Australian Government
Productivity Commission

# Caring For Older Australians

## Productivity Commission Draft Report

January 2011

This is a draft report prepared for further public consultation and input.

The Commission will finalise its report after these processes have taken place.

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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.

Further information on the Productivity Commission can be obtained from the Commission's website (www.pc.gov.au) or by contacting Media and Publications on (03) 9653 2244 or email: maps@pc.gov.au

# Opportunity for further comment

You are invited to examine this draft report and make written submissions to the Productivity Commission. Written submissions should reach the Commission by **Monday 21 March 2011**. If possible, please provide submissions by email (agedcare@pc.gov.au).

The Commission will present its final report to the Government by the end of June 2011.

## Public hearing date and venues

| Location | Date | Venue |
|---|---|---|
| Melbourne | Monday 21 March<br>8.30am – 5.00pm | Productivity Commission<br>Level 28<br>35 Collins Street |
| Hobart | Thursday 24 March<br>8.30am – 5.00pm | Hotel Grand Chancellor<br>1 Davey Street |
| Brisbane | Friday 25 March<br>8.30am – 5.00pm | Rendezvous Hotel<br>244 Ann Street |
| | Thursday 7 April<br>8.30am – 5.00pm | |
| Sydney | Monday 28 March<br>8.30am – 5.00pm | Medina on Crown<br>359 Crown Street<br>Surry Hills |
| Adelaide | Thursday 31 March<br>8.30am – 5.00pm | Stamford Grand<br>Moseley Square<br>Glenelg |
| Perth | Friday 1 April<br>8.30am – 5.00pm | Novotel Hotel<br>221 Adelaide Terrace |
| Canberra | Tuesday 5 April<br>8.30am – 5.00pm | Level 2<br>15 Moore Street<br>Canberra City |

If you wish to participate at a public hearing, please contact Jill Irvine on (02) 6240 3223, email agedcare@pc.gov.au or register online at http://www.pc.gov.au/projects/inquiry/aged-care.

## Commissioners

For the purposes of this inquiry and draft report, in accordance with section 40 of the *Productivity Commission Act 1998* the powers of the Productivity Commission have been exercised by:

| | |
|---|---|
| Mike Woods | Deputy Chairman |
| Robert Fitzgerald AM | Commissioner |
| Susanne 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 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 organisation:

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

Current consultancy clients

- T Guild Accountants
- T Leecare 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.

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The following appendices are referred to in the chapters but not included in this draft report. They will be made available on the study website (www.pc.gov.au/projects/inquiry/agedcare).

**B New aged care model options**

**C International experience**

**D Cost implications of recommended changes**

**E Aged care regulation**

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# Abbreviations and explanations

## Abbreviations

| | |
|---|---|
| AACRC | Australian Aged Care Regulation Commission |
| AAT | Administrative Appeals Tribunal |
| ABS | Australian Bureau of Statistics |
| ACAR | Aged Care Approval Round |
| ACAT | Aged Care Assessment Team |
| ACCC | Australian Competition and Consumer Commission |
| ACD | Advanced Care Directive |
| ACFI | Aged Care Funding Instrument |
| 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 | The Australian Local Government Association |
| ANAO | Australian National Audit Office |
| ASIC | Australian Securities Investment Commission |
| BCA | Building Code of Australia |
| CACP | Community Aged Care Package |
| CALD | Culturally and Linguistically Diverse |
| 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 (Australia) |
| 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 |
| GDP | Gross Domestic Product |
| GLBTI | Gay, lesbian, bi-sexual, transgender and intersex |
| GP | General Practitioner |
| HACC | Home and Community Care |
| HMM | Home Maintenance and Modification |
| IADL | Instrumental Activities of Daily Living |
| IGR | Intergenerational Report |
| LTC | Long-Term Care |
| MDS | Minimum Data Set |
| MPS | Multi-purpose Services |
| NCAC | National Childcare Accreditation Council |
| NESB | Non-English speaking backgrounds |
| NHHRC | National Health and Hospitals Reform Commission |
| NQRF | National Quality Reporting Framework |
| NRCP | National Respite for Carers Program |
| 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 |
| RACF | Residential Aged Care Facility |
| RCS | Resident Classification Scale |
| RTO | Registered Training Organisation |
| RVA | Retirement Village Association Ltd. |
| SCARC | Senate Community Affairs References Committee |
| SCRGSP | Steering Committee for the Review of Government Service Provision |
| SSAT | Social Security Appeals Tribunal |
| UCA | UnitingCare Australia |

| | |
|---|---|
| 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 ($10^9$). |
| Findings | *Findings in the body of the report are paragraphs highlighted using italics, as this is.* |
| Recommendations | ***Recommendations in the body of the report are highlighted using bold italics with an outside border, as this is.*** |
| Requests for further information | *Information requests are paragraphs highlighted using italics, as this is.* |

# Glossary

| | |
|---|---|
| Activities of Daily Living (ADLs) | Basic activities that are necessary to independent living, including eating, bathing and toileting. It is a concept of function that has several assessment tools to determine an individual's ability to perform the activity with or without assistance. |
| Aged Care Assessment Team (ACAT) | A multidisciplinary team of health professionals responsible for determining the care needs and services an individual may require. |
| Aged Care Funding Instrument (ACFI) | The ACFI is a resource allocation instrument and focuses on three domains that discriminate care needs among residents. The ACFI assesses core needs as a basis for allocating funding. |
| Ageing in Place | The provision of care which allows a person to remain 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'. |
| 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. |
| 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 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 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 | The provision of care and support for people who want to stay independent and living at home for as long as possible. This includes 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-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. |
| 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. |
| 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 comprehensive, coordinated and integrated range of basic maintenance 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 almost complete assistance with most daily living activities. It includes accommodation services as well as personal care. Medical needs are managed by nursing staff. |
| 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. |
| 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 services such as meals, laundry and cleaning as well as additional help with personal care. Nursing care may be provided if required. |
| Multidisciplinary care | Where health professionals from multiple disciplines work together to provide team-based care to a patient. |
| 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. |
| 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. |
| Residential aged care | Personal and/or nursing care provided to a person in a residential aged care facility (RACF) in which the person is also provided with accommodation that includes meals, cleaning services, furniture and equipment. |
| 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. |

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| Sub-acute services | Includes rehabilitation and geriatric evaluation and management care. Some sub-acute care is 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 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 | Care which provides short-term care that seeks to optimise the functioning and independence of older people after a hospital stay. If seeks to enable more people to return home after a hospital stay rather than enter a residential age care facility |
| Veterans’ Home Care (VHC) | Provides low level home care services to eligible veterans and war widows and widowers. |

# OVERVIEW

## Key points

Aged care assists over one million older Australians and its range and quality of services have improved over the last decade.

But the system suffers several key weaknesses. It is difficult to navigate and the quantity of services is limited. Quality can be variable, there are gaps in service coverage and limited choices for care recipients. Pricing, subsidies and user co-contributions are inconsistent and inequitable within and between care settings. Workforce shortages are exacerbated by uncompetitive wages and over-regulation.

The system will be further challenged by an increase in the numbers and expectations of older people, a relative decline in informal carers and the need for a larger workforce.

