services are not sufficiently responsive to aged care needs, and residents in aged care facilities face difficulties in accessing a range of health care services.	Promote the expanded use of in-reach services to residential aged care facilities and the development of visiting multi-disciplinary aged care health teams. The Australian Government to set cost reflective fees for certain sub-acute services delivered in a residential care facility.	Improve wellbeing of residents from not having to move between residential and hospital care. Reduce cost burdens on the health system. Teams will develop expertise in aged care, deliver more responsive services and attract health workers to this sector. Assists providers to deliver a more flexible range of care services, and diversify their client and revenue bases.

<i>Current problem</i>	<i>Proposed reform</i>	<i>Main benefits of change</i>
Achieving continuity of care for people with disabilities as they age is difficult with different funding and care systems	<p>Arrangements for funding individuals in the aged care system should be consistent with those in the National Health and Hospitals Network Agreement.</p> <p>A person supported within the disability care system should be able to continue to be supported by the system best able to meet their care needs as they age. Older people with disabilities can elect to stay with disability system or transfer to aged care system.</p>	Ensure continuity of care for people with disabilities as they age, and allow them to choose services from providers who best meet their needs.
Quality of care		
<i>Quality assurance framework</i>		
Current aged care standards focus more on meeting minimum standards rather than on continuous quality improvement. Also, the quality framework is not focussed enough on outcomes for care recipients.	Publish quality indicators at the service provider level. The AACC to develop a Quality and Outcomes data set, accessible via the Gateway.	<p>Assist care recipients and their families to make informed choices about care.</p> <p>Improve accountability for government subsidies received for approved aged care services.</p>
<i>Access to general practitioners</i>		
Older people in residential care or in their homes do not always have ready access to medical services.	Review the Medicare rebate for services provided by GPs visiting residential care facilities or people in their homes.	Improve older people's access to medical services at a time in their life when their care needs are highest.
<i>End-of-life care</i>		
Palliative and end-of-life care needs of older Australians are not being adequately met under the current arrangements.	Ensure that residential and community care providers receive appropriate payments for delivering palliative and end-of-life care.	A greater role by residential and community care providers in delivering these services will provide more appropriate care and be less expensive than services delivered in a hospital.
Catering for diversity		
<i>Caring for special needs groups</i>		
Older people from culturally and linguistically diverse backgrounds can have difficulty in communicating their care needs or having their preferences and cultural needs respected. These circumstances can adversely affect the wellbeing of the older person receiving care.	The proposed Gateway should cater for diversity by establishing access hubs for older people from CALD backgrounds, providing interpreter services and ensuring its diagnostic tools are culturally appropriate for the assessment of care needs. Greater recognition in aged care standards of the rights and needs of older people from diverse backgrounds.	<p>Improved assessments of care needs and improved delivery of appropriate care for people from culturally diverse backgrounds will help enhance consumer wellbeing.</p> <p>Newer diversity needs will be better recognised including refugees and sexually diverse care recipients.</p>

<i>Current problem</i>	<i>Proposed reform</i>	<i>Main benefits of change</i>
Caring for special needs groups can involve added costs, which are not fully reflected in scheduled prices and subsidies.	The proposed AACC, in recommending care prices and subsidies, should take into account costs associated with catering for diversity.	Improved wellbeing of care recipients by facilitating access to services that are more appropriate to their particular needs.
There is limited capacity within Indigenous and remote communities to provide aged care services.	Ensure that rural and remote and Indigenous aged care services be actively supported before remedial intervention is required with an emphasis on building local capacity and service sustainability.	Address current and prospective workforce shortages. Help to ensure sustainable, culturally appropriate services.
Many programs that are currently block funded should receive funding through consumer entitlement commensurate with usage. But some will need to be directly funded.	Governments should block fund programs only where there is a demonstrated need to do so, based on specific service needs, such as for some remote and Indigenous specific services and homeless persons' aged care services.	Direct funding would target a limited number of aged care programs to ensure sustainability or where entitlement funding is not appropriate.

Housing of older Australians

Improving the ability of older Australians to age in their homes and communities

There is no overarching policy framework for providing home maintenance and modification (HMM) services at the national level or in most states.	Governments should develop a coordinated and integrated national policy approach to providing home maintenance and modification services.	Improved effectiveness of HMM services in achieving health, community care and housing outcomes for older people.
The absence of integrated information systems hampers planning and development of HMM services.	All governments should develop benchmarks for levels of services to be provided, eligibility and co-contributions, and professional and technical expertise.	
Access standards in building regulations have not been developed specifically for residential dwellings or been based on the characteristics of people 65 and older.	Develop building design standards for residential housing that meet the access and mobility needs of older people.	Improve the ability of older people to remain living in their homes and communities by using more appropriate standards, if they wish to modify their house.

Improving the supply of affordable housing for older Australians

Australia has a shortage of affordable rental housing, and rental markets are pressed to meet the demands of older renters. This shortage is expected to worsen.	COAG to develop a strategic policy framework for providing affordable housing that would cost effectively meet the demands of an ageing population.	Identify what changes or additional policies (including assessing current initiatives) are required to ensure the housing needs of people as they age are being met.
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<i>Current problem</i>	<i>Proposed reform</i>	<i>Main benefits of change</i>
Regulation of retirement-specific living options		
Retirement-specific living options are attracting an increasing share of older Australians.	Regulation of retirement villages and other retirement-specific living options should not be aligned with the regulation of aged care.	Not imposing additional and inappropriate costs on retirement village accommodation.
Potential residents face complex and confusing financial arrangements and contracts.	State and territory governments should pursue nationally consistent retirement village legislation under the aegis of COAG.	Greater transparency in financial arrangements and residents' contractual rights and responsibilities.
Differing state and territory retirement village legislation impose costs which deters investment.		Reduce a significant impediment to new investment in the industry.
Carers and volunteers		
Improving support for informal carers		
Many carers are financially and socially disadvantaged and may have poor health, partly as a result of their caring activities.	The Gateway, when assessing the care needs of older people, should also assess the capacity of informal carers to provide ongoing support.	Encourage a strong and sustainable community of informal carers.
Carer support is currently administered in an ad hoc way across a number of programs and jurisdictions.	Carer Support Centres be developed from the existing carer support programs and to provide a broader range of carer support services.	Ensure carers access the services they, and those they care for, need and are entitled to receive.
		Make respite and other services more easily accessible and responsive to the needs of informal carers.
Improving conditions for volunteers		
Organisations face significant costs associated with organising, training and managing volunteers.	Funding for services which engage volunteers should take into account the costs associated with: volunteer administration and regulation; and appropriate training and support for volunteers.	Reduce barriers to individuals volunteering and improve organisations' ability to harness volunteers.
Activities can impose substantial costs on volunteers.		
Workforce issues		
Improving employment conditions and training for the formal care workforce		
Inadequate funding and indexation mechanisms diminish aged care providers' ability to pay fair and competitive wages.	Scheduled prices for aged care should take into account the need to pay fair and competitive wages to nursing and other care staff delivering aged care services.	The payment of fair and competitive remuneration for aged care workers should reduce the lack of parity, especially with the acute health care system, and enhance the attractiveness of the aged care sector to employees.

<i>Current problem</i>	<i>Proposed reform</i>	<i>Main benefits of change</i>
A lack of vocational training packages for the aged care sector and poor quality of training provided by some registered training organisations.	Promote skill development through an expansion of accredited courses to provide aged care workers at all levels with the skills they need.	Develop and promote career paths for aged care workers and improve the quality of care that those workers are able to deliver.
A limited number of specialist 'teaching aged care facilities'.	Fund the expansion of 'teaching aged care services' to promote the sector and provide appropriate training for personal carers and medical, nursing and allied health students and professionals.	Increase the willingness of personal carers and health professionals to enter the aged care sector and provide the training to equip the aged care workforce to deliver better quality aged care.
The quality of aged care training delivered by registered training organisations is variable.	Independently review delivery and outcomes of aged care related vocational education and training courses by registered training organisations.	Ensure that appropriate minimum standards are applied in the delivery of accredited aged care courses and that students demonstrate the appropriate competencies.

Regulatory institutions

New regulatory arrangements are needed

Governance arrangements in aged care do not clearly separate policy, regulation and appeals, which create inherent conflicts of interest within DoHA.	Establish a new regulatory agency — the Australian Aged Care Commission — with statutory offices and Commissioners for Care Quality and for Complaints and Reviews.	Removes potential conflicts of interests, ensures greater independence of regulatory roles and, thus, establishes a more effective regulatory governance structure.
A number of regulatory functions are undertaken by multiple jurisdictions, agencies and departments. This duplication creates confusion for providers, adds to regulatory costs incurred by the industry and can compromise the quality of care.	Also to have responsibility for recommending scheduled prices, subsidies and rate of indexation for care services, and administering prudential and all other aged care regulation.	
Complaint handling within DoHA creates conflicts of interest.	The AACC should handle complaints by consumers and providers in the first instance.	Create an independent complaints handling process which is separate from the funding and policy department.
A complex management and accountability structure exists within the Complaints Investigation Scheme and the Office of Aged Care Quality and Compliance.	The Gateway should establish a separate complaints handling and review office to deal with complaints about its decisions.	Provide a separate mechanism to determine appeals at arm's length to both the proposed independent regulator and the proposed Gateway Agency.
	Appeals in respect of AACC decisions and those of the Gateway should be heard by the Administrative Appeals Tribunal (AAT).	
	Abolish the Office of the Aged Care Commissioner.	

<i>Current problem</i>	<i>Proposed reform</i>	<i>Main benefits of change</i>
Concerns about retribution inhibit the free flow of complaints from those receiving care or from their families and friends.	Implement an independent statutory Community Visitors Program.	Promote and protect the rights and wellbeing of residents in aged care facilities. Increase access to, and enhance confidence in, the workings of the complaints processes. Allow objective scrutiny on a more informal basis.
<i>Publicising information about assessments of the quality care provided</i>		
No certainty that the results of quality assessments using the Community Care Common Standards be made publicly available.	COAG should agree to publish the results of community care quality assessments using the Community Care Common Standards, consistent with the publication of quality of care assessment of residential care.	Assist providers and consumers in making informed decisions about the aged care services they supply or receive.
<i>Encouraging and enforcing compliance</i>		
The range of enforcement options is limited, which in practice restricts their usefulness.	Provide a range of enforcement tools to the AACC to ensure penalties are proportional to the severity of non-compliance.	Better targeting and more effective penalties and interventions allow the regulator to more effectively manage risks of non-compliance.
<i>Putting streamlined reporting requirements into place</i>		
Reporting requirements are overly burdensome and duplicative, consuming management and staff time which could be better directed towards providing care services.	Introduce a streamlined reporting mechanism for all service providers (across both community and residential aged care) based on the model used to develop Standard Business Reporting.	Reduce unnecessary costs to providers while delivering timely reporting information to the regulator.
<i>Reducing the extent of some mandatory reporting requirements</i>		
Mandatory disclosure requirements to consumers impose unnecessary costs on providers.	Amend the residential aged care prudential standards to allow providers to disclose information (to care recipients or prospective care recipients) on request, rather than automatically.	Reduce the significant disclosure burden associated with servicing incumbent and prospective care recipients.
Reporting requirements impose a significant compliance cost and regulatory burden, and take resources away from the priority of finding the missing resident.	Amend the mandatory reporting requirements for missing residents.	Reduce costs to providers and free up resources to find missing residents.
<i>Clarifying and simplifying jurisdictional responsibilities and harmonising some regulations</i>		
Duplicate and inconsistent regulations impose unnecessary costs and impede achieving the objectives of those regulations.	COAG should identify and remove, as far as possible, onerous duplicate and inconsistent regulations.	Improve the efficiency and effectiveness of regulations.

<i>Current problem</i>	<i>Proposed reform</i>	<i>Main benefits of change</i>
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Policy research and evaluation

Improving data collection and access

There is a significant lack of publicly available data and policy relevant evidence in the area of aged care.	<p>The AACC should be responsible for ensuring the provision of a national 'clearinghouse' for aged care data.</p> <p>Introduce measures to improve the usefulness, collection and public reporting of aged care data and research findings on aged care and on trial and pilot program evaluations.</p>	<p>Provide a better evidence base for government policy and for decision making by providers, care recipients and their families.</p> <p>Improve transparency within the sector.</p>
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Implementing the proposed package of reforms

The path to a new aged care system

The implementation of reforms will require significant changes for all stakeholders and could have unintended costs to government and industry if not introduced carefully.	The Government should announce a timetable for reforms and how they are expected to affect the sector, and establish a high level implementation taskforce.	Provide a clear transition to new arrangements which allow the sector time to adjust and moderate disruption to consumers, providers and governments.
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1 About the inquiry

Australia's population, like that in many countries, is ageing. The average age of Australians is increasing, and there will be many more older Australians. Over the next 40 years, the number of Australians aged 85 and over — the major users of aged care services — is projected to more than quadruple, from around 0.4 million in 2010 to 1.8 million by 2050 (Australian Government 2010d).

The ageing of our population is largely in response to improvements in life expectancy. In 1983, in Australia, a female reaching the age of 65 could expect to live on average for another 18 years, while a male could expect to live for a further 14 years. By 2002, these figures had risen to 21 years for females and 18 years for males. And, by 2021, they are expected to increase further — to 24 years for females and 21 years for males (Department of Health and Ageing (DoHA), sub. 482).

This is something to celebrate. As the World Health Organization (WHO) said:

... population ageing is one of humanity's greatest triumphs. (2002, p. 6)

The Minister for Mental Health and Ageing also recently said:

We worked for a long period of time — medical researchers, public health experts and Australians changing their own lifestyles not to die in our 50s. We now pretty much as a matter of right are able to look forward after we've finished raising our families, after we've finished the peak years of our work, to some time to smell the roses, time to travel, time to spend with our grandchildren and then hand them back as soon as they get ratty; also time to do a little bit of study, part-time work and volunteering.

This is something that should be celebrated. It is one of the great achievements of humanity and deserves a much more positive frame. (Butler 2011, p. 2)

The Benevolent Society, while agreeing, also recognises that this presents some challenges:

The ageing of the population is a triumph in terms of medical, social and economic advancement and it offers many opportunities. But it also presents social and economic challenges for individuals, communities and for governments in relation to systems of social support. (2010, p. 12)

A key driver of increased life expectancy is advances in health care that were not available to, or affordable for, previous generations. However, while older Australians are living longer than previous generations, it is inevitable that many will become frail and require care and support. More older Australians will mean a significant increase in both demand for aged care services and spending on aged care.

In terms of demand, the number of Australians receiving aged care is projected to increase by around 150 per cent over the next 40 years. This equates to over 2.5 million older people (those aged 65 or older) or almost 8 per cent of the population using aged care services by 2050 (DoHA, sub. 482). Government expenditure on aged care is expected to increase from 0.8 to 1.8 per cent of GDP by 2050 (Australian Government 2010d).

While life expectancy has been increasing, Australia has also experienced a period of strong economic growth and this has led to significantly higher real incomes and wealth. Looking forward, the *2010 Intergenerational Report* projects that real GDP per person will grow by 1.5 per cent per annum over the next 40 years (Australian Government 2010d). Clearly, a productivity driven reform agenda will increase the capacity of the community to meet the higher costs of aged care.

The older population themselves will, on average, be more affluent and are likely to expect higher quality care and greater choice over how they live their lives and the care and support they receive. As Colombo et al. at the Organisation for Economic Cooperation and Development (OECD) said:

... as societies become wealthier, individuals demand better quality and more responsive social-care systems. People want care systems that are patient-oriented and that can supply well co-ordinated care services. (2011, p. 38)

Demand for aged care services is also expected to become more diverse in the future because of:

- changing patterns of disease among the aged (including the increasing prevalence of chronic diseases and dementia)
- a wider range of preferences and expectations (including rising preferences for independent living).

It is expected that older Australians will also want to take advantage of advances in care and technology to assist them to remain independent and engaged in society for longer. The United Kingdom Government's recent White Paper — *Building the National Care Service* — noted:

It is safe to imagine that the pace of technological change that we have seen over the last 20 years will continue, and that by 2030 the kinds of technology that will be available to us will be far beyond anything we know at the moment. Those using the care and support system will increasingly expect technology to play a part in helping them decide what care to choose and helping to improve their quality of life, and the care and support sector will need to be positioned to take advantage of these innovations. (HM Government 2010, p. 50)

A further challenge will be the need to secure a significant expansion in the aged care workforce at a time of age-induced tightening of the labour market, an expected relative decline in family support and informal carers and strong competition for workers from within parts of the health and disability systems.

1.1 The Commission's brief

Deficiencies in Australia's aged care system are well known and the need for significant reform to meet future challenges has been highlighted in a number of recent reports including:

- *Australia's future tax system: Report to the Treasurer* (Henry Review 2010)
- the National Health and Hospitals Reform Commission's (NHHRC) *A Healthier Future for All Australians* (NHHRC 2009)
- the Productivity Commission's (PC) *Trends in Aged Care Services* (PC 2008) and *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services* (PC 2009a)
- the Senate Standing Committee on Finance and Public Administration's *Inquiry into Residential and Community Aged Care in Australia* (SSCFPA 2009)
- the *Review of Pricing Arrangements in Residential Aged Care* (Hogan 2004b).

In view of the well documented weaknesses of the current system and the future challenges, the Government asked the Commission to undertake a broad-ranging inquiry with the aim of developing detailed options for redesigning Australia's aged care system to ensure that it can meet the challenges facing it in coming decades. Specifically, the Commission was asked to:

- systematically examine the social, clinical and institutional aspects of aged care in Australia, building on past reviews of the sector
- develop options for reforming the funding and regulatory arrangements across residential and community aged care (including the Home and Community Care (HACC) program)

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- address the interests of special needs groups, including people living in rural and remote locations, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities and veterans
 - systematically examine the future workforce requirements of the aged care sector, and develop options to ensure that the sector has access to a sufficient and appropriately trained workforce
 - recommend a path for transitioning from the current funding and regulatory arrangements to a new system that ensures continuity of care and allows the sector time to adjust
 - examine whether the regulation of retirement-specific living options, such as retirement villages, should be aligned more closely with the rest of the aged care sector and, if so, how this should be achieved
 - assess the medium and long term fiscal implications of any change in aged care roles and responsibilities.

The full terms of reference are available at the front of this report.

In November 2010, the Commission requested, and the Government granted, an extension to the inquiry's reporting date from April 2011 to the end of June 2011.

1.2 What is aged care?

Aged care essentially refers to the services available to older people who, because of frailty and other age-related conditions, are unable to live independently without assistance. Services range from relatively low intensity support such as assistance in the preparation of meals and household maintenance to high-level care in a congruent environment or institution (box 1.1).

In recent years increasing emphasis has been placed on the promotion of healthy ageing or wellness, with a greater focus on support and services that allow older Australians to maintain their connectedness to the community and to be actively engaged citizens.

Most aged care is provided by informal carers (such as partners and children, mostly daughters, and neighbours and friends). In addition, many older people and their carers are supported by charitable organisations and volunteers. An extensive array of services are provided privately through the market, ranging from house cleaning and home maintenance to personal care and private nursing. A further subset of aged care services are subsidised, regulated and, at times, directly delivered by governments.

Compared to the general population, older Australians report higher levels of disabling conditions (or morbidities) such as dementia, paralysis, speech-related impairments, arthritis and hearing disorders. Many older Australians live with multiple disabling conditions (or co-morbidities) — people aged 65 or over reported an average of 2.8 health conditions in 2003 (Australian Institute of Health and Welfare (AIHW) 2010a). Older people are also at significantly higher risk of injury due to falls, compared to the general population.

Box 1.1 What is aged care or long term care?

The OECD defines 'long term care' as:

... a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living (ADL). This "personal care" component is frequently provided in combination with help with basic medical services such as "nursing care" (help with wound dressing, pain management, medication, health monitoring), as well as prevention, rehabilitation or services of palliative care. Long term care services can also be combined with lower-level care related to "domestic help" or help with instrumental activities of daily living (IADL). (Colombo et al. 2011, pp. 11-12)

An International Consensus on Policy For Long-Term Care of the Ageing, developed by the WHO and the Milbank Memorial Fund, defined long term care as:

... the system of activities undertaken by informal caregivers (family, friends and/or neighbours) and/or professionals (health, social services and others) to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation, personal fulfilment, and human dignity. (WHO and the Milbank Memorial Fund 2000, p. 6)

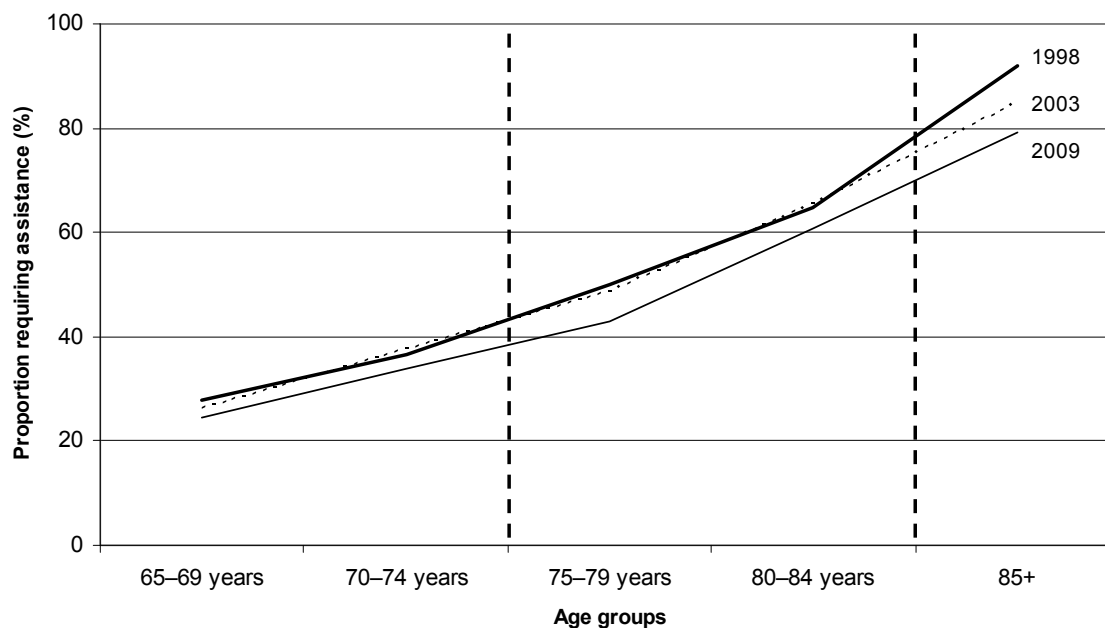
DoHA described aged care as:

... care for chronic illness or disability for which hospital care is no longer deemed appropriate. ... In Australia, this form of long term care is generally referred to as 'aged care' (sub. 482, p. 10)

The onset of age-related disability and frailty can create a need for assistance with everyday living activities and, progressively, personal care (figure 1.1). Over half of all older people in 2003 reported having a disability that led to them requiring assistance, including with self-care, mobility and communication (ABS 2004).

The need for care and support is particularly characteristic of people aged 85 and older. There is a noticeable rise in the prevalence of severe or profound limitations at those ages and in the use of aged care services (chapter 2).

Figure 1.1 Need for assistance by age of older person



Data sources: ABS Cat. no. 3201.0, 4430.0, and 44300do001.

1.3 Who are older Australians?

While there is no agreed definition of ‘older Australians’, they are typically defined as people aged 65 years or over. This reflects, until recently, the Age Pension eligibility age, which was set when the Age Pension commenced in 1909 under the authority of the *Invalid and Old-Age Pensions Act 1908*. In the same year though, the United Kingdom Parliament passed the *Old Age Pensions Act 1908* which set 70 years as the minimum pension age (box 1.2).

The Australian Government has announced that the minimum eligible age for the Age Pension will increase to 67 from 1 July 2023. The Minister for Families, Community Services and Indigenous Affairs stated:

As Australians are healthier and living longer, the qualifying age for the Age Pension for men and women will be increased by six months every two years, commencing from 1 July 2017 and reaching 67 on 1 July 2023. (Macklin 2009, p. 1)

Box 1.2 Defining 'older Australians'

There is no agreed definition of 'older Australians'. The effects of ageing vary from person to person in terms of their time of appearance, their cause and consequence, their severity and their duration.

- The WHO defines an older person as 'a person who has reached a certain age that varies among countries but is often associated with the age of normal retirement' (WHO 2004, p. 42).
- The United Nations (UN) (including through the 'International Day of Older Persons') uses 60 as the minimum age for an older person (UN 2002). So too does the Australian Bureau of Statistics (ABS) in its *Disability, Ageing and Carers* publication (2004).
- The Australian Institute of Health and Welfare (AIHW 2010a) and the OECD (2005b) typically define an older person as someone aged 65 or older.

There are two main extant governing acts in Australia for aged care; the *Aged Care Act 1997* and the *Aged or Disabled Persons Care Act 1954*. The 1997 Act does not specify a particular minimum age for care, although section 2 of the 1954 Act defines an 'aged person' as 'a person who has attained the age of 60'.

- For aged care planning purposes, the Government uses 70 as the minimum age, with a target by June 2011 of 113 residential and community operational places per 1000 people aged more than 70 (chapter 2). Another consideration is the minimum age eligibility for an older person to access the Age Pension. As the Commission's report identifies, there are several interfaces between the income support and aged care systems.
- The NHHRC proposed (recommendation 42) that the Government change the planning ratio from 113 places per 1000 people aged 70 and over to 620 care recipients per 1000 people aged 85 and over (NHHRC 2009, p. 263).

The Commission is defining an older Australian as someone who has reached the eligibility age for an Age Pension. However, there are several important caveats that apply to this definition.

- Given the marked differences in the health status of many Indigenous Australians, old age is generally defined as commencing at 50 years of age.
- While the use of broad age intervals is useful to define what is meant by 'older Australians', it should not obscure the significant differences in health status, living arrangements, family circumstances, income and wealth, accommodation arrangements and social and cultural practices across the older age cohorts.
- A number of younger individuals, under age 65, with a severe or profound disability currently receive services from, and reside in, the aged care system.

The aged care system will continue as the best place to receive services for such conditions as younger onset dementia.

This age — the *pension age* — is used in this report as a general guide for ‘older Australians’ rather than a fixed age of 65, although the availability of statistics will generally dictate the continued use of age 65. However, given significant changes in life expectancy and chronic disease prevalence in the adult population, the policy and system design issues dealt with in this report more often focus on those aged 85 and older. This report also acknowledges that Indigenous people over the age of 50 and others with younger onset ageing-related conditions are able to access aged care services currently and would continue to do so in accordance with Government policies.

1.4 The Commission’s approach

Consistent with both the terms of reference and its own legislation, the Commission’s assessments of the current aged care system, and proposed options for change, are predicated on improving the wellbeing of the community as a whole.

The Commission’s proposals, based on this wellbeing framework, are aimed at developing a system of care and support for older Australians that is more efficient, equitable, effective (relating to choice, quality and appropriateness) and sustainable.

Such a system would promote the independence of older Australians, their wellness and exercise of choice, provide appropriate and flexible services, be easy to navigate, be affordable yet financially sustainable, ensure the adequacy and efficient use of resources (including a skilled workforce), and assist informal carers.

Considerable judgement is required to achieve an appropriate balance between the various interests: older people requiring aged care and their families; providers of aged care services; aged care workers: the government in its funding, regulatory and delivery roles; and current and future taxpayers more generally.

To inform its judgements, the Commission has had regard to the quantitative and qualitative evidence relevant to assessing the benefits and costs of the current system and options for reform. The Commission has also undertaken modelling and empirical analysis to assess indicative public and private costs and benefits of its proposals and how they might affect older Australians. It tested these judgements at a modelling workshop held in February 2011. The Commission also contracted Applied Aged Care Solutions Pty Ltd to undertake a study into a new care model — the results of the study are presented in appendix C.

The Commission wishes to acknowledge the Departments of Health and Ageing; Veterans’ Affairs; Families, Housing, Community Services and Indigenous Affairs;

and the Treasury for providing supplementary data to the inquiry. A number of aged care providers and industry groups were also generous in providing data to the Commission, as have consumer groups.

Extensive public input

In preparing this report, the Commission actively sought input from stakeholders:

- Shortly after receiving its terms of reference, the Commission released an Issues Paper outlining a range of matters on which it was seeking information and advice. In response to that paper, it received close to 490 submissions.
- It met informally with a broad cross-section of interest parties within Australia, including: older Australians and their representative organisations; providers of community and residential care; health and aged care professionals and researchers including those in fields such as nursing, general practice, geriatrics, allied health and personal care.
- To gain a better understanding of various key issues, the Commission held roundtables on the topics of financing and funding, the workforce, accommodation, care, technology and modelling/cost projections. The Commission also held an informal forum on rural and remote area issues.
- Following the release of the draft report in January 2011, the Commission held formal hearings in every state and territory capital city.
- In response to the draft report, the Commission received more than 430 further submissions.

The Commission wishes to acknowledge the efforts of the very many people who have taken the time to lodge a submission to the inquiry and to appear at the hearings. Each submission was closely read and has been valuable in informing the Commission.

More detail relating to public input to the inquiry is provided in appendix A.

Interfaces with the disability sector

Concurrent with this inquiry, the Commission is undertaking an inquiry into disability care and support (see chapter 9 for more details). That inquiry released its draft report in February 2011 and is scheduled to deliver its final report to the Government in July 2011. In defining an appropriate interface between the two sectors, the Commission is mindful of the importance of the service provision being seamless for the person receiving care. In the Commission's view, services should

be drawn from the sector with the most relevant expertise, irrespective of the funding source.

1.5 A road map to the rest of the report

The remainder of the report comprises three parts.

Part 1 examines the aged care environment, including expected drivers of future demand:

- chapter 2 provides an overview of the current aged care system in Australia.
- chapter 3 reports on the drivers of demand for the aged care system over future years.

Part 2 assesses the strengths and weaknesses of the current aged care system in the context of an analytical framework developed by the Commission:

- chapter 4 outlines an analytical framework against which the current system and the Commission's proposed reforms are assessed.
- chapter 5 assesses the current system including its strengths and weaknesses.

Part 3 outlines the Commission's analysis of, and recommendations on:

- a funding model (chapters 6, 7 and 8)
- access to the new care system (chapter 9)
- quality in the provision of care services (chapter 10)
- care for special needs groups and other diverse groupings of older people (chapter 11)
- age-friendly housing and retirement villages (chapter 12)
- informal carers and volunteers (chapter 13)
- the aged care workforce (chapter 14)
- a new regulatory framework (chapter 15)
- strengthening the aged care evidence base (chapter 16)
- a transitional framework to support the implementation of the Commission's recommendations (chapter 17).

The Commission's final report is published in two volumes.

- Volume 1 comprises the overview, summary of recommendations, a summary of proposals, and chapters 1 to 5.
- Volume 2 comprises chapters 6 through 17 and appendix A.

Additional supporting analysis is contained in the other appendices to the report. Appendices B to H, and two technical papers provided by DoHA are available in electronic form from the Commission's website at <http://www.pc.gov.au/projects/inquiry/aged-care>.

2 The current aged care system

Key points

- Over one million older Australians receive some form of aged care and support each year. Services are delivered in the community and in residential facilities, and include assistance with everyday living, personal care and health care. In 2009-10:
 - over 610 000 people aged 70 years or over received Home and Community Care (HACC) services
 - around 70 000 people received more intensive packaged community care at home
 - around 215 000 people received permanent residential care, of whom 70 per cent received high level care. In recent years, around 70 per cent of residents were female and 55 per cent were aged 85 years or older.
- Australia's aged care system has evolved in an ad hoc way in response to: the increasing and changing needs and demands of older people; failures in risk management; political compromises; and concern to contain public expenditure to sustainable levels.
- The formal 'aged care system' is primarily funded and regulated by the Australian Government, with state and territory governments mainly involved in home and community care. Regulation of the sector is extensive in scope and intensive in its detail.
- Community and residential care services are provided by religious, charitable, community-based and commercial organisations, as well as state, territory and local governments.
- The aged care workforce consists of informal carers, the paid workforce and volunteers. Services are also supported by, and are dependent on, the medical workforce and allied health professionals.
- The aged care system interacts with many other social policy areas, including primary health, acute care, disability services, housing (including social housing), transport and income support. Service delivery in each of these areas affects the performance of the aged care sector and vice versa.

This chapter provides an overview of Australia’s current aged care system. It outlines the main care and support services and key characteristics of care recipients, providers and the workforce. The chapter is intended as background to the following chapters, rather than as an exhaustive description of the current system or the history of its development — this can be readily accessed elsewhere (for example, AIHW 2009a; DoHA 2010n; SCRGSP 2011).

Section 2.1 identifies the foundations of Australia’s current aged care system and sets out its legislated objectives. Section 2.2 describes the main publicly subsidised aged care programs, the numbers of older people using those programs, eligibility and assessment processes, funding arrangements, providers and the workforce. The financing of aged care is summarised in section 2.3 while the regulatory framework is profiled in section 2.4. Finally, section 2.5 briefly outlines the interfaces between the aged care system and health, disability and other services.

2.1 Foundations of Australia’s aged care system

Australian Government involvement in aged care was initially as a funder of maintenance subsidies for pensioners in Benevolent Asylums (1909 to 1963). These payments were provided as a substitute for the Age Pension and, as the costs of aged care outgrew the level of the Age Pension, the Government became involved in funding aged care.

The Australian Government’s first direct involvement in the capital funding of aged care was a housing initiative under the *Aged Persons Homes Act 1954* and, in terms of funding care, the introduction of nursing home benefits in 1963. As noted by the Department of Health and Ageing (DoHA):

The Commonwealth’s involvement in the funding of aged care arose at the intersection of pension (and more generally, income support), housing and health care policy. (sub. 482, p. 41)

There has been substantial evolution of the aged care system since those early years. (A more detailed history is provided in DoHA, sub. 482) The current system is largely reflective of various reforms undertaken in the mid 1980s, and again in 1997, in response to the increasing and changing needs and demands of older people, failures in risk management, political compromises and a concern by governments to contain the level of public expenditure.

In 1985, the Australian Government and the state and territory governments jointly funded the Home and Community Care (HACC) program, which replaced a range of disparate community care services that were being delivered to older people and

those with a disability. It aimed to provide care in the community without the need for institutionalisation and also to reduce the demand and financial pressures being placed on residential facilities.

The 1986 Nursing Home and Hostel Review (Commonwealth of Australia 1986) led to the amalgamation of the formerly separate nursing home (high care) and hostel (low care) programs and to admission into residential care being dependent on approval by a Geriatric Assessment Team.

The provision of more intensive care services for older people at home increased in 1992 through the introduction of Community Aged Care Packages (CACPs) and again in 1998 with Extended Aged Care at Home (EACH) and EACH Dementia (EACH-D) packages. Unlike HACC, these packages are funded exclusively by the Australian Government.

Further substantial reform occurred in 1997, through the introduction of the *Aged Care Act 1997* (the Act), including:

- a single Resident Classification Scale which determined the government subsidy paid for residents in high and low care. (In March 2008, the Resident Classification Scale was replaced by the Aged Care Funding Instrument (ACFI) which aimed to provide a more coherent set of subsidies based on the assessed care needs of each resident.)
- income testing of recurrent subsidies to ensure that wealthier residents made a fair and reasonable contribution to the cost of their care
- nursing home operators having the same capacity to raise market-driven entry contributions as hostel operators, subject to meeting minimum building and other standards, and with appropriate protections (overturned in November 1997, except for high care extra service places)
- accreditation procedures based on legislated standards
- improved access to anonymous complaints resolution procedures
- certification of residential services to ensure appropriate levels of safety, privacy and community access.

National regulation of aged care is effected through two principal Acts of Parliament (which also specify the Government's aged care objectives — box 2.1).

- The *Aged Care Act 1997* governs residential care, community care packages, multi-purpose services (MPS), innovative care and transition care. The main areas of regulatory control are: funding services; allocating aged care places to approved providers; assessing client eligibility; pricing; determining quality

standards (both for care and accommodation); ensuring compliance; and handling complaints.

- The *Home and Community Care Act 1985* governs the provision of basic maintenance and support services to older people who live at home (irrespective of whether that home is owned, rented or within a retirement village).

A third Act, the *Aged or Disabled Persons Act 1954* is extant and provides coverage for capital grants.

Box 2.1 **Objectives of Australia's aged care system**

Objectives set out in the *Aged Care Act 1997* and *Aged Care Principles*:

- promote a high quality of care and accommodation for the recipients of aged care services that meets the needs of individuals
- protect the health and wellbeing of the recipients of aged care services
- ensure that aged care services are targeted towards the people with the greatest needs for those services
- facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstances or geographic location
- provide respite for families, and others, who care for older people
- encourage services that are diverse, flexible and responsive to individual needs
- help those recipients to enjoy the same rights as all other people in Australia
- plan effectively for the delivery of aged care services
- promote ageing in place through the linking of care and support services to the places where older people prefer to live.

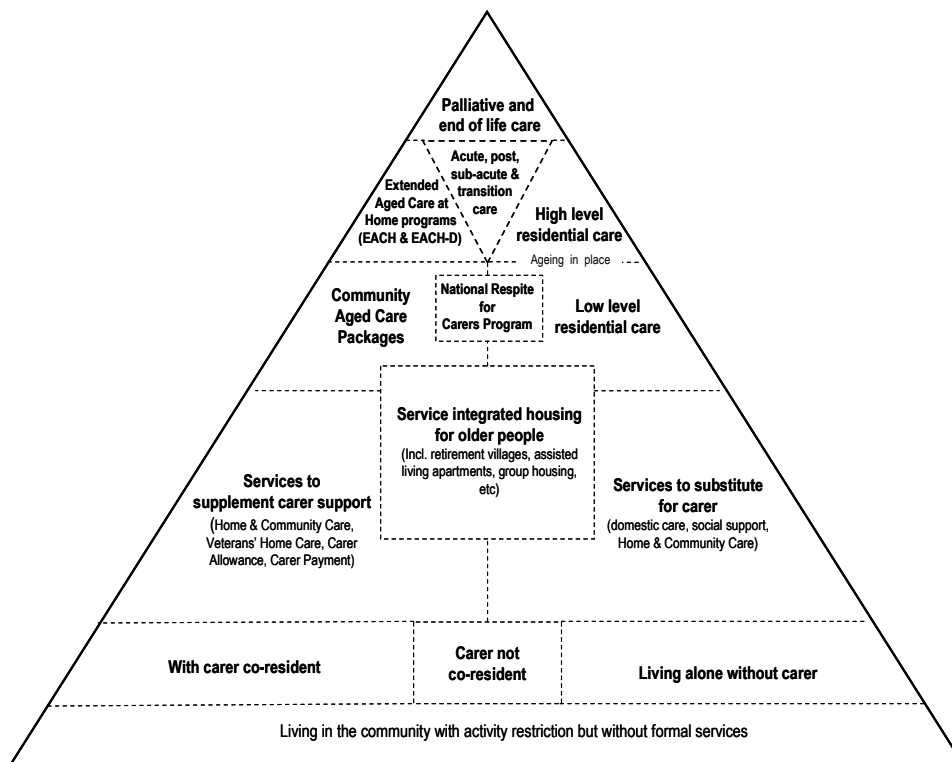
Objectives of the *Home and Community Care Act 1985*:

- ensure access to HACC among all groups within the target population
- ensure that, within available resources, priority is directed to persons within the target population most in need of HACC
- provide services which are equitably between regions and responsive to regional differences
- ensure delivery of services in a cost effective manner
- promote an integrated and coordinated approach between the delivery of HACC and related health and welfare programs (including residential care).

2.2 Care and support services

Older people receive care and support from informal carers, from publicly subsidised formal community and residential care services and directly from market suppliers of services ranging from home maintenance to private nursing (figure 2.1). The most resource intensive services are located in the upper half of the pyramid.

Figure 2.1 **Current modes of care in the aged care system**



Data source: Howe (1996), revised with advice from Howe, A., pers. comm., 18 May 2010.

Most older Australians, including those who receive formal aged care services, live at home. As the Australian Institute of Health and Welfare (AIHW) states:

Despite a common myth that most older people live in some type of cared accommodation, the majority of older Australians (in 2006 92%) lived in private dwellings as members of family, group or lone-person households. Only 8% were usual residents in non-private dwellings, which include hotels, motels, guest houses, and cared accommodation such as hospitals, aged care homes and supported accommodation offered by some retirement villages. Although the proportion of older people living in non-private dwellings increased with age, most people in each age group — 65–74 years, 75–84 years and 85 years and over — lived in private dwellings. (2009a, p. 88)

The care needs of older people can vary markedly and they may need intensive periods of restorative care or rehabilitation to assist them to regain their independence. Overall, however, their needs tend to rise over time and the availability of able informal carers tends to decline. As a result, those aged 85 years or above have a higher level of reliance on formal care services.

Informal carers

Informal carers, predominantly family, but also friends, neighbours and community groups, provide most of the care and mainly provided support required by older people (chapter 13). Informal assistance is in the form of communication, paperwork, mobility, cognitive tasks, emotional support and transport (ABS 2003). Informal carers also play a fundamental role in the coordination and facilitation of formal community care services. According to the Australian Bureau of Statistics' (ABS) 2009 *Survey of Disability Ageing and Carers*, there were 352 000 primary carers of people aged 65 years and over (ABS 2010b; appendix H).

Access Economics (2010b) estimated that if the informal care provided by unpaid family carers to all people in need, including the frail aged, were replaced by formal paid care, the cost would be in excess of \$40 billion per annum in 2010.

In recognition of the demands placed on informal carers, governments provide support through respite services (both in home, at day centres and in residential care), as well as income support (such as the Carer Allowance and Carer Payment). In 2009-10, almost 60 000 people received short term respite care in residential care facilities, equivalent to around 1.34 million respite days. The National Respite for Carers Program, which complements residential respite care, provided 5.1 million hours of respite in 2009-10 (DoHA 2010n).

Formal aged care services

The Australian Government and state and territory governments provide a number of subsidised formal aged care programs (table 2.1). These include the block funded HACC program, community care packages, and residential aged care.

Table 2.1 Total number of clients serviced by program, 2009-10^a

<i>Program</i>	<i>Clients</i>
Residential care ^b	214 418
Community care packages	
CACP	57 742
EACH	7 995
EACH-D	3 847
Transition Care	14 976
Residential Respite	44 160
Home and Community Care ^c	616 000
Veterans' Home Care ^d	73 100
Department of Veterans' Affairs (DVA)	
Community Nursing ^d	33 100

^a Some clients receive services from more than one program in any one year. As some people do not spend the entire year in residential care or on a community care package, multiple people can use the same residential place or package at different points of time through the year. As such, the number of people who receive care throughout the year exceeds the number of care places available. ^b 70 per cent of all permanent residents were classified as high care at 30 June 2010. ^c For those aged 70 years or over. ^d The 2009-10 numbers reflect the services provided as notified to the Department by the extraction date. Once all provider notifications have been received, the final number of clients is likely to be higher.

Sources: DoHA (2010n); DVA's DMIS Service Item Cube (extracted 17 June 2011).

Home and community care and related programs for veterans

HACC is by far the largest and most extensive program of support for older people. It plays a valuable role in assisting older people to continue to live independently in their own accommodation and remain part of their local community.

In 2009-10, around 616 000 people aged 70 years or older received HACC services — representing around 70 per cent of the people receiving care under the program. (HACC is also widely used by younger people with disabilities.) HACC primarily provides low intensity levels of support. It includes meal preparation and delivery, community transport, domestic assistance such as house cleaning and home maintenance, home modification, personal care and allied health care (table 2.2).

Providers of HACC range from large organisations which deliver multiple services over a wide area to local community groups that might supply only one service. There were over 3300 HACC agencies providing services at 30 June 2009 (DoHA 2009c). They employ a significant proportion of the community care workforce and draw on a large contingent of volunteers (box 2.2).

Table 2.2 Community care programs: services provided to clients aged 65 years or over, 2007-08

Per cent of clients in program

Service Type	HACC	Veterans' Home Care	DVA Community Nursing	CACP	EACH	EACH-D
	2007-08	2007-08 ^a	2007-08	Dec 2008	Dec 2008	Dec 2008
Non-specialist care services						
Domestic assistance	32.6	93.1	x	81.5	68.3	61.6
Meals at home or a centre	19.5	x	x	13.7	7.4	8.1
Other food services	0.6	x	x	21.4	35.3	34.6
Transport services	17.0	x	x	20.8	9.9	14.2
Home or garden maintenance	17.8	18.7	x	11.6	11.4	11.2
Activity programs	10.9	x	x	3.1	9.8	9.8
Social support	12.0	x	✓	36.4	26.4	34.4
Personal care	10.0	4.3	31.2	39.3	83.3	74.2
Counselling (care recipient)	6.8	x	✓	✓	11.7	18.0
Counselling (carer)	1.3	x	x	x	x	x
Goods and equip.	3.1	x	x	✓	✓	✓
Home modifications	4.3	x	x	✓	✓	✓
Respite care	2.2	8.3 ^b	x	4.4	32.2	44.0
Linen services	0.3	x	x	0.7	2.0	2.6
Accommodation and related services	x	x	x	x	x	x
Specialist services						
Nursing (home and centre)	21.1	x	78.7	x	21.9	16.9
Allied health/therapy (home and centre)	19.5	x	x	x	7.1	6.4
Total clients (number)	638 218	77 284	32 625	33 411	3 354	1 314

✓ Service type provided but data unavailable. x Service type not provided. ^a Clients who received VHC services may have received DVA Community Nursing at the same time. Data on simultaneous use is not provided. ^b Figure related to provision of in-home respite care and emergency respite care only, and excludes DVA clients who used residential respite.

Source: AIHW (2009a).

Box 2.2 Community care workforce

Researchers at the National Institute of Labour Studies found that around 87 500 people were employed in the provision of community care services to older Australians in 2007. The authors consider this figure is an underestimate.

About 85 per cent of the community care workforce is involved in direct care activities. By occupation, the direct care workforce is a mix of registered nurses (10.2 per cent), enrolled nurses (2.4 per cent), community care workers (82.6 per cent) and allied health workers (4.8 per cent).

Data limitations mean it is not possible to split community care workers by program type — that is, between HACC, CACP, EACH and EACH-D.

A large number of volunteers also provide support services to older Australians living in the community and are integral to the delivery of community programs such as meals-on-wheels.

Source: Martin and King (2008).

HACC providers undertake a needs assessment for older people who may require services, and support is prioritised to those with the greatest need, within the budget funding available to the provider. The majority of HACC clients (90 per cent) receive less than two hours of support each week.

HACC is jointly funded by the Australian, state and territory governments under the *Home and Community Care Act 1985*. In line with the changes to roles and responsibilities under the National Health and Hospitals Network Agreement, aged care funding (but not the component relating to disability) under the National Partnership on Home and Community Care will transfer to the Commonwealth from 2011-12 (at the time of writing, the Victorian and Western Australian Governments are not parties to these reforms).

The Department of Veterans' Affairs (DVA) also assists a large number of older people through its Veterans' Home Care (VHC) and Community Nursing programs (see table 2.2 for a list of services). These programs offer a range of services similar to those available through HACC. In 2009-10, 69 700 veterans aged 70 years or over received VHC and 32 000 received Community Nursing.¹

¹ From DVA's DMIS Service Item Cube, extracted 17 June 2011. The 2009-10 numbers reflect the services provided as notified to the DVA by the extraction date. Once all provider notifications have been received, the final number of clients is likely to be higher.

Community care packages

The three community care packages — CACPs, EACH and EACH-D — are designed for older people who are eligible for residential care but who prefer to remain in the community and are safely capable of doing so (normally with the support of family or other informal carers).

In 2008, CACPs provided 5.4 hours of direct assistance per week on average, primarily for home help (including meals and laundry) and personal care (including showering and dressing) (DoHA 2010e).

EACH and EACH-D packages are individually planned and coordinated for people with complex needs who require higher levels of care, including nursing and allied health. EACH-D packages are designed specifically for people who experience behaviours of concern and psychological symptoms associated with dementia. In 2008, the average weekly hours of direct assistance provided was 14.1 hours under EACH packages and 15.2 hours under EACH-D packages (DoHA 2010e).

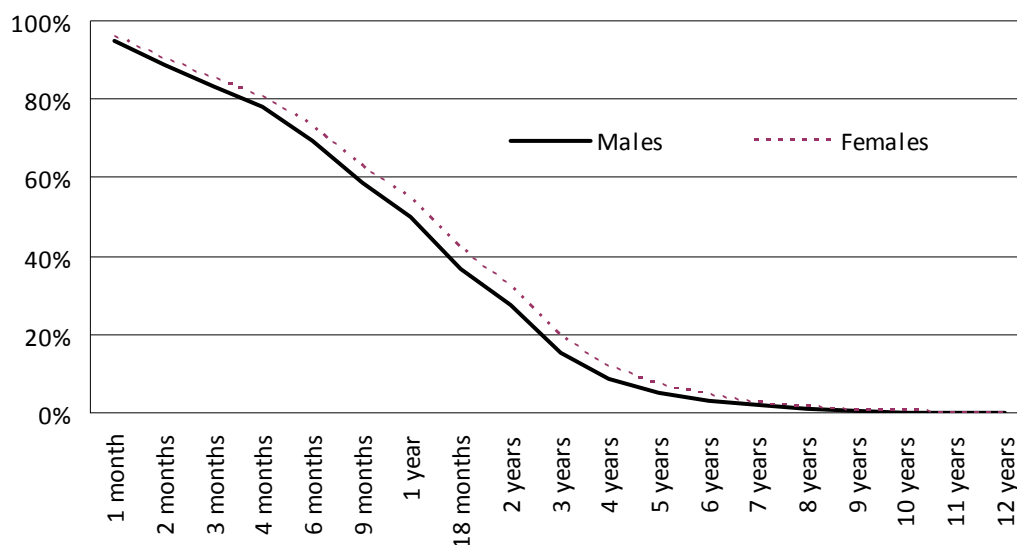
At June 2010, there were around 47 700 community care package recipients — including 40 100 CACPs, 5200 EACH packages and 2300 EACH-D packages — with over 69 000 people using those packages during 2009-10. (See table 2.2 for care package services provided to clients at December 2008.)

Most people do not receive community care services for an extended period of time. The median length of stay on a community care package for people receiving community care between July 1997 and December 2009 was just under 12 months for males and 14 months for females. However, there is considerable variation in the length of time people spend receiving services from packages (figure 2.2).

Around 84 per cent of community care packages are delivered by charitable and other not-for-profit (NFP) community-based providers. The remaining 16 per cent of packages are provided by commercial organisations, state and territory and local governments (DoHA 2010n).

Figure 2.2 Probability of remaining on a community care package after a length of time

Per cent of all people who were enrolled on a CACP, EACH or EACH-D package for at least some of the period July 1997 to December 2009



Data source: DoHA Aged Care Data Warehouse (supplied on 29 October 2010).

The assessment of an older person’s eligibility for a package (and for subsidised residential care — see below) is undertaken by Aged Care Assessment Teams (ACATs) (known as Aged Care Assessment Services in Victoria). ACATs generally comprise, or have access to, a range of health professionals, including geriatricians, physicians, registered nurses, social workers, physiotherapists, occupational therapists and psychologists. Having assessed the care needs of an older person, the ACAT team works closely with the client, their carer and family to identify the most suitable aged care services available to them. The Australian Government will take over full responsibility for the Aged Care Assessment Program from 2012-13, although it will still be provided by state and territory governments under contract.

The Australian Government subsidises the cost of community care packages. Its fiscal exposure is limited by the number of older people approved as eligible for a subsidised service and by the restricted allocation of formal care places through a needs based planning framework (box 2.3). The framework seeks to align places with the growth in the aged population through a target provision ratio. The current ratio is scheduled to reach 113 operational places per 1000 people aged 70 years or over by June 2011 — 25 of the places are for community care and 88 for residential care (table 2.3).

Box 2.3 Needs-based planning arrangements

The Australian Government makes available new residential care licences and community care packages for allocation in Aged Care Planning Regions in each state and territory. From 1985 the planning arrangements provided 100 aged care places for every 1000 people aged 70 years or over. This is scheduled to reach 113 aged care places for every 1000 people aged 70 years or over by June 2011. Planning also takes account of the Indigenous population aged 50–69 years.

There has been a small, but growing emphasis on community care and a re-balancing from low level residential care to high level residential care. The intention is for 25 out of every 113 places to be for community care places (which includes CACPs, EACH packages and other flexible care places), 44 places for residential low care and 44 for residential high care.

Operational aged care provision differs from these planning ratios. ‘Ageing in place’ allows a resident who enters a low care place to remain in that place if and when he/she comes to need high care; that is, effectively high care is provided under a low care licence. In addition, providers may decide to not take up new licences and they may fail to operationalise their licences or hand them back.

New places are allocated, after an open tender, to approved providers that demonstrate they can best meet the aged care needs within a particular planning region. Providers have two years to make residential places operational. Community care packages tend to become operational relatively soon after allocation.

Providers are expected to meet regional targets for supported (formerly concessional and assisted) residents to ensure that those who cannot afford to pay for accommodation have equal access to care. The targets are based on socio-economic indicators and range from 16 to 40 per cent of residents.

Some residential aged care facilities may be approved to offer ‘extra service’ to residents, up to a limit of 15 per cent of places in each state or territory, and with regional limits as well. Approval of extra service status is not granted if it would result in an unreasonable reduction of access for supported, concessional or assisted care recipients in any particular region. Many extra service facilities are exempt from providing a minimum number of supported resident places.

Source: SCRGSP (2010b).

Over the last 20 years, there has been an increasing emphasis on community care (though it still represents only one quarter of all places) and a re-balancing from low level residential care to high level residential care.

Table 2.3 Target provision ratios announced between 1985 and 2007

Aged care places/packages per 1000 people aged 70 years or older, including Indigenous people aged 50–69 years

<i>Year</i>	<i>Residential high care places</i>	<i>Residential low care places</i>	<i>Total residential places</i>	<i>CACP packages</i>	<i>EACH & EACHD packages</i>	<i>Total community packages</i>	<i>Total aged care places & packages</i>
1985	40	60	100		100
1992	40	55	95	5	..	5	100
1993	40	52.5	92.5	7.5	..	7.5	100
1995	40	50	90	10	..	10	100
2004	40	48	88	20	..	20	108
2007	44	44	88	21	4	25	113

Sources: AIHW (1995, 2001); Cullen (2003); Hogan (2004b); PC (2008); Pyne (2007); Santoro (2007); SCRGSP (2006).

Residential care

Residential care is provided to older people when their care needs (physical, medical, psychological and/or social) exceed the scope of community care. These needs can be triggered by a range of factors, including an acute health episode, inappropriate living arrangements or a lack of support from an informal carer. Some facilities specialise in providing care and support for homeless and drug and alcohol affected older people.

Low level residential care provides accommodation and related everyday living support (meals, laundry, cleaning), as well as some personal care services. ‘Personal care services’ can include assistance with bathing, toileting, eating, dressing, mobility, managing incontinence, community rehabilitation support, assistance in obtaining health and therapy services and support for people with cognitive impairments

High level care covers additional services such as nursing care, palliative care, other complex care, equipment to assist with mobility, medical management and therapy services. With ‘ageing in place’, many people who entered a facility as a low care resident are now receiving high care in that facility.

Extra service places in high care facilities provide a higher standard of accommodation, food and other hotel-type services for a higher charge.

At June 2010, permanent residential aged care was provided to around 163 000 people (with a greater number of people receiving residential care during the year). Of these, 70 per cent received high level care (DoHA 2010n). In recent years,

around 70 per cent of residential care residents were female and 55 per cent of all residents were aged 85 years or older.

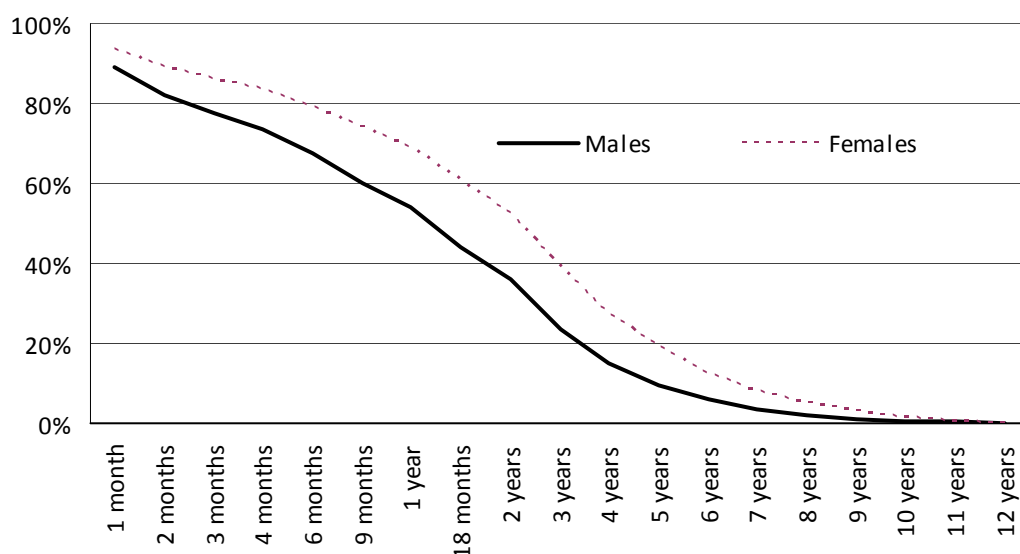
There has been a steady increase in the proportion of residents being classified as needing high level care. That is, an increasingly dependent and frail group of older people are entering residential aged care. Between 1998 and 2008, the proportion of high care entrants rose from 58 to 70 per cent of total residential aged care entrants (AIHW 2008b).

On average, older people spend more time in permanent residential care than on community care packages. The Commission estimates that the median length of time in permanent residential care for anyone who received residential care between July 1997 and December 2009 was 1.2 years for males and 2.2 years for females. However, as with community care packages, there is considerable variation in the length of time individuals spent in residential care (figure 2.3).

There were 2773 aged care facilities in Australia delivering formal residential care in June 2010. Around 59 per cent of the beds were operated by NFPs; 35 per cent by commercial organisations; and 6 per cent by some state and local governments (DoHA 2010n). The average size of residential facilities increased from 46 to 61 places between 1998 and 2008, although there remains a wide range of facility sizes (AIHW 2009c).

Figure 2.3 Probability of remaining in residential care after a length of time

Per cent of all people who were in residential care for at least some of the period July 1997 to December 2009



Data source: DoHA Aged Care Data Warehouse (supplied on 24 September 2010).

Assessments of older people for entry into residential care are undertaken by ACATs. An ACFI is used by providers to assess the level of government funding according to a resident's assessed level of personal and health care needs (box 2.4).

Box 2.4 The Aged Care Funding Instrument

Aged care residents are classified into one of 65 Aged Care Funding Instrument (ACFI) classifications based on the level of approval for care granted to the resident by an ACAT and on the approved residential care provider's appraisal of the care needs of the resident against the ACFI. A provider's appraisals of the care needs of a resident are subject to validation by the DoHA on a risk assessed basis.

The ACFI was introduced on 20 March 2008 to replace the Resident Classification Scale, which had been in place since 1997. The ACFI was intended to more closely match funding to the care needs of residents; reduce documentation; and reduce the level of disagreement between providers' appraisals of the care needs of their residents and the findings of DoHA's validators.

In terms of overall design and structure, the ACFI consists of 12 care need questions that align with three major care domains, namely, activities of daily living, behaviour and complex health care.

In the course of completing the ACFI, diagnostic data about mental and behavioural disorders and other medical conditions are collected and used to categorise residents as having nil, low, medium or high needs in each of the three care domains. No funding is provided for a domain if the resident has no or minimal assessed care needs in that domain.

A care subsidy is paid for each level of the three care domains, except the nil level. The total care subsidy paid for each resident is generally the sum of the rates for all three domains.

Source: DoHA (2009g).

In 2007, around 175 000 people were employed in residential care and, of those, around 133 000 were direct care employees (Martin and King 2008) comprising:

- registered nurses (16.8 per cent of the workforce)
- enrolled nurses (12.2 per cent)
- personal carers, including assistants in nursing (63.6 per cent)
- allied health workers (7.4 per cent).

The non-direct care staff of the residential care workforce included cooks, cleaners and administrators.

In addition, over 50 000 volunteers provided companionship and support services to older Australians in residential facilities in 2008-09 (ABS 2010a).

Flexible care, care in rural and remote areas and care for people with special needs

Flexible care is aimed at addressing the needs of care recipients in ways other than through mainstream community and residential care. It includes transition care places, MPS and innovative pool care and was an important part of the growth in community care places over the past decade.

Transition care places provide time-limited, goal-oriented and therapy-focused care for older people after a hospital stay. This form of care can be provided for up to 12 weeks in either a residential setting or in the community. Transition care is a jointly funded initiative of the Australian, state and territory governments.

MPS integrates health and aged care services and are individually tailored for rural and remote communities depending on their geography, population and care needs. Each MPS is financed from a flexible funding pool, with contributions from the Australian and relevant state or territory governments.

Innovative pool care supports the development and testing of flexible models of service delivery. The program provides opportunities to use flexible care places to test new approaches to providing care for specific target groups.

Flexible models of care are also provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. The services aim to provide culturally appropriate aged care close to the communities of older Indigenous people, principally in rural and remote areas.

Additional funding and assistance (including through the provision of zero nominal interest loans) is provided to aged care services in rural and remote areas to assist with the extra cost of delivering services. In 2008-09, a further 1488 community aged care places and 1418 residential places were allocated to regional, rural and remote areas (DoHA 2009e).

Places are allocated to providers of care for special needs groups, involving a further 1425 community care places and 851 residential aged care places (DoHA 2009e). These places are provided for:

- people from Indigenous communities
- people from non-English speaking (culturally and linguistically diverse) backgrounds

-
- people who are financially or socially disadvantaged
 - veterans.

Retirement villages

Retirement villages (inclusive of independent and assisted living units) are playing an increasingly important role in accommodating older Australians. The Retirement Village Association (RVA) estimates that there are currently around 160 000 residents living in 1870 retirement villages in Australia. Over the period 1999–2010, the market penetration in the retirement living sector has more than doubled from 2.3 to 5.3 per cent of people aged 65 years or over (RVA 2010). For those aged 75 or over, the current market penetration rate is around 10 per cent (RVA, sub. 424). The RVA also estimates that the national penetration rate could increase to 7.5–8 per cent by 2025 as a result of population ageing and stronger preferences for this form of accommodation.

The quality of the accommodation in retirement villages (and choice of in-house services) can range from basic to luxury resort-style living. Following the successful piloting of CACPs and EACH packages in retirement villages in 2003-04, retirement village operators have greater scope for competing in aged care approval rounds for new community care places.

2.3 The financing of aged care

Formal aged care services in Australia are predominantly financed by taxpayers with some user co-contributions (including contributions from government-funded income support pensions, principally the Age Pension).

In 2009-10, total direct government expenditure on aged care services was around \$11 billion (SCRGSP 2011). Around two-thirds of that expenditure was directed at residential care, with the balance for community care, assessment and information services and services provided in mixed delivery settings (table 2.4). The Australian Government funds community care packages (CACPs, EACH and EACH-D) and residential care and currently shares funding responsibility for HACC with the states and territories.

Table 2.4 Government expenditure on aged care services, 2009-10

<i>Expenditure component</i>	<i>\$ million</i>
Assessment and information services ^a	97
Residential care services ^b	7 290
Community care services ^c	3 169
Services provided in mixed delivery settings ^d	458
Total	11 014

^a Assessment and information services include only Australian Government expenditure. ^b Residential care services include DoHA and DVA (including payroll tax supplement) and state and territory governments' expenditure. ^c Community care services include HACC, CACP, EACH and EACH-D, National Respite for Carers Program, community care grants, VHC, DVA Community Nursing, Assistance with Care and Housing for the Aged. ^d Services include the Transition Care Program, MPS and residential ATSI flexible services, Day Therapy Centres, Continence Aids Assistance Scheme, National Continence Management Strategy, Innovative Care Pool and Dementia Education and Support, Long Stay Older Patient Initiative, Community Visitors Scheme and Culturally and Linguistically Diverse expenditure.

Source: SCRGSP (2011).

The HACC program receives the bulk of public subsidies that are directed to the provision of community care — around \$1.9 billion in 2009-10. Currently, the Australian Government provides 60 per cent of funding and the states and territories 40 per cent (DoHA 2010n). While there are national guidelines for HACC service standards, there is significant variation in the operation and charging regimes for services across the jurisdictions. User contributions for HACC services are estimated to average around 5 per cent of the cost of the services (DoHA 2008b).

In 2009-10, Australian Government spending on CACPs was \$510 million, and \$306 million on EACH and EACH-D packages combined (DoHA 2010n). On average, user contributions account for around 16 per cent of the costs of CACPs and about 5 per cent of the cost of EACH packages (DoHA 2008b).

Australian Government funding for residential care, paid to aged care providers, was \$7.1 billion in 2009-10. Around 70 per cent of the cost of residential care is provided by the government subsidy, with the annual subsidy per residential place averaging \$43 050 in 2009-10 — \$51 550 for high care residents and \$20 150 for low care residents (DoHA 2010n).

Aged care residents who can afford to, contribute to the cost of their care and accommodation. Residents contribute via basic daily fees, income tested fees, total asset tested accommodation payments, extra service fees and additional services fees (box 2.5). Total direct private expenditure on aged care services cannot be reliably calculated as data on private expenditure for some services are not collected.

Box 2.5 Residential aged care co-contributions

Basic daily fee — all residents in aged care facilities, including respite residents, can be asked to pay a basic daily fee as a contribution towards accommodation costs and living expenses like meals, cleaning, laundry, heating and cooling. The maximum basic daily fee for permanent residents entering an aged care home on or after 20 September 2009 is 84 per cent of the annual single basic Age Pension.

Income tested fee — residents in permanent aged care with total assessable income above the maximum income of the full rate of the Age Pension are asked to pay an income tested fee (in addition to the basic daily fee) as a contribution to the costs of care. The amount they pay depends on their income and the level of care they require.

Accommodation charge — as at 21 March 2011, residents with total assets, including the former principal residence (unless it is exempt because of the presence of a protected person), in excess of \$39 000 who enter high care may be asked to pay an accommodation charge. The charge increases to a maximum of \$30.55 per day for residents with assets of just over \$102 500.

Accommodation bonds — as at 21 March 2011, residents with sufficient assets who enter low level or who enter an extra service high care place may be asked to pay a bond. The bond amount and payment arrangements are negotiated between providers and residents. However, residents cannot be charged a bond which would leave them with less than \$39 000 in assets. The aged care provider can deduct monthly retentions from the bond for up to five years and derive income from the investment of the bond. The Australian Government sets the maximum retention amount, currently \$307.50 a month (fixed at the date of entry). The balance of the bond is refunded to the resident or their estate on leaving the facility.

Lump sum accommodation bonds paid by residents in aged care homes are exempt from the Age Pension assets test. A resident's former principal residence is exempted from the Age Pension assets test for two years for people entering residential care (and longer if the person's partner is living there). If a resident's former principal residence is rented out to pay some or all of a periodic payment for an agreed accommodation bond, the former residence and the rental income are exempt from the Age Pension assets and income tests for as long as the former residence is rented out and the periodic payment continues to be made.

Extra service charges — for the provision of a higher standard of accommodation services and food (where extra service applies to residents occupying extra service places).

Additional service fee — where the resident requests or agrees to additional services (such as newspapers and hairdressing).

Sources: DoHA (2010o, 2011h).

Entrants to high care are required to pay an accommodation charge, while those entering low level care or those receiving extra services in high level facilities can be asked to pay an accommodation bond, effectively an interest free loan to the facility. Providers can deduct monthly retention amounts from the bond for up to five years and derive income from the investment of the bond, or offset other interest bearing debt. The income from accommodation bonds and retention amounts is intended to be used to meet capital costs, retire debt related to residential care, or to improve the quality and range of aged care services. In 2009-10:

- the average accommodation charge for new residents was \$22.51 per day
- the average bond agreed with a new resident was \$232 276 (DoHA 2010n).

The average new resident's bond is now more than three and a half times than it was in 1998 (when the average new bond value was around \$60 000). Between 1998 and 2008, the average value of each new accommodation bond increased by 13 per cent per year (ANAO 2009). The balance between public and private contributions to aged care has changed over the past decade, with a rise in user contributions and private funding for services.

2.4 Regulation of aged care

Australian Government

Australian Government regulation of residential care facilities and community care packages is both extensive in scope and intensive in its level of detailed prescription. It limits the number of available residential care bed licences and community care packages, and sets the level of payments to providers and co-contributions from care recipients. Australian Government regulation also includes quality assurance and consumer protection measures, such as:

- accreditation of residential care facilities by the Aged Care Standards and Accreditation Agency (ACSAA)
- prudential regulation in relation to accommodation bonds
- building certification requirements (in addition to those included in the Building Code of Australia)
- a Complaints Investigation Scheme (CIS)
- an Aged Care Commissioner.