The Commission's proposals address these weaknesses and challenges and promote higher quality care. The focus is on enhancing the wellbeing of older Australians — promoting independence, connectedness and choice. Under the proposed reforms, older Australians would:

- contact a simplified 'gateway' for: easily understood information; assessments of care needs; assessments of financial capacity to make co-contributions; entitlements to approved services; and care coordination — all at a regional level
- receive a flexible range of care and support services that meet their individual needs and that emphasise, where possible, restorative care and rehabilitation
- choose, where feasible and appropriate, to receive care at home or in a residential facility and choose their approved provider
- contribute in part to their cost of care (with a maximum lifetime limit) and meet their accommodation and living expenses (with safety nets for those with limited means)
- have access to a government sponsored equity release scheme to pay for their care and accommodation charges if they have assets but limited annual incomes
- choose between paying a daily charge or an equivalent bond for the accommodation costs of residential care — with both aligned to the real cost of accommodation
- retain their age pension when selling their home (and if paying a lower capital sum or a daily charge for their new accommodation) by purchasing an Australian Pensioners Bond
- choose whether to purchase additional services or a higher quality of accommodation if that is what they want and can afford to do so.

Safety and quality standards would be retained but current limits on the number of residential places and care packages would be removed, as would the distinctions between low and high care and between ordinary and extra service status.

A new independent regulatory commission would transparently recommend to the Government the price for care services and for standard accommodation for supported residents, be responsible for quality accreditation, and address complaints.

The Australian Government would 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.

# Overview

Older Australians generally want to remain independent and in control of how and where they live their lives, continue to be connected and relevant to their families and communities, and be able to exercise some measure of choice if they require care.

Changes to the aged care system over the past decade or so have improved the range and quality of care and support available to older Australians. However, fundamental reform is required to overcome the delays, discontinuities, constraints and shortages that currently exist, and to respond to future challenges. These challenges include a significant increase in the number of older people, rising expectations about the care they receive, community concerns about variability in the quality of care, a relative decline in informal carers and a need for significantly more nurses and aged care workers.

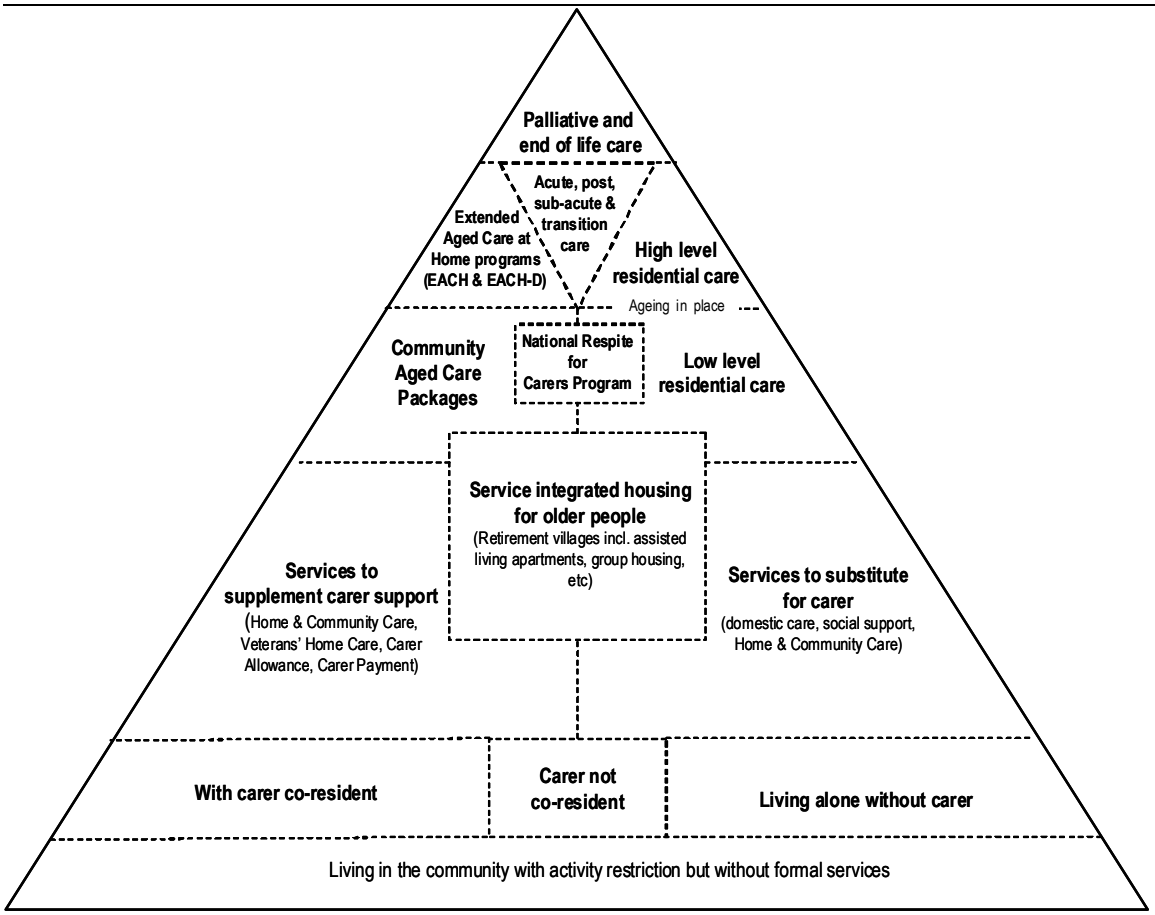
Government policies, programs and regulations, and the services offered by community groups and businesses, need to be redesigned around people's wellbeing and delivered in ways that respect their dignity and support their independence. Services need to be affordable both for older people and for society. The Productivity Commission has been asked to develop detailed options to achieve this redesign and to recommend a transition path to the new arrangements.

## Australia's aged care system

Many older Australians receive care and support from the aged care system. 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.

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

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




Government-subsidised services are provided to over one million older people and their carers each year, with more than half receiving low intensity support through the home and community care 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. Not all places are operational in each region.

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

In 2008-09, Australian, state and territory government expenditure on aged care was $10.1 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, there has been an increase in the range and quality of care and support available to older people and the quality and safety standards continue to improve. The workforce is generally appropriately skilled and dedicated to caring for those in need.

However, there are many weaknesses, and the need for fundamental reform has been identified in the 2004 Hogan Review, the 2009 National Health and Hospitals Reform Commission Report, the 2010 Henry Tax Review, the Commission's previous reports and the analysis it has undertaken for this inquiry, and 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 the '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
- financial inequities — the levels of user co-contributions are inconsistent and inequitable within and between community and residential care
- insufficient and inadequately funded restorative and rehabilitative care, and insufficient funding for palliative and end-of-life care
- variable care quality across the system
- uncertainty about care availability — there is limited confidence among those needing care that they can leave their program during periods of greater wellness and independence and re-engage readily should their circumstances change
- 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

- incomplete and overlapping interfaces — within and between jurisdictions, and between aged care and health, disability, mental health, housing and income support.

## Future challenges

The dimensions of the challenges facing aged care are also 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.
- The *2010 Intergenerational Report* estimates that Australian Government spending on aged care will increase from 0.8 per cent of GDP in 2010 to 1.8 per cent 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 care.
- Many older Australians have substantial wealth, which gives them the capacity to meet their lifetime accommodation costs and to make a greater contribution to the costs of their care. A safety net will still be needed for those with limited means.
- The relative availability of informal carers will decline, reducing the ability of some older people to receive home based care.
- There is an increasing diversity among older Australians in their preferences and expectations, including a greater desire for independent living and culturally relevant care. This is particularly relevant for many culturally and linguistically diverse and Indigenous communities.
- The aged care workforce will need to expand 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 health workers from other parts of the health system.
- New, cost-effective, assistive and information technologies offer some opportunities for productivity gains and higher quality care.

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

## Policy objectives

There are strong rationales for government involvement in aged care, including equity of access to appropriate care and the correction of market failures (information gaps and protection of vulnerable consumers). 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 also had common themes, including that the focus should be on wellbeing, that services should promote independence and that people should be able to make their own life choices, even if it means they accept higher levels of risk. Participants were also adamant that 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 from harm. At a broader level, the wellbeing of family members, friends and neighbours providing care to older people and people providing formal care also need to be considered. The impact 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 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*
- *treat older Australians receiving care and support with dignity and respect*
- *be easy to navigate — Australians need to know 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.*

This report offers a detailed plan for the implementation of a new policy framework which encapsulates these objectives.

## 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 and whether to purchase additional services or a higher standard of accommodation.

There is strong empirical evidence that consumer choice leads to positive wellbeing outcomes, such as higher life satisfaction, more independent living and better continuity of care. Competition among providers also leads to a more dynamic system, with incentives for greater efficiency, innovation and quality improvements. A highly regulated, risk averse system is unlikely to produce such outcomes. Regulations should revert to their more appropriate role of ensuring safety and quality, protecting the vulnerable and overcoming market failures.

### Simplified access 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 is proposing 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 Department of Health and Ageing sites). A single aged care gateway agency would be responsible for the platform. Older Australians would be able to access the gateway's information directly or through general practitioners (GPs), health clinics, Centrelink or other entry points.

The agency would also consolidate the needs assessment processes currently undertaken by Home and Community Care providers and the various state and territory Aged Care Assessment Teams. Approval to an entitlement for basic home support would involve minimal assessment over the telephone or through a simple form. Those needing complex care would be assessed by local teams of

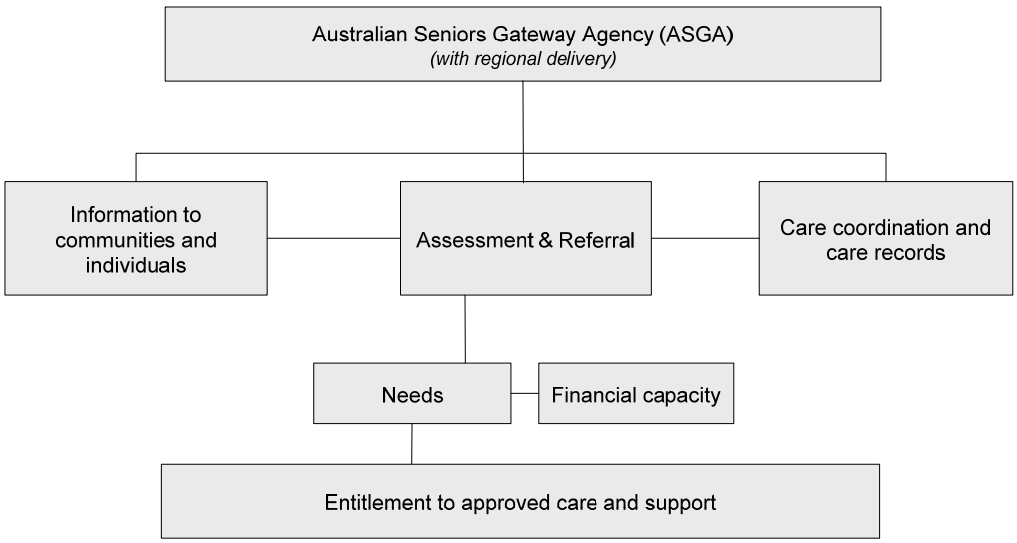
professionals. An assessment of the capacity of informal carers, and any support they may require, would be part of the process.

Assessors would use a set of criteria that would be applicable for all levels of care and support in both community and residential settings. The ensuing care entitlement would specify the approved services that a person requires, the intensity of service delivery, and the Government's set price for the service. The gateway agency would arrange for a separate assessment of the older person's financial capacity to make co-contributions (to be undertaken by Centrelink, where required).

Coordination of personal care 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 provided by a number of GPs, nurse practitioners, community health clinics and Community Options Program providers, but the Commission is proposing a default care coordination service be offered to all older Australians through the gateway agency, if requested. It would also assess a person's need for more complex case management as appropriate.

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

Figure 2 **Australian Seniors Gateway**



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 would reduce errors and inconsistencies in care records and enhance care 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, as ageing is a unique experience. Care needs depend on a person's functional capacity, 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 needs and, to the extent possible, restore their independence and wellness.

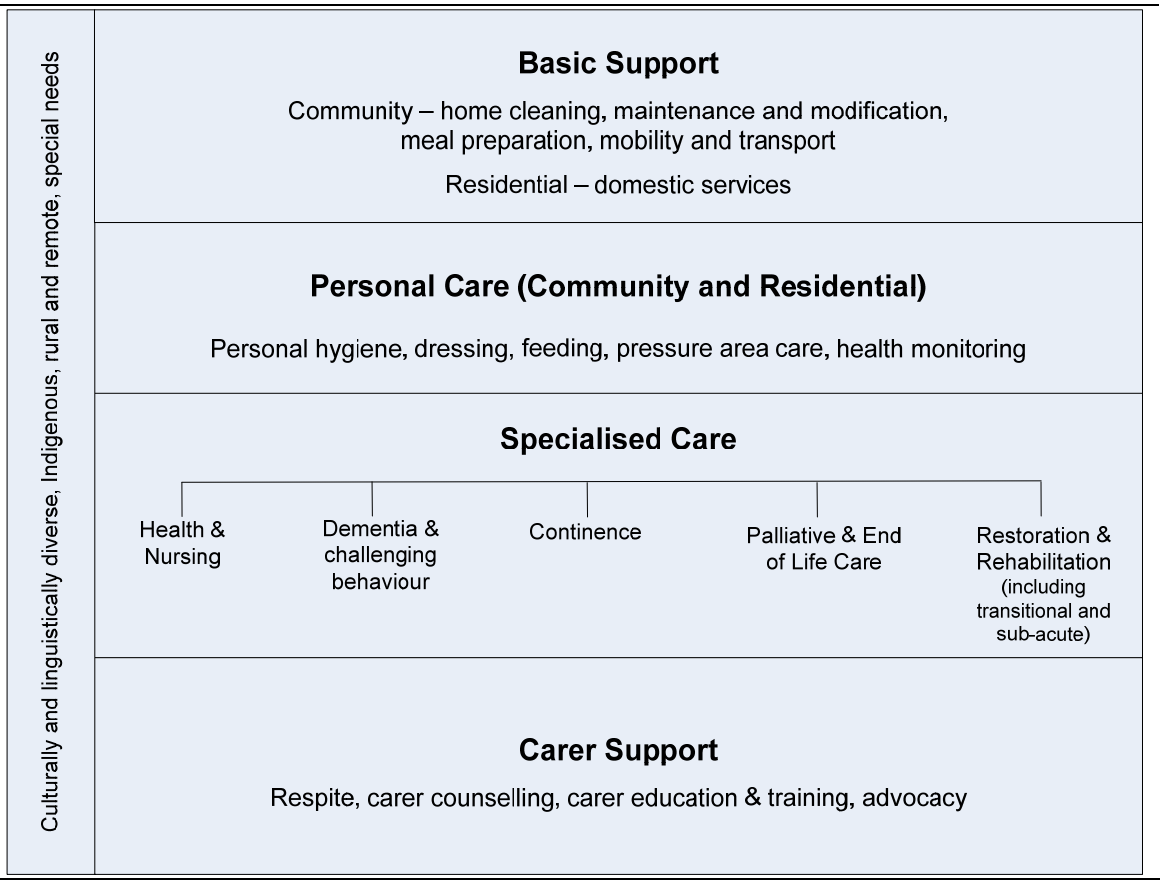
However under the current system, some care needs are not being met because of inflexibilities within the system. The Home and Community Care program has some ability to deliver a variety of services that meet the individual needs of its clients. Community care packages, however, are delivered to older people by funded providers as less flexible bundles of services. There are limits to their supply and funding, and gaps in service provision between them.