The Office of Aged Care Quality and Compliance (OACQC) (a division of DoHA) is responsible for aged care regulation policy and its enforcement. It has overarching responsibility (and is accountable) for accreditation and compliance (through ACSAA) as well as complaints handling (through the CIS).

Accreditation of quality

ACSAA, an independent company limited by guarantee and under the *Commonwealth Authorities and Companies Act 1997*, is appointed by DoHA as the accreditation body for residential aged care. Its legislative functions are set down in the *Aged Care Act 1997*, the *Accountability Principles 1998*, and the *Accreditation Grant Principles 2011*, and include:

- management of the accreditation process for residential care using the Accreditation Standards
- promotion of high quality care and assistance to industry to improve service quality by identifying best practice and providing information, education and training
- assessment and strategic management of services working towards accreditation
- liaison with DoHA about services that do not comply with the relevant Accreditation Standards.

Community-based providers (that is, those funded by the Australian Government's packaged community care programs and the HACC Program) must also be approved under the *Aged Care Act 1997*, but are subject to a number of different quality standards and reporting arrangements. The Council of Australian Governments (COAG) has recently agreed on Community Care Common Standards (DoHA 2010d).

Complaint handling

The CIS is managed by the OACQC within DoHA although, in practice, the reporting arrangements are complex and spread across all state and territory offices of DoHA (Walton Review 2009). It is available to anyone who wishes to provide information or raise a complaint or concern about an Australian Government-subsidised aged care service, including:

- people living in residential care facilities
- people receiving packaged community aged care or flexible care
- relatives, guardians or legal representatives of those receiving care.

The CIS is also able to receive complaints in relation to care funded under the *Home and Community Care Act 1985*.

The Office of the Aged Care Commissioner (OACC) has been established independently of DoHA. The Aged Care Commissioner (the AAC) is appointed by the Minister for Mental Health and Ageing and is able to review decisions and examine complaints about CIS processes and examine the conduct of AOCQC audits and assessors. The AAC may only make recommendations (generally to the Secretary of DoHA) when examining complaints. While the AAC is a statutory appointment, the AAC's officers are DoHA employees.

The Administrative Appeals Tribunal (AAT) is the main avenue for appeals to administrative decisions.

A more detailed description of regulation of aged care is provided in appendix F. Issues relating to aged care regulation are examined in chapter 15.

State, territory and local government regulation

State, territory and local government involvement in aged care regulation covers building, planning and design, occupational health and safety, fire, food and drug preparation and storage and consumer protection (Hogan 2004b; PC 2008, 2009a). Nurses, allied health professionals and personal carers are regulated under different state and territory acts, while further layers of regulation deal with financial assistance programs, complaints handling and the operation of retirement villages, social housing and caravan parks.

2.5 Aged care and other social policy areas

The aged care system sits within a much broader framework of services and policies that assist older Australians. Service delivery in many of these other areas affects the performance of the aged care sector and vice-versa. For example, the National Health and Hospitals Reform Commission (NHHRC) considered that improved interactions of services would be beneficial in reducing unnecessary hospitalisations:

Greater choice in aged care services, better primary health and palliative care support and improved communication, advice and outreach to residential care facilities should reduce avoidable hospitalisations and enable more effective discharge to the best care environment for patients. (2009, p. 75)

Indeed, there are fundamental interactions between aged care and health care including, particularly, acute care in hospitals and primary care provided by general practitioners (GPs), clinical nurse specialists and allied health professionals. A more detailed discussion is contained in chapters 9 and 10.

Other services that a number of older people access regularly, and which may be necessary to ensure their continued wellbeing, include disability services, housing (including social housing) and transport. There are also fundamental and complex interactions between the aged care and income support systems, with the design features of the latter giving rise to various distortions in the aged care system. These interactions are discussed in several chapters of this report.

For each of the interacting systems there are key interfaces, or points of entry and exit, that older people frequently deal with. A common complaint of many older people is that they ‘fall between the gaps’. This report explores ways to achieve a more seamless delivery of aged care services and to help ensure that the system will meet the needs of future older Australians requiring care and support.

3 Drivers of future demand

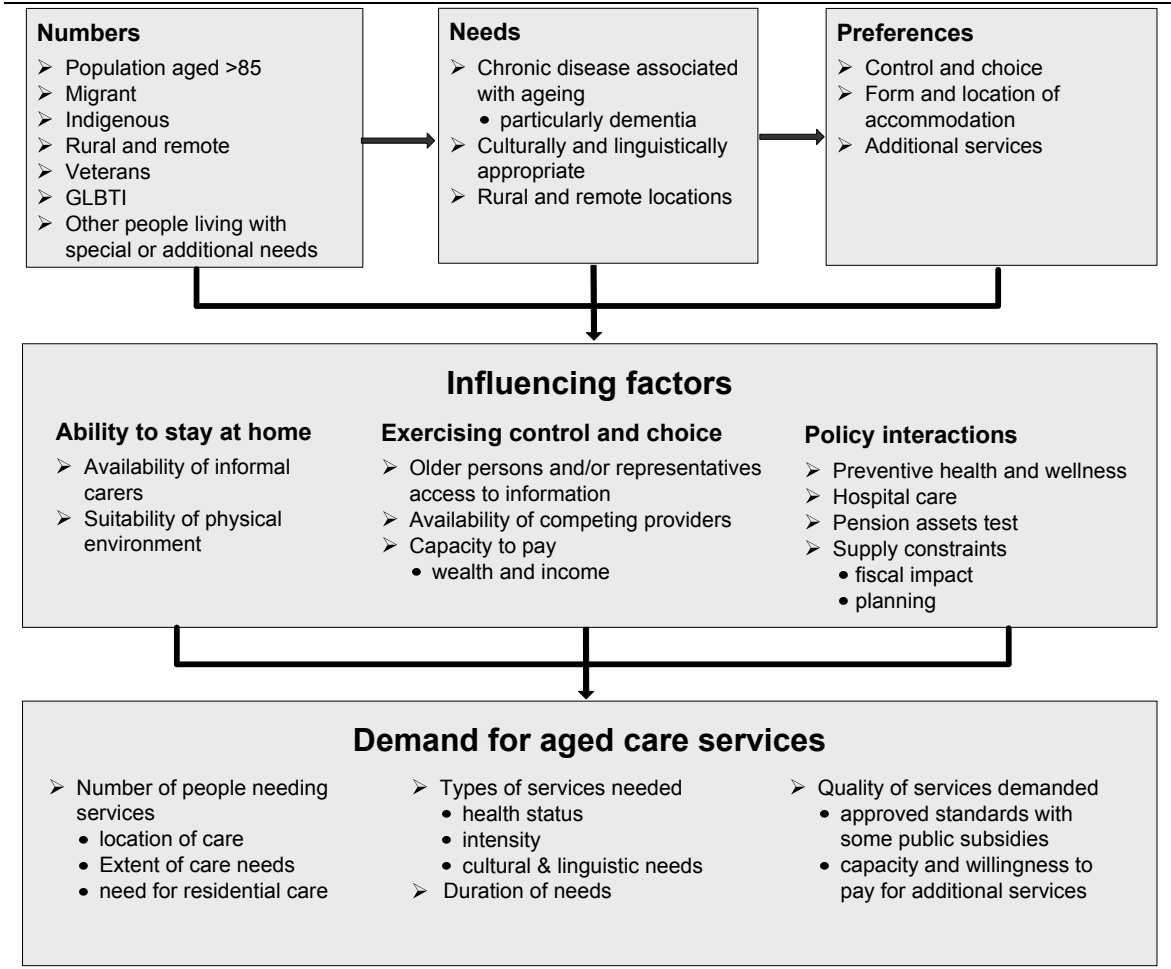
Key points

- The number of people aged 85 and over is projected to more than quadruple (from 0.4 to 1.8 million) between 2010 and 2050. This is expected to drive a major increase in the demand for aged care services over the next 40 years.
 - The demographic impact of increased longevity will permanently raise the proportion of the population aged 85 years and older. There will also be a temporary bulge in demand as the baby boomer generation reaches this age.
 - While age-specific rates of disability may have been declining slowly, the limited available evidence suggests that any effect this has on lowering the demand for care is out-weighted by the longevity effect as the rate of disability rises with age.
 - Longevity also brings shifting patterns of disease — increasing demand for complex chronic care associated with dementia, diabetes and other co-morbidities, as well as geriatric and palliative care.
- The population needing aged care services will be increasingly diverse — there will be a relative rise in the share of:
 - older people who want culturally and linguistically appropriate aged care services, including migrants from non-English speaking backgrounds
 - Aboriginal and Torres Strait Islander people who also require culturally and linguistically appropriate aged care services in urban, rural and remote areas
 - older people as a proportion of the population living in regional and rural areas.
- There is growing consumer demand for higher quality services, and for control and choice.
 - Older people want to age at home, and there is growing interest in retirement-specific living options that offer integrated (and potentially more efficient) modes of delivering community care.
- Demand for formal aged care services also depends on:
 - the relative availability of informal carers, which is expected to decline, thus adding to the demand for residential aged care
 - information and assistive technology and the suitability of the home and local environment in enabling people to meet their own needs for longer
 - policy settings in other areas, such as providing alternatives to hospitalisation for frail older people who do not have acute care needs
 - the quality of the care on offer and the cost of the services to the individual
 - the capacity to pay — while a significant proportion of Australia's future older population will have higher incomes and wealth; many will continue to be financially vulnerable and thus heavily reliant on government support.

A growing number of reviews and assessments point to significant changes in both the level and composition of demand for aged care services over the next 40 years. These changes have far-reaching implications for Australia’s aged care system.

The demand for aged care services depends on the number of older people needing care and support. However, care needs are not homogenous and the nature and location of aged care services demanded will depend on the physical and mental health of older people, their capacity and willingness to pay, their preferences, and the availability of informal carers. These factors, and policy settings that can affect them, are summarised in figure 3.1.

Figure 3.1 Factors affecting the extent and type of aged care service demand



This chapter examines: how population ageing affects the demand for aged care (section 3.1); the growing diversity of aged care needs (section 3.2); trends in the availability of informal carers (section 3.3); the effects of price and wealth on demand (section 3.4); and concludes with calculating the trends in demand (section 3.5).

3.1 Population ageing and demand for aged care

The need for aged care services expands rapidly after people reach the age of 85 years. Over the next 40 years the 85 years plus age cohort is projected to increase from about 0.4 to just over 1.8 million (table 3.1). This reflects the rapid population growth during the baby boom period (1947 to 1964). It also is a result of increases in longevity, with the life expectancy at 65 rising from 83 for women and 79 for men in 1983 to 86 for women and 83 for men in 2001-02. By 2012 it is expected to rise to 89 for women and 86 for men (Department of Health and Ageing (DoHA), sub. 482, p. 31).

Over the next 40 years there will be a progression toward a higher proportion of much older people as a share of the population. There will also be a bulge in the demand for aged care over the period 2030 to 2050.

Table 3.1 Projected size of selected age cohorts and their share of total population

	2010	2020	2030	2040	2050
0–64	19 241 000 86.51%	21 487 000 83.63%	23 584 000 80.68%	25 645 000 78.72%	27 744 000 77.38%
70+	2 092 000 9.41%	2 950 000 11.48%	4 143 000 14.17%	5 286 000 16.22%	6 232 000 17.38%
85+	365 000 1.64%	532 000 2.07%	802 000 2.75%	1 319 000 4.05%	1 815 000 5.06%
100+	4 000 0.02%	7 000 0.03%	14 000 0.05%	24 000 0.07%	50 000 0.14%

Source: Data provided by Treasury. Treasury projections are published on page 10 of Australian Government 2010d.

There is little that governments can do to change the age profile of the population over this period. The effect of higher fertility rates is very small in the short-run, takes many years to work through, and is not readily influenced by government policies. Migration has been a moderating factor on the overall demographic profile but it has not prevented, and even at the relatively high present levels will not prevent, significant ageing of the population (PC 2005b, 2006). After all, migrants also age and for migration policies to permanently reduce ageing pressure there would need to be progressively larger immigrant intakes of younger cohorts.

The effect of longevity on population disability rates is unclear

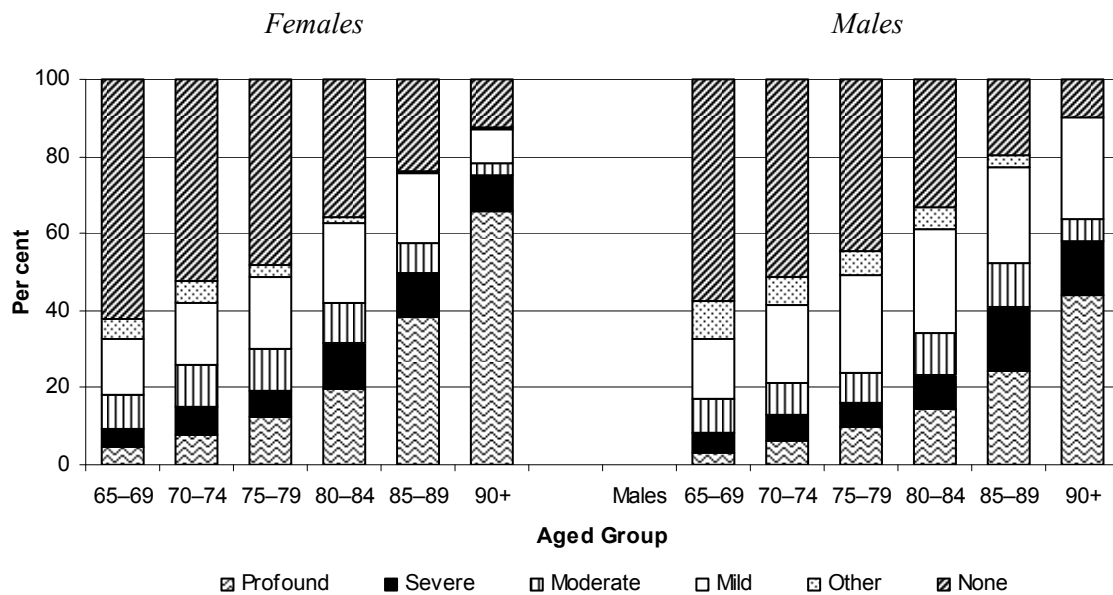
As people age, the likelihood of experiencing a disability rises. Increases in longevity will see rising rates of disability in the over 65 years population unless offset by improvements in health and interventions that lower the age-specific disability rates. The net effect on the overall level of disability in Australia's older population is an empirical question. While the evidence is patchy, it appears that over the last decade the longevity effect has outweighed the decline in age-specific disability rates (Hogan 2004b; PC 2005b). Credible projections of future trends need to take account of the health of the population and prospective medical advances.

Overall, international evidence indicates that the number of disability-free years of older people increase along with life expectancy. However, the international evidence on the net effects of longevity on disability rates is mixed (OECD 2007). Rising incomes, levels of education, and living conditions are linked to improvements in health and the functional status of older people (Cutler, Landrum and Stewart 2006; OECD 2007, p. 53; Redfoot and Pandya 2002). But changing lifestyles, notably obesity and associated diabetes, have added new risks.

The rate of disability grows most rapidly after the age of 85. This is reflected in self-reported assessments of the need for assistance with daily living. For example, the 2006 Census reported that, on Census night, 44 per cent of women and 32 per cent of men over the age of 80 years required assistance with daily living. For those aged over 90 years, the share was 72 per cent for women and 56 per cent for men (Gibson 2010, p. 21).

The Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC) collects self-assessed information on the ability of people to undertake core activities (self-care, mobility or communication). The survey also records disabilities in non-core areas (such as breathing difficulties that limit exercise, or difficulty using public transport). Figure 3.2 shows how, for the 2009 SDAC survey (ABS 2010b), the severity and extent of disability rises with age. The rapid increase in severe or profound limitations for the 85 years and over age group is apparent, as is the much higher rates of disability for women compared to men.

Figure 3.2 Proportion with core activity limitation or other disability, by age and sex, 2009



Data source: ABS (2010b), table 2.

The use of services by each age group provides another indicator of the level of age-related disability. The Australian Institute of Health and Welfare (AIHW) reports the usage of Home and Community Care (HACC), Community Aged Care Package (CACP), Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACH-D) packages and residential aged care per thousand people in the relevant age groups (table 3.2). However, the supply of services has a considerable influence over these numbers and, to the extent that there are unmet needs, these estimates will understate the level and nature of demand arising from age-related disability. This issue is discussed later in this chapter.

Assessing trends in disability is difficult. Both the Census and the SDAC collect self-assessed, rather than clinically assessed, disability ratings. Perceptions of disability may diverge from more objective clinical assessments over time (Waidmann and Manton 2000, p. 7). In this regard, Donald et al. (2010) found that while (clinically assessed) age-adjusted disability rates among older people had declined over a 10-year period, self-rated health had not changed at all.

Table 3.2 Use of formal aged care services

Per 1000 persons in each age cohort

	65–74	75–84	85+
HACC (2004-05)	102.5	278.5	474.9
Domestic assistance	27.3	86.9	154.2
Meals	15.1	58.9	136.0
Transport	16.0	50.4	81.7
Nursing	21.1	54.8	109.4
Personal care	6.7	22.5	58.7
CACP (2006) ^a	3.2	13.7	35.8
EACH and EACH-D (2006)	0.3	0.9	1.9
Permanent residential (2006)	9.1	53.2	235.2
RCS1-4 (high)	6.5	36.7	158.7
RCS5-8 (low)	2.6	16.4	76.5

^a CACP recipients can also access HACC services.

Source: AIHW (2007a, tables 36.1 37.1, 38.1, 40.1, A41.1, A43.1).

This inquiry uses SDAC surveys from 1998, 2003 and 2009. For the population as a whole there was a statistically significant decline in the self-reported rates of disability between 2003 and 2009. However, for the older age groups, only women in the 80–84 years group reported a statistically lower rate of disability in 2009 than in 2003, with the rate of severe and profound disability falling from 35.7 to 28 per cent (ABS 2010b). Comparing the three surveys (2009, 2003 and 1998) this is the only change that is statistically significant (ABS 2004, table 3), suggesting that firm trends have yet to emerge for the older age groups.

A more detailed analysis of trends is provided by DoHA. It decomposed the change in first time admission rates to residential care in the decade to 2007-08 into the effect due to changes in the population age structure (increased numbers) and that due to the changing age-specific rates of entry. For both women and men the analysis found that the positive population ageing effect on residential care entry (0.59 and 0.52 respectively) just outweighed the negative effect due to a decline in age-specific entry rates (-0.44 and -0.29 respectively) (DoHA, sub. 482, p. 34). Part of the decline in age-specific entry rates is due to the higher share of older people living with a disability who are able to remain in their own homes, so a broader analysis of all formal care is needed to give a clearer picture of the overall effect.

Previous studies have assumed that, for Australia, age-specific disability rates will decline on average by 0.25 per cent annually (Hogan 2004b; PC 2003, 2005b). Such work, in concert with sensitivity analyses, has highlighted that even relatively

modest reductions in disability rates among the aged should have a significant effect on the demand for aged care (Australian Government 2010d, p. 145).

The nature of disability may be changing

A consequence of increasing longevity is that the pattern of diseases that people experience changes. Improvements in lifestyles and better disease management have reduced the prevalence of many debilitating diseases. However, offsetting these gains is the marked increase in the prevalence of chronic disease as more people live to older ages.

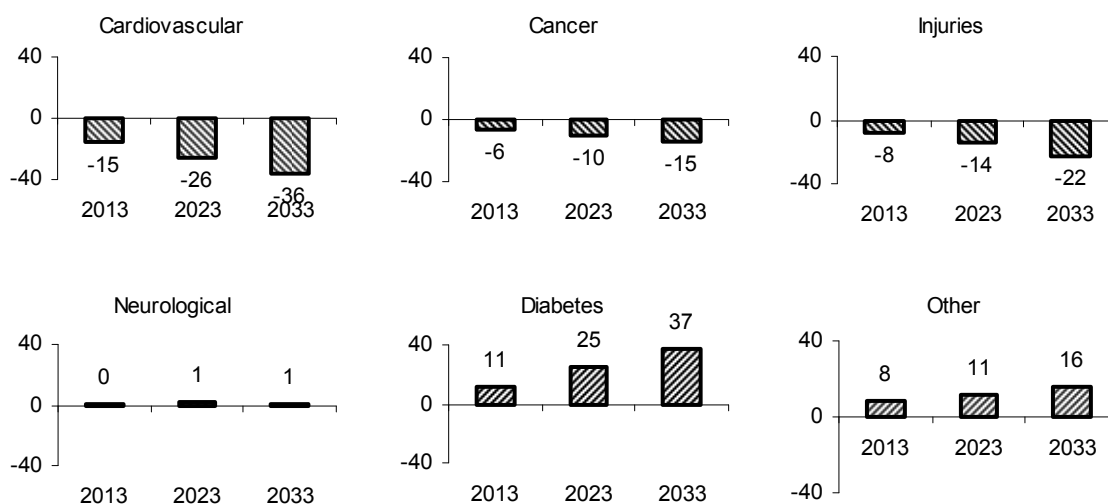
There has been a gradual reduction in some health risk factors through increased public education (healthy lifestyles and diets) and advancements in disease management (including diagnostic, pharmaceutical, surgical and other technological innovations). For example, the prevalence of cardiovascular diseases, cancers and injuries among people aged 85 years and over is projected to fall further in the coming decades (figure 3.3).

The increase in obesity bucks this more general trend, and brings with it a greater risk of diabetes. Insofar as survival rates for people with diabetes increase, there will be an increased risk of them developing other non-fatal, but disabling, conditions including renal failure and vision loss (Begg et al. 2007, p. 8).

The growth in the ‘Other’ category in figure 3.3 largely reflects the increasing prevalence of many of age-related conditions among older Australians, including extreme frailty. With improved lifestyle choices and medical interventions, more older people are surviving major diseases that have been previously associated with high mortality, but are left to manage chronic conditions.

Even if disease prevalence rates for those aged over 85 remain unchanged, the growth in the share of the population over the age of 85 will result in a rise in the population prevalence of age-related diseases.

Figure 3.3 Projected percentage change in disability (PYLD) prevalence rates since 2003 for selected major causes in people aged 85 years and over, Australia, 2013 to 2033^a



^a Prevalent years lived with disability (PYLD).

Data source: Pers. comm. Theo Vos, School of Population Health, The University of Queensland, 22 June 2010.

A rising share of the population requiring aged care will have dementia

The 2009 SDAC estimates that, based on self-assessment, just over 108 000 Australians suffer from dementia (including Alzheimer’s disease) (see box 3.1). Self-reported data may well understate the number. Based on international evidence on clinical diagnosis rates, Access Economics estimated that there were around 257 000 people with dementia in Australia in 2010 (1.2 per cent of the total population) (Access Economics 2010a). People with dementia are much more likely to be in residential care, with AIHW reporting that, in 2008-09, over 104 400 people living in Australian Government subsidised aged care facilities (53 per cent of residents) were appraised with an ACFI as having a diagnosis of dementia (AIHW 2011).

With the ageing of the population the burden of dementia will rise as the prevalence of dementia rises with age. Low rates of dementia are reported at the ages 70 to 75 years (3.5 and 3.3 per cent respectively for men and women), rising to 21.1 and 24.4 per cent for men and women aged 85 to 89 years, and 37.2 and 47.3 per cent for men and women aged 95 years and over (Access Economics 2010a, based on international studies). While considerably below these rates, the SDAC data shows the same age-related rise with the 2009 rates for dementia estimated as 1.2 per cent

of the 70-74 years age group, 2.6 per cent for 75-79 years, 6 per cent for 80 to 84 years and 14 per cent for 85 years plus.

Box 3.1 What is dementia?

Dementia describes a collection of symptoms that are caused by disorders affecting the brain. It is not one specific disease. Dementia affects thinking, behaviour and the ability to perform everyday tasks. Brain function is affected enough to interfere with the person's normal social or working life.

Most people with dementia are older, but it is important to remember that not all older people get dementia. It is not a normal part of ageing. Dementia can happen to anybody, but it is more common after the age of 65 years. People in their 40s and 50s can also have dementia.

There are many different forms of dementia and each has its own causes. The most common types of dementia are: Alzheimer's disease, Vascular dementia, Parkinson's disease, Dementia with Lewy bodies, Fronto Temporal Lobar Degeneration (FTLD), Huntington's disease, Alcohol-related dementia (Korsakoff's syndrome) and Creutzfeldt-Jacob disease.

At present there is no prevention or cure for most forms of dementia. However, some medications have been found to reduce some symptoms. Support is vital for people with dementia and the help of families, friends and carers can make a positive difference to managing the condition.

Source: Alzheimer's Australia (2010).

Although the rates of dementia rise rapidly at older ages, dementia can occur in younger people. AIHW (2011) reported that 2 per cent of people with dementia in residential care are aged under 65 years. As the expertise for dealing with people with dementia lies mainly within the aged care system, the growth in younger people with dementia should also be taken into account in estimating future demand for services.

The SDAC data suggests a trend decline in dementia prevalence rates for the population aged 70 years and over, falling from 5.55 per cent of people aged over 70 years in 1998, to 5.30 per cent in 2003, and to 4.91 per cent in 2009. While a small sample, the decline is most pronounced in the SDAC data for the 85 years plus age group with the prevalence rate falling from 22 in 1998 to 18 in 2003 and 14 per cent in 2009 (see appendix H). However, this is self-reported data, and further evidence is required before any robust conclusions on trends are possible. Better evidence on trends is important for making projections of future demand, as dementia has major cost implications as the ability of people to care for themselves,

and for informal carers to provide safe and effective care, declines as the disease progresses.

Based on the international prevalence rates, Access Economics (2010a) projected that with the rise in longevity the number of people with dementia will increase to around 981 000 by 2050 (2.8 per cent of the population). The projected increase in the prevalence of dementia will have a substantial impact on the demand for complex and costly care services. It is already one of the major reasons for entry into residential aged care as advanced dementia patients require high levels of care, with facility design being important in assisting to manage difficult behaviours such as wandering and agitation.

Other sources of disability that may change the pattern of demand

As discussed above, the rise in obesity in Australia has seen a growth in obesity related diseases, notably diabetes. This increase is reflected in the SDAC data, which shows a strong rise in the prevalence of diabetes. In 2009, age groups from 70 years up to the 85 years plus group reported a diabetes prevalence rate of 16 per cent (appendix H). Older people who suffer from diabetes are more likely to suffer from a range of associated problems, including endocrine, nutritional and metabolic disorders, the prevalence of which has risen strongly since 1998 (appendix H).

One consequence of the changing disease prevalence is a growing demand for palliative care in aged care settings, including private homes (NHHRC 2009, p. 6; WHO 2004). Traditionally, hospitals have provided most palliative care services, typically to people with acute conditions. This is in part because the course of such illnesses is more predictable. Although there is a perception that palliative care is provided only in the last few weeks of life and by specialised services, the World Health Organization (WHO) (2004, p. 14) argues that palliative care may be needed over many years and needs to allow for an unpredictable time of death. More recently, the National Health and Hospitals Reform Commission (NHHRC) (2009) recommended (nos. 55-56) strengthening access to specialist palliative care services in residential and community care settings.

3.2 A growing diversity of aged care needs

Aged care services must be tailored to the needs and preferences of the ageing population. The nature of a disability is one major determinant of the type of services required, but so too are cultural and linguistic differences, and preferences for the location of services.

The *Aged Care Act 1997* defines special needs groups for the purpose of promoting diversity in choice. To the extent that these groups can be identified with specific service requirements this distinction is useful in projecting the trends in demand. This raises two issues; first, the extent to which people in these groups have needs that require services that differ from, or are additional to, the ‘mainstream’ services; and second, the growth in the groups requiring such services relative to the growth of the groups requiring mainstream services. Moreover, the types of services being regarded as mainstream is also becoming more diverse, with a relative growth in demand for community-based care, services that support social connectedness, and wellness more generally.

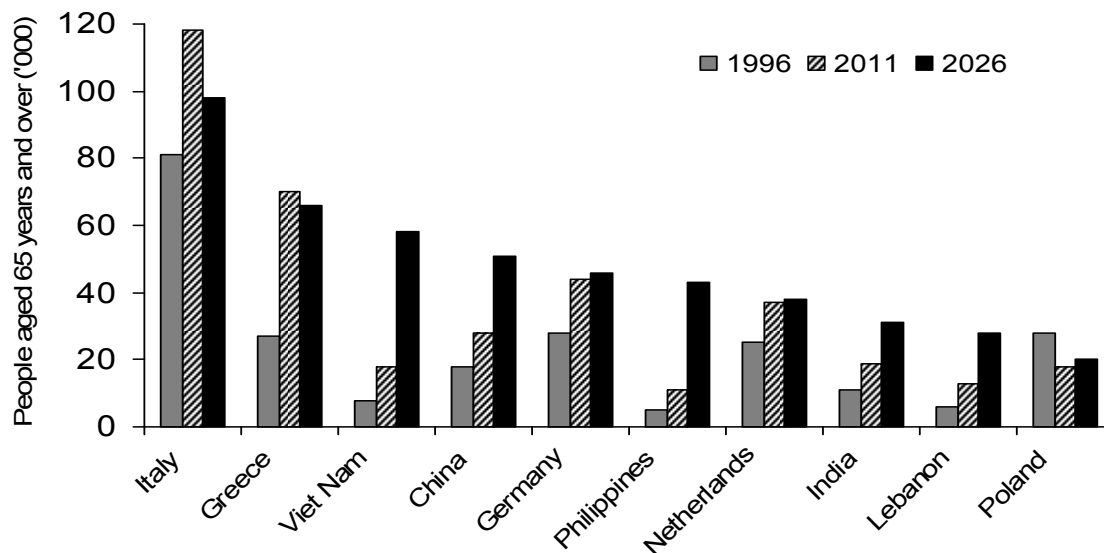
This section looks at the main sources of likely changes in the mix of services that will be demanded in the future.

Older people from culturally and linguistically diverse backgrounds

The number of older Australians from culturally and linguistically diverse (CALD) backgrounds is projected to increase substantially in the coming decades. The number of people who have migrated from non-English speaking backgrounds is expected to grow broadly in-line with the overall increase in the older population. Over the next 15 years this cohort is projected to grow by a further 43 per cent to around 940 000 in 2026. However, the diversity of this group is expected to increase, as different immigrant communities move into older age cohorts at different times (figure 3.4). Reflecting post-war immigration patterns, the number of older people with European backgrounds will stabilise or decline, while those with an Asian background will increase.

Victoria is projected to have the most diverse older population with around 28 per cent of people aged 65 years and over coming from non-English speaking migrant backgrounds. This is followed by New South Wales with 26 per cent. At the other end of the spectrum are Queensland (10 per cent) and Tasmania (6 per cent) (Gibson et al. 2001, p. xx). Although the vast majority of these people live in metropolitan areas, the CALD population is also widely dispersed across rural areas with particular ethnic concentrations in some rural towns (Howe et al. 2006, p. 2).

Figure 3.4 Projected numbers of older immigrants by selected countries



Data source: Gibson et al. (2001, pp. 4–5).

Different culture and language can add other dimensions to the provision of aged care (Howe et al. 2006, p. 26). Services may need to be tailored to enable older people to maintain continuity with life patterns established at younger ages. Mainstream services can provide appropriate care by employing staff that speak the language and understand the cultures of the people in their care (Anna Howe, sub. 355). Ethno-specific agencies can provide services where warranted by the population density.

Older people from non-English speaking backgrounds also display a preference for receiving care in the home (DutchCare, sub. 128, Ethnic Communities’ Council of Victoria, sub. 169). This is reflected in their significantly lower use of residential aged care, for example, for the 85 years and over age group, the use rate of residential aged care per 1000 people for non-English speaking migrants was 184, compared with 238 for English speaking migrants and 248 for Australian-born people. By contrast older immigrants from non-English speaking countries tend to be over represented in community care (AIHW 2007a, table 43.1, p. 147).

Providing linguistically appropriate care to CALD people with dementia is particularly important as they often experience language reversion and forget their acquired English due to a cognitive impairment (Hogan 2004b). Access Economics (2005), in projections undertaken for Alzheimer’s Australia, estimated that, by 2050, 6.4 per cent of people with dementia would speak a European language at

home, 3.8 per cent an Asian language, and just under 1 per cent a Middle Eastern language.

Indigenous peoples

Indigenous people also need culturally and linguistically appropriate care. Older people are under-represented in the Indigenous population. In 2006, only 1 per cent of Indigenous people were aged 75 or over, compared with 6.3 per cent of the non-Indigenous population (SCRGSP 2010a). This reflects the lower life expectancy for Indigenous people, which was 72.8 for females and 67.1 for males in 2006. Strong population growth over the last 60 years should see Australia's older Indigenous population grow more rapidly than Australia's total older population, more so if significant improvements are made in life expectancy. An increase in life expectancy at birth by five years would see the older Indigenous population (aged 55 years and over) more than double by 2021, from around 40 000 in 2006 to over 85 000 (ABS 2009c).

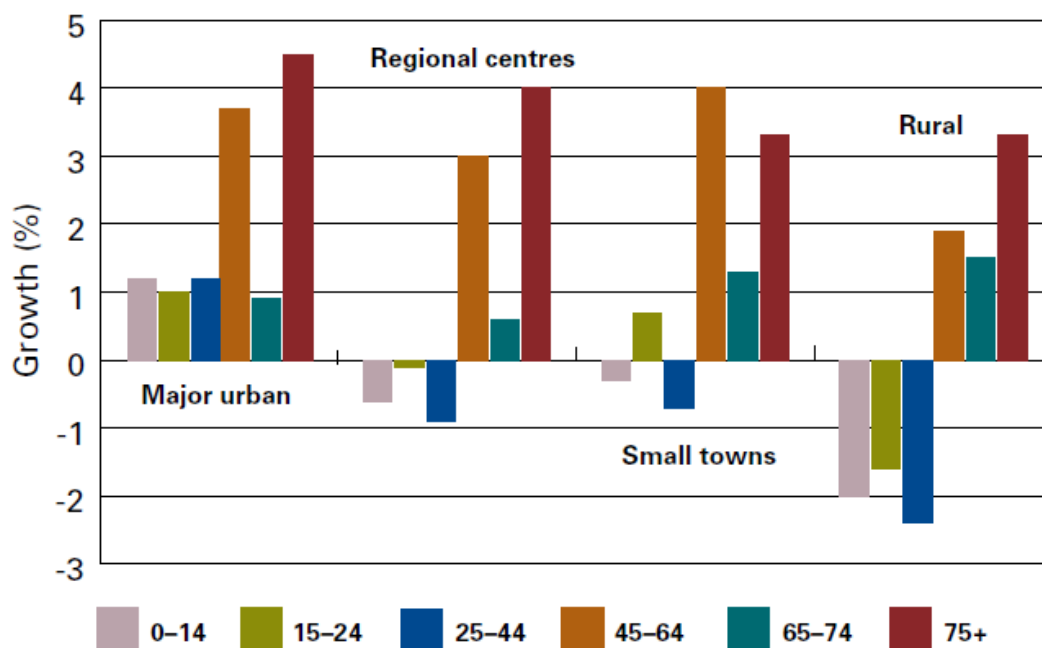
Age-related rates of disability are higher for Indigenous people, with 20 per cent aged 55 years and over reporting a need for assistance with a core activity compared with 12 per cent for the same cohort of non-Indigenous Australians (2006 Census data reported in SCRGSP 2010a). Indigenous people also experience a higher rate of dementia, although they are less likely to receive a diagnosis or to access services (Henry Brodaty, sub. 45, p. 3). This has led to the Government setting an age threshold of 50 for Indigenous Australians to access the aged care system. However, some have questioned whether aged care services are an appropriate response to the health problems of Indigenous people in the 50–69 years age group (Anna Howe, sub. 355, p. 18).

Challenges relating to cultural appropriateness, geographical isolation, English-language proficiency, and greater needs for assistance confront many older Indigenous people as well as the providers delivering care services to them. In 2006, only around half of all Indigenous people aged 55 years and older lived in urban areas, with 23 per cent living in outer regional areas and 26 per cent in remote and very remote areas (ABS 2008b). Indigenous people, particularly those in remote areas, are also a more mobile population than the non-Indigenous population, which makes the provision of care more difficult (Prout 2008). Moreover, one-third of Indigenous people aged 45 years and older who lived in a very remote area did not speak English well or at all (ABS 2010c). While many of the people who provide care in these locations are likely to speak the same language, there is potential for the overlay of formal aged care services to undermine the social norms about responsibility for caring for older family members.

People living in rural and remote areas

While ‘ageing in place’ usually refers to being able to remain in one’s own home, or to receiving progressively more complex services in residential care, for those people living in rural and remote areas it also means being able to access formal care services in or near where they live. On current trends, the population in rural areas (including small towns) is ageing more rapidly than the population in major urban and regional centres. While, overall, the rural population is declining by an average of 0.8 per cent per year, primarily as a result of the emigration of people aged less than 45 years to urban areas, the number of older people in rural areas is rising. This is despite a significant migration of older people from rural to regional areas, and is a result of increasing longevity combined with a ‘humped’ age profile that means a growing share of the rural population is entering these older age groups. The Bureau of Rural Science (BRS) reported in 2008 that the size of the older (75 years plus) rural population had been growing at over 3 per cent per year for around a decade (figure 3.5).

Figure 3.5 **Average annual rural population growth, by age group, 1996–2006^a**



^a Major urban centre (100 000 people and over including capital cities), regional centre (1000 to 100 000 people), small town 200 to 1000 people, rural area (less than 200 people).

Data source: BRS (2008, p. 3).

Older people in rural and remote areas are likely to have a greater need for aged care services than those living in urban areas for a number of reasons. First, the health of

older people in rural and remote areas is generally poorer than in metropolitan areas, even after allowing for the significantly lower health status of many Indigenous people who make up the greater proportion of the population in remote areas (NRHA and ACSA 2004, p. 3). Poorer health contributes to premature ageing later in life.

A second factor is that many rural areas are characterised by a substantially higher proportion of older single men. In 2006, the ratio of males to females aged 65 years and over was 1.2 in rural areas compared to a population average of 0.8 (BRS 2008; ABS 2007b). Community care options tend to be less viable without the availability of informal care and women tend to provide the majority of such care.

Finally, as discussed, older people are making up a much greater share of the local population. This raises concerns about the provision of not just informal care, but also the sustainability of the workforce in general, and the health and aged care workforce more specifically, in regional and remote areas.

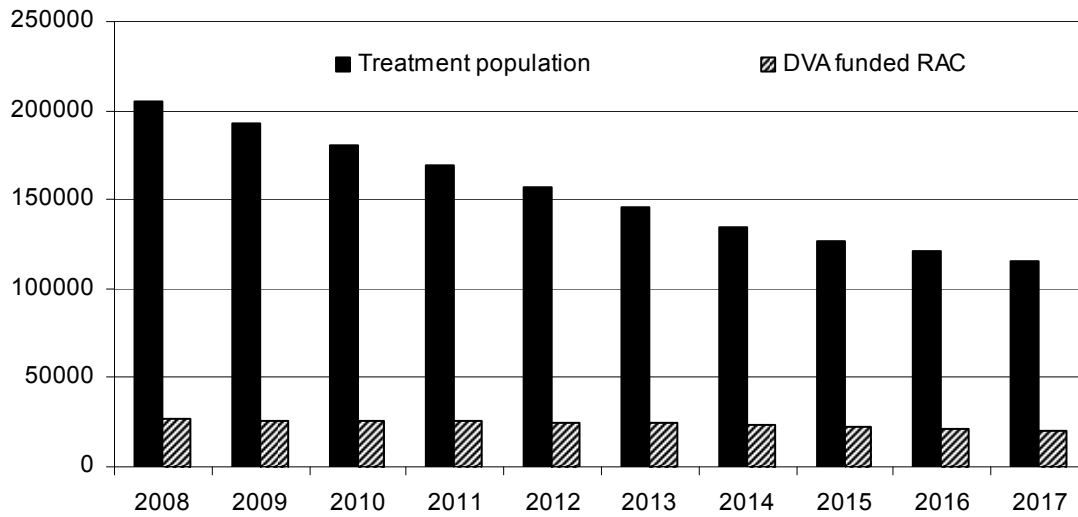
Veterans

The Department of Veterans' Affairs (DVA) client population — veterans and their widows/widowers and dependents with gold and white cards — make up a sizeable minority of aged care recipients. DVA income recipients represent around 10 per cent of the population aged over 65 years and 27 per cent of the population aged over 85. It is estimated that, in 2006, DVA recipients made up 17 per cent of permanent residents of aged care services, 9 per cent of HACC clients, and 14 per cent of CACP recipients in 2002 (AIHW 2007a, p. 153). This is in addition to those who receive veterans' home care and DVA community nursing.

While the DVA client population is currently trending downwards (figure 3.6), after 2020 there is expected to be a resurgence in demand by veterans for aged care as the Vietnam veterans move into their 80s (figure 3.7).

From a clinical perspective, veterans are a distinct population in so far as the prevalence of particular health conditions, and how they acquired them, differ markedly from the broader population (AIHW 2008a, p. 98). The nature and severity of hazards faced in military service can have long term physical and mental health consequences, which may also vary with their time of service. For example, the rate of alcohol and non-medical drug abuse is higher in the veteran community as a result of post-traumatic stress disorder and other military exposures (SSCFPA 2009, p. 89). In addition, the higher rate and pattern of mental health conditions among veterans differs from the rest of the population (AIHW 2008a, p. 100).

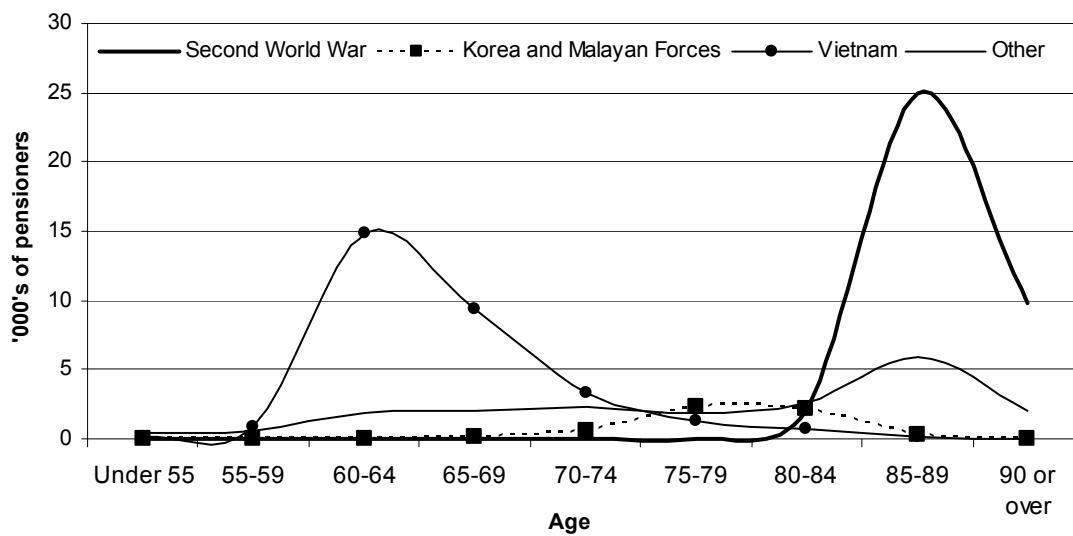
Figure 3.6 DVA projection: eligible population and numbers requiring residential aged care^a



^a Treatment population comprise veterans, their dependents and war widows/widowers.

Data source: Repatriation Commission, sub. DR 754.

Figure 3.7 Age profile of veterans by armed conflict



Data source: DVA Pensioner Summary December 2010.

Other groups that have different aged care needs

There are a range of other groups who may require services that differ to mainstream services.

Homeless older people

The 2006 Census and other sources identified around 18 000 homeless people aged over 55 years whose accommodation situation was below the minimum community standard of a small self-contained flat (Chamberlain and MacKenzie 2008). However, others have suggested that over the course of a year, the prevalence of homelessness could be three to five times that experienced on any one night (Wright and Devine 1995).

Homeless older Australians, who are typically financially and socially disadvantaged, often find it very difficult to access mainstream aged care service. In many instances, homeless older people are reluctant to seek out services or to assert their right to care, which may be in part, as Lippman (2009, p. 6) suggests, because they do not recognise that they require care and support.

The trend in homelessness for older people is not known, and will largely depend upon policies other than aged care.

People with a disability

Increased access to quality health care, better living conditions, and enhanced social support and participation have led to improved life expectancy for people with a disability (Futures Alliance, sub. 44, p. 1). The trend toward more people with an early onset disability reaching retirement age is expected to continue in the future.

People with early onset disability, such as intellectual disability, also experience the ageing process at an earlier age than the general population (AIHW 2000), and their needs are frequently more complex (Futures Alliance, sub. 44, p. 3). They are also more likely to have had disjointed work histories and therefore their access to funds via superannuation is often limited or absent (Futures Alliance, sub. 44, p. 3). Many, including the most disabled, will already be in receipt of disability support.

People caring for those with a disability

Carers of people with a disability are likely to have special needs if they experience age associated frailty while at the same time retaining responsibility for caring. The

physical demands of caring may require carers to seek an assisted living place sooner than they otherwise would have done. But it is quite likely that they will want to be able to accommodate the person they are caring for as well as themselves. This has implications for the type of accommodation these carers will demand as they age. The 2009 SDAC survey found that of the mothers and fathers who were the primary carer for their disabled child, 6.5 per cent were aged over 70 years (see appendix H).

Frail aged couples

The increase in the number of frail aged couples who may wish to remain together in care is yet another dimension of the type of demand that is likely to grow in the future. Increasing longevity, the narrowing gap in life expectancy between the sexes, and the likelihood that some older people will require residential care simply because their frail partner or spouse is no longer able to appropriately care for them, are likely to place additional demands on residential care for more flexible accommodation arrangements for couples. The 2009 SDAC survey found that of the primary carers for a disabled spouse or partner, some 32 per cent were aged over 70 years, and 10.6 per cent were over 80 years of age. Almost 12 000 people over the age of 85 were primary carers for their spouse or partner in 2009 (appendix H).

Gay, lesbian, bisexual, transgender and intersex people

Gay, lesbian, bisexual, transgender and intersex (GLBTI) people can also want services tailored to their specific needs. Like others who may experience discrimination in mainstream services, or who have particular health, cultural or social needs, aged care services for GLBTI people need to be flexible and appropriate (GLBTI Retirement Association, sub. 57).

Growing expectations that preferences will be accommodated

Older people typically express a strong desire to preserve their sense of self, to maintain their independence, retain control and exercise choice, and to make provision for their security in an uncertain future later in life (for example, Boldy et al. 2009; Leeson et al. 2003; Tanner 2001). Baby boomers seemingly have higher expectations of being able to exercise greater control over their own lives and, more particularly, of being more involved in tailoring aged care services to meet their individual needs and preferences (Quine and Carter 2006). This view is reflected in many submissions such as by Uniting Care Community Options:

With the changing demographics of our communities there is an expectation that models of service will reflect the expectations and requirements of those needing or desiring services, and most importantly that services will reflect needs — rather than dictating what a client can receive or is eligible for. (sub. 152, p. 6)

These expectations will have considerable consequences, not just for the type of aged care services demanded but also for the way they are delivered. Consumer choice involves care recipients being able to choose between services that are differentiated to some degree, such as by:

- the location, type and quality of accommodation in which the care services are provided (including private homes, retirement villages, assisted living environments and residential aged care facilities)
- the options available to pay for accommodation and for care services (periodic or lump sum, ex ante or ex post)
- choice over a ‘menu of service’ options for the approved standard of care which providers offer to care recipients to meet their specific needs and preferences (such as cultural alignment and languages spoken, choice of carer, or timing of service delivery), as well as the option to purchase additional services at their own expense.

A preference to remain at home as long as possible

As older people are less able to care for themselves, the majority prefer to remain, and be cared for, in their own home (Just Better Care, sub. 131).

Living at home supports a person’s independence and can sustain the comfort of memories, as well as provide other opportunities which may not be as available in more institutional settings, such continuing with established social activities, gardening, caring for pets, and enjoying flexibility in daily routines and choice of food.

The extent to which the home has an aged-friendly design and location, assistive technologies (such as alarm buttons), and support services will affect the capacity of an older person to remain at home. Retirement villages are often designed with these features to accommodate the desire to age in place. Over the period 1999 to 2010, the market penetration in the retirement living sector has more than doubled from 2.3 per cent to around 5.3 per cent of people aged 65 or over (RVA 2010). For those aged 75 or over, the market penetration rate is around 10 per cent (RVA, sub. 424).

The proportion of older people needing care who are able to remain at home rather than in residential care will depend in large part on the availability of informal carers. It will also depend on the levels of care services available in the community to support these carers. However, it should be noted that as needs progress there will be a point where care becomes more expensive, and less efficacious, to provide at home (Howe et al. 2006).

3.3 Trends in the availability of informal carers

Social and demographic factors are reducing the ratio of informal carers relative to those needing care

Social and demographic trends suggest that in future there are likely to be fewer informal carers relative to the growing older population. The number of people aged over 70 years relative to those of traditional working age (15–64) is projected to double, from 14 per cent in 2010 to 28 per cent by 2050, while the number of people of working age relative to those over the age of 65 will fall from 5 per cent to 2.7 per cent over the same period (chapter 6). While an extension of the traditional working age (or an increase in labour force participation) can partially offset the effects on the labour force, this could serve to reduce the availability of informal carers if they are less able to combine their caring role with working. Looking forward, there are a number of factors that are likely to have differing impacts on the availability of carers (AIHW 2004a; NATSEM 2004; PC 2005b).

The primary source of informal carers is spouses/partners or other family members (particularly daughters). However, their availability relative to the growing number of older people with a need for assistance is expected to decline over time because of lower marriage rates, smaller family sizes and the increasing age of first-time mothers (ABS 2005, 2006, 2007a). It is worth noting that the current population over 80 years of age actually have a higher pool of carers because they are the parents of the baby boom generation (Gibson 2010). But the availability of carers also depends on co-location and the willingness and ability to provide care.

The increasing prevalence of single person households (due to increased rates of separation and divorce and the decision of more people not to marry) is also likely to reduce the availability of informal carers. Currently, 44 per cent of persons aged 65 years or older live by themselves (ABS 2005).

There are several factors working to offset this trend. An increasing number of partners are living longer, which could increase the availability of informal carers. According to the 2003 SDAC, partners comprise 34 per cent of all informal carers (ABS 2004). This rose to 45 per cent in the 2009 SDAC survey (ABS 2010b). In addition, the narrowing of the gap between male and female life expectancy is expected to reduce the relative need for formal care of widows and widowers.

The ability and willingness to provide informal care may also be declining

Increasing female workforce participation may compound the anticipated shortage of informal carers. That said, much of the increase in female labour force participation in Australia over the past 20 years can be attributed to the growth in part-time employment, which may be more compatible with performing a caring role. The proportion of women working part-time has increased from 37.6 to 45.2 per cent between 1986 and 2006 (ABS 2007c). The Household, Income and Labour Dynamics in Australia (HILDA) 2007 survey found that 1 per cent of women aged 15–64 and 3.7 per cent of women aged 55–64 who work part-time gave caring for disabled or elderly relatives as their reason for doing so. However, there is a consistent 10 percentage point gap in labour force participation between women and men aged 20–34 and 45–54 who are carers compared with those who are not carers (AMP.NATSEM 2006). Further, the trend towards greater flexibility in employment arrangements for some occupations may increase the capacity of some workers to provide informal care.

The willingness of family members, especially children, to provide informal care appears to be declining. Some analysts of social trends point to a society that is becoming more fragmented with a diminishing sense of obligation and responsibility to family — suggesting that the availability of informal carers may decline in coming years (for example, Ganong and Coleman 1999). Others, such as Ozanne (2007), have highlighted the diversity and complexity of family forms and underlying values. Allied to this, de Vaus (1996), drawing on data from the Australian Family Values Survey conducted in 1995, noted that there is considerable variation in the extent to which people accept family obligations. In de Vaus's view, the survey results:

... did not support the model of a society in which a sense of responsibility and obligation to older family members had been destroyed by rampant individualism. Nor was there evidence of generational self-interest. However, the acceptance of responsibilities and obligations to care and support elderly parents was by no means universal, unequivocal or without qualification. (1996, p. 20)

Interestingly, de Vaus also observed that:

There appears to be a hierarchy of obligations. The more the obligation has a direct impact on people's lives the more reluctant they are to accept responsibility. (1996, p. 19)

Moreover, it appears that baby boomers are expressing a greater reluctance to be cared for by their children than the current and previous generations of older Australians. Research by the Australian Housing and Urban Research Institute (AHURI) found: 'the question of agreeing to mutual living arrangements with the children, be it in the form of co-habitation or the "granny flat" option, was met with quite animated articulations of disdain and dismissal' (AHURI 2005, p. 82). The study did find that the idea of living with adult children and their families was more likely to be acceptable for people from migrant backgrounds.

The adequacy of support provided to informal carers can be a significant factor in influencing their willingness and capacity to undertake and maintain a caring role. Given the high personal costs that informal carers sometimes experience, programs that enhance access to information, financial support, respite, flexible workplace arrangements, training and assistive technologies can play an important role in encouraging and ensuring that informal care services continue to be provided.

Effects on demand for formal care

Several analysts have used various approaches to explore the future availability of informal carers and, regardless of which metrics are used, they all concluded that the relative supply is expected to decline. Representative of this research is NATSEM (2004, p. 30), which projected that the supply of informal carers could rise by 60 per cent between 2001 and 2031, while on current trends demand would rise by 160 per cent.

To the extent that community care is predicated on the availability of an informal carer, the anticipated shortage of carers will reduce the sustainability of some community care programs and increase the demand for residential care. Anecdotal evidence suggests that the absence of an informal carer is the single most common trigger for an older person moving into residential care. For example, the report for the Community Care Coalition observed that 'several carers noted that their role as an informal carer is not suitably recognised as imperative to clients' ability to live independently at home' (Allen Consulting 2007, p. viii).

This issue is also reflected in the AIHW's assessment in its submission to the House of Representatives Inquiry into better support for carers:

... if the 1981 patterns of use of institutionalised care had been maintained until 1996, then an additional 80 700 people would have been living in health and welfare institutions in 1996, or 38 per cent more than were actually according to the 1996 Census. (AIHW 2009d, p.5)

3.4 The influence of price and wealth on demand

In a free market the price of services, along with people's capacity to pay and their preferences, determine the demand for the service. Many aged care services are heavily subsidised by government, in part to reduce the need for more expensive publicly-funded services, but in the main to ensure that older Australians receive adequate care. For such services, price signals are dampened by free provision or the need for the client to only make a small co-contribution. Wealthier older Australians have the resources to make a greater contribution to the cost of their aged care, and to purchase services beyond those subsidised by government. Hence future demand for publicly-funded services will depend on the policy choices about co-contributions to the cost of care, what services are covered by the aged care system, eligibility for care, and how these interact with older Australian's wealth and their sensitivity to prices. The demand for aged care services will also depend on the policy stance in other areas such as acute care hospitals and preventative and wellness programs.

The effect of price on the demand for aged care services

Demand for some aged care services has been managed through the use of means-tested co-contributions. While for some programs these are set by government, for others providers can set co-payments based on their assessment of the consumer's capacity to pay (HACC, charges for extra services, accommodation bonds).

The exposure to a charge for service can affect demand, but the extent of the impact is quite uncertain, and likely to vary with the nature of the service (see appendix E). Hogan reported that:

At the lower end, some studies indicate that demand is relatively inelastic with respect to price, with demand decreasing by only 0.16 per cent for every 1.0 per cent increase in the price of care. At the higher end, some studies have found much greater price elasticity of demand, with demand decreasing by 2.3 per cent for every 1.0 per cent increase in the price of care. This considerable difference in predicted elasticity is mainly due to the highly subsidised nature of residential services. This high level of subsidisation distorts demand because the benefit individuals receive is leveraged by the subsidy and this leverage dilutes the influence of price on demand. (2004b, p. 94)

The capacity of older Australians to pay for aged care

The baby boomer cohort has, on average, higher levels of income and wealth than previous generations. Wealth and income is not, however, evenly distributed across this cohort. Those with significant income and/or assets will be able to make significant contributions to the aged care services they may need or want in the future. But some will be totally reliant on publicly subsidised care. These factors have important implications for the design of the aged care system.

Older Australians account for a growing share of household wealth

The distribution of wealth has been shifting towards older Australians since the mid-1980s and this trend is expected to continue over the next few decades. Indeed, older people in the future are likely to have significantly more wealth in real terms (that is, adjusted for the effects of inflation) than previous older cohorts (table 3.3). Kelly (2002) estimated that the share of Australia's total household net wealth for those aged 65 and over could increase from around 22 to 47 per cent between 2000 and 2030, while their share of the population is projected to grow from 12 per cent to around 19 per cent over the same period.

Table 3.3 Projected average family wealth by asset and age

Share of family wealth by asset class

	<i>Cash deposits^a</i>	<i>Shares</i>	<i>Equity in own home</i>	<i>Equity in rental property</i>	<i>Super-annuation</i>	<i>Total net worth</i>
	%	%	%	%	%	In 2000 \$
Year 2000						
65–69	20	7	56	5	12	270 000
70–74	22	6	63	5	4	221 800
75+	17	4	75	4	1	139 500
Year 2030						
65–69	31	8	43	3	14	811 400
70–74	32	6	53	5	4	691 300
75+	33	4	56	7	1	622 700

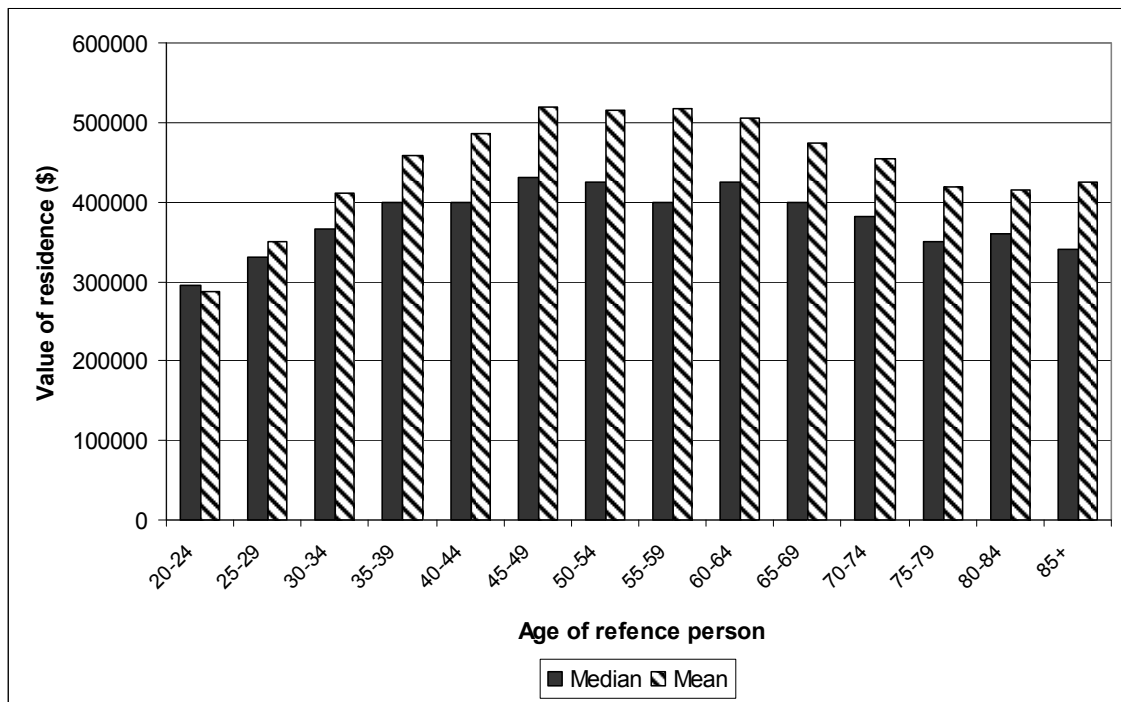
^a Cash deposits also includes annuities, allocated pensions and managed funds.

Source: Kelly (2002, pp. 21–22).

As Table 3.3 shows, equity in the home is a major source of wealth for all ages, but a greater share for older ages. This is expected as people draw on their assets during their retirement years, and will draw on the more liquid assets before accessing their home equity. The family home does, however, remain the main savings vehicle for

most households. The ABS' *Survey of Income and Housing 2007-08* shows that the mean value of the household residence by the age of the reference person. For those aged 65 years and over the mean value was over \$400 000 (figure 3.8).

Figure 3.8 Mean and median values of household residence by age
2007-08



Data source: ABS (2009d) Expanded Confidential Unit Record File (CURF).

But the average masks major differences in capacity to pay

Beyond the overall picture of increased affluence there lies considerable diversity in wealth among older Australians. For example, it is estimated that the average personal net worth of the wealthiest one-quarter of baby boomers (born between 1945 and 1964) is \$910 400, while the least wealthy one-quarter of baby boomers have an average personal net worth of \$68 300. This means that the poorest one-quarter of baby boomers possess 4.4 per cent of the group's net worth while the wealthiest one-quarter enjoy 60 per cent of the boomers' \$1 648 billion net worth (AMP.NATSEM 2007, p. 18).

Given that few recent retirees need aged care, it is the wealth of the older age groups that largely determines the capacity to pay for aged care. People save during their working years and run down their assets in retirement, so peak wealth is likely to be at the point of retirement. The structure of the Age Pension assets test may

encourage people to run down their assets other than their principal residence in order to qualify for a part pension, and there is some evidence to suggest that this is occurring (Bradbury 2010).

The HILDA survey data provides some indication of the distribution of assets for individuals over the age of 65 (table 3.4). In general, for this cohort, wealth declines with age, but to a lesser extent than might be expected if people are drawing down their wealth to meet their living expenses. The data suggests that, apart from those in the lowest deciles, people have some financial capacity to contribute to the cost of their aged care services.

Table 3.4 Identified individual wealth including apportioned equities^a
In 2006 dollars

<i>Decile</i>	65+	75+	80+
10th	4 500	5 200	6 000
20 th	82 634	44 000	32 220
30 th	149 404	130 350	122 637
40 th	200 003	180 000	185 515
50 th	252 900	221 860	220 430
60 th	314 800	280 000	272 300
70 th	411 760	352 358	344 120
80 th	610 160	500 750	518 602
90 th	1006 450	790 881	765 450
Max	15 373 196	5 084 977	4 697 560

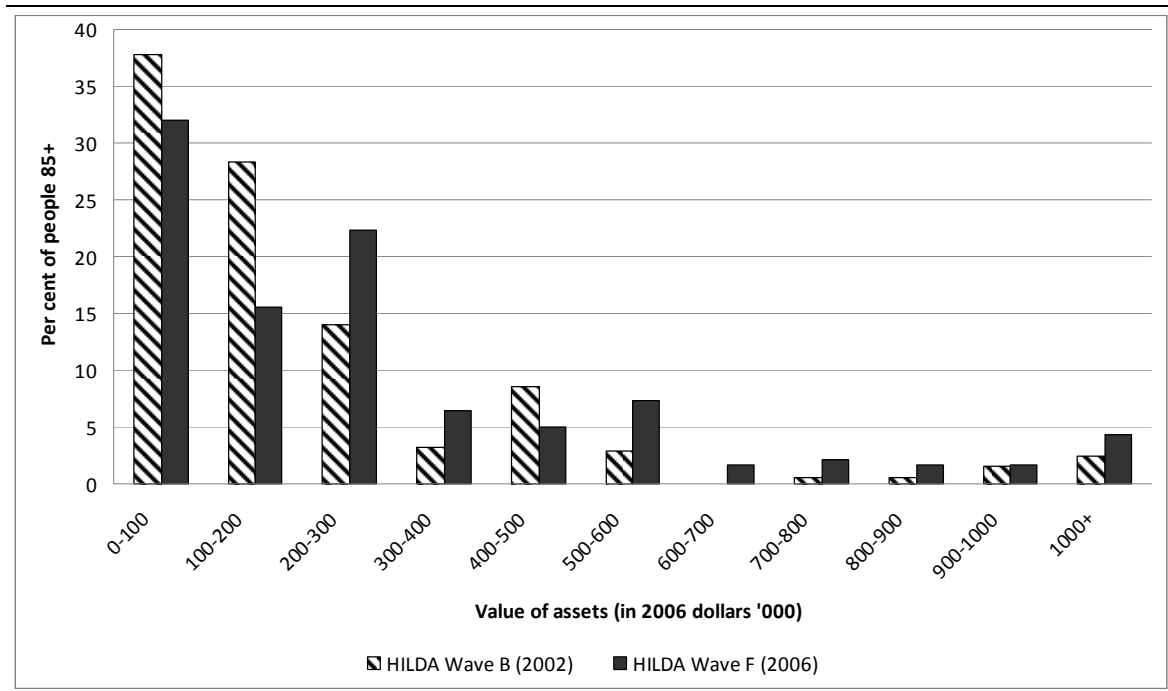
^a Composed of the number of dollars a person has in both individual and joint bank accounts, the dollar value of an individual's superannuation assets, the dollar value of any apportioned equity an individual holds in any residential dwellings and the dollar value of any apportioned investments an individual holds in shares, managed funds and property trusts.

Source: HILDA (2010) Release 8.0.

Figure 3.9 draws on the HILDA data to identify the trends in the real wealth of people aged 85 years or over. This includes an individual's equity in their family home. The relatively small size of the sample and the absence from the data of those people living in residential care means that conclusions about a rising value of assets for the 85 years and over age group are only tentative.

Figure 3.9 Assets of people aged 85+

For 2002 and 2006



Data source: HILDA Waves B and F.

The effects of other policy areas on the demand for aged care

Changes to policy settings in other social policy areas can also affect the demand for aged care. In terms of capacity to pay, the structure of the Age Pension assets test affects the incentives to save to meet the uncertain costs of aged care. The distortions in the aged care system arising from the exclusion of the home (and accommodation bond) in the social security assets test is analysed in chapter 7. Policy changes in this area have implications for savings and the willingness to use home equity to pay for additional care.

Health policy that affects the burden of disease will have implications for care needs, while building codes and planning and zoning can influence the availability of housing that allows older people to remain independent in their own home. There are also some more direct policies that affect the availability of alternatives to the aged care system.

Changes in the provision of 'aged care' beds in acute care hospitals

There is evidence that 'acute care' beds are being used to meet 'aged care' needs. The NHHRC estimated that almost 20 per cent of older patients in public hospitals

would receive more appropriate care outside an acute hospital (NHHRC 2009, p. 54). In its view, the reasons older patients receive inappropriate care include lack of appropriate post-acute care services, delays in the discharge process, delays in diagnostic tests, and delays in medical and other specialised consultations.

The National Health and Hospitals Network recently estimated that 340 000 people were unnecessarily admitted or readmitted to the acute hospital system due to a lack of palliative or sub-acute services such as rehabilitation, geriatric and psychogeriatric care. Moreover, 31 per cent of transfers from residential aged care facilities to acute hospitals are potentially avoidable (Australian Government 2010a).

The NHHRC proposed, and the Council of Australian Governments (COAG) (2010a) has agreed to, reforms to the hospital system that aim to reduce the extent to which hospitals provide care to older people that could be provided more appropriately in the individuals' homes or in residential care (chapters 9 and 10). These reforms are expected to provide more appropriate care for the older patients as well as reduce the overall cost to government.

Wellness and preventative programs

Advances in treatment, prevention and cure in the future may mitigate the disabling consequences of diseases that cause dementia and reduce obesity and its consequences. Public health programs can play a role. For example, some forms of cancer and coronary heart disease have fallen as a result of reduced rates of smoking and improvements in diet, as well as through screening programs and early interventions such as the use of statins (DoHA 2003). There is also growing recognition of the scope to reduce the incidence of disabilities for older people through preventative and wellness interventions.

These developments can result in a relative decline in demand for aged care services. In some cases, however, this may not reduce pressures on overall government expenditure. On the contrary, increased spending on health care is a precondition for lower disability (OECD 2006). However, there may be a range of other interventions targeted at older people that are cost effective for government to provide.

3.5 Calculating the trends in demand

The 2010 *Intergenerational Report* projected that Australian Government spending on aged care as a proportion of Gross Domestic Product (GDP) could increase from 0.8 per cent in 2009-10 to around 1.8 per cent by 2050 (Australian Government 2010a, p. 57). Such estimates depend not just on the number of older Australians needing aged care services but also on the scope of publicly supported services, eligibility criteria, co-contributions, and the costs of the services provided.

Working out the impacts of all the various factors on demand is complex. Figure 3.10 sets out the data required to make robust projections of demand. Demand needs to be differentiated by type of service, location, level of co-contributions, and potentially different ‘lifestyle’ quality aspects. The first column in the figure lists the main sources of data available to inform demand projections. Much of this data is collected by DoHA, and is available only in a relatively aggregate form.