*The Commission is proposing a model of care and support which offers a flexible range of services that meet older people's individual needs using a building block approach (figure 3).*

The model proposes that assistance with basic support — such as home cleaning, maintenance and modification, meal preparation, mobility and transport — would be the foundation of the overall range of available services. These services help older Australians stay in their homes for longer, be supported by informal carers where possible, stay connected with their community, and avoid early entry into higher cost residential care and into the health system more generally.

For the most part, approved providers of basic support services should be minimally regulated, with competition being driven by a diversity of approved providers. Older people in residential care facilities receive these services as a matter of course.

Figure 3 **Aged care and support: a building block approach**




Older people who experience an increase in frailty may require personal care services such as daily showering and dressing, assistance with feeding, pressure area care and health monitoring. The number and/or intensity of care services that older people need can increase — either temporarily or permanently — or decrease.

Older Australians may also increasingly require specialised care such as for wound management and other health and nursing care, dementia and challenging behaviour, incontinence, palliative and end-of-life care, and restoration and rehabilitation including transitional and sub-acute care. Services could include care coordination (where not provided by the gateway agency) and more advanced case management as required. Providers of personal and specialised care (in the community or as operators of residential aged care facilities) would need to be accredited, and would be more highly regulated.

Where appropriate, services would be modified to meet the particular needs of special needs groups. Assistance would be provided to informal carers, including ongoing and emergency respite.

## Opening up the supply of care and accommodation to enhance choice

Current trends in service usage 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, a decline in demand for residential low care, and a deferral of entry into residential high care until people reach greater frailty. Providers are 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 effectively preclude older people who have an entitlement to services from choosing between competing accredited 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 address individuals' needs.

*As part of the new consumer–directed arrangements, the Commission is proposing the progressive relaxation and eventual removal of supply-side limits on bed licences, community care packages and other services, while maintaining quality accreditation.*

To improve the flexibility of supply in residential care, an appropriate reform would be 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' is already blurring the boundaries. The methods of charging for accommodation also differentiate between high care (daily charges) and low care and extra service (bonds). And for high care, the one daily rate applies equally to old three bed wards and to newly constructed single rooms with ensuites.

*The Commission is proposing that the current distinctions between 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 their additional services. Quality accreditation assessments for community care should be published by the accreditation agency, as currently applies to residential care.

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 viability of the aged care industry — although not necessarily the viability of all current providers.

The Commission recognises that being able to choose from competing providers is not always feasible. In some situations, the pricing recommendations of the independent regulatory commission would include viability supplements to providers of specialised services and to those operating in rural and remote areas. The report provides commentary on testing the further use of market based instruments, block funding and multi purpose 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 ageing of the baby boomers. The costs of public health and age pensions will also rise. Although there are currently 5 people of working age to support each Australian aged 65 or older, by 2050 the ratio is expected to reduce to 2.7. Thus, service delivery must become more effective and efficient, but this will not, of itself, sufficiently reduce the rate of growth of public expenditure.

The relaxation of supply-side constraints, through improving choice and competition, 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 to 1.8 per cent of GDP by 2050.

Many participants to the inquiry, including consumer organisations, called for greater aged care contributions from those older Australians who had the financial capacity to do so, provided that those in need 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.

Providers' concerns with the funding arrangements were 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 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. The average bond exceeds the cost of new construction for basic residential accommodation.

A further significant funding issue is the complex and distortionary interaction between the income and asset 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. A provider's incentive to ask for high bonds is that they are an interest free source of financing.

## A new care co-contribution regime

Under current arrangements, there is considerable discontinuity between the levels of co-contributions paid for Home and Community Care services, for Community Aged Care and Extended Aged Care at Home packages, and for care delivered in residential aged care facilities. These arrangements lead to inequities between older people with the same needs and the same financial capacity, and to the inefficient allocation of resources within and between the different forms of community and residential care.

The Commission is proposing that the current arrangements be replaced by a single national care co-contribution regime which would apply across all approved basic support and personal care services, whether they be delivered in the community or in a residential care facility. The private co-contribution would vary in proportion to the underlying price set for the care by the Government.

To reinforce the transfer of choice and control to older people, they would be responsible for paying their co-contribution for purchased services directly to the provider. For administrative efficiency, older people purchasing services would also 'sign over' to the provider their service subsidy from the government

The design of the co-contribution scheme needs to take into account the variability of the financial capacity of older people to pay a user fee. While the majority of older Australians will continue to receive either a full or part pension looking out to around 2050, a large proportion of these pensioners have considerable wealth, with the home making up most of this wealth. Currently the median household of those aged 65-74 holds around 79 per cent of their net worth in the primary residence, rising to 90 per cent for the median household of those aged 75 and over.

The Commission is proposing that a person's capacity to pay for aged care be based on both their income and their assets, and that this assessment be undertaken by Centrelink. For the income assessment, the age pension test would be used — for ease of understanding by older people and for efficiency of administration. However, the assets test needs to overcome the age pension's exclusion of homes and residential care bonds. A further complexity of the current age pension asset test is that lump sums arising from the sale of the home, but invested in instruments

other than housing or accommodation bonds of similar value, are not exempt assets. The Commission is therefore proposing that all people be subject to the age pension non-home owner asset test, and for that test to include a person's home or accommodation bond. Such an approach would retain the familiarity with, and efficiency of, a Centrelink pension assessment.

*The Commission is proposing that the assessment of financial capacity to pay care co-contributions use a 'comprehensive aged care means test'. The test applies the age pension income test (including deemed income from a range of financial assets), and the age pension non-home owner asset test for all people (including any housing assets or accommodation bonds).*

However, for older people who receive a minimum level of care services (say where the value of services is less than $100 per week), their financial capacity to make co-contributions will rely simply on their pensioner status, rather than a more comprehensive test.

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 access capital tied up in their assets to receive, or top up, their pension payments up to the level of a full age pension. The 'loan' is secured against Australian real estate owned by the person — primarily their home. A similar arrangement could be attractive where an older person moves into residential care and their partner or dependent remains in the home, or to help them fund their care co-contributions while living at home.

*The Commission is proposing that, for older Australians whose financial capacity is mainly in the form of a home, accommodation bond or other non-liquid assets, there be a Government backed aged care equity release scheme, along the lines of the current Pension Loans Scheme, which they could flexibly draw against for their care co-contributions. As a safeguard, there would be a minimum asset floor below which the costs of care would be fully met from public funds.*

## Protection against very high costs of care

The costs of aged care 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 the highest cost of care in residential settings can generate an income for providers of around $65 000 per annum.

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's indicative range of co-contributions for care services is between 5 and 25 per cent of cost of the approved care services in either community or residential settings depending on an individual's financial capacity to pay. Even in this case, hardship provisions would continue to apply. This range will be further tested during consultations on the draft report, and may vary in the final report.

However, 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, such as formal community or residential care. Less predictable is whether an individual will require intensive aged care 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 is proposing that, as a safeguard (including to the overall level of funds that can be drawn down under the equity release scheme), there would be an upper limit to the value of care co-contributions for approved aged care services that any one person pays over their lifetime.*

The price paid to providers for care services (that is, the user co-contribution and the signed over public subsidy) should be set by the Australian Government at a level which meets the cost of efficiently delivered approved care in each of the different care settings. It should be updated annually based on a transparent recommendation from an independent regulatory commission. 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.

## 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 for those in need.

As noted earlier, there are many distortions in the 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 high care charge does not provide an adequate return on the cost of new supply. For example, 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 bond values are a consequence of their attraction to providers (as a zero interest offset to debt and a way to compensate for insufficient accommodation charges in high care) and to pensioners (to protect their pension and reduce care co-contributions). A number of participants argued for the extension of bonds to high care, but if bonds were left uncapped, this would burden many more older people.

Accommodation payments need to reflect the underlying cost of supplying the accommodation.

To remove residents' incentives to pay a high bond, the proposed assessment of financial capacity to pay care co-contributions will incorporate the value of any accommodation bond. Resident's pensions would not be affected but a high bond would not reduce their level of care co-contributions. The Commission is also proposing that the Government establish an Australian Pensioners Bond for pensioners to invest any proceeds from the sale of their home above that required to pay a value-based accommodation bond or other accommodation charge. Monies invested in the Australian Pensioners Bond would be excluded from the age pension asset test.

*The Commission is proposing the establishment of an Australian Pensioners Bond, for those on an age pension who wish to deposit all or some of the proceeds of the sale of their home. The real value of the bond would be maintained by consumer price indexation, and be excluded from the age pension asset test. The bond could be drawn down to meet aged care co-contributions, pay for accommodation or meet other living expenses.*

From a provider perspective, the Commission is proposing that they be required to offer a periodic charge which reflects the underlying cost of supplying accommodation. Providers could also choose to offer a bond option, but the value of the bond would need to be equivalent, at the time, to the periodic charge.

*The Commission is proposing that residential care providers be required to offer a periodic accommodation charge, or an accommodation bond of equal value (if they wish), and for both to be published. The values would reflect the cost of the accommodation.*

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 can afford, just as they have done when living in the community. They would be able to pay a periodic charge, or a bond, with no effect on their pension eligibility or on their assessed capacity to make care co-contributions.

To ensure sufficient provision of an approved basic standard of accommodation (potentially being a two-bed room with shared bathroom) for those with limited financial means, the Commission is proposing that providers be obliged to make available a proportion of their accommodation to 'supported' residents (with grandfathered exclusions) set on a regional basis. This requirement should be reviewed in five years. Yet there needs to be some flexibility to meet different provider's business models, as some may prefer to cater for higher numbers of supported residents.

*The Commission is proposing that the Australian Government set a regional quota for supported residents, to be met by residential care providers. The obligation would be transferable between providers in the same region to lessen inflexibilities in the delivery of services.*

## 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 a stop-loss taxpayer model where the Government covered 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. The Commission would argue against any unnecessary legislative restrictions to voluntary personal insurance being offered by the private sector.

In relation to meeting the 'public' costs, two 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 being 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, but 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.

There are also uncertainties relating to the actual premiums that should be set for future care, as well as administrative and funds 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. Also, 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 disability. In addition, 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.

At this stage, the Commission is not convinced that, in relation to aged care, a compulsory insurance scheme represents a significant improvement over the pay-as-you-go tax financed system supplemented by higher co-contributions from those with the financial capacity to make them, and a stop-loss mechanism (to achieve risk pooling) for the high costs of care.

*The Commission is seeking comments on the merit of introducing a compulsory insurance scheme to broaden the current funding base for aged care.*

The Commission's preliminary modelling suggests that the publicly funded cost of the reformed arrangements could represent in the order of 1.9 per cent of GDP by 2050, compared to the *Intergenerational Report's* estimate, adjusted for more recent trends in the cost and use of care, of 1.5 per cent for the existing system.

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. Equally, it is this second fiscal gatekeeper that is restricting

the exercise of choice by older people and the introduction of competition by providers, and, therefore, its removal is warranted. The Australian Government would 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.

## 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 provide most of the care for older people. They assist with personal care and health care, and coordinate the various formal services that the older person may be using.

It is expected that 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 the very frail and those with dementia. This will place increasing pressure on public expenditure.

The significant value to society from the care delivered by informal carers has been estimated in various studies, and this is recognised by governments through carer payments and other support measures.

To further support carers of older Australians, the Commission is proposing that the assessment of the needs of older people by the gateway agency also include an assessment of the capacity of their carers to provide ongoing support. This may lead to entitlements to planned and emergency respite care, carer education and training, carer counselling and peer group support, and advocacy services. Services specifically for supporting carers should be co-ordinated and undertaken, where appropriate, by a network of Carer Support Centres.

Broader reforms to the aged care system will also be of assistance to carers, such as the replacement of a variety of information sources with a single, easily understood and navigable information platform, and the availability of a more flexible range of care options which is designed to meet individual needs.

## The formal workforce

The standards of care received by older people are due, in large part, to the skill and dedication of Australia's health and personal care workforces. In this inquiry, the Commission has focused mainly on nurses, personal carers, allied health professionals and medical specialists whose roles and skill sets are directly concerned with providing care to older Australians. However, it also recognises the important contributions made by supporting workers in residential facilities and in home maintenance services for the elderly, 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. It is anticipated that the workforce will need to almost triple 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 reduce the level of demand on the workforce are canvassed elsewhere in this report, such as through the promotion of independence and wellness, and the greater provision of rehabilitation and restorative care services.

In terms of improving productivity, there are opportunities to remove unnecessary and complex regulatory and administrative burdens, develop more effective and efficient models of care and scopes of practice, and make more strategic use of information technology. Productivity may also be improved through increasing the skills of care workers and managers. The Commission is proposing the promotion of skill development through an expansion of vocational courses and through the expansion of aged care services which have a teaching role.

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 long standing disparity between the wages paid to nurses in the sector compared to those employed in the public acute sector. This disparity is also becoming more apparent in rural areas where there are both high care residential operators and multi-purpose services, with the latter paying the higher public sector salaries. Wage increases in

the sector are highly likely, and their fiscal impact would be felt equally on the current system or the reformed system as proposed by the Commission.

Action in one area alone will not be enough to set the industry on a sustainable path. Most of the solutions lie with aged care providers who have the principle responsibility for ensuring that they provide an attractive workplace.

*The Commission is proposing that scheduled care prices take into account the need to pay competitive wages to nursing and other care staff. The Commission is also supporting the development of more attractive career paths, opportunities for professional development and improved managerial expertise.*

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 ethnic backgrounds will be especially important in the provision of culturally appropriate care.

## Reform of the regulatory framework

This inquiry has 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. 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.