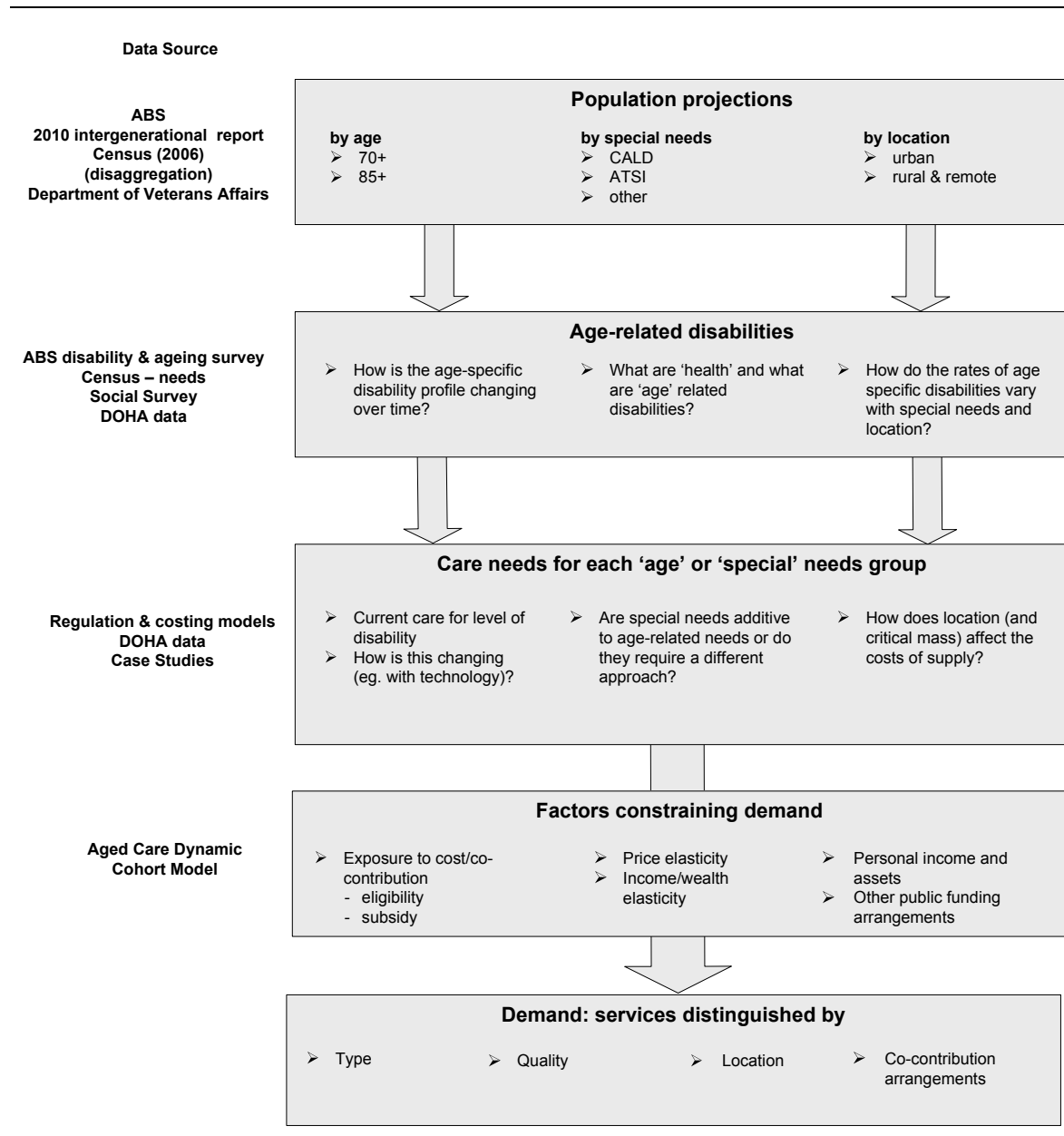
Unmet demand

Access to aged care services is currently managed by an eligibility assessment process and by control over the supply of services through planning ratios. These ratios allow the Government to manage its fiscal exposure through the rationing of residential bed licences and community care. As discussed in chapter 2, from July 2011 the planning ratios provide for 113 allocated aged care places per 1000 people aged 70 or over, comprising 88 for residential care and 25 for community care packages. The planning ratio for residential places has declined from 100 in 1985, while community care packages have taken up a rising share of places since they were introduced in 1992. These numbers do not include HACC services.

Planning ratios do not necessarily reflect the level of demand. If demand exceeds supply the ratios are binding, while if there is excess supply the ratios are irrelevant and could be removed. The evidence suggests that there may be considerable unmet demand. For example, Access Economics (2010a) cite the 2003 SDAC to estimate that 678,800 people requiring assistance either had their needs partly met, or not met at all, or 18.1 per cent of people requiring assistance. The 2009 SDAC data suggests that overall the share of people whose needs were being fully met has not changed significantly since 2003. There was, however, a significant decline in the share of people with a disability whose needs are not met at all, from 3 per cent in 2003 to 1 per cent in 2009. The 2009 survey reported that 53 per cent of people with a profound core activity limitation stated that their needs were fully met, while this

was lower at 32 per cent for those with a mild core activity limitation (ABS 2011). However, this self-assessment of needs and the extent to which they are being met depends on what the individual's views are, and may over or underestimate the unmet level of need.

Figure 3.10 Data needed to make projections for the demand for various services



Another way of defining unmet demand is the gap between those wanting services under current arrangements and the services they receive. While data is available on the number of services received there is no reliable data available on those who would like, but cannot receive, these services.

The over-subscription of services is another indicator of excess demand. In community care the evidence suggests a shortage of places — the 2008-09 funding application rounds for community care packages were oversubscribed, with the (then) Minister Justine Elliot reporting that the ‘... aged care sector has sought 27,039 community care places for the 2,784 places on offer’ (Elliot 2009). However, this would not pick up those who do not apply for the services, nor those who already access services through HACC, but would prefer CACP which also has different co-contribution rates.

Moreover, there are other factors that might affect the take up of available services. In 2009 fewer bed licences were taken up than were made available, and some bed licences have been handed back. Industry representatives have argued that this reflects difficulties in raising capital to invest in new high care beds under current funding arrangements rather than a shortfall in demand (Cam Ansell and Jim Toohey, sub. 464, p. 3).

Other indicators of whether demand is fully met are the usage rates of available services. There are reports of unusually high vacancy rates being experienced by some residential care providers (for example, Anglican Care, sub. 49; Fronditha Care, sub. 436; Cook Care, sub. 442). But this decline in occupancy rates has not affected all services, as DoHA noted in its submission:

It is still the case that two in five aged care homes are operating with occupancy rates above 98 per cent. (sub. 482, p. 55)

Estimates of unmet demand are essential for estimating the cost of implementing the proposed reforms. One way of approximating demand is to use the number of people approved by Aged Care Assessment Teams (ACATs), however this would only be relevant for the more intensive services that require prior ACAT assessment. This approach is not without problems (see box 3.2), but while the ACAT approval data is an imperfect measure of demand for aged care, it is the best basis available to the Commission, and it is likely to provide an indication of the order of magnitude of demand.

Data supplied by DoHA clearly shows that in each year between 2006 and 2009 there was a substantial difference between the number of people approved for more intensive care for the first time in their lives and the number entering such care for the first time (table 3.5). However, this difference between approvals and entry into

care has narrowed. In 2006, for every 100 people admitted into care for the first time, another 105 were approved for care for the first time in their life. By 2009, this number had fallen so that for every 100 people admitted into care for the first time, only 53 more people were approved for care for the first time.

Box 3.2 Estimating unmet demand

To obtain an approximate indication of the magnitude of unmet demand, the Commission has compared the number of people who are approved for care by an ACAT team for the first time in their lives to the number of people who enter care for the first time. The information provided on approval for care and entry into care are from different datasets, and there is currently no basis for identifying which individuals have entered care.

As many people approved for care by an ACAT team are already receiving HACC services, a proportion of unmet demand would actually be 'inadequately met demand' rather than 'completely unmet demand'. However, there will also be people who need HACC services who do not currently receive them.

There are a number of problems with this approach:

- the ACAT assessment process is often the first point of contact and information that people receive about the aged care system and their emerging care needs — as such, it does not necessarily reflect what services a person wants to access as opposed to their assessed need
- people only learn about the amount they are expected to pay for aged care after they have been assessed — so approved care does not necessarily reflect the type or quantity of services a person is willing to pay for (based on current subsidy arrangements)
- people's circumstances and conditions change over time — their condition can improve, deteriorate or they may die. ACAT assessments may take the potential for increased need into account, but that need may not eventuate
- the widely reported wait times both to receive an ACAT assessment and to enter care may discourage people from being assessed for care.

The interaction of these factors means it is uncertain if the number of approvals for aged care services understates or overstates the demand for aged care services.

Source: Appendix E.

Table 3.5 First lifetime approval or entry into aged care^a

	<i>First lifetime ACAT approval</i>	<i>First lifetime admission</i>	<i>Difference between approved and admitted</i>	
	<i>'000 people</i>	<i>'000 people</i>	<i>'000 people</i>	<i>% of first lifetime admissions</i>
2006	134	66	70	105
2007	123	69	57	82
2008	117	72	48	67
2009	108	72	38	52
Average	121	70	53	76

^a First lifetime approval is the number of people who were approved for any of respite care, CACP, EACH, EACH-D or permanent residential care in a given year — but only if they have never been approved by the same ACAT team for any of these services before. There may be some double counting if people had previously been approved for care by an ACAT team in another region. First lifetime entry into care is the number of people who enter respite care, CACP, EACH, EACH-D or permanent residential care in a year who have never used any of those services before.

Source: DoHA *Aged Care Data Warehouse*, supplied by DoHA on 24 September (admissions) and 10 November (approvals) 2010.

The gap between approvals and entry for care has narrowed each year both because more people are accessing care for the first time and less people are being approved for care for the first time. However, most of this change is because of the reduced number of first lifetime approvals. It is not clear why the first time approvals have declined, but it is possible that reduced access to assessment has been a contributing factor. At least one ACAT team has indicated that only approving people with more urgent care needs, with the result being shorter waiting times for those approved (Stevens et al. 2010), and at least one aged care provider has noted that some ACAT teams withhold approving people for care until places are available (Blue Care, sub. 254, p. 58).

The comparison between first lifetime approval and entry into care has only been presented for four years, based on DoHA advice that data on approvals in earlier years were incomplete.

Future demand for aged care services

The growth in the population of older Australians, increases in longevity and with it some age-related conditions (notably dementia), and growing diversity in the types of services that are needed and wanted, all point to considerable growth in the demand for aged care services.

Access Economics (2011) provides some estimates of the shortfall in supply relative to demand if the current over 70 years planning ratios were continued. Its 85+

scenario takes into account the change in the demographic profile of the 70+ population and hence a higher need for services in this 70 years and over age cohort in the future.

Deficits in aged care supply will first start to emerge in 2012 as the demand for aged care driven by the increasing number of people aged 85 and over begins to outstrip the planned growth in supply under current policy. Specifically, if there were no changes to current policy, the projected deficit in aged care supply under the 85+ scenario would reach almost 280,000 places and packages across Australia by 2050. (Access Economics 2011, p.5).

The projections of future demand used to estimate the public and private costs of the aged care system under the proposals set out in this report are provided in appendix E.

4 A framework for assessing aged care

Key points

- A wellbeing framework for assessing policy options is required to guide the development of future aged care policy.
- There are strong rationales for government involvement in aged care, including the pursuit of equity of access to care and correcting market failures (information gaps and the protection of vulnerable consumers).
- The ultimate objective of policy is to improve the wellbeing of the community overall. As such, the benefits from reform must outweigh the costs to the community.
- To guide future policy change, the system of aged care and support should aim to:
 - promote the independence and wellness of older Australians and their continuing contribution to society
 - ensure that all older Australians needing care and support have access to person-centred services that can change as their needs change
 - be consumer-directed, allowing older Australians to have choice and control over their lives and to die well
 - treat older Australians receiving care and support with dignity and respect
 - be easy to navigate, with older Australians knowing what care and support is available and how to access those services
 - assist informal carers to perform their caring role
 - be affordable for those requiring care and for society more generally
 - provide incentives to ensure the efficient use of resources devoted to caring for older Australians and broadly equitable contributions between generations.
- Based on a wellbeing framework and the governments stated objectives, the system for care and support for older Australians should be assessed against the criteria of equity, efficiency, effectiveness (choice, quality, appropriateness) and sustainability.

While many participants to this inquiry acknowledged that reforms over the last decade or so had improved access to care and the range and quality of care, they were also of the view that, in light of future challenges, ‘fundamental’ reform was required. For example, the Victorian Government said:

The scale of forecast requirements for aged care services demands fundamental changes in both the underpinning economics of the sector and how the system itself is planned and developed to stimulate the necessary capital investment. ... Services need

to be planned, allocated, funded and managed around optimising the experience for the client. This will require fundamental changes to many aspects of the service system to put older Australians at the centre and make them active participants in both decisions about and delivery of services. (sub. 420, p. 5)

The National Aged Care Alliance (NACA) maintained that:

... it is now time for action to substantially change the system and take ... reforms to the next level. (sub. 88, p. 3)

And Anglicare Australia said:

There is a need for systemic change which gives stronger influence and participation in aged care service delivery to service users. (sub. 461, p. 1)

This chapter looks firstly at participants' visions for future care and support for older Australians (section 4.1). It then looks at the reasons why governments are involved in aged care and the steps to securing good policy (section 4.2). Section 4.3 provides a framework for informing aged care policy. Section 4.4 sets out criteria for assessing the performance of the aged care system.

4.1 A new vision for care and support

A number of participants presented their visions of what they thought a future system of care and support for older Australians should look like. In the main, the impetus for change was based on the view that the current system was not sufficiently person-centred, nor consumer directed, as 'choice' for older Australians receiving care was limited. Also, the system was considered poorly placed to respond to future challenges — including the increasing number of older people with diverse needs and the rising expectations about how care should be delivered. A number of participants' 'visions' are presented in box 4.1.

The vision and principles put forward in *Leading the Way: Our Vision for Support and Care of Older Australians*, developed by the National Aged Care Alliance (NACA 2009) (a coalition of consumer, provider, professional associations and unions involved in the provision of care and support for older people) received wide support. NACA's vision is that:

Every older Australian is able to live with dignity and independence in a place of their choosing with a choice of appropriate and affordable support and care services as and when they need them. (sub. 88, p. 4)

Box 4.1 Participants' visions for future aged care and support

The National Aged Care Alliance's (NACA's) underpinning principles for older Australians requiring support and care are that they:

- will have access to services in their own communities and homes that:
 - are readily available, affordable and client-directed
 - promote wellness and wellbeing, and assist them to realise their aspirations
 - provide genuine choice to meet the aspirations, needs and preferences of a diverse older population
- are underpinned by a commitment to quality improvement, evaluation and ongoing research
- be the principal decision makers about when they may need assistance and the nature of the assistance
- have access to affordable, effective, and safe health and medical care
- have easy access to reliable and relevant information about the availability, quality and cost of aged care services. (sub. 88, p. 5)

Medibank:

Medibank has a vision for how aged care and supports which assist people to live independently will be delivered in the future. This vision encompasses a future where a seamless continuum of supports incorporating preventative activity, healthcare, community based services, aged care and other supports are delivered in the right setting at the right time. (sub. 250, p. 3)

Aged and Community Services Australia (ACSA):

Aged care services will support older people to have a good old age — to live satisfying, self-directed lives to the maximum extent of their capacity. This aim should be the driving force for any changes to the aged care system. To achieve this aim the aged care service system of the future must deliver older people more **choice** of, and better **access** to, financially **sustainable** aged care services. (sub. 181, p. 17)

Uniting Care Australia:

Imagine ... an Australian community where older people are valued and included in community life, enabled to maintain health & independence, are able to contribute their talents and wisdom, pursue their interests, nurture relationships, maintain their culture and spirituality and be in control of their future. Imagine if those who need support can receive it in a way that supports the above, and is provided with dignity and respect. (sub. 406, p. 8)

The Older People's Reference Group (sub. 25) said any reforms to the aged care system should embody the following principles and values: autonomy and choice; social inclusion and community participation, quality, equity and affordability; the crucial role of carers; information and access.

The underpinning principles of NACA’s vision include access, affordability, promotion of wellness and wellbeing, choice and access to health services and information.

The Victorian Government’s vision for the future system spoke about having ‘fun and enjoying life’, being able to make choices, take risks and feel safe:

Older Australians can: make their own choices and decisions; are valued and respected; can take risks; connect with family, friends and others; are involved in the community; feel safe and comfortable; are active; get their health and care needs met; have fun and enjoy life. (sub. 420, p. 6)

The New South Wales Government considered that a reformed system should promote ‘wellbeing’, prevention and early intervention and give stronger recognition to the role of carers:

Any reform of the aged care system should be aimed at achieving better linkages and smoother transitions between services as and when needed by older people. It will also need to: promote well-being, including independence, through a person-centred, enabling approach; increasingly emphasise prevention and early intervention; give stronger recognition to the role and importance of carers; and provide holistic and seamless continuity of care across health and aged care service sectors. (sub. 329, p. 3)

While the visions presented by participants varied, they also had common themes, including the importance of focussing on wellbeing and promoting wellness, independence and choice. System oriented themes included the provision of easily understood information, a more continuous person-centred range of services and smoother transitions between aged care, and health and housing services. Carer support was also an important theme.

4.2 Caring for older Australians — what role for government?

An important first step in considering a new system of care and support for older Australians, and the policy changes it would require, is to revisit the rationales for government involvement in aged care.

Governments are currently involved in almost every aspect of caring for and supporting older Australians. They organise and subsidise care and support services, support aged care infrastructure and provide assistance to carers of older people. Governments regulate the supply and distribution of funded care places and the prices that aged care providers can charge their clients. The Australian Government also regulates the quality of aged care through quality assurance and consumer

protection arrangements, including the accreditation of aged care homes, building certification requirements, a Complaints Investigation Scheme (CIS), an Aged Care Commissioner and prudential regulation covering accommodation bonds (chapter 10 and 15).

The pursuit of equity is a key reason for government involvement in aged care. It seeks to ensure that all older Australians have access to affordable support and care at a standard that is in line with community expectations. National Seniors Australia (NSA) quoted the Special Secretary of Human Rights for Brazil as saying:

A country that does not look after its older people does not have a soul. (sub. 411, p. 8)

Addressing failures of the aged care market is a further reason for government involvement. There are a number of areas where the market for aged care lacks features of an ideal market:

- People or families seeking aged care services may not have the information or expertise to accurately judge the quality of aged care (particularly clinical quality). They may use unreliable indicators to assess quality (such as the appearance of the facilities), where what may matter more is the experience, attitude and attention of staff and the time they take in providing care services. People may make choices based on inadequate information about preventative or early intervention measures.
- Often decisions about aged care are made at short notice during times of emotional or acute medical crisis. This can limit the scope for individuals and their families to be fully informed about their options and can also mean that there are a limited number of options available. As such, providers may have less incentive to compete on quality (especially if it is difficult to move between providers).
- Aged care is not a service people normally want to buy; rather they do so because of need, and often in response to circumstances beyond their control. In the absence of government support, a proportion of older Australians may not be able to access services which are important to their health and wellbeing because they cannot afford them.
- The level of demand for aged care services varies across locations and the cost of providing care differs with scale and with location. As such, if left to the market, services may not be provided in some areas, such as rural, remote or low income locations or to groups who have special needs.
- Elderly and frail people may be vulnerable to exploitation and need protection. For example, they may not be able to judge quality for themselves due to cognitive impairment or be able to communicate their wishes to their representatives, or have family or friends who are able to look after their

interests. Poor quality aged care can mean reduced quality of life, physical or mental harm or even premature death for older people and can also impose substantial costs of others.

Government intervention may also be required to correct failures arising from existing government policies. By way of example, the current supply constraints on the number of bed licences and community care packages reduces incentives for providers to compete on price and quality. Where public subsidies are provided to defray the costs of providing aged care services, further government intervention to promote accountability, ensure quality outcomes and contain expenditure (lessen fiscal risk) is warranted.

But ‘when’ should policies be implemented or reformed?

An in-principle rationale for government intervention does not of itself justify a policy response. Because interventions have costs, it is necessary to demonstrate that the benefits to the community from a new policy, program or regulation outweigh the costs of the intervention. There are a number of key steps in ensuring good policy outcomes. As a general rule, policies should:

- address problems that are large enough to justify government action and are amenable to such action
- have clear objectives, to underpin the development of targeted policies and to reduce the risk of unintended consequences
- reflect assessment of the likely effectiveness of different policy options, including the likely costs and benefits for the community as a whole (taking into account economic, social and environmental impacts)
- enable consumers, industry and the community to give their views about policy development and the performance of existing policies — supported by transparent decision making (and public availability of data) — to facilitate effective design, implementation, monitoring and modification of policy over time.

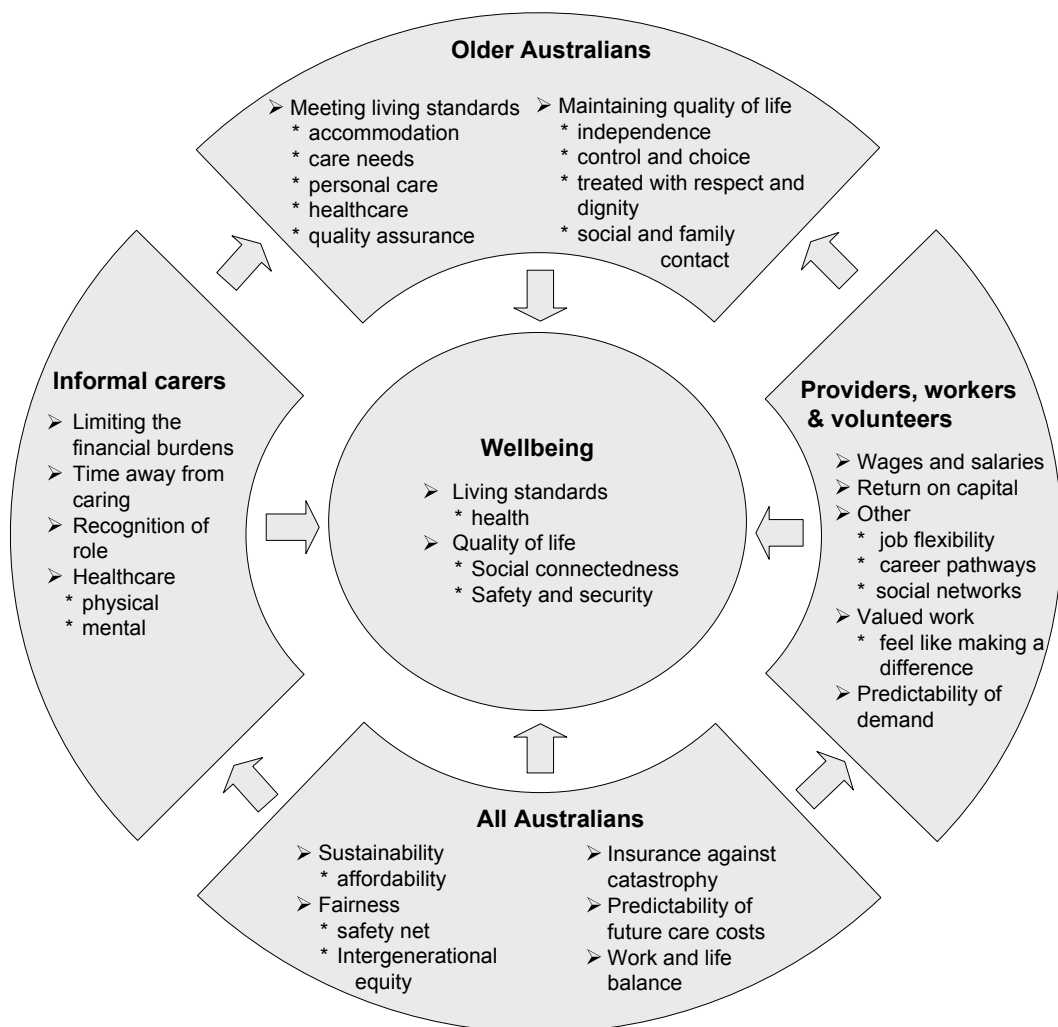
4.3 ‘Wellbeing’ of the community — the key objective

The ultimate objective of any government policy should be to enhance the ‘wellbeing’ of the community overall. The Australian Bureau of Statistics (ABS) suggests that wellbeing relates to ‘the desire for optimal health, for better living conditions and improved quality of life’ (2001, p. 3).

Wellbeing, or quality of life, is a multi-dimensional concept incorporating physical and emotional needs, connectedness to others, the ability to exert influence over one's environment and safety from harm (figure 4.1). The World Health Organization (WHO) defines quality of life as:

... an individual's perception of his or her position in life in the context of the culture and value system where they live, and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept, incorporating in a complex way a person's physical health, psychological state, level of dependence, social relationships, personal beliefs and relationship to salient features in the environment. (1994, p. 43)

Figure 4.1 Factors influencing wellbeing in the context of aged care



The domains of wellbeing are 'person-centric', reflecting the view that at a community level wellbeing is a collective of individual wellbeing. At the broadest level, the social, material and natural environments surrounding individuals become part of the wellbeing equation (ABS 2001). The Benevolent Society put to the

Commission a broad wellbeing framework comprising several domains under three broad categories — physical, mental/emotional and social (sub. 252).

Measuring wellbeing, however, is not easy because it involves making value judgements about what aspects of life are important to an individual's wellbeing (knowing that people value outcomes differently) and what matters to society. As the Australian Treasury said:

... each person will have their own interpretation of what is specifically important with respect to their own wellbeing, the wellbeing of others, and the weight that they place on each dimension of wellbeing. (Treasury 2004, p. 2)

One approach to measuring wellbeing is to use an individual's assessment of how happy or satisfied they are with particular aspects of their lives. While the results can be aggregated to get a community view about life satisfaction, the scope to use such measures to guide policy is debateable.

The Australian Unity Wellbeing Index, a measure of subjective wellbeing and of national and personal satisfaction with life, finds that some of the happiest Australians are those aged 65 years and over with an annual household income of more than \$60 000. Although older Australians have lower satisfaction with their health (which declines as aged related ailments set in), positive personal relationships with others are found to offset this (Australian Unity Wellbeing Index, sub. DR626)

In the context of aged care policy, while the focus is on supporting the highest possible quality of life for older Australians unable to care for themselves, the wellbeing of family members, friends and neighbours providing care to older people (they provide most of the care), and people providing formal care (owners of services, workers and volunteers) is also important and should be considered. The impact of policies on the broader community, including current and future taxpayers who can be asked to pay for care subsidies, should also be taken into account (figure 4.1).

The wellbeing of older Australians needing care

The focus of the United Nations Principles for Older Persons is:

To add life to the years that have been added to life. (United Nations 1991)

The WHO also states that the goal of long term care should be about maintaining the best quality of life:

... to ensure that an individual who is not fully capable of long-term self-care can maintain the best possible quality of life, with the greatest possible degree of

independence, autonomy, participation, personal fulfilment, and human dignity. Appropriate long-term care therefore includes respect for that individual's values, preferences, and needs; it may be home-based or institutional. (2000, p. 1)

Participants also suggested that enhancing wellbeing or 'quality of life' should be the goal of providing care and support for older Australians. National Seniors Australia (NSA) said:

... quality of life should be a fundamental goal of the aged care system. At present, however, the aged care system is more heavily focused on technical constraints, such as risk management, economic imperatives, and rigid timetabling. (sub. 411, p. 9)

Anglicare Australia said:

In caring for older people services have to take into account the needs of the whole person, physical, emotional, psychological, social and spiritual. (sub. 461, p. 16)

Access to services that provide the required level of support for maintaining health, personal hygiene, physical safety and pain management forms the first level of support and care that promotes the wellbeing of older Australians. ('Health', in this context refers to physical, mental and social wellbeing, as defined by the WHO.)

The Commission repeatedly heard from older Australians that they wanted to be confident that appropriate and affordable care would be available if or when it was required. NSA said:

The ability to access aged care services, from home assistance through to residential care, is an *essential* service to protect older Australians when they become more vulnerable. (sub. 411, p. 4)

To achieve this, services should be person-centred. They should be available and accessible when and where they are needed, tailored to the person's own needs, changed as required, and not be limited as a result of inability to pay. This points to the importance of continuous and seamless care and effective interactions with the health care system.

Participants also noted the importance of having a system that is easy for older Australians and their families to navigate. For example, the Victorian Government claimed:

Into the future, services and support should be organised and delivered in ways that ensure that older people can easily find the *right types* of aged care services in the *right settings* when they need them. ... We need to make it as simple as possible for older Australians to receive the supports they need as their requirements change over time, recognising that in many instances, the relationships they have with both their communities and their current service providers are critical to positive health outcomes and need to be maintained. (sub. 420, p. 5)

The aged care system should seek to ensure that all older Australians needing care and support have timely access to appropriate person-centred services that can change as their needs change.

The aged care system needs to be easy to navigate. Australians need to know what to expect from the system in terms of accessing care and support and their responsibilities (including what they are required to contribute).

Older people requiring care are not all the same

While the process of ageing is continuous from birth to death, it varies considerably from one person to another. As the Department of Health and Ageing (DoHA) said:

Ageing affects every person throughout their lifespan at different rates and in different ways as unique individuals. It is inescapable, normal and not necessarily an indication of frailty. (sub. 482, p. 7)

Some of the factors influencing the way that people age include genetics, gender (women, on average, live longer than men, but tend to experience more disabling diseases as they grow older), ethnic and cultural backgrounds, health/disease experience throughout life, lifestyle choices and general life experiences and exposures (WHO 1999).

A life course perspective on ageing shows that individual diversity increases with age (figure 4.2). That is, the range of function of two 80 year-olds is likely to be less similar than those of two 10 year-olds.

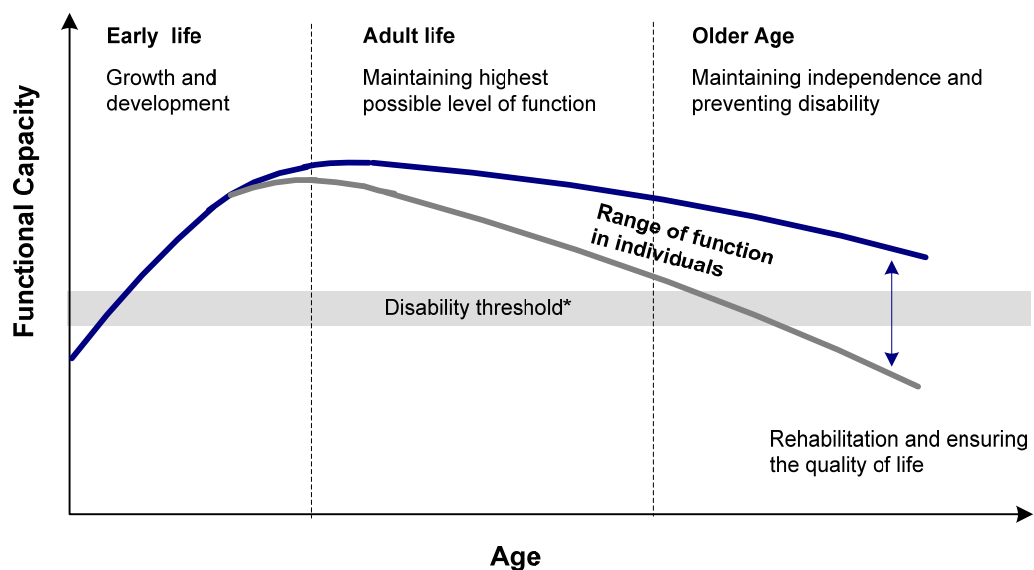
Because people age in unique ways, the needs of older people will vary markedly, depending on functional capacity, physical and mental health, culture and language and the built environment in which they live. Support and care should, therefore be flexible enough to recognise diverse needs and be able to adapt the services provided accordingly. This points to the importance of a person-centred (rather than program-centred) approach to providing care and support. As Banksia Villages said:

Ageing is an incremental, highly variable and unique process that requires a response that is incremental, flexible and accessible. (sub. 467, p. 1)

NSA argued that an aged care system:

... should not just 'facilitate access to care' or 'guarantee an acceptable or even a minimum standard of care', rather it should customise care and meet individual care needs as identified in a personal care assessment. (sub. 411, p. 7)

Figure 4.2 Maintaining functional capacity over the life course^a



^a Changes in the environment can lower the disability threshold, thus decreasing the number of people with a disability in a given community. Functional capacity (such as ventilatory capacity, muscular strength, and cardiovascular output) increases in childhood and peaks in early adulthood, eventually followed by a decline. The rate of decline, however, is largely determined by factors related to adult lifestyle — such as smoking, alcohol consumption, levels of physical activity and diet — as well as external and environmental factors. The gradient of decline may become so steep as to result in premature disability. However, the acceleration in decline can be influenced and may be reversible at any age through individual and public policy measures.

Source: Kalache and Kickbursch 1997, in WHO (2002).

Anglicare Australia also said:

Older people do not want to be made to fit into programs. Not surprisingly, they would like the care designed to suit their needs. By necessity then, older Australians and the families need to be partners in the design and management of the care they receive. In terms of people's wellbeing, this is where the notion of choice is most useful. (sub. 461, p. 3)

Sensitivity to specific cultural requirements is also important for wellbeing. As a participant to the Ministerial Advisory Council of Senior Victorians said:

(We are) the same as other sections of the community — we are still diverse — only older. Give us choices! (Written input, 2008, p. 13)

Culturally appropriate care is particularly important for people with dementia because the language most recently acquired is lost first (Access Economics 2009b). Indeed, some people in their final years find comfort in revisiting earlier customs, languages and other meaningful symbols of their life. Even small differences, such as food preferences and recognising special days and/or events, can make a difference to someone's wellbeing. In this context, Pratt said:

One of the more visible differences among cultures is the type of food preferred. Being able to eat the foods we like plays an important part in how we define the quality of our lives. Yet, until recently, most nursing facilities paid little attention to satisfying the seemingly exotic culinary wishes of their residents, ignoring their importance. (2010, p. 39)

The importance of independence and being a contributor to society

A very strong message coming from older Australians participating in this inquiry was that they wanted ‘support’ in older age to be able to manage their own lives and to remain independent (to the extent that is possible). The then Minister for Ageing stated:

I have the opportunity to speak with older Australians on a regular basis and their resounding message is that they want to live with maximum independence and maximum dignity. They want to remain active in their communities and close to their families, friends and neighbours. (DoHA 2009e, p. iii)

Recent focus group research also showed that older people living in Victoria had a strong desire to remain independent as they age (Victorian Government, sub. 420).