As discussed previously, the Commission is proposing to simplify and streamline the front end of the aged care system through the establishment of an Australian Seniors Gateway Agency. This reform would consolidate a number of functions currently carried out by the Department of Health and Ageing and by state and territory agencies and funded services.

A comparison of the current system with best practice has highlighted the need to separate the policy functions of the Department of Health and Ageing from the regulation of aged care, and it is proposed that the latter be undertaken by an independent regulatory commission.

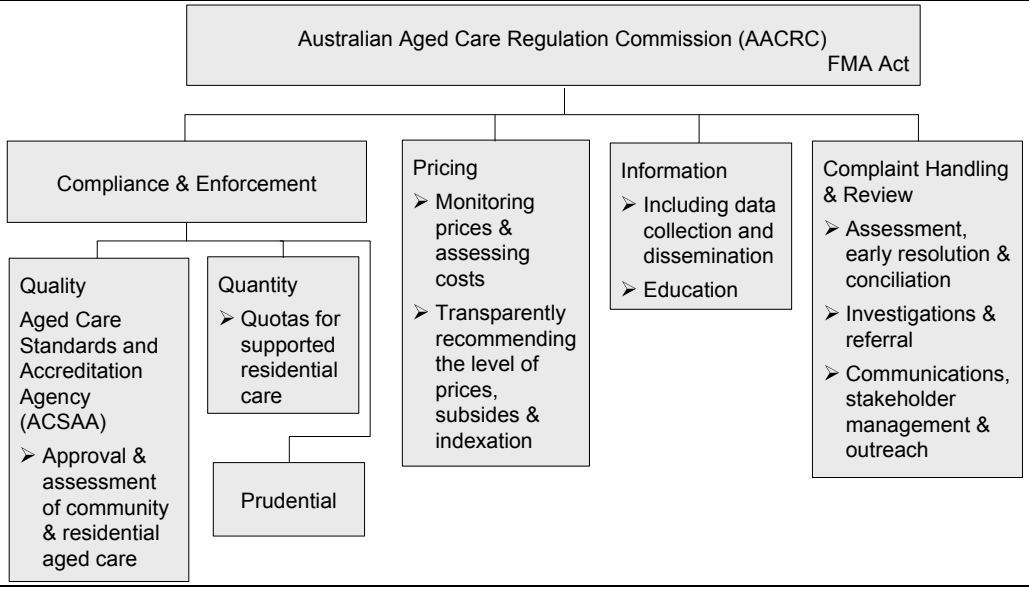
*The Commission is proposing the establishment of an independent regulator — the Australian Aged Care Regulation Commission (AACRC).*

The main functions of AACRC would include (figure 4):

- regulating the quality of community and residential care
- assessing, transparently recommending and monitoring service prices
- enforcing regulation, including prudential regulation, and assisting and educating providers in relation to compliance and continuous improvement
- communicating with stakeholders, and collecting and disseminating data
- determining and referring complaints and handling reviews.

*The Commission is proposing that the Aged Care Standards and Accreditation Agency operate as a statutory office within AACRC and undertake the quality assessment and accreditation of community and residential care providers.*

Figure 4 **Proposed functions of the independent aged care regulator**




In order to facilitate feedback loops between complaints and the regulator's compliance and enforcement activities, complaints handling and review should be handled by a division of the regulatory commission. 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. This reform, together with the referral of all appeals to the decisions of AACRC and the gateway agency to the Administrative Appeals Tribunal, means that the Office of the Aged Care Commissioner would become redundant and should be abolished.

## 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 evaluation, and there are 'gaps' in ageing research. There are also potential conflicts of interest with DoHA's role as policymaker, evaluator and main data repository for aged care.

*To promote greater transparency and accountability, the Commission is proposing that the AACRC be appointed the national aged care data clearinghouse.*

Its role will include coordinating, storing and distributing aged care data and allowing for greater access to datasets for researchers, policymakers, and the community at large. This will not only assist the various decision makers in the sector (particularly under a more market-based and consumer directed regime) but — through a stronger evidence base — also help to ensure that aged care policies are soundly based.

## Enhancing Quality

Participants have expressed views about the variability of quality of care provided within the aged care sector. Often quality is not related to the physical infrastructure but rather the attitude of staff and senior managers. This variation in quality may have a number of causes including the design of the current system which allows poorer quality operators who 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 assist to promote high quality care through:

- greater consumer choice and more competitive and responsive service providers
- improved funding and, as a result, improved working conditions
- improved regulation and regulatory oversight
- greater recognition by providers, staff and trainers of the needs of culturally diverse groups and those with special needs
- increased access to consumer advocates.

## 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.

The Commission believes that the systemic reforms proposed will assist all groups. In developing its proposals, the Commission has 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, to ensure better outcomes for those with special needs.

The Commission will outline its preliminary preferred option on the split in funding between the aged care and disability sectors in the draft disability care and support inquiry report.

## The implementation pathway

To be credible, the Commission considers that the proposed reforms need a strong commitment to change from the Australian Government and from the states and territories. 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 and providers all need certainty about the reform plan and confidence that it will be implemented. The implementation plan includes grandfathering provisions to protect existing consumers and certain providers of aged care services from disruptive changes and provides a sequenced approach to facilitate a smooth transition to the new arrangements.

The Commission is proposing that, for the first five-year period, there be an Aged Care Implementation Taskforce which would drive the reform agenda. A draft implementation plan, involving three broad stages of reform, is set out in box 1 for comment by participants.

Box 1 **Draft Implementation Plan**

**Stage 1: expedited measures within two years**

- remove the distinctions between low and high care, and between ordinary and extra-service status
- require residential aged care facilities to set accommodation charges consistent with the cost of supply, to disclose the charges and an equivalent accommodation bond (if offered) and remove accommodation bond retention amounts
- introduce the Australian Pensioners Bond
- conduct a public benchmarking study of aged care costs to initially set the scheduled prices, progressively increase the accommodation charge paid by the Government for supported residents, set regional quotas for supported residents and allow providers to trade those quota obligations.

**Stage 2: within two to five years**

- establish the Australian Seniors Gateway Agency, terminate redundant services and introduce the new model of care assessments and services entitlements
- establish the Australian Aged Care Regulation Commission (AACRC) and transfer regulatory responsibility to it from the Department of Health and Ageing
- transfer the Aged Care Standards and Accreditation Agency to a statutory office in the AACRC
- introduce the new co-contribution and stop-loss funding arrangements and equity release scheme, and set care prices and the accommodation charge for supported residents based on transparent recommendations from the AACRC
- implement the Commission's draft recommendations relating to age friendly housing and communities, workforce and catering for diversity reforms
- gradually increase the quantity of residential and community places by 10 to 20 per cent above the baseline established by the Aged Care Approvals Round

**Stage 3: five years and beyond**

- after five years, remove supply restrictions in both residential and community care
- commission a public review which would analyse and recommend:
  - whether the consumer directed system had developed sufficiently so that care and supported accommodation prices could be liberalised in certain markets
  - whether the quota arrangements for supported residents be continued or replaced by a tendering mechanism
  - any changes to aged care accreditation standards
  - any changes that may be needed to maintain fiscal sustainability
  - any changes that may be needed to ensure access for special needs groups.