Beresford, commenting on the concept of ‘care’ in a policy sense, said:

Many see care as inextricably associated with dependence, control and inequality. Few of us want to see ourselves as, or be seen as, dependent.

... what’s needed next is a truly public debate about what frameworks are likely to help all of us secure the personal and social support that improvements in our societies mean more and more of us are likely to need. (2008, p. 15)

The WHO describes active ageing as ‘the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age’ (2002, p. 12). An important dimension to active ageing for a person is maintaining their functional capacity over their lifetime. While the degree of functional capacity progressively widens between individuals over their lifetime, active ageing is about ensuring individuals are at the highest level of function possible for their age (figure 4.2). For older individuals this means maintaining independence and preventing disability for as long as possible (Oxley 2009).

An aged care system with a focus on promoting wellness, active ageing and enhancing the independence of people in later life might not only enhance the wellbeing of older people, but could also be effective in reducing demand for more expensive and ongoing services (box 4.2). There is emerging evidence that timely intervention, restorative home support, education and assistive technologies can improve quality of life and the functional status of older people, and reduce costs because of a reduction in the ongoing use of home care services (Ryburn et al. 2009). Support to help older people maintain independence can involve making

available assistive devices (hand rails, safety bells, etc), changing the physical environment, providing restorative care, rehabilitation services and support for families and carers. For example, helping someone maintain independence could mean facilitating a move into more congregate living arrangements where they will require less assistance to perform functions related to daily living.

Box 4.2 Participants support healthy ageing and maintaining independence

Alzheimer’s Australia, WA:

‘Aging well’ is a life span approach to the aging process, with the objective of contributing to the health and wellbeing of all members of the Australian community. Health and the capacity to remain independent are important aspects of older people’s lives, are intrinsically linked and thus government policy and spending on one aspect is likely to impact on outcomes of the other. (sub. 345, p. 4)

Aged Care Assessment Service Victoria:

A goal should be to revise the system with the main aim to restore/retain the independence of older people in a timely manner rather than responding to their advanced decline with less capacity to reverse the functional deterioration. (sub. 214, p. 2)

Business Council of Australia:

Just as policy attention is turning to greater efforts at prevention for the population at large, so too should it turn to promotion of healthy living for ageing Australians. Preventing or managing chronic disease and limiting disability are vital elements in managing the demand for care and health services and for improving the quality of life of both the ageing and their carers. This necessarily requires consideration of all the elements of wellness as well as access to ongoing physical and mental activity; social connection; cultural activities and transport for all services. (sub. 274, p. 10)

Australian General Practice Network:

A greater focus on restoring functionality amongst individuals receiving HACC services should be supported through more flexible funding arrangements and performance indicators and reporting requirements linked to reduction of dependence amongst service recipients. (sub. 295, p. 19)

Community Care (Northern Beaches):

International and national research and service pilots have demonstrated the capacity of community-based allied health interventions/independence models with service provision (e.g. Re-ablement Project in the UK, TARGET Project in New Zealand, Home Independence Pilot in Western Australia, Active Service Model Pilots in Victoria, and the IMPACT/Better Practice in HACC Project in NSW) in the promotion of wellbeing, and prevention of unnecessary functional decline for older people living in the community. While potentially more resource intensive in the early stages, these models have proven the long term financial savings, in addition to positive health and wellbeing outcomes for older people. (sub. 142, pp. 2–3)

Being a contributor to society for as long as possible can also influence people's sense of worth and hence their wellbeing. The Council on the Ageing (COTA) Australia argued that older people want recognition of the fact that they continue to play a valuable role.

The often unstated assumption is that life has a point or period when it is at its best. After that we are 'over the hill' or 'on the downhill slope', with the 'best years behind us' or another of many more similarly negative colloquialisms. Older people are increasingly laying claim to a different paradigm of ageing, which gives explicit recognition to the fact that even if experiencing physical and health challenges they continue to have roles that have value and meaning. Most older people still have goals to achieve, contributions to make, a life to live. (COTA Australia, sub. 337, p. 8)

Pratt also argued that:

We all have a need to be needed, perhaps our greatest need. Our self-worth is diminished if we feel that we are not contributing something useful to those around us. One of the ways in which the system can ... allow its consumers to contribute is by promoting their highest achievable level of functioning and by showing society in general, and people as individuals, that they have value. (2010, p. 40)

The psychology literature suggests that 'meaning' and 'engagement' are important dimensions of wellbeing (Vella-Broderick et al. 2009). The notion of 'meaning' captures the idea that people seek to find purpose in their lives, while 'engagement' is about the degree to which people immerse themselves in specific activities. The evidence suggests a link between 'meaning' and 'engagement' and positive physical and mental health outcomes.

The aged care system should promote independence, wellness and the continuing contribution of older people to society.

Being able to exercise choice is important to wellbeing

How older Australians' needs are met can also have a significant influence on their wellbeing. People generally value the opportunity to make choices about things that are important to them. At a time in life when people may feel that they have little personal control over many aspects of their daily lives (for example, because they require assistance with meals and showering), it is particularly important that they can exercise choice and maintain control over those aspects of their life where they can. Sen argues that freedom to exercise choice 'makes our lives richer':

Expanding the freedoms that we have reason to value not only makes our lives richer and more unfettered, but also allows us to be fuller social persons, exercising our own

volitions and interacting with — and influencing — the world in which we live. (1999, pp. 14–5)

Having choice empowers people and can allow better matching of preferences. When people can choose freely, they will generally choose in a way that maximises their wellbeing. NACA said:

Older Australians deserve and are entitled to a care and support system that ensures them the same freedoms and choices as all other Australians. (sub. 88, p. 10)

Just Better Care also said:

We need to change the way we provide services, from one of ‘giving’ services to one of ‘empowering’ individuals to unlock productivity potentials. It is what our ageing Australians demand, and it is also good for the country as a whole. ... Empowered service users will be healthier, happier and more capable and willing to be independent, therefore having less need for services. (sub. 281, pp. 3–4)

There is strong empirical evidence to suggest a wide range of positive wellbeing outcomes, including higher life satisfaction, more independent living and better continuity of care from providing greater choice in the context of health care (Barnett et al. 2008).

Choices will, however, inevitably involve individuals making some trade-offs, for example, trading off the risk of physical injury for being able to engage in activities such as gardening or making a cup of tea. As one participant said ‘people are the experts of their own lives so who can be better placed to make decisions about their care?’. Choice can be constrained by limited service options, access to information and capacity to pay. And, individuals with cognitive impairment may not have the ability to make choices that are in their best interest.

There is also some evidence that people do not always value choice when there are too many options (Schwartz 2004). Choice can impose costs if people worry about making the wrong choice or they find the range of options confusing. There is a balance between choice that empowers and choice that can detract from wellbeing. Because people have different preferences regarding risk, wellbeing is likely to be improved if there is a better match between people’s risk preferences and the risk borne (Treasury 2004).

How care is provided can also be important for wellbeing as assistance with daily living activities often involves intimate tasks. Anglicare Australia said:

Older people may receive the best practice medical and clinical care yet have little life satisfaction. (sub. 461, p. 16)

Another participant, Jean Wortley, in relation to the care provided to her frail and ageing parents said:

Care in itself means much more than clean floors, bed making and fixing meals for people. It means building relationships that allow a frail, helpless and often frightened older person to know who to expect will be coming through their door. (My parents were initially very anxious about allowing strangers in to handle their possessions, take over their kitchens and ultimately handle their bodies, shower them, dress them etc.) These are intimate tasks that of necessity challenge people's privacy, control over their shrinking world and trust in others. (sub. 470, pp. 1–2)

While quality of care is often assessed on an objective basis, an important dimension of quality is subjective — how people feel about who is delivering the service and how the service is delivered. The Commission was told on a number of occasions of people having a succession of strangers coming into their homes to provide care and people not wanting to receive higher levels of care because it meant they could not retain their current carer. Beresford argued that:

Care is increasingly organised as a set of mechanical tasks. The range of these tasks has tended over time to be restricted and sometimes divorced from their human associations. The skill and experience required to undertake these often intimate and potentially invasive tasks in a sensitive, respectful and positive manner tend to be overlooked. (2008, p. 3)

For older people receiving care, the respectful nature of the engagement is particularly important as it contributes to their self esteem. It is also important for the family and friends of older people that their loved ones are treated with respect and dignity. Aged Care Crisis spoke about the 'loss of human rights that so often occurs at the end of life — when it is far too easy for individuals to lose their social identity and the rights of citizenship' once they enter residential care (sub. 433, p. 2).

Dying well

A number of participants also spoke about the importance of 'dying well' for positive wellbeing outcomes. Palliative Care Australia argued that issues of death and dying should be included in the objectives for aged care:

With 50,000 older Australians approaching death and dying each year in residential aged care facilities alone, the wellbeing of older Australians would be further advanced through explicit recognition of the issues of death and dying and the inclusion of an additional key goal of the aged care reforms — to assist all older Australians to die well. (sub. DR731, p. 2)

Others spoke about the importance of advance planning for people to have a good death. Hal Kendig, for example, said:

A ‘good death’ is part of a good life and this requires advance planning for individuals as well as a care and health system focused on comfort and dignity to the end of life. (sub. 431, p. 4)

Palliative and end-of-life care is ‘core’ business of any aged care system. This points to the importance of access to good palliative and end-of-life care for elderly Australians. According to Palliative Care Australia:

... all Australians should be able to expect to die with their preventable pain and other symptoms well managed, with the people they wish to be present and, whenever, possible, in the place of their choice. (sub. 77, p. 2)

A survey conducted by the British Medical Journal of people approaching death asked ‘what is a good death’ and came up with 12 principles. The principles include, amongst other things, being able to retain reasonable control of what happens, to have control of pain and other symptoms, to have access to information and expertise and to be able to issue advance directives so that one’s wishes are respected (box 4.3 provides the full list of principles).

Box 4.3 Dying well — what is a good death?

British Medical Journal surveys of people who are approaching death (and their relatives) resulted in a supplement — ‘What is a good death?’. The views of people were summarised as ‘principles of a good death’ in the following 12 points:

- to have an idea of when death is coming and what can be expected
- to be able to retain reasonable control of what happens
- to be afforded dignity and privacy
- to have control of pain and other symptoms
- to have reasonable choice and control over where death occurs
- to have access to necessary information and expertise
- to have access to any spiritual or emotional support required
- to have access to ‘hospice style’ quality care in any location
- to have control over who is present and who shares the end
- to be able to issue advance directives to ensure one's wishes are respected
- to have time to say goodbye and to arrange important things
- to be able to leave when it is time, and not to have life prolonged pointlessly.

Source: Jones and Willis (2003).

The aged care system should be consumer-directed. It should promote choice and be sufficiently flexible to allow people to live their lives the way they wish and to die well. Older Australians receiving care and support (including palliative and end-of-life care) should be treated with dignity and respect.

The importance of social connections

Maintaining family and social connections matters for older people, just as it matters for people of all ages. The Benevolent Society said:

Social dimensions feature strongly in older people's perceptions of their wellbeing. Social networks, activity and access to confidants can help protect people from the negative impact of stressful life events and are associated with higher quality of life and life satisfaction and better physical, mental and emotional health.

Conversely, social isolation and loneliness in old age are linked to a decline in physical and mental wellbeing. Life events such as bereavement and loss of mobility may trigger social isolation, especially among people who are more at risk. (2010, p. 3)

Many participants also noted the importance of social inclusion to the wellbeing of older people (box 4.4). The Australian Government has a social inclusion agenda in relation to older Australians.

There are differing views in the literature about the extent to which particular types of relationships matter in terms of a person's wellbeing (for example, how significant and lasting the welfare effects are of a happy marriage). But, there is general agreement that 'connectedness to others' is a key dimension of wellbeing.

Inadequate social support is associated with an increase in mortality, morbidity and psychological distress. A Japanese study, for example, found that older people who reported a lack of social contact were 1.5 times more likely to die within the next three years than those with higher social support (Sugiswawa et al. 1994).

Older people are also more likely than people at other stages in life to be losing friends and family members (because of death) and so can be particularly vulnerable to loneliness and social isolation, especially those with reduced mobility.

The location of services and their accessibility can be very important for maintaining independence and social connections. Carers NSW said:

Transport is also crucial to improve the social inclusion of older people, and to enable them to retain more independence for longer. (sub. 211, p. 7)

Box 4.4 Social connections and wellbeing — participants' views

The Victorian Government:

Older people still want to be connected, contributing, and cared for. (sub. 420, p. 10)

NSW Government:

The NSW Government is also keen to see social exclusion addressed as an issue affecting the wellbeing of individuals and their capacity to remain healthy and independent as they age. The provision of flexible access to community and support services is critical to helping people maintain social networks and retain independence, particularly if their functional capacity is declining. (sub. 329, p. 9)

National Rural Health Alliance:

... older people are particularly vulnerable to social isolation which can impact heavily on their health. Community support from someone to drop in for a cup of tea or help with transport to a Senior Citizens craft session can be extremely important for people living in small communities. (sub. 277, p. 9)

The Benevolent Society:

In older age social exclusion can result in poor quality of life, avoidable illness and disability, higher rates of hospitalisation, premature institutionalisation and premature death. ... Most older people want to live as independently as possible, continuing to do the things they enjoy and staying connected to their community. (sub. 252, p. 14)

Diversional Therapy Australia:

Not only is it proven that life enriched with meaningful activity, social connections and laughter is an effective preventative medicine, it is also a vital part of being human. (sub. 175, p. 1)

The Benevolent Society also said:

There are also systemic barriers to social connectedness. They include lack of suitable transport and aspects of the built environment such as inappropriate housing, public spaces without seating, poor footpaths and inaccessible public buildings. These can reduce people's ability to take part in social activities outside the house, or can force them to have to move elsewhere away from their social networks. (2010, p. 3)

Broader issues relating to age-friendly neighbourhoods are discussed in chapter 12.

The wellbeing of carers

Informal carers

Many people wish to care for their partners, parents and friends whenever they are able to do so. Older people themselves can also be the providers of care, such as to their partners or to dependent children. The experience of caring for a partner,

relative or friend can be a positive experience and give a sense of purpose that is important for the self-esteem of carers (chapter 13).

However, the positive effects on wellbeing from caring can be eroded if carers:

- are unable to look after their own physical and emotional needs, including finding time to engage in leisure activities or maintain social connections (activities that can be important for the health and self-esteem of carers). The demands of caring can be stressful and isolating and this can affect the health and wellbeing of caregivers. There is a substantial body of evidence that shows the personal costs of caring on carers. Informal carers have poorer physical and mental and emotional health and less social support than non carers (chapter 13; ABS 2008a; Access Economics 2009b; McKenzie et al. 2009). A number of participants to this inquiry spoke about the effect caring has on carers' lives (box 4.5). The Australian Unity Wellbeing Index (sub. DR626) found that informal carers have the lowest level of wellbeing of any group.
- experience financial stress. If a caring role means someone is not able to participate in paid work or to participate less, a carer's income is likely to be lower than would otherwise have been the case
- feel they are struggling to provide the quality of care they want for their loved ones, or that the care they are providing is not appreciated by other family members or the community more generally.

Many participants acknowledged the important role of carers in supporting older people. The New South Wales Government, for example, said:

The important role of carers and volunteers in supporting older people and the health and aged care sectors as a whole must continue to be acknowledged, sustained and facilitated. (sub. 329, p. 7)

The Australian Institute of Health and Welfare (AIHW) describe carers as the 'enablers of community care' noting that:

... for many older people with disability, the level of assistance provided by formal services is not sufficient to enable them to remain at home. But the presence of a carer who provides ongoing assistance (which is supplemented by community care services) can tip the balance in favour of home-based care. (2009a, p. 212)

Box 4.5 The impact of caring on the wellbeing of carers

Alzheimer's Australia:

... caring for a person with dementia has a negative impact on the health and wellbeing of family carers. Social impacts may include loss of work, friends and acquaintances and social activities. Health impacts can include depression, anxiety, stress, physical health impacts and sleep disruption. Additional stresses can occur if the family carer is older and in failing health themselves. (sub. 79, p. 12)

Eva Gross:

Carers burn out, become physically and psychologically unwell, have to take days off work, drop out of work etc because of the demands of care, adding costs to the health and welfare systems and impacting on productivity. (sub. 435, p. 7)

Carers Australia:

Long-term caring can take its toll, socially, emotionally, physically and economically. Older carers are caring at a time when their own health may be deteriorating and they are at risk of the normal range of health issues that arise for older Australians. (p. 247, p. 8)

Jennifer Proberts:

Ask any carer and you will be told they have put their life on hold because they do what they do because of the love they have for the person they are looking after. Many families break up with this constant extra pressure on emotional, physical and mental wellbeing. Obviously as time goes on the work load and pressure increases which results in the carer suffering burn out or breakdown. (sub. 66, p. 1)

The wellbeing of informal carers can be enhanced by arrangements that allow them time away from caring to engage in activities for themselves, assistance with the financial burden of caring, access to counselling and training, and by having a role that is recognised and valued. Without support and assistance, carers can burn out which can then mean greater reliance on more formal forms of care. Providing support for people who care for older Australians can also be an important aspect of improving the quality of care. As Hal Kendig put it:

In many cases, support for frail older people is best achieved by sharing responsibilities for care and providing respite and other services that can lessen stress. Research has shown that caregiver stress is one of the main predictors of entry to residential care. It is important to recognise, however, that the interests of frail older people and their caregivers can diverge, and it is important to listen to and respond to both parties. (sub. 431, p. 4)

People who provide care and support for older Australians should be provided with support to assist them to continue performing this role.

Formal carers and providers

Opportunities for career progression, job flexibility, workplace safety, social engagement, and the personal sense of value people get from their work are important contributors to the wellbeing of workers. Some of these non-monetary aspects of working may be more important in aged care than in other industries (chapter 14).

While an aged care system needs to offer competitive remuneration to attract labour, workers may be willing to trade off some financial returns for more flexible work arrangements, potential career progression, and enhanced self esteem (although the financial recognition of the contribution also contributes to self esteem). The funding and regulatory arrangements of the aged care system can enable or constrain the scope for employers to offer such outcomes.

The high level of involvement of not-for-profit providers in aged care reflects the interest in a wider range of outcomes in this industry. While the original involvement of faith-based and local community organisations in the provision of aged care services may have been motivated by the desire to alleviate the poverty suffered by some older Australians, many such organisations have evolved to provide services to a much broader share of the aged population. This has been accompanied by increased professionalisation of much of the management and staffing. Volunteers also play an important role in service delivery and seek to enhance the wellbeing of those they assist as well as gain a sense of satisfaction themselves.

The wellbeing of the broader community

As ageing is an inevitable process, there are few Australians who will not engage with the system over time. In general, wellbeing of the broader community is enhanced by knowing that care services will be there when required, that there is a safety net and that nobody will be faced with catastrophic costs of care.

Care and support should not only be affordable to those requiring care, but also affordable to society (taxpayers) who contribute to the costs of care. To ensure that care services will be available over time requires that the system be fiscally sustainable.

Sustainability can be thought of broadly as the ability of the system of care over time to provide services of an appropriate standard in a way that meets community expectations in relation to their accessibility, affordability and quality. With a smoothly growing population, a pay-as-you-go system can be affordable as there

are always more younger people to support the aged care needs of the older generation. However, the post-world war II baby boom, combined with an increase in life expectancy, means that the dependency ratio is predicted to rise substantially over the next 40 years (chapter 6).

There are some concerns that the intergenerational inequities that are arising, in part, from greater costs of aged care, may create tensions between generations. For example, the then Governor of the Reserve Bank of Australia, Ian Macfarlane, said at the *2003 Economic and Social Outlook Conference* that:

If we are not careful, there is a potential for conflict between generations. The young may resent the tax burden imposed on them to pay for pensions and health expenditure on the old. This will particularly be the case if they see the old as owning most of the community's assets. Housing is the most obvious example, where people of my generation have benefited from 30 years of asset price inflation, while new entrants to the workforce struggle to buy their first home. (Macfarlane 2003, p. 19)

Getting the best 'value' out of the resources devoted to providing care and support to older Australians is also important for taxpayers and for the community more generally because it is about maximising overall welfare and living standards. This requires that resources are used where they give the greatest benefit (allocative efficiency), and that services are produced using the lowest level of resources required to meet a specific quantity and quality standard (technical efficiency). It also requires that investments are made where the stream of future benefits more than outweighs the costs, including the opportunity cost. Another dimension is how aged care services interact with other services that are critical to the health of older Australian, including health, housing and transport services.

When considering efficiency in the context of aged care, it is important to design appropriate incentives within the system to:

- ensure services are provided as needed, but with the older person's choice of provider being made on a value-for-money basis
- reduce the unit cost of producing services of any given quality
- be innovative and flexible in the face of changing expectations and economic and social circumstances.

The role of consumers in facilitating competition and promoting well-functioning markets has long been recognised. In seeking to get the 'best' value (the good or service and price/quality combination most appropriate for them), consumers not only advance their own self-interest, but also provide signals to suppliers about the product characteristics they require. People who have the information and capacity

to make informed choices will choose the services that best suit their needs (and retain control over their lives).

Competition between suppliers, who respond to these signals, can variously lead to lower costs, improved product quality and choice, greater innovation and higher productivity.

Markets, by their nature, cannot offer certainty and providers who cannot attract enough clients will fail. This can pose risks for the clients of these providers, especially in the case of aged care. There are also risks that providers will not enter a market where demand is limited, such as in rural and remote areas or where there are relatively few clients with particular needs, or a capacity to pay. Insufficient demand can be managed by financial support to marginal providers, but such support can also erode incentives for efficiency. In such cases, the provision of public subsidies which reflect the higher costs of service provision can be combined with competitive tendering arrangements.

There are also quality risks where consumers have difficulty assessing the quality and safety of a service. This risk is compounded where there are high costs associated with changing a service provider. As discussed in section 4.2, these risks can justify government intervention. However, any intervention must be carefully designed to not raise costs without a commensurate reduction in risks. These costs are not just financial in nature. Regulation that erodes choice and control, reduces recognition of the value of carers, or reduces the flexibility the industry can offer its workers, can also impose costs. A recent United Kingdom report titled *'Nothing Ventured, Nothing Gained': Risk guidance for people with dementia*, explored balancing the positive benefits of taking risks against the negative effects of attempting to avoid risk and said:

Risk enablement goes beyond the *physical* components of risk, such as the risk of falling over or of getting lost, to consider the *psychosocial* aspects of risk, such as the effects on wellbeing or self-identity if a person is unable to do something that is important to them, for example, making a cup of tea. (DOH 2010a, p. 9)

Imperfect markets may well deliver better outcomes for the community than would be achieved through additional government intervention. In many situations, individual consumers are best placed to decide what is in their best interest, and importantly, be able to take responsibility for their decisions, even when they do (sometimes) make less than 'optimal' decisions.

The funding and regulatory arrangements for the delivery of aged care services to older Australians must find the right balance between market forces and government intervention to manage risks while encouraging the efficient provision of services. The funding formula needs to be affordable and considered fair within

and across generations. There is no one right balance — it depends on the overall preferences of the community, its appetite for control and for risk, and the importance attached to equity.

Care and support needs to be affordable for those requiring care and for society more generally.

Funding arrangements for care and support should encourage broadly even contributions between groups over time (that is, promote intergenerational equity) and provide incentives to ensure Australians are getting the most out of the resources devoted to the care and support of the elderly.

RECOMMENDATION 4.1

To guide future policy change, the aged care system should aim to:

- ***promote the independence and wellness of older Australians and their continuing contribution to society***
- ***ensure that all older Australians needing care and support have access to person-centred services that can change as their needs change***
- ***be consumer-directed, allowing older Australians to have choice and control over their lives and to die well***
- ***treat older Australians receiving care and support with dignity and respect***
- ***be easy to navigate, with older Australians knowing what care and support is available and how to access those services***
- ***assist informal carers to perform their caring role***
- ***be affordable for those requiring care and for society more generally***
- ***provide incentives to ensure the efficient use of resources devoted to caring for older Australians and broadly equitable contributions between generations.***

4.4 Criteria for assessment

Based on the wellbeing framework discussed above and the Government's stated objectives for the current system set out in the *Aged Care Act 1997* (chapter 2), the current system for care and support for older Australians should be assessed against the criteria of: equity (access), efficiency, effectiveness (choice, quality, appropriateness) and sustainability. The Commission's proposed reforms have also been developed based on the wellbeing framework and these criteria. Each of the criteria is examined below.

Equity

Equity is a multifaceted concept. In the context of access to care and support, equity has several dimensions.

- *Equity of financial access* — that access to care is not denied because of an individual's inability to pay. Subsidies and co-contributions (based on income and asset tests) should be based on ensuring that care is affordable for those who need it, having regard to their ability to pay and the ability of society more generally to fund the subsidies.
- *Equity of physical access* — that the necessary physical and human resources for the provision of care are available in a suitable location. This does not mean, however, that it is inappropriate for the range of aged care services to vary in response to the cost of delivering these services or the number of individuals seeking a given service in a particular location.
- *Equity in terms of standards of care* — that the care provided meets a benchmark standard of care that addresses the needs of each person. This does not rule out allowing people to pay for additional services over and above acceptable quality standards.

Equity of access also has a dynamic dimension. It is not only important when an older person first accesses care and support services, but also as the person's circumstances and needs change over time.

There is also the issue of 'fairness' or equity in terms of who pays for aged care and providing protection against excessive or catastrophic costs of care.

Efficiency

The efficiency criterion is essentially about getting the most out of the limited resources devoted to aged care, so as to maximise overall welfare and living standards. Efficiency has a number of dimensions.

- *Allocative efficiency* — requires that funding arrangements provide incentives for achieving an allocation of resources among the different modes of aged care (and between health and other related services) that produces the combination which best meets users' demands and results in an efficient overall level of aged care spending. Allocative efficiency depends primarily on resources being used where they are valued most — this is problematic in the current system where prices may not always be an adequate reflection of value.

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- *Technical efficiency* — involves the delivery of an appropriate level and quality of care with the least use of resources. The system needs to provide incentives for providers and users to encourage the efficient delivery of services and avoid the wasteful consumption of care services.
 - *Administrative efficiency* — involves designing regulatory and funding arrangements that avoid unduly complex or ambiguous procedures and rules. Unnecessary complexity gives rise to avoidable costs for providers and consumers alike.
 - *Dynamic efficiency* — refers to the capacity to improve efficiency over time. This can mean finding better products (or more highly valued products) and better ways of producing goods and services. It can also refer to the ability to adapt quickly, and at low cost, to changed (and changing) economic and social conditions.

Effectiveness

Effectiveness covers choice, quality and appropriateness of services in relation to needs. It refers to the extent to which the outputs produced by the system lead to the outcomes desired by individuals and the wider community.

Funding and regulatory arrangements must be able to support standard benchmarks of care and facilitate the maintenance of quality standards over time. Achieving these benchmarks of care is also dependent on having access to a sufficient and appropriately trained workforce.

Sustainability

In the context of an aged care system, sustainability can be thought of broadly as the ability over the longer term to provide services of an appropriate standard and in a way that meets community expectations in relation to their accessibility, affordability, and quality. Sustainability has a number of dimensions.

- *Fiscal sustainability* — the extent to which financing arrangements can accommodate projected changes in the number of older Australians (in absolute and relative terms) requiring care over the longer term and changes in the value of that care.
- *Provider sustainability* — the financial viability of aged care providers in the long term. Under current arrangements, aged care providers operate within a highly regulated environment and the design of regulatory and funding

arrangements should not undermine the financial viability of providers or distort signals for new investment.

- *Workforce sustainability* — the ability of the aged care industry to attract and retain people with the requisite skills needed to provide the level of quality care expected by the community. This dimension of sustainability focuses on whether future models of care are able to be supported by the available workforce.
- *Social sustainability* — the ability to maintain social harmony within the community concerning the fairness of the distribution and use of available resources.

Assessing the achievement of the objectives in practice

The overarching objective of providing care and support to older Australians that enhances their wellbeing is only useful to the community if governments can, in a practical sense, assess whether this objective is being achieved. In practice, this requires that objectives are clearly identified along with indicative guides to desired outcome measures to facilitate an effective assessment of the system's performance.

Table 4.1. sets out some indicative outcome measures against the stated objectives of Australia's aged care system.

The next chapter assesses the current aged care system against these indicative outcome measures.

Table 4.1 Some indicative outcomes measures against proposed objectives of Australia’s aged care system

<i>Objectives</i>		<i>Some indicative outcome measures</i>
To promote independence and wellness of older Australians and their continuing contribution to society	⇒	Measures of individual functioning, reduced rates of some disabilities and need for assistance with daily living activities. Intensity of care, reduced ‘continuous’ use of community and residential care, lower hospitalisation rates. Higher social participation, lower rates of depression among older Australians.
To ensure that all older Australians needing care and support have access to person-centred services that can change as their needs change	⇒	Measures of unmet need, waiting lists (assessment, care and support), use of care and support by different groups (Indigenous, regional, special needs access). Better continuity of care, greater emphasis on restorative care, rehabilitation, improved satisfaction.
To be consumer-directed, allowing older Australians to have choice and control over their lives and to die well	⇒	Capacity of older Australians to self-direct funding (if so chosen) and to choose services within entitlements and to choose providers. Perceptions of choice, control and satisfaction. Reduced complaints about service.
To treat older Australians receiving care and support with dignity and respect	⇒	Improved satisfaction of older Australians with care and support provided. Reduced complaints about service.
To be easy to navigate, with older Australians knowing what care and support is available and how to access those services.	⇒	Improved satisfaction of older Australians and their families in terms of ease of access to information. Greater certainty for individuals about the cost of care.
To assist informal carers to perform their caring role.	⇒	Access to respite care, lower rates of depression/improved wellbeing of carers.
To be affordable for those requiring care and for society more generally.	⇒	Affordable co-payments, protection from catastrophic costs and a fair balance between public and private contributions. Fiscal sustainability.
To provide incentives to ensure the efficient use of resources devoted to caring for older Australians and broadly equitable contributions between generations.	⇒	Costs per unit of output, lower rates of multiple assessments, savings on future costs, more cost-effective use of technology, lower costs of complying with regulation.

5 Assessment of the current aged care system

Key points

- There are many positive attributes to Australia's aged care system, notably the large number of services delivered each day, the range of services that are offered, and the quality of most of these services. However, the system is not functioning as well as it could in many areas.
- Many older Australians have difficulty accessing information, care and support.
 - The aged care system is complex and difficult to navigate.
 - Waiting times for low priority assessment services can be significant.
 - Services, including respite, can be difficult to access in the settings that older Australians and their carers prefer.
 - Access to medical practitioners and allied health professionals can be difficult.
 - Consumer choice and the ability of providers to offer continuity of care is limited by restrictions on the number of bed licenses and care packages and regulations governing the services that providers can offer.
 - There is a lack of continuity of services to respond to changing care needs.
 - There is a lack of incentives for providers to engage in restorative activities to maintain and improve the functional independence of older people.
- The pricing, subsidy and private co-contribution regimes are inconsistent and inequitable for clients both within, and between, care settings.
 - Some aspects of the pricing regime are not sustainable and, as a result, providers are not investing enough in these areas to meet demand — for example, in the provision of new non-extra service high care residential facilities.
- Aspects of the regulatory system are excessive, unnecessary and/or duplicative, resulting in high compliance costs for providers.
 - The focus of the accreditation and quality assurance system emphasises good process rather than good outcomes.
 - Several regulatory initiatives in recent years have imposed significant and avoidable regulatory burdens on service providers.
- Consistent with other reviews and inquiries, the Commission believes that Australia's aged care system is in need of fundamental reform.

The Commission heard from a number of participants to this inquiry that Australia's aged care system is 'world class'. For example, the joint submission from ECH, Eldercare and Resthaven stated:

International comparisons are often difficult to make but anecdotally at least, Australia is regarded as having one of the best aged care systems in the world. This is perhaps best interpreted in an overall sense rather than a consideration of any one aspect of aged care. ... it is fair to say that in Australia, almost every form of care and service is available, or potentially available, to the entire older population, with a markedly high level of quality and affordability. (sub. 453, p. 2)

Similarly, the Australian Association of Gerontology observed:

... there are elements of aged care in Australia that work effectively to deliver a world class system of care ... (sub. 83, p. 3)

However, many submissions to the inquiry identified significant weaknesses in the funding and delivery arrangements and pointed to where there was scope for improvement.

The chapter does not provide a comprehensive assessment of the aged care system. Rather, it focuses on the areas that offer the highest potential gains from reform. It assesses the system against the criteria of equity, efficiency, effectiveness (including choice, quality and appropriateness) and sustainability as set out in chapter 4. It looks first at access, continuity of care, choice, and unmet demand (section 5.1); then examines pricing, subsidies and co-contributions (section 5.2), and the considers regulation (section 5.3). It concludes with an overall assessment of the scope for improvements in efficiency and the need for further reform for the system to be sustainable (section 5.4).

5.1 Access, continuity and choice is limited

The Australian Government states that it:

... aims to ensure that all frail older Australians have timely access to appropriate care and support services as they age by providing: information assessment and referral mechanisms; needs-based planning arrangements; support for special needs groups and for carers; a choice of service types and high quality, accessible and affordable care through a safe and secure aged care system. (DoHA 2009e, p. xi)

Over 1 million older people received care and support in 2009-10 (chapter 2). The planning framework for care packages and residential places seeks to ensure that services are geographically distributed and that disadvantaged groups can access care through requirements on providers to meet the needs of particular groups.

However, the Commission heard many reports of people experiencing difficulties accessing and understanding information about the aged care system, and problems in accessing aged care services.

A key challenge in providing aged care services is ensuring that service providers have the flexibility and capacity to meet the level and diversity of demand for aged care services. Currently, the highly regulated system where aged care services are rationed via the planning and allocation system and via an eligibility assessment results in unmet demand for aged care services. In addition, restrictions on the types of services that can be offered in different settings affect the capacity of providers to offer continuity of care, particularly in community settings.

Accessing information and understanding the aged care system

Older Australians and their carers told the Commission that they have difficulty getting comprehensive and timely information about the aged care system, about their rights and responsibilities with regard to the services they can access, and about the level of co-contributions they are required to make. This was confirmed by providers. For example, the Villa Maria Society said:

A lack of information about aged care is a major barrier to accessing appropriate services. Many people are confused by the various community care programs and how they interact, while others faced with accessing residential care, often at a time of crisis, find the system very complex. Older people and their carers often highlight the following issues:

- Negotiation with a number of service providers
- Understanding the processes required to receive the services
- The number of separate assessments that may need to take place to receive different services
- Understanding the program under which the services are provided. (sub. 395, p. 14)

There is no comprehensive information portal that consumers can access — that is, one that can illuminate the aged care services available and the links between aged care and other welfare support systems. The Health Care Consumers Association of the ACT said:

The current system is complex. Whether it be the maze of accessing an ACAT [Aged Care Assessment Team] assessment, completing the 26 page Centrelink form, or trying to find providers of in home care, finding the information at the right time in order to make informed decisions is very difficult. Many are defeated by the challenge. We make choices about services without knowing how well they perform or whether they are appropriately located. Information is also difficult to find. Accurate, up to date and

plain English information needs to be centrally located and easily accessible. (sub. 326, p. 4)

The lack of clear and accessible information also affects the willingness of carers to engage with the formal aged care system. On this point, Carers NSW contended:

For the Australian aged care system to be accessible, the information needs of carers must be met. The provision of information must be simplified and improved so that older people and carers are informed of what services exist and how to access them. Carers should not have to spend time, energy and resources they do not have to find out what they need, nor should they ‘stumble’ upon services and supports long after they are first required. Accessing the necessary services should not depend on chance. (sub. 211, p. 7)

Another concern of older Australians from special needs groups, particularly those from Indigenous and non-English speaking backgrounds, is that information about the aged care system is not available in their native language. Dutch Care said:

Much has been said in recent years on the complexity of the aged care system. For the poor, or non-English speaker, negotiation of the aged care maze is even more difficult. Commonwealth government assistance in this regard is limited. (sub. 128, p. 6)

Waiting times for assessment services

Eligibility for Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) and EACH-Dementia (EACH-D) packages, transition care and residential care (including some respite services), is determined through the Aged Care Assessment Program (ACAP). While funded by the Australian Government, state and territory jurisdictions have responsibility for assessments which are undertaken by Aged Care Assessment Teams (ACATs or Aged Care Assessment Services in Victoria) at the local level.

A number of submissions pointed to significant variations in access to, and the timeliness of, assessment services for medium to high level aged care. The Older People’s Reference Group, for example, said:

Delays occur at many points on the hopscotch grid. There is often a waiting time of several weeks, even months, before someone is assessed by an ACAT team. (sub. 25, p. 5)

Similarly, Just Better Care noted:

In many areas throughout Sydney the waiting time for an ACAT assessment is six to nine months. The ACAT teams have been under-resourced for the past decade to deal with the growing numbers of older people they need to assess and the waiting times are unmanageable. (sub. 131, p. 1)

Access to restorative aged care programs can also be constrained because of delays in receiving ACAT assessments. As outlined by Janine Masso, this can mean an extended stay in hospital:

There are an increasing number of programs which require an ACAT assessment in order to gain access. This requirement can affect the timeliness of an older person entering the program and delay their discharge from hospital while they await the completion of the ACAT assessment. An example is the Transitional Aged Care Program. A very beneficial program for older people on discharge from hospital to assist in reconditioning and gaining increased strength but limited because of the requirement to have an ACAT assessment prior to admission to the program. (sub. 249, p. 2)

And delays in ACAT assessments can take their toll on both older Australians and their carers. This point was made by the Australian Medical Association:

In some jurisdictions, difficulty in accessing an ACAT assessment means it can take months before approval for respite care is given. In the meantime, sometimes the only option is to admit the patient to hospital in order to give the carer some relief. This causes great distress for patients and their carers ... (sub. 330, p. 3)

Aged care assessments are provided to those older Australians in most urgent need of services as determined by a prioritisation process. Over half of all ACAT referrals are Priority 1 or 2 — that is, the expected timeframe between referral and first intervention is within 48 hours and between 3 and 14 days respectively. While over 83 per cent of first interventions were completed ‘on-time’ for Priority 1 and 2 referrals in 2007-08, there was considerable variation between jurisdictions at both priority levels (table 5.1).

The most recent data from the National Data Repository (NDR) shows that the average length of time from referral to the first face-to-face contact was 22 days across Australia, ranging from nine days in Tasmania to 31 days in Queensland (table 5.2). Between 2003-04 and 2007-08, the average length of time between referral and first face-to-face contact increased from 18 to 22 days (NDR 2009).

Data also indicates that some older Australians have to wait extended periods for an assessment after a referral has been made, especially those deemed low priority. High and medium priority referrals (that is, Priority 1 and 2) are attended to relatively quickly with the median length of time between referral and first face-to-face contact being 0 and 4 days respectively (table 5.1). However, non-urgent low priority referrals (defined as priority category 3) may take much longer to progress. These low priority referrals account for around half of all referrals and, if it is assumed that all high and medium priority referrals are attended to in a reasonable length of time, one in five lower-priority referrals take more than 57 days before face-to-face contact is made (table 5.2).

Table 5.1 Length of time between referral and first intervention by priority category, 2007-08

	<i>Mean days</i>	<i>Median days</i>	<i>Percentage 'on-time'</i>
<i>Priority 1 (<48 hours)</i>			
NSW	2.6	0	85.2
Vic	1.2	0	90.0
Qld	3.0	1	79.0
SA	4.8	1	70.2
WA	1.3	0	89.1
Tas	0.7	0	90.0
NT	1.8	0	95.0
ACT	2.7	0	85.6
Australia	2.6	0	83.2
<i>Priority 2 (3 to 14 days)</i>			
NSW	13.0	4	77.3
Vic	5.1	2	92.1
Qld	9.9	6	82.6
SA	11.3	4	85.4
WA	6.4	4	88.3
Tas	6.5	5	88.5
NT	8.7	5	80.3
ACT	4.2	1	95.8
Australia	9.7	4	83.6

Source: NDR (2009).

Table 5.2 Length of time between ACAT referral and first face-to-face contact, 2007-08

All referrals

	<i>Mean days</i>	<i>Median days</i>	<i>90th percentile (days)</i>
NSW	24.8	9	71
Vic	18.4	12	45
Qld	31.1	15	84
SA	22.0	7	48
WA	12.8	8	32
Tas	9.1	7	21
NT	13.6	8	33
ACT	21.5	7	58
Australia	22.2	10	57

Source: NDR (2009).

Although the Australian Government funds the ACAP, it is operated by the states and territories. Such arrangements can create an incentive for the states and territories to give priority in assessment to people who are using their funded

services, particularly relatively expensive and limited acute care (hospital) services. A comment to the National Review of Aged Care Assessment Teams noted that ‘many “urgents” are actually urgent for the hospital not the client’ (Communio 2007, p. 44).

One of the constraints on the capacity of ACAT teams to undertake assessments is the level of funding allocated to the program. However, if the capacity to undertake assessments was increased without a commensurate increase in aged care service availability, there would be greater numbers of older people on a waiting list for approved aged care services.

Access to care services

Most low intensity support services (mainly Home and Community Care (HACC)) are block funded. Providers assess clients for need and allocate services on a prioritised basis within their budget limitations. By contrast, access to community care packages and residential care is restricted by the aged care planning and allocation system and by ACAT-determined eligibility.

While restrictions on the supply of aged care services are a way of managing the Australian Government’s fiscal exposure, they can result in older Australians failing to receive the aged care services they require in a timely manner. Submissions from individuals and providers suggest that some older Australians are waiting excessive periods to access the care services they need in both residential and community settings. The Australian Asian Association of Western Australia, for example, said that the availability of beds in residential care in that state:

... are not at all related to the needs of the ageing which has resulted in both CACP & EACH clients having to wait long periods of time to access any residential care let alone care of their choice. These long waiting periods also means that their urgent care needs are not met with the limited hours and services that can be provided under CACP. (sub. 188, p. 2)

Submissions suggest that waiting times for community care packages are the longest. Willoughby City Council said that:

... North Sydney has had unmanageable and inhumane waiting times for CACPs, EACH and EACH-D packages. Waiting times range from 6 months to 18 months, with EACH and EACH-D recipients waiting the longest periods.

Due to the lengthy waiting time for packages HACC service providers have been required to continue to provide services to clients who require a higher level of care. Duty of care requirements for HACC staff are often exceeded and older people assessed as requiring a high care level of service are struggling to survive at home.

Many of these people pass away or are forced into [residential] care before their packages become available. (sub. 50, p. 2)

Other participants suggested that ACATs refer people to those services where they know there are vacancies despite the package not meeting the person's care requirements:

ACATS refer clients to those services where they know there are vacancies. For example we have numerous cases where clients are referred for a CACP, yet on assessment it is revealed that they are actually high care and require EACH. We can sometimes go above our benchmarked hours/week, and top them up with NRCP to keep them going until an EACH becomes available, but tight budgets and accountability requirements often do not allow this. Invariably some people are forced to move to residential care. (Provider's comment in Catholic Health Australia, sub. 217, p. 7)

Excessive delays in accessing care and support services undermine the objectives of the aged care system and can reduce the quality of life of older Australians and their carers. However, there are no guidelines on what is an acceptable time to wait to access aged care services after eligibility has been determined by an assessment.

Data indicates that under half of all older Australians accessing aged care services did so within one month of their most recent ACAT assessment in 2009-10 (table 5.3). The only exception is for entry into high level residential care, where 51 per cent of eligible clients accessed this service within one month of their ACAT approval.

Table 5.3 Length of time between ACAT approval and entry into a care program (residential and community settings), 2009-10

	<i>High care</i>	<i>Low care</i>	<i>EACH</i>	<i>EACH-D</i>	<i>CACP</i>
2 days or less (%)	10.8	5.2	4.3	5.0	4.4
7 days or less (%)	24.9	12.0	10.6	12.7	11.4
Less than a month (%)	50.9	32.0	31.5	41.6	38.8
Less than 3 months (%)	76.4	63.3	59.7	70.7	69.7
Less than 9 months (%)	92.3	91.0	87.6	93.7	94.4
Median time (days)	29	61	64	41	45
Total number (program entrants)	19 726	16 426	3 459	1 863	18 890

Source: SCRGSP (2011).

There is also considerable variation in waiting times between jurisdictions. For example, there are proportionately fewer people entering residential services within one month of ACAT approval in Western Australia but proportionately more entering community care programs, compared to Australia as a whole (table 5.4).

Table 5.4 Proportion of clients entering a program within one month of ACAT approval, 2009-10

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^a</i>	<i>Aust</i>
High care	52.5	57.8	46.0	45.1	44.3	55.7	34.7	22.1	50.9
Low care	30.4	36.5	32.1	28.6	26.3	48.4	18.4	25.6	32.0
EACH	26.0	25.3	37.0	41.2	29.3	27.2	36.4	66.1	31.5
EACH-D	33.9	32.8	53.2	57.7	33.8	38.8	54.5	66.7	41.6
CACP	27.8	32.7	52.0	60.4	37.2	32.9	37.3	51.8	38.8

^a NT data are based on the experience of a small number of residents and may not be representative of the experience of NT residents over time.

Source: SCRGSP (2011).

Variations in waiting times are not even uniform between nearby locations. Southern Cross Care (Tasmania) highlighted that:

As far as Community Aged Care Packages (CACP's) allocations in Tasmania are concerned, some areas continually have empty packages while others have huge waiting lists. Southern Cross Care's north west coast services often have empty packages with no one on the waiting list; yet in Hobart the waiting list for 40 packages is currently 134. (sub. 267, p. 8)

However, this evidence should be interpreted with caution as there may be a number of reasons why older Australians do not enter the services for which they are approved, including:

- the data only includes people who have been allocated a package or place, not those who are still waiting or those who have died before accessing care
- as some ACAT recommendations are only valid for a limited period of time, it is unclear whether the data captures the elapsed time between the initial instance that a person was approved for care and when care is actually accessed
- some people do not accept the first offer of a package or residential care place. In those instances, the elapsed time between the ACAT assessment and placement would include the time people wait for an offer of placement as well as the time people wait for placement with their preferred provider.

It is also unclear whether differences in waiting times for access to aged care services are due to the planning and allocation mechanism, variable conduct of the

ACAP in different regions, or a combination of both. Blue Care explained that the differences in waiting times were the result of a combination of supply constraints and the approach taken by each assessment team:

ACAT referral processes vary across jurisdictions. Some ACATs ‘hold’ approved clients until a local service provider has the capacity to take the new referral. In contrast, other ACATs simply complete the assessment and notify multiple service providers, who then collectively ‘hold’ the new referral themselves until a place is available. (sub. 254, p. 58)

Restrictions on the supply of aged care services create inefficiencies beyond aged care, particularly for the health care system. For example, the *National Health and Hospitals Network: Further Investments in Australia’s Health* reported that:

In 2006, about 2,400 patients eligible and approved for aged care and no longer requiring care in hospital were waiting in a hospital bed for an aged care place to become available (‘Long Stay Older Patients’), with 63 per cent waiting in hospital for more than 35 days. (Australian Government 2010b, p. 68)

Access to respite services

Respite enables carers to have a break from their caring role. Having access to respite services, particularly emergency respite, is an important factor in the decision of many carers to continue in this role. Carers of older Australians and consumer advocates indicate that they have difficulty in accessing appropriate and timely respite services. For example, Eva Gross noted:

In terms of carer support, residential respite care is often not easy to access unless well-planned in advance, though the need often tends to arise suddenly (e.g. the carer suddenly becomes unwell), due to the limited number of beds set aside for respite purposes. In terms of community respite, demand way outstrips supply and waiting lists tend to be extensive. Whilst carers wait for relief, via residential or community respite, the risks of them burning out increases. (sub. 435, p. 7)

The relative inflexibility of programs designed to support informal carers may also restrict access to respite.

The greatest problem is that some frail seniors are not able or do not wish to access day respite programs that provide socialization because they have received EACH or [CACPs] packages and are not allowed access to the HACC funded service. Domestic care such as cleaning, laundry, shopping and help with meals and personal care ... (help with dressing, eating and toileting) are prioritized ahead of social participation as would be expected. The pity is that social participation provides many health benefits that may require less reliance on medication and personal care. (Sherwood Respite Services, sub. 399, p. 2)

Further, Alzheimer's Australia expressed concerns about respite for informal carers of people with dementia:

One of the main barriers to accessing respite services is a lack of flexibility and choice. This includes flexibility in when the respite is available, where the respite is provided, and what types of activities are included in the respite care.

... there is a need for specialist dementia respite care services that respond flexibly to the needs of both people with dementia and their family carers at any stage of the dementia journey. (sub. 79, p. 18)

Indeed, the Department of Health and Ageing (DoHA) acknowledged that there are some issues with the current suite of respite supports. For example, a

... situation can arise that a client of a respite provider may seek additional respite from their provider, but the provider is unable to meet this need even though they have spare capacity, because that spare capacity is related to a separate funding initiative with a different target group. This is clearly suboptimal for both the client, who cannot access the respite they need, and the provider, who is required to return the funding for the unused respite to the Commonwealth while meeting the fixed costs of operating their service. (sub. 482, p. 49)

Choice in relation to services

Many participants pointed to the lack of choice and flexibility resulting from the rationing of care places under the current planning ratios. The Victorian Government called for the planning process to be:

... more responsive and flexible to reflect demographic changes and changing client needs, as well as changing sector demands. ... Commonwealth planning and allocation processes for all aged care services need to be reviewed to ensure there will be sufficient supply and an optimal mix that can meet forecast need, recognising both the growing demand for community care and the importance of avoiding unnecessary admission into residential aged care. (sub. 420, p. 22)

Perth Home Care Services argued that the planning ratios were 'outdated':

The methodology of population ratios used for planning is outdated. It was developed on the basis of two residential service types i.e. hostel and nursing home. Over time it has expanded to 4 service types, CACP, EACH, Low Care and High Care but these are still based on residential care. It is recognised that aged care is a continuum from low level community care to high level residential care with many points along the way. Ageing in place is a fundamental principle and is not consistent with the 4 service types named in the ratio model. People move in and out and up and down the continuum. (sub. 398, p. 3)

Baptist Village Baxter highlighted the implications for care recipients of a shortage of care places:

The client, if they wish to receive subsidised care services, firstly must satisfy the eligibility criteria established by the Government (through the Aged Care Assessment Teams) and then find a care provider willing to admit them into residency. The willingness of the provider is based upon current waiting lists, ability of the person to contribute to the capital costs (through payment of an accommodation bond or meet 'exempt bed' requirements), the level of care to be delivered and other stipulations. In reality, the consumer has little effective choice in this process as most aged care providers have few vacancies, which results in the client placing their name on many waiting lists, often far removed, from their ideal location.

If the client chooses to receive care in their existing home, again they must approach the approved providers of community based services in the region and (often) place their names on a waiting list. (sub. 170, p. 3)

Potential care recipients seeking a care place or package, especially at the high level end of care, often do so following an event or sharp deterioration in functionality. As such, finding a place or securing a package often involves a sense of urgency. And, for those seeking residential care, the search is usually confined to a particular geographical area. With high occupancy rates (in excess of 90 per cent) common in residential aged care facilities, care recipients can have very few options available to them.

Under the current planning ratios, just 22 per cent of Government-subsidised aged care places are for care services delivered in the community (DoHA 2010n). According to Catholic Health Australia, this compromises care recipients' choices:

The rationing of overall places means that not all older people assessed as being in need of aged care have an equal opportunity for timely access to services. Also, the current regulations which limit the choice of community aged care to 22 per cent of the aged care places provided under the planning ratios means that older people are effectively being denied equal opportunity to choose whether they receive care in their own home or in an aged care home, or the security of knowing that as their care needs change, they will have the option of continuing to receive care in their own home. (sub. 217, p. 7)

And, the evidence suggests that demand for formal care packages in community care is higher, relative to residential care, from those older Australians assessed as eligible for care. Across Australia, only 32 and 22 per cent (respectively) of the number of people approved for CACP and EACH packages were admitted to a package compared to 35 per cent and 49 per cent for low and high level residential care respectively in 2008-09 (table 5.5). This comparison of admissions in the following year relative to approvals over the previous 12 month period suggests that there is significant unmet demand for aged care services, notwithstanding the

limitations of using ACAT approval data as a measure of unmet demand (chapter 3).

The current rationing of care places also reduces the incentives for providers to innovate and to respond to demand more generally. This will become more pronounced as the Australian population ages and the demand for aged care services increases significantly. As discussed in chapter 3, the baby boomer generation will have the financial capacity and the inclination to demand greater control and choice of aged care services.

Table 5.5 First-time admissions as a per cent of first-time ACAT approvals

2008-09 admissions as a per cent of 2007-08 ACAT approvals

	<i>Community care</i>			<i>Residential care</i>		<i>Total</i>
	<i>CACP</i>	<i>EACH</i>	<i>EACH-D</i>	<i>Low care</i>	<i>High care</i>	
NSW	27	19	63	35	50	36
Vic	45	23	54	37	49	42
Qld	33	22	41	33	47	37
SA	28	22	36	28	55	36
WA	30	24	44	34	41	35
Tas	47	38	76	56	53	53
NT	29	88	85	52	32	38
ACT	24	21	33	32	44	31
Australia	32	22	51	35	49	38

Data sources: NDR (2009); SCRGSP (2010b).

While a gatekeeper plays an important role in controlling access to public subsidies, aged care services should be targeted to those with assessed needs, not wants. But within this there is scope to do better to match the preferences of older Australians, particularly for remaining independent and living in their own home. Constrained competition and restricted choice for care recipients can be addressed by reducing and ultimately removing controls over the number of community care and residential places. A number of recent reviews have argued the need to remove the restrictions on the number of community care and residential places (box 5.1).

Reforms aimed at increasing consumer choice, flexibility and access are discussed in chapters 7 and 9.

Continuity of care

Restrictions on the number and scope of services that providers can offer also reduce the capacity of providers to offer continuity in care service delivery, particularly in community care. The result is a care system that is fragmented and constrained in its ability to meet the aged care needs of older Australians. Some older Australians are forced to change care providers to access higher levels of care if their current provider cannot offer the service or does not have a place available.

Box 5.1 Limiting supply of care places comes at a cost

Limiting the supply of care places, while helping to manage fiscal risk for government spending (notwithstanding the gatekeeping role performed by ACATs) also limits competition which in turn reduces choice for users and dampens the incentive for providers to operate efficiently and to be innovative. Recent reviews point to the benefits of removing supply constraints on aged care places.

The National Health and Hospitals Reform Commission (NHHRC) recommended:

... that the current restrictions on the number of aged care places an approved provider can offer be lifted. This means good aged care providers will be able to take as many people as wish to use their services, and older people will no longer have to accept the only place they can find. Aged care services will compete with each other to attract older people. Older people who are unhappy with their care will find it easier to shift to a different service. (NHHRC 2009, p. 109)

The Productivity Commission (PC) in *Trends in Aged Care Services: some implications* said:

The planning and allocation system effectively lessens competition between providers, thereby reducing incentives for cost consciousness, efficiency improvement and innovation in service delivery. Relaxing this barrier to entry would create more competition in the market for aged care services. (PC 2008, p. 190)

And, in the *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services*, that:

... the Government should consider possibilities for relaxing supply constraints in the provision of aged care services as a means of improving the quality and diversity of services and reducing the reliance on regulation and the need for price controls in areas where there is effective competition. (PC 2009a, p. 30)

The *Review of Pricing Arrangements in Residential Aged Care* noted:

Restraints on the allocation of bed numbers reflect also a fiscal restraint designed to reduce a government's exposure to unbounded future expenditures. The effect is to limit severely the choice of facilities available to users of services. When the industry operates at about 96 per cent of its capacity as measured by beds occupied, as it does at present, there is no more than 'Hobson's Choice' around Australia for users of services. (Hogan 2004b, p. 19)

The Commission heard of some care recipients choosing to receive inappropriate aged care services because they were reluctant to change personal carers — for example, some people stay on HACC when they are eligible for CACP or EACH(-D). As a result, HACC providers may experience increased demand for services if older Australians are unable to access high level community care services, are unwilling to change carer, do not wish to pay higher co-contributions or are unwilling to enter residential care (where a community care place is not available). Redfern and Inner City Home Support said:

The Interface between HACC and CACP can be difficult. Clients who receive a range of HACC services are often reluctant to go on to a CACP because they lose the social aspects of their care. They lose the community relationships that have been fostered through HACC services. (sub. 348, p. 2)

Community care packages are only available in discrete blocks which often do not reflect the level of an individual's need. Many participants spoke about the affect of the gap between CACP and EACH packages on continuity of care. For example, Shirley Anderson said:

CACPs packages provide around 5–6 hours of direct assistance per week. EACH packages provide between 15–20 hours of assistance. I do not find the CACPs quite enough assistance, but it does not seem logical to jump from 5–6 hours of care and then to suddenly seek 15–20 hours. Deterioration is often a slow process. I think what really happens is that carers really struggle for too long on the CACPs package. (sub. 60, p. 2)

The South Australian Government argued:

... there needs to be improved coordination and integration in policy and service system development between the various programs (i.e. Home and Community Care (HACC), National Respite for Carers and other Commonwealth carer support initiatives and Commonwealth packaged care) ... The lack of continuity in care between HACC, Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH and EACH D) is perhaps the most significant issue for community care. (sub. 336, p. 4)

Continuity of care is less of a problem in residential care where the Australian Government has introduced 'ageing in place', whereby low care residents can remain in the same facility as their care needs change (depending on the capacity of the provider to meet these increased care needs). However, there are other aspects of care continuity, such as high staff turnover, that may result from inadequate funding or poor management practices.

Restrictions on the capacity of providers to offer greater continuity of care can affect other service interfaces, including through inappropriate admission to acute care and/or premature admission to residential care, resulting in inefficient use of resources and a reduction in the wellbeing of care recipients.

Lack of incentives for restorative care, rehabilitation and maintenance

One of the objectives of the *Aged Care Act 1997* is to provide aged care services that maintain and increase functional independence in older Australians. Many participants, however, argued that under current arrangements there is little focus on early intervention and the promotion of independence (box 5.2).

Box 5.2 Participants said a greater focus on early intervention and promotion of independence is needed

Occupational Therapy Australia:

Systems currently focus on people at risk of hospitalisation or admission to residential care. This results in reactive rather than proactive approaches to triage and management of wait lists. Interventions which enable consumers to remain active and independent generate downstream cost benefits and are a worthwhile investment. Occupational therapists strongly advise that responding to people's needs as they begin to develop activity restrictions and participation limitations is necessary, in addition to focussing on people with high support needs. (sub. 203, p. 11)

Bega Valley Meals on Wheel Plus:

The wellness or re-enablement model has been part of the Victorian HACC system for several years. For service users this may be a better model for providing choice and the possibility of leaving the HACC system if possible. Service users once in the system tend to stay, and this leads to dependency, lack of choice and an emphasis on their failings. (sub. 51, p. 4)

Meals on Wheels Association:

... a strategic shift in funding to prevention and early intervention and support will both delay and reduce absolute costs for both residential and acute care. (sub. 209, p. 1)

City of Port Adelaide Enfield:

As with other human services and health services, prevention and early intervention, is the most cost-effective way of providing effective services that contain costs for future generations. Provision of accessible community-based services is a cost-effective way of managing and delaying the demand on hostels and nursing-home beds, as well as medical services. (sub. 32, p. 1)

Further, there is little incentive for providers to invest in activities that promote the restoration of health and functional independence in care recipients as restoration generally results in a reduced care subsidy, particularly in residential aged care. As a general practitioner (GP) said:

... the current scramble that goes on in nursing homes to fudge figures so that patients can be classified with as many diseases as possible to get maximum funding is both an insult to the patient and an insult to the medical profession who it is expected will provide the evidence ... The patient 'who has more wrong with them' is more valuable to the institution in which they are being cared. (Peter Winterton, sub. 41, p. 2)

The Australian Nursing Federation (Victorian Branch) also indicated that:

There is a conflict of interest between aged care accreditation standards which encourage independence and ACFI [Aged Care Funding Instrument] which allocates funding based on dependence. (sub. 341, p. 116)

Similarly, S. Van Deventer noted:

The ACFI funding tool, contradicts the aged care accreditation standards. The standards require that we maintain a resident's independence for as long as possible, which often involves more time by the staff. It takes longer to walk with a resident (thus maintaining his independence) than what it does to transport a resident in a wheelchair, yet we are funded at a maximum for the wheelchair, rather than for supervising the ambulant resident. Therefore, this may not always be happening, as facilities do not have the staff to do this. (sub. 109, p. 1)

Others participants considered that greater emphasis on assistive technology and home modification services was required, as these services have the potential to assist older Australians to remain in community settings for longer periods than might otherwise be the case. According to the South Australian Government:

There is a focus and culture of providing maintenance and support in community care rather than the provision of adequate support for people to regain function and maximise independence. An increased focus on prevention, capacity and restorative approaches is essential, including an emphasis on assistive technology, equipment and home modification. This can be achieved through clearer service contract specification, reporting and building in financial incentives for preventative and restorative services. (sub. 336, p. 4)

The lack of emphasis on restorative care and maintenance, and prevention more generally, can be inefficient. That is, the return to public funding from such investments may more than pay for themselves in lower future costs of acute and aged care. There is emerging evidence that this is the case (chapter 6).

Difficulty accessing general practitioners and other health services

Strong relationships with the primary health system are important to providing quality aged care services. However, a number of submissions indicated that some older Australians, living in residential care facilities or in the community, have difficulty in attracting GPs to deliver services in these settings. The Australian Medical Association argued that GPs are reluctant to provide services because GPs:

... are the primary medical care providers for older people living in the community and form long term relationships with their patients and their families. They play a crucial role in managing and coordinating care for an older person. However current Medicare benefit arrangements do not reflect the time it takes to provide care to older people with chronic long term conditions and do not cover the costs of delivering medical care

outside of the doctor's surgery. As a result, home visits no longer feature in general practitioner care as much as they once did...

Adequate incentives must be developed, and access to nursing and allied health services must be improved, to support the medical workforce to provide medical care to older Australians living at home and in aged care facilities. (sub. 330, p. 1)

Aged care service providers and older people also indicated that they experienced difficulties accessing and attracting the services of physiotherapists, podiatrists, dentists, dieticians and other allied health professionals (Consumers Health Forum of Australia, sub. 287; General Practice South Tasmania, sub. 278). For example, the Victorian Day Therapy Centres Network said:

In Victoria DTC's have historically had difficulty attracting appropriately qualified Allied Health Professionals. Current funding means agencies that run DTC's are not able to offer salaries that are comparable with public health services and current market demand. (sub. 448, p. 2)

Some participants argued that part of the problem in accessing the allied health services is related to Medicare benefits restrictions. For example, the Dieticians Association of Australia stated:

The current chronic disease Medicare items are inadequate. Australians with a chronic disease can access five visits to allied health practitioners per year. These limited item numbers are currently shared across allied health professionals. People with a chronic disease often require multiple visits with a number of allied health service providers to achieve improved health outcomes and better management of their chronic condition/s. (sub. 371, p. 5)

Incentives to increase access to allied health services are inequitably aimed towards low care residents. As the Australian General Practice Network explains:

... a number of GPNs [General Practice Networks] following consultation with local aged care facility providers have directed their local implementation of the ACAI [Aged Care Access Initiative] towards supporting better access to dental care for residents, by brokering access to dental assessment and in some cases treatment for low care residents in RACFs. Dental Staff visiting facilities and GPN staff have noted the inequity in providing access to this vital service to only low care residents, when many facilities are unable to effectively do so for high care residents due to workforce shortages of dentists and dental hygienists and limitations in getting dental staff to travel to provide assessments of residents in the facility. (sub. 295, p. 7)

Poor access to medical and allied health services affects the capacity of the aged care sector to deliver timely and appropriate care, and can result in unnecessary pressure on other parts of the health system (chapters 9 and 10).

5.2 Pricing, subsidies and co-contributions are inequitable and distort investment

The Australian Government sets most of the prices that can be charged by providers, the level of subsidies and rates of private co-contributions. Providers have flexibility on the amount they can charge for accommodation bonds.

There are a number of inequities in the different pricing regimes between types of services and between care settings. Some violate the principle of treating people with the same capacity to pay equally, while others introduce distortions in choice. The levels of personal co-contributions are different for different services, people may pay different co-contributions for the same service despite having the same capacity to pay. For providers, the pricing of some services does not cover the cost of those services. This is a particular problem for accommodation charges and retention amounts, the behavioural domain under the Aged Care Funding Instrument (ACFI), and indexation of public subsidies for personal care.

Different levels of private co-contributions for services

Under the current pricing regimes, the Secretary of DoHA sets the private co-contributions guidelines for care services delivered in community settings and for accommodation, everyday living expenses and care services in residential settings.

Co-contributions across community care services are inequitable

While the Government does not set fees for community care packages (CACP, EACH and EACH-D), it does set a maximum level that providers can charge — all care recipients can be asked to pay a fee equivalent to 17.5 per cent of the single age pension. Recipients can also be asked to pay an additional fee of up to 50 per cent of their income above the pension. This contrasts with services under the HACC banner, where providers can charge users a small nominal fee (or even nothing if transactions costs of collecting the contribution are significant). These inequities have led to a number of participants urging a review of fee structures, including Southern Cross Care (Tasmania) which highlighted:

Contributions by the consumer to the cost of providing community care services needs urgent review. HACC and Veterans contributions have remained at a base level of \$10 per week since inception while other programmes such as Community Aged Care Packages (CACP) and Extended Aged Community at Home (EACH) Packages have a different fee structure. Often the level of care is the same but the fee structures bear no resemblance to each other. (sub. 267, p. 14)

The inconsistent requirements for co-contributions for equivalent services may result in older Australians being reluctant to move into formal aged care packages that better suit their needs, particularly if the co-contribution is likely to be higher (as may be the case if their income is significantly above the basic rate of the Age Pension). Baptistcare (WA) explained the reaction of consumers to the inconsistent pricing of community care services:

The complexity of the aged care system ... has led to a plethora of programs which overlap with differing eligibility criteria and differing levels of direct cost to the consumer ... this negatively influences client decisions regarding entering programs, based on solely economic considerations (lower fees) rather than need ... complaints arise when people move from HACC to Community Aged Care Packages (CACP) and sometimes result in people not accepting a CACP, which includes a 'care' element, in part because of the higher contribution. In maintaining their HACC services which might only provide 'domestic' services, they thereby deny themselves the 'care' that they are assessed as needing. (sub. 426, p. 2)

Different co-contributions for care in residential and community settings

Another inequity under the current pricing arrangements is that full-rate age pensioners in receipt of community care packages are asked to contribute to the cost of their care (as opposed to accommodation and everyday living expenses) while full-rate age pensioners in residential settings are not.

As noted, age pension recipients of formal community care packages may be asked to contribute up to 17.5 per cent of the basic Age Pension to cover their costs of care. Accommodation and everyday living expenses are paid from the balance of their pension and any other income or welfare support they receive.

By contrast, full-rate age pensioners in residential settings are not required to make any contributions to the costs of their care. The 'basic daily fee' of 84 per cent of their age pension is only a co-contribution to their everyday living expenses and accommodation. They cannot be charged any contribution to their personal care costs, even if they have equity in assets that could be drawn down.

Residents pay for different services depending on their care classification

Another inequity exists where the classification of residents between high and low care means that providers can charge low care residents for some care services and consumables that providers are expected to provide free of charge to high care clients.

St Johns Village Wangaratta noted that:

Cost of care services are different, for example, a resident in low care pays for allied health services compared to a resident in high care where facilities pay for the allied health service. (sub. 404, p. 3)

Low care residents are also expected to pay for incontinence pads and other aids and equipment that they require for their care while high care residents are not charged. These charges are levied regardless of the resident's income.

Different co-contributions for accommodation in residential settings

One of the most inequitable co-contribution issues is the variable pricing of accommodation services in residential settings.

Residents who enter as low care and all residents receiving extra services (regardless of their care needs) can be asked to pay an accommodation bond of any amount provided they are left with a minimum asset amount (currently \$39 000). The level of the accommodation bond is based on a resident's assets and does not necessarily relate to the quality of the accommodation.

The average level of accommodation bonds charged by providers exhibit substantial variations (table 5.6). However, these variations do not necessarily reflect the underlying costs of providing the accommodation. Not-for-profit (NFP) providers historically charge high extra services bonds but only operate a limited number of these beds.