# Draft recommendations

## A framework for assessing aged care

DRAFT RECOMMENDATION 4.1

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

- ***promote 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***
- ***treat older Australians receiving care and support with dignity and respect***
- ***be easy to navigate — Australians need to know 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.***

## Paying for aged care

DRAFT 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 (personal and health), everyday living expenses and accommodation.***

DRAFT RECOMMENDATION 6.2

***The Australian Government should adopt the following principles to guide the funding of aged care:***

- ***accommodation and everyday living expenses should be the responsibility of individuals, with a safety net for those of limited means***
- ***health services should attract a universal subsidy, consistent with Australia's public health care funding policies***
- ***individuals should contribute to the cost of their personal care according to their capacity to pay, but should not be exposed to catastrophic costs of care.***

DRAFT RECOMMENDATION 6.3

***The Australian Government should remove regulatory restrictions on the number of community care packages and residential bed licences over a five-year period. It should also remove the distinction between residential high care and low care places.***

DRAFT RECOMMENDATION 6.4

***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 retention amounts on accommodation bonds. The Government should require that those entering residential care have the option of paying for their accommodation costs either as:***

- ***a periodic payment for the duration of their stay***
- ***a lump sum (an accommodation bond held for the duration of their stay).***
- ***or some combination of the above.***

***To ensure that accommodation payments reflect the cost of supply, and are equally attractive to care recipients and providers, the Australian Government should require that providers offer an accommodation bond that is equivalent to, but no more than, the relevant periodic accommodation charge. Accommodation charges and their bond equivalents should be published by the residential aged care facility.***

DRAFT RECOMMENDATION 6.5

***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. This would not apply to existing providers who are currently not obliged to make accommodation available to supported residents.***

***Over the first five years, the obligation would be tradable between providers in the same region. After five years, the Australian Government should consider the introduction of a competitive tendering arrangement to cover the ongoing provision of accommodation to supported residents.***

DRAFT RECOMMENDATION 6.6

***The Australian Government should establish an Australian Pensioners Bond scheme to allow age pensioners to purchase a bond from the Government on the sale of their primary residence.***

- ***The bond would be exempt from the age pension assets test and income tests and would be indexed by the consumer price index to maintain its real value. All bonds would be free of entry, exit and management fees.***
- ***Age pensioners could flexibly draw upon their bond to fund living expenses and aged care costs.***

DRAFT RECOMMENDATION 6.7

***The Australian Government's contribution for the approved basic standard of residential care accommodation for supported residents should reflect the average cost of providing such accommodation and should be set:***

- ***on the basis of a two-bed room with shared bathroom***
- ***on a regional basis where there are significant regional cost variations.***

DRAFT RECOMMENDATION 6.8

***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.***

DRAFT RECOMMENDATION 6.9

***The Australian Government should:***

- ***prescribe the scale of care recipients' co-contributions for approved care services which would be applied through the proposed Australian Seniors Gateway Agency (draft recommendation 8.1)***

- ***set a comprehensive means test for care recipients' co-contributions for approved care services. This test should apply the age pension income test and the non-home owner asset test (including any housing assets, such as the primary residence, accommodation bonds and the proposed Australian Pensioners Bond). The comprehensive aged care means test would apply where the approved care services have a combined value of around $100 or more on average per week (the 'comprehensive aged care means test threshold') and all home modification services***
- ***adopt for approved care services below the comprehensive aged care means test threshold, a test for determining car recipients' co-contributions for such services which relies simply on pensioner status.***

***To facilitate greater consistency in co-contributions across community and residential care, comprehensive aged care means testing to determine care recipient contributions to care costs in both settings should be undertaken through the proposed Australian Seniors Gateway Agency (draft recommendation 8.1) by Centrelink.***

***Care recipients' co-contributions should be regularly reviewed by the Australian Government based on transparent recommendations from the proposed Australian Aged Care Regulation Commission (draft recommendation 12.1).***

DRAFT RECOMMENDATION 6.10

***The Australian Government should set a lifetime stop-loss limit comprising the care recipients' co-contributions towards the cost of government-subsidised 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.***

DRAFT RECOMMENDATION 6.11

***The proposed Australian Aged Care Regulation Commission (draft recommendation 12.1) should make transparent recommendations to the Australian Government on the scheduled set of prices for care services and the required level of indexation, the lifetime stop-loss limit, and the price for the approved basic standard of residential care accommodation. The Commission should monitor and report on the cost of care, basic accommodation and the stop-loss limit.***

## Options for broadening the funding base

DRAFT RECOMMENDATION 7.1

***The Australian Government should establish a government-backed Aged Care Equity Release scheme which would enable individuals to draw down on the equity in their home to contribute to the costs of their aged care and support.***

## Care and support

DRAFT RECOMMENDATION 8.1

***The Australian Government should establish an Australian Seniors Gateway Agency to provide information, 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 also 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, with the level of assessment resourcing varying according to anticipated need.***
- ***An aged care needs assessment instrument would be used to conduct assessments and an individual's entitlement to basic support, personal care and specialised care, and carer support. Assessments of financial capacity to make care co-contributions toward the cost of the services would also be arranged.***
- ***Initial care coordination services would be provided, where appropriate, as part of the Gateway. If required, case management would be provided in the community or in residential aged care facilities by an individual's provider of choice.***

***The Gateway would be established as a separate agency under the Financial Management and Accountability Act 1997.***

DRAFT RECOMMENDATION 8.2

***The Australian Government should replace the current system of discrete care packages with a single integrated, and flexible, system of care provision. This would deliver care services currently provided under Home and Community Care, Commonwealth funded care packages and the care component of residential aged care services.***

***The Australian Government should approve a range of care services to individuals on an entitlement basis, based on assessed need. Individuals should be given an option to choose an approved provider or providers.***

***The Australian Government would set the scheduled price of each service.***

***To support these revised arrangements, Australian governments should fund an expanded system of aged care consumer advocacy services.***

DRAFT RECOMMENDATION 8.3

***The Australian Government should ensure that, through the Independent Hospital Pricing Authority, residential and community care providers receive appropriate case mix payments for delivering palliative and end-of-life care.***

DRAFT RECOMMENDATION 8.4

***The Australian, state and territory governments should only continue to directly block fund programs where there is a demonstrated need to do so based on a detailed consideration of scale economies, generic service need and community involvement.***

DRAFT RECOMMENDATION 8.5

***The Australian, state and territory governments should, subject to further evaluation, promote the expanded use of in-reach services to residential aged care facilities and the development of regionally or locally-based visiting multidisciplinary health care teams.***

## Catering for diversity — caring for special needs groups

DRAFT RECOMMENDATION 9.1

***The proposed Australian Seniors Gateway Agency (draft recommendation 8.1) should cater for diversity by:***

- ***ensuring all older people have access to information and assessment services***
- ***providing interpreter services to convey information to older people and their carers, to enable them to make informed choices***
- ***ensuring that diagnostic tools are culturally appropriate for the assessment of care needs.***

DRAFT RECOMMENDATION 9.2

***The proposed Australian Aged Care Regulation Commission (draft recommendation 12.1), 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 interpreter services (either within facilities or through telephone translators) for clients from non-English speaking backgrounds***
- ***ensuring staff can undertake professional development activities which increase their cultural awareness.***

DRAFT RECOMMENDATION 9.3

***The Australian Government should ensure that 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***
- ***funding models that are aimed at ensuring service sustainability and that recognise the need for the building of local capacity to staff and manage such services over time.***

## Age-friendly housing and retirement villages

DRAFT RECOMMENDATION 10.1

***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.***

DRAFT RECOMMENDATION 10.2

***For older people with functional limitations who want to adapt their housing, the Australian Government should develop building design standards for residential housing that meet their access needs. Those standards should be informed by an evidence base of the dimensions and capabilities of people aged 65 and older and of the dimensions and capabilities of contemporary disability aids.***

DRAFT RECOMMENDATION 10.3

***The Council of Australian Governments should develop a strategic policy framework for ensuring that sufficient housing is available that would cost effectively meet the demands of an ageing population.***

DRAFT RECOMMENDATION 10.4

***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.***

DRAFT RECOMMENDATION 10.5

***State and territory governments should pursue nationally consistent retirement village legislation under the aegis of the Council of Australian Governments. Changes to state and territory government legislation under this process should:***

- ***be informed by research jointly commissioned by the industry and government***
- ***have regard to the industry's accreditation process.***

## Delivering care to the aged — workforce issues

DRAFT RECOMMENDATION 11.1

***The proposed Australian Seniors Gateway Agency (draft recommendation 8.1), 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 and/or assisted referral for:***

- ***carer education and training***
- ***planned and emergency respite***
- ***carer counselling and peer group support***

- *advocacy services.*

***Carer Support Centres should be developed from the existing National Carelink and Respite Centres to provide a broad range of carer support services.***

DRAFT RECOMMENDATION 11.2

***The proposed Australian Aged Care Regulation Commission (draft recommendation 12.1), when assessing and recommending scheduled care prices, should take into account the need to pay competitive wages to nursing and other care staff delivering aged care services.***

DRAFT RECOMMENDATION 11.3

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

- *advanced clinical courses for nurses to become nurse practitioners*
- *management courses for health and care workers entering management roles.*

DRAFT RECOMMENDATION 11.4

***The Australian Government, in conjunction with universities and providers, should fund the expansion of 'teaching aged care services' to promote the sector among medical, nursing and allied health students.***

DRAFT RECOMMENDATION 11.5

***The proposed Australian Aged Care Regulation Commission (draft recommendation 12.1), in assessing and recommending scheduled care prices, should take into account the costs associated with:***

- *volunteer administration and regulatory costs*
- *appropriate training and support for volunteers*
- *reimbursement of out-of-pocket expenses for those volunteers who are at risk of not participating because of these expenses.*

## Regulation — the future direction

DRAFT RECOMMENDATION 12.1

***The Australian Government should establish a new regulatory agency — the Australian Aged Care Regulation Commission (AACRC) — under the Financial Management and Accountability Act 1997. This would involve:***

- ***the Department of Health and Ageing ceasing its regulatory activities (except for regulation policy development — including quality standards — and advice)***
- ***establishing the Aged Care Standards and Accreditation Agency as a statutory office within the AACRC***
- ***establishing a statutory office for complaints handling and reviews within the AACRC.***

***The AACRC would have three full time, statutorily appointed Commissioners:***

- ***a Chairperson***
- ***a Commissioner for Standards and Accreditation***
- ***a Commissioner for Complaints and Reviews.***

***The Chairperson would have responsibility for pricing and all other regulatory matters.***

***Key functions of AACRC would include:***

- ***responsibility for compliance checking and the enforcement of regulations covering the quality of community and residential aged care***
- ***approving community and residential aged care providers for the provision of government subsidised aged care services***
- ***administering prudential regulation and all other aged care regulation, such as quotas for supported residential care***
- ***monitoring and assessing costs and transparently recommending a scheduled set of prices, subsidies and a rate of indexation for subsidised aged care services***
- ***assisting and educating providers with compliance and continuous improvement***
- ***handling consumer and provider complaints and reviews***
- ***providing information to stakeholders, including disseminating and collecting data and information.***

DRAFT RECOMMENDATION 12.2

***The Australian Aged Care Regulation Commission's (AACRC) Commissioner for Complaints and Review should determine complaints by consumers and providers in the first instance. Complaints handling and reviews should be structured into the three areas: assessment, early resolution and conciliation; investigations and referral; and communication, stakeholder management and outreach. The Australian Government should abolish the Office of the Aged Care Commissioner.***

***All appeals in respect of decisions of the AACRC and the Australian Seniors Gateway Agency (draft recommendation 8.1) should be heard by the Administrative Appeals Tribunal (AAT). Consideration should be given to the establishment of an Aged Care Division within the AAT.***

DRAFT RECOMMENDATION 12.3

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

DRAFT RECOMMENDATION 12.4

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

DRAFT RECOMMENDATION 12.5

***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 that allows for 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.***

DRAFT RECOMMENDATION 12.6

***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 (SBR).***

***The Australian Aged Care Regulation Commission (AACRC) should explore the case for embracing technological advances in receiving and transmitting information from and to providers in line with SBR. This could be facilitated by imposing a requirement that all providers submit key reports electronically to AACRC.***

DRAFT RECOMMENDATION 12.7

***The Australian Government should amend the residential aged care prudential standards to allow residential aged care providers to disclose (to care recipients or prospective care recipients) on request, rather than automatically:***

- ***a statement about whether the provider complied with the prudential standards in the financial year***
- ***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.***

DRAFT RECOMMENDATION 12.8

***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 Department of Health and Ageing, while continuing to promptly report missing residents to police services.***

DRAFT RECOMMENDATION 12.9

***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 scope of practice, power of attorney, guardianship and advanced care plans.***

## Aged care policy research and evaluation

DRAFT RECOMMENDATION 13.1

***To encourage transparency and independence in aged care policy research and evaluation, the proposed Australian Aged Care Regulation Commission (draft recommendation 12.1) should perform the role of a national 'clearinghouse' for aged care data. This will involve:***

- ***being the central repository for aged care data and coordinating its 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 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.***

## Reform implementation

DRAFT RECOMMENDATION 14.1

***In implementing reform, the Australian Government should:***

- ***announce a timetable for changes and how they are expected to affect the sector***
- ***consult with providers, consumers, carers and government agencies on issues expected to arise from the implementation of the new system***
- ***embed feedback processes and enable fine-tuning of the new system***
- ***grandfather current users of care services, including those in residential aged care facilities, and relevant financial arrangements of some of the providers of aged care services***
- ***sequence reforms carefully to facilitate adjustment to the new system***
- ***establish an Aged Care Implementation Taskforce to oversee the implementation of the reforms and to liaise with stakeholders.***

# Summary of draft proposals

| *Current problem* | *Proposed reform* | *Main benefits of change* |
|---|---|---|
| ***Funding*** | | |
| *Principles to guide the funding of aged care to meet the challenges of the future* | | |
| The present funding regime is not delivering a sufficiently sustainable aged care system, and fails to adequately take into account consumers capacity to pay | Provide guiding funding principles to develop an aged care system that is financially sustainable, and better aligned to consumers needs and capacity to pay. | Move to a more equitable funding regime that supports the sustainable provision of the quantity and quality of aged care needed into the future. |
| *The major components of aged care need separate policy settings* | | |
| 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. |
| *Regulatory restrictions on community care packages and residential aged care bed licences* | | |
| 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.<br>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.<br>Consumer access to care will be substantially improved, regardless of their type of accommodation. |
| *Regulatory restrictions on residential accommodation payments* | | |
| 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 retention charges and give residents the choice of a periodic charge, an accommodation bond or a combination of these.<br>Limit accommodation bonds to the equivalent of periodic accommodation charges. But