Non-extra service high care residents, regardless of their means, do not pay an accommodation bond but contribute an accommodation charge which is currently capped at \$30.55 per day irrespective of the quality and location of the accommodation. As explained by a care recipient in the Catholic Health Australia submission:

I was assessed as needing to go into high care and the need was urgent. Despite the fact that I was living alone and wanted to have my own room and bathroom, I was told that I had to go into a four bed room. I subsequently found out that I had to pay the same for my bed with shared bathroom as my friend in a single room with an ensuite.

The DON [Director of Nursing] explained that the government sets the maximum price and it's the same for all residents regardless of the room configuration. (sub. 217, p. 8)

Table 5.6 Average new accommodation bond, by sector and extra service status, 2007-08 to 2009-10

	2007-08	2008-09	2009-10
	\$	\$	\$
Residents taking up non-extra services places			
Not-for-profit	169 608	194 758	209 797
For-profit	205 217	221 041	237 099
Government	135 122	164 951	162 559
<i>All sectors</i>	<i>176 625</i>	<i>200 362</i>	<i>215 175</i>
Residents taking up extra services places			
Not-for-profit	313 649	256 973	334 715
For-profit	230 709	259 037	281 070
Government	—	170 727	259 383
<i>All sectors</i>	<i>246 755</i>	<i>257 796</i>	<i>292 744</i>

Source: DoHA (2010h).

As bonds are not capped, many care recipients who pay large bonds contribute far in excess of the cost of the accommodation that they use — bonds in excess of \$1 million are not unusual. In many cases, providers use this revenue to cross-subsidise high care residents who make accommodation payments that are less than the cost of providing newly constructed accommodation. These arrangements are irrespective of the resident’s capacity to pay (chapter 7).

The current arrangements make many older Australians feel financially exploited on entering residential aged care. For example, a participant who did not wish to be named said:

I don’t feel it is fair for villages [residential aged care facilities] to charge people on the basis of their assets with no limit as to what they can charge. It is contrary to the usual way in which our society operates. I am sure we would think it very strange if we went into Harvey Norman to buy a heater and the salesperson asked us how much money we had before he answered the question. (sub. 58, p. 2)

The inequitable pricing arrangements for accommodation services also mean that wealthy older people with an ACAT assessment can effectively ‘buy’ their way into residential care, particularly extra services high care, in a relatively timely manner when those with less means have to wait for a place to become available.

Co-contributions for formal community care programs are not capped

Older Australians receiving formal community care services whose income is above the basic Age Pension rate may be asked to contribute up to 50 per cent of this

additional income (after tax and the Medicare levy have been deducted) (DoHA 2010c).

Effectively, this means that a client's contribution towards the cost of their care is not capped and not limited to the cost of the care that they receive. These design features for wealthy community care recipients are inequitable. By contrast, residential care contributions are capped at around half the maximum care subsidy and service recipients are not required to pay more than the cost of their care.

In reality, community care recipients have been able to negotiate a price with their service provider, so payment above the cost of the service would be rare. However, as information about co-contributions for formal community care services is not collected by governments, it is not known how many formal package recipients are contributing more than the basic age pension contribution and how many are contributing more than the cost of the services that they are receiving.

Pricing of services

Providers argued that some of the prices for aged care services set by DoHA are not adequate to cover costs. The result is that some providers are particularly reluctant to invest in maintaining and building capacity in the sector.

Accommodation charges and retention amounts

Many residential aged care providers advised that the maximum price set for the accommodation charge and public subsidies for accommodation in non-extra service high care do not cover the financing cost and depreciation of buildings and maintenance. Access Economics (2009a) estimated that accommodation charges need to be at least 50 per cent higher in order to cover these costs (that is, around \$43 per day compared to then current maximum charge of \$28.72). This situation has arisen because the maximum price and subsidy for ordinary high care accommodation has not been indexed at a rate that reflects increases in building costs for residential aged care.

These pricing restrictions are causing some providers to delay the building and/or refurbishment of non-extra service high care facilities. Others are not applying for new licenses to construct and operate ordinary high care beds because it is not viable to make such investments under the current pricing regime. For example, Catholic Health Australia noted that there:

... has been under allocation of residential high care places in recent Aged Care Approval Rounds (ACAR), and the handing back of allocated places (bed licenses). The under allocation of residential places in the 2009 ACAR was 1,915 places or 25%

of residential places advertised (5748 allocated compared with 7663 places advertised). (sub. 217, p. 9)

In the 2009-10 aged care approval, only 5643 of the 8140 proposed residential aged care places were allocated. The shortfall was made up by increasing the allocation of CACPs, EACH and EACH-D (DoHA 2010a; DoHA 2010p; Elliot 2010).

For services that charge accommodation bonds, pricing restrictions and time limits on the size of the retention amount can affect the capacity of some providers to cover the costs of depreciation and capital replacement.

Aged Care Funding Instrument (ACFI) domains

The introduction of the ACFI in 2008 was an important step in seeking to better align the residential aged care pricing and subsidises with the broad areas, or domains, for which older Australians require care. The three domains — activities of daily living, behaviour and complex care — are each funded at a low, medium or high level. DoHA determines the range of needs for each level, the scope of services required to meet these needs, and their cost of supply.

While the ACFI has generally been welcomed by industry as providing a sustainable funding platform for service delivery, the funding of the behavioural domain has been highlighted in some submissions as an area of concern for a few providers. As Mercy Aged Care explains, in relation to people with a disability who are ageing:

Funding under the aged care funding instrument (ACFI) does not recognise the complex clinical, behavioural and support needs of this population. This support often involves long periods of one on one staff time. The current (maximum) behavioural supplement of \$30 per resident per day provides less than one hour of direct staff time per resident per day associated with the management of behaviour and emotional support. Most residents in this group have significantly higher support needs. (sub. 221, p. 5)

Underpricing of the behavioural ACFI domain is particularly a problem where a service caters specifically for older Australians with behavioural issues but who do not have significant difficulties with activities of everyday living or do not require complex care. Wintringham, an NFP provider of support and aged care services to the homeless or those at risk of becoming homeless, have encountered an adverse experience with the transition to the ACFI:

The ACFI in its current guise acts as a powerful disincentive to any provider wishing to care for the elderly homeless ... Behavioural issues, which resulted in high overall RCS [Resident Classification Scale] claims, are not able to be claimed at the same rate under ACFI. Behavioural issues require vast amounts of staff time and patience, these care

requirements then ‘leech’ into the care provided in the other two ACFI domains, to an extent, governing how care is provided overall. The three ACFI ‘silos of care’ do not allow this to occur – for example, should resident be reluctant to shower, this is classified as a behaviour and can only be claimed in this silo ... In addition, in comparison to the other two ACFI silos (ADLs and Complex Health Care), the ... [ACFI] Behaviour ‘silo’ is poorly funded and cannot be easily adapted to acknowledge the high cost of catastrophic behaviours. (sub. 195, pp. 9-10)

As a result, Wintringham and other providers who deliver aged care services to older Australians with significant behavioural problems claim that it is increasingly difficult to operate sustainably under the current scheduled price in some ACFI domains.

Indexation

One of the factors influencing the viability of providers in residential and community settings is the level of indexation of prices and subsidies. A number of submissions claim that current base indexation levels for residential and community care services have been consistently less than the increase in the cost of providing services.

Residential care

Some of these cost pressures have been ameliorated in residential settings by a conditional adjustment payment. Yet even with this top-up payment, some providers, such as Catholic Health Australia, indicated that the arrangements are not sustainable:

The cost pressures facing nursing and personal care as the result of COPO [Commonwealth Own-purpose Outlays] indexation of the *basic care subsidy* and care-related supplements are reflected in financial performance surveys which show that margins are declining and a large proportion of providers are operating at a loss. (sub. 217, p. 10)

Other policy changes, such as Award Modernisation, have also affected the cost of providing services. As Kincare described:

The Award Modernisation process and recent pay rises have introduced new and challenging dynamics to this process. It is bringing better pay and conditions to employees in the industry which will help make the industry more attractive to staff. However, it has increased costs for community care providers by up to 10–15%. This is in stark contrast to indexation of around 1.7% in an industry already under strain from years of indexation not keeping pace with costs. Wages are the major input cost of community care. An increase of this size, this quickly, is impossible for organisations to absorb and will inevitably result in reduced services and further financial strain on providers. (sub. 324, p. 26)

Community care

A number of providers argued that, as a result of sustained underfunding, the number of hours of direct care delivered to clients under community packages has been reduced. According to Aged Care Queensland:

In community care, the hours of care being provided to clients have reduced significantly because funding levels no longer cover the true costs of care. The daily funding amounts for CACP's were first determined in the early 1990's and have only been subject to inadequate COPO indexation since that time. As a result CACP providers have gradually been forced to provide less hours of support. The average Community Aged Care Package previously provided 7 hours or more of support each week but now only delivers 5. (sub. 199, p. 14)

To the extent that indexation is insufficient, there will be pressure on providers to keep wages low, which is a major contributor to the unattractiveness of working in the aged care sector compared to health and other services sectors. Concerns in regard to the sustainability of the aged care workforce are dealt with in detail in chapter 14.

Differences in the taxation treatment between for profit and not-for profit-providers

The Commission's study *The Contribution of the Not-for-Profit Sector* (NFP Report) (PC 2010b) identified differences in taxation treatment between community service providers who were for profit and those that were NFP or government owned. For aged care, the Australian Government has recognised the differences in payroll costs faced by the for profit provider, with a subsidy to offset the costs of payroll tax. However, no adjustment to prices and subsidies is currently made for the differences in fringe benefit tax (FBT) treatment.

Most NFP providers are able to offer their workers a FBT free package of up to \$30 000 in non-salary benefits before these forms of compensation are subject to FBT. In addition, they can offer a meal entertainment exemption, which is uncapped. A number of submissions raised the inequity in the treatment of FBT as an issue of concern — Aged and Community Care Victoria (sub. 408), Cook Care Group (sub. 10), Martindale et al. (sub. 304), Pakary, Yalding and Hahndorf Holdings (sub. 308), Spakia (sub. 306), Salisbury Private Nursing Home (sub. 310), Tickled Pink Aged Care (sub. 301) and Woodville Nursing Home (sub. 298).

The NFP Report concluded that the FBT treatment did violate competitive neutrality principles in certain competitive human services areas including hospitals and aged care. Subsequently, the *Australia's Future Tax System* review recommended that FBT concessions for NFPs be phased out over 10 years (Henry

Review 2010). The Australian Government rejected this recommendation (Rudd and Swan 2010).

The extent of the competitive advantage provided by the different treatment for FBT is unclear as take-up rates by aged care workers are not known. The Commission reiterates the conclusion of the NFP Report that the FBT concessions should be phased out slowly to provide the sector the opportunity to adjust. Importantly, such a phasing out should be accompanied by government recognition of the full costs of providing community services, and that the benefits foregone should be redirected to the sector in more appropriate ways. In the event of a significant increase in aged care salaries, the efficacy of the FBT concession should be re-examined.

5.3 Regulatory burdens are excessive

The aged care system is characterised by high levels of government intervention and associated regulation. Restrictions on the planning and allocation of aged care services together with restrictions on prices, subsidies and co-contributions have been considered in previous sections. This section focuses on other regulations and associated burdens placed on providers in the delivery of aged care services, including accreditation and quality assurance.

Regulatory oversight is essential to protect older Australians, many of whom are vulnerable, and to ensure that public subsidies are not fraudulently claimed. However, some of the regulations imposed on the sector provide relatively little gain compared to the costs they impose. Costs arise where regulations reduce the efficiency of service providers or where they distort the nature of the services provided in ways that do not benefit the clients. The Commission's *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services* report (PC 2009a), which looked at the community services sector including aged care, and the NFP Report (PC 2010b) both identified a number of excess regulatory burdens in the aged care sector. In particular, efforts to reduce risk to residents, often in response to a single unfortunate (but well publicised) incident, have added to monitoring and reporting costs and constrained the nature of the activities services are willing to offer their clients.

Getting the regulatory balance right is not easy, but there is a strong case that in some areas the balance has tipped too far toward over-regulation to the detriment of the efficiency and effectiveness of the system.

Accreditation — focus on process rather than outcomes

One of the strengths of the Australian aged care system is that it is considered by both stakeholders and international peers to generally provide good quality services. The accreditation and quality assurance system is important in ensuring that care standards are maintained and improved.

One of the three reasons cited for the move from the Resident Classification Scheme funding model to ACFI was to reduce the level of documentation (DoHA 2009g). However, submissions indicated that there is still excessive reliance on documentation, which reduces the time staff can spend with the older Australians they care for. For example, the Council on the Ageing (Australia) (COTA) argued that:

... the accreditation process should not require substantially more paperwork than is required for normal business, clinical and care management needs. We have some sympathy with the view that quality accreditation processes in the health and aged care sectors have placed too much emphasis on excessive paper trails rather than on actual outcomes being achieved. (sub. 337, attachment 6, p. 7).

In a similar vein, UnitingCare Australia (UCA) (sub. 369) suggested that the system for accreditation and quality control be redirected away from a heavy focus on processes and inputs towards one which places greater weight on outcomes for older Australians. Similarly, the submission by Aged Care Crisis states:

A system which takes staff time away from residents in order to complete a myriad of bureaucratic tasks fails both residents and staff. Currently, documenting the minute details of a person's life seems to have become more important than actually helping them live their lives. Documentation and the keeping of records is an important part of care — as is developing well-formulated care plans. However, the current system is out of balance and the staff time spent on documentation rarely, if ever, appears to result in improved care. (sub. 433, p. 4)

In addition, Maree Bernoth wrote:

The way the accreditation process works currently, the aged care facilities that are delivering high quality care are disadvantaged because the process does not recognise this just as it does not recognise when poor quality care is given. Most facilities pass accreditation because managers and staff know how to subvert the process. It is not about care given, it is about having systems in place and on paper. It is irrelevant whether or not those systems are functioning because the real, tangible outcomes are not looked at, that is, the actual care delivered (or not) in the bathrooms and the bedrooms. (sub. 253, p. 22)

Too much emphasis on process and documentation adds to costs without commensurate benefit. Moreover it can 'crowd out' time and resources which could be devoted to other aspects of caring which enhance the wellbeing of older

Australians receiving aged care services — such as allied health services, music therapy, nutritional care (Dieticians Association of Australia, sub. 371), and grief counselling and spiritual support (Villa Maria Society, sub. 395).

Excessive paperwork was also cited as an impediment to attracting and retaining staff who are attracted into the industry by the opportunity to provide care, not to undertake clerical tasks (chapter 14).

Other excessive regulatory burdens

Over the last five years, there have been a number of government initiatives which have imposed significant burdens on aged care providers including, mandatory police checks, reporting of missing residents, and mandatory reporting of assaults. Like unannounced visits by the Aged Care Standards and Accreditation Agency (ACSAA), these may be part of a well functioning regulatory environment, but how they have been implemented is raising costs unnecessarily and limiting innovative alternatives. There are clear links between some of these regulatory imposts and high profile incidents that have seen highly prescriptive and onerous regulation introduced for all industry participants, regardless of whether the risk is systemic (could apply across all providers) or idiosyncratic (arising from the behaviour of a few providers).

Some providers were critical of what they perceive as an excessive regulatory regime and the associated compliance costs. For example, Blue Care said:

The Commission is well aware of industry frustrations with the inefficient and burdensome regulatory regime currently in place, and the corresponding suggestions from the industry to standardise quality/accreditation frameworks. For a large organisation like Blue Care, tapping into a multitude of government subsidies enables us to provide an extensive range of care options, but each funding program applies a separate set of standards, which amplifies our burden of compliance. Many of our community services are accountable for regulatory compliance under four external funding programs (i.e. HACC, DoHA, DSQ and DVA), and sometimes, accreditation is even applied at the sub-program level. The inefficiencies of managing our compliance activities across multiple programs are enormous. (sub. 254, p. 58)

The appropriate response to risk depends on the overall risk posed, the nature of the risk and whether it can be managed, and the consequences of failure to manage the risk. While any incident that negatively affects vulnerable individuals (and their families) is regrettable, a judgement must be made about whether the risk can be reduced and at what cost. Idiosyncratic risks are often best managed through an effective complaints mechanism that allows clients, their families and staff to raise concerns. Systemic risks are generally better managed through regulation, but the

costs need to be explicitly considered as do the benefits of reducing the risk. In the aged care sector, it seems that successive Australian Governments have tended toward a ‘zero tolerance to risk’ approach rather than adhere to the principles of good regulatory practice, including undertaking Regulatory Impact Statements to develop appropriate risk management regimes (PC 2009a).

Unannounced visits by the ACSAA

Some submissions from providers indicated that unannounced visits took up significant amounts of senior staff time at very little notice. For example, Southern Cross Care noted:

Spot checks are a serious cause of emotional worry to staff ... three assessors arrived at our Rosary Gardens facility without any warning at 9.15 am and remained there until approximately 5.00 pm. This sudden visit took up the time of senior staff at this aged care facility for the whole of the day. The unannounced visit was a ‘routine’ inspection and not related to any issue of concern. (sub. 267, p. 18)

DoHA signalled (in the Walton Review (2009)) that it will give consideration to changing the visits program as part of its broader review of accreditation processes.

Overlapping and duplicative regulations

Under the current regulatory system there is also a large amount of duplication, both within the Australian Government (between agencies) and between jurisdictions. Particular areas were highlighted by the Commission’s Regulatory Burdens report (PC 2009a).

In the case of complaints investigations, it is not uncommon for ACSAA and DoHA to undertake concurrent investigations into the same incident. Some of this duplication arises as both agencies have different responsibilities for ensuring the delivery of quality aged care services (PC 2009a). However, this split of responsibilities appears inefficient and there may be opportunities to streamline these processes.

While ACSAA (sub. DR763, p.11) accepts there is some confusion about the roles of ACSAA, DoHA and the Complaints Investigation Scheme (CIS), it also notes that it is appropriate that it receives information about a complaint when the CIS ‘believes the issue they are investigating may reflect a broader systematic issue’ in relation to accreditation. In 2009-10 ACSAA received 2138 referrals from DoHA.

There are also significant overlaps in regulatory requirements between ACSAA and state and territory governments, primarily over infectious disease outbreaks, occupational health and safety, food safety, nursing scopes of practice and building certification (PC 2009a). While overlapping regulations are inefficient, inconsistent regulations can create serious problems for providers.

The Australian Government has accepted that the burden from overlapping and duplicative regulation should be reduced, and has implemented the recommendations on fire safety declarations (chapter 12; Australian Government 2009a). However, it has yet to announce any other significant initiatives in this regard. Further discussion on duplicate and overlapping regulation is in chapter 15.

5.4 How much reform is required?

As outlined in previous sections, there are many aspects of the Australian aged care system that do not measure up well against the criteria of equity, efficiency, effectiveness (choice, quality, and appropriateness) and sustainability outlined in chapter 4. A summary of how the current system is performing against the criteria is given in table 5.7. The summary provides a broad indication of several areas where there is scope for reform. But perhaps the major challenge is the sustainability of the system in its current form.

Is the current system sustainable?

There is some evidence that the system is currently under pressure, raising questions about its long term sustainability. Rationing of supply means unmet demand, while underfunding puts pressure on providers, and those people providing informal care. These problems will only be exacerbated with the ageing of the Australian population and growing diversity of demand (chapter 3). The sustainability of funding for what is largely a publicly funded aged care system is discussed in chapter 6.

Table 5.7 Performance against the proposed objectives of Australia's aged care system

<i>Objectives</i>	<i>Areas for improvement</i>
To promote the independence and wellness of older Australians and their continuing contribution to society	→ There is little incentive for providers to engage in activities that promote the restoration of health and functional independence in care recipients as restoration generally results in a reduced care subsidy, particularly in residential aged care Access to home modifications is limited
To ensure that all older Australians needing care and support have access to person-centred services that can change as their needs change	→ There are significant variations in access to, and timeliness of, assessment services for medium to high level aged care. Delays in assessment for restorative aged care programs and respite care are a particular concern Restrictions on the number and scope of services that providers can offer reduces their capacity to offer continuity in care service delivery, particularly in community care Some older Australians, living in residential care facilities or in the community, have difficulty in attracting general practitioners (GPs) to deliver services in these settings. This is also the case for some allied health services
To be consumer-directed, the system should allow older Australians to have choice and control over their lives and to die well	→ Regulations and planning ratios can limit the capacity to providers to offer greater choice. Older Australians may be unable to access the services of their choice, such as accessing care in the community rather than entering residential care
To treat older Australians receiving care and support with dignity and respect	→ The Australian aged care system is considered by both stakeholders and international peers to generally provide good quality services. But emphasis on process and documentation to enforce standards reduces time available for greater face time with clients
To be easy to navigate, with older Australians knowing what care and support is available and how to access those services.	→ Reports of difficulty in getting comprehensive and timely information about the aged care system, understanding their rights and responsibilities with regard to the services they can access, and the level of co-contributions they are required to make
To assist informal carers to perform their caring role.	→ Carers of older Australians and consumer advocates indicate that they have difficulty in accessing appropriate and timely respite services
To be affordable for those requiring care and for society more generally. To provide incentives to ensure the efficient use of resources devoted to caring for older Australians and broadly equitable contributions between generations	→ Co-contributions vary across the different programs and can vary across clients with the same need and capacity to pay. Accommodation bonds and uncapped contributions to community care programs are inequitable and can exceed the cost of the service

There is evidence of underfunding

Concerns about the adequacy of care subsidies and the effectiveness of the current indexation arrangements were raised by care recipients, their families and providers. Consumer representatives have argued that the level of government funding is insufficient. For example, Carers Australia argues:

Caring is not financially sustainable for many carers and this is just one of the pressures that can increase the difficulty of providing care in the home. Carers currently carry an unfair burden of the cost of care for older people comparative to government expenditure on supporting their needs. (sub. 247, p. 16)

While COTA said that:

At the micro-economic level it is also becoming increasingly clear that there will need to be a significant increase in the resourcing of both community and residential care if the industry is going to be sustainable and if Australia is to continue to have good quality support and care that everybody can access ... Indexation of government subsidies [is] consistently below price inflators for both wages and goods and services, with almost no means for this to be compensated for by providers as user charges are tightly government regulated. (sub. 337, pp. 10-11)

According to a number of providers, inadequate subsidies mean that they struggle to provide quality care for residents and to attract and retain appropriate staff to provide the care expected. They also expressed concern about the ability of their staff to provide the social and emotional support to residents that is important to maintaining the quality of life of residents (funding is not provided for social and emotional support for residents and their families). And, as discussed above, the current system of indexation applying to public subsidies for aged care is regarded by many participants as failing to cover the cost increases faced by the industry.

Providers, if they are to remain in the industry, need to be adequately compensated for the cost of providing care. As the Victorian Government said:

Like any market, the 'price' paid for aged care services needs to be sufficient to both stimulate capital investment and meet the full, ongoing costs of operating services. (sub. 420, p. 5)

Blue Care also said:

Under-funding and inadequate indexation of subsidies has occurred for many years and can only continue for so long. In the long term, unless providers are compensated for the full economic cost of provision of service to supported residents, supply will be eventually withdrawn. (sub. 254, p. 10)

Blue Care estimated that residential care is currently under funded by \$15 per resident per day. Based on the current population in residential care and allowing

for income tested fees they estimated the underfunding to be around \$900 million annually (sub. 254).

If care subsidies are currently under-funded, ensuring subsidies accurately reflect the cost of supplying care would mean a larger public aged care bill. Funding must be adequate, but generous funding can reduce the incentives for providers to be innovative and continuously look for ways to reduce costs without compromising quality. It can prop up inefficient providers who may be providing poor quality care services. It also puts pressure on the Commonwealth budget as well as on individuals paying co-contributions.

The level of unmet demand is not known but could be high

The rate of approvals for residential care services exceeds the number of admissions, suggesting unmet demand for these services. However, assessments can be based on prospective (rather than current) need especially for those at the low care end of the spectrum whose needs are expected to accelerate with time. Howe et al. (2006), from an analysis of ACAT assessments, report that while the number of clients recommended for high level residential care is close to the number of admissions, the number recommended for low level care is almost twice the number of admissions.

In community care the evidence suggests a shortage of places — the 2008-09 funding application rounds for community care packages were oversubscribed, with the (then) Minister, Justine Elliot, reporting that the ‘aged care sector has sought 27 039 community care places for the 2784 places on offer’ (Elliot 2009, p. 1). Providers receiving HACC funding are required to ration their services to the available budget.

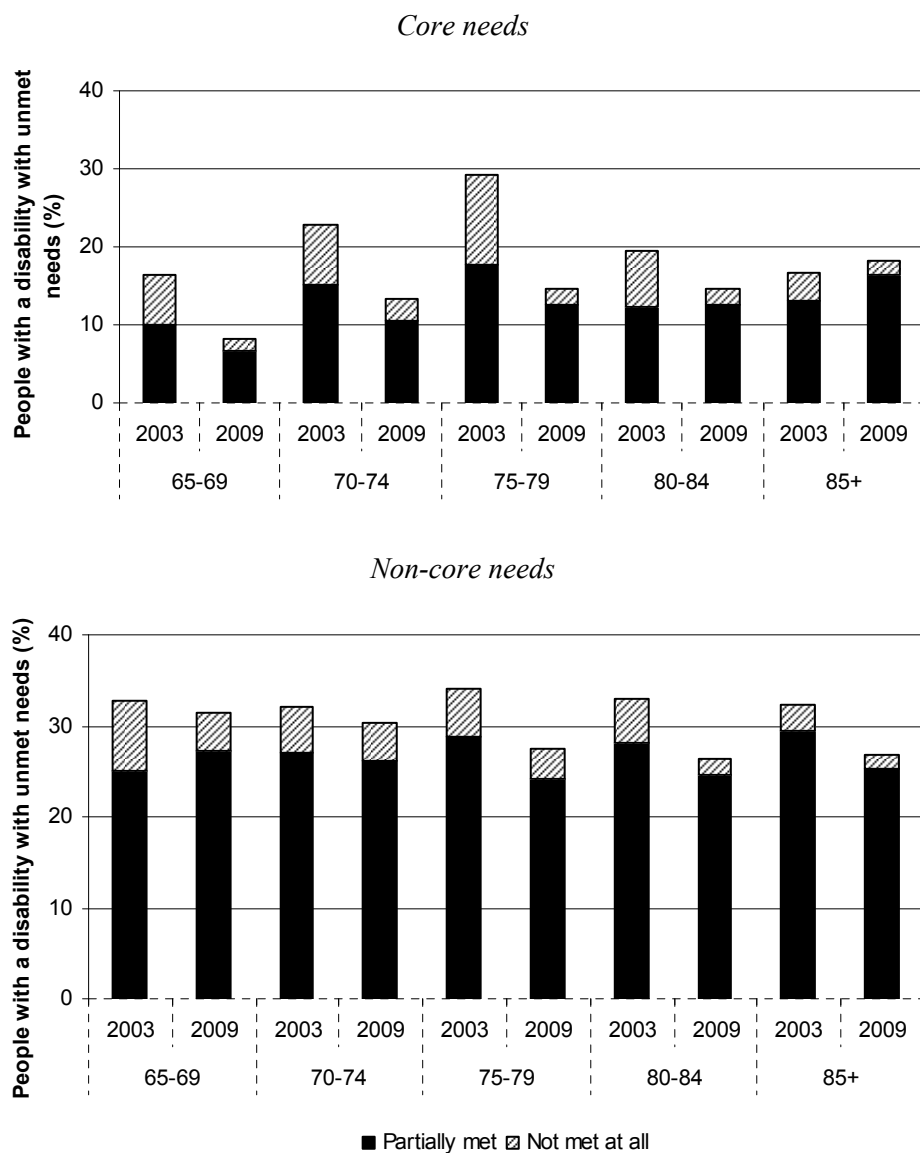
The Australian Bureau of Statistics (ABS) Survey of Disability Ageing and Carers (SDAC) reports on the extent to which people who are living in households and have care needs, consider that their needs are met. The ABS seeks separate information on needs arising from a person’s ‘core’ and ‘non-core’ restrictions. Core restrictions are those that affect an individual’s ability to communicate, be mobile and care for themselves, while non-core restrictions affect an individual’s ability to participate in work, schooling and social activities.

Generally, the level of unmet need that older Australians reported fell between the 2003 and 2009 SDACs (figure 5.1). The share of people whose needs are completely unmet has fallen across all age groups, both for people with needs relating to their core and non-core functions. However, the same trend is not as pervasive for people with partially met needs. Overall, the only group of older

Australians experiencing a rise in people reporting their needs to be partially or full unmet is for those aged 85 years or older with care needs arising from their core restrictions. This indicates that while the aged care system has improved access to almost all aged care services since 2003, it is not able to provide adequate levels of service to those older Australians aged 85 years and over with core needs, arguably the group most in need.

Figure 5.1 Proportion of older Australians with a disability who have unmet needs

Core and non-core needs by age



Data sources: 2003 & 2009 ABS Survey of Disability, Ageing and Carers CURF files.

Is there scope to improve efficiency?

There is significant scope to reduce the cost of providing aged care services through reducing excessive red tape and other regulatory burdens as discussed above. Such changes can provide a one-off reduction in costs. However, to promote on-going improvements in efficiency, providers need incentives to seek better, and lower cost, ways of doing things.

As noted earlier in the chapter, many of the current arrangements, such as supply constraints, do anything *but* encourage competition between providers or provide incentives for innovation. Moreover, as discussed in chapter 6, addressing impediments to competition would provide scope for improving productivity and enhancing efficiency.

Indeed, there are other opportunities to improve efficiency in the sector as outlined by the Business Council of Australia:

The limited consolidation within the sector, which has been driven by the poor investment returns, has meant that the ‘cottage industry’ nature of the sector has remained unchanged. As a result, there is, at the broadest level, a striking underinvestment in information and communication technologies and other infrastructure that might improve efficiency and productivity. (sub. 274, p. 6)

Other participants identified inefficiencies at the interface between the aged care system and the health care system. Health Care Consumers’ Association of the ACT noted:

There are numerous facilities which are not visited by a medical practitioner, meaning that aged care residents are often transported to hospital ... for medical care which they could have received at their residential facility had there been a suitably trained practitioner (nurse or doctor) available to treat the individual. This situation is ridiculous, costly, traumatic and inefficient. (sub. 326, p. 6)

Measures aimed at getting the different parts of the aged care system and the health care system to work together are discussed in chapters 9 and 10 .

Where to from here?

The Commission believes that to better meet the objectives of the aged care system, and ensure its sustainability, a fundamental redesign of the aged care system is required. A number of recent reviews and inquiries into the aged care system have also consistently identified a need for fundamental reform to address the weaknesses associated with the current system and to allow the sector to respond to the challenges outlined in this report (box [Error! Not a valid link.](#)).

Box 5.3 A consistent message from recent reviews is the need for significant reform

Australia's future tax system: Report to the Treasurer (Henry Review):

Limiting the number of subsidised aged care places and associated price controls impedes competition between providers, undermining both their capacity to respond to the needs of older people and their incentive and ability to plan for future growth in an industry driven by an increasingly ageing population. Responsive and sustainable aged care services are particularly important because many people requiring the services are vulnerable, and the fiscal costs to the economy are increasing. (2010, p. 629)

NHRC's A Healthier Future for All Australians: Final Report:

The underlying premise of our recommendations ... is that we need to redesign health services around people, making sure that people can access the right care in the right setting. This must include a 'full service menu' of health and aged care services necessary to meet the needs of an ageing population and the rise of chronic disease. Redesign also involves ensuring that this complex array of services is well coordinated and integrated. (2009, p. 102)

Senate Standing Committee on Finance and Public Administration's (SSFPA) Inquiry into Residential and Community Aged Care in Australia:

... it became overwhelmingly evident that aged care providers and involved stakeholders across the country recognised a need to reform the aged care sector in Australia. Witnesses commented on the 'bandaid' approach that has been taken to problems within the aged care sector and of the fact that they have been calling for reform for many years. It was argued that the significant problems currently facing the sector and the need to meet future demand must be addressed immediately and in a comprehensive and coherent manner. (2009, p. 15)

Productivity Commission's Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services:

The aged care industry is characterised by centralised planning processes which result in a heavy regulatory burden on aged care providers in order to maintain the quality of care. Without tackling the underlying policy framework that constrains supply it is unlikely that the regulatory burden can be substantially reduced ... the government should explore options for:

- relaxing supply constraints in the provision of aged care services
- providing better information to older people and their families so they can make more meaningful comparisons in choosing an aged care service
- removing the regulatory restriction on bonds as a source of funding. (2009, p. 19)

Review of Pricing Arrangements in Residential Aged Care (Hogan review):

... regulatory arrangements stem, at least in part, from fears about the vulnerability of residents to exploitation and unsafe practices. Nevertheless, these constraints affect a wide range of economic outcomes. First, they diminish the extent of competition between providers and, in particular, make it more difficult for prospective providers to enter the market. Second, they restrict consumer choice and reduce the consumer's ability to bargain over entry conditions. Third, they curtail innovation in service design and delivery. Finally, they adversely restrict enterprise mix and investment in the sector. (2004b, p. 2)

These views are echoed by a vast number of submissions from a variety of stakeholders including consumers and consumer groups, providers and industry bodies, and governments. For example, the Aged Care Association of Australia contended:

The time for continuing to apply band-aid solutions has passed. Together, we have the opportunity to construct a new aged care system which will allow a smooth transition to a new model which will effectively provide the care needed in 10–20 years time ... The Australian aged care system needs to migrate from its current inflexible structure to a new, more flexible and viable model which will provide greater choice within a quality system. (sub. 291, pp. 4–5)

And, according to the Australian Nursing Federation (Victorian Branch):

The aged care system is at the crossroads. The Australian Government has commissioned ample reports and inquiries to consider how the overall quality of aged care services can be improved. There is no shortage of knowledge on the factors contributing to its decline or about the measures required to steer it onto a path of sustainability.

What appears to have been lacking to date is a willingness to take firm action, and a commitment to implement the concerted, brave and bold reform that is required if the system is to be equipped to competently meet rising demand ... (sub. 341, pp. 8–9)

While it must be recognised that the system has generally performed well, the problems can no longer be fixed by small adjustments. As COTA argued:

On an internationally comparative basis Australia's current aged care system has served many of its users and their families well over recent decades. It has gone through a number of major improvements since the 1980s. These have focused primarily on improving service quality and user rights within the current service paradigm. There are now marginal returns at best in further 'tweaking' the current system. (sub. 337, p. 11)

The Commission agrees that the time is right to consider broad changes that will build on the strengths of the current system to set the industry on a sustainable path to meet the challenges outlined in earlier chapters. The following chapters outline proposed reforms which the Commission considers are required to enable government, industry, carers and volunteers to better meet the objectives of caring for older Australians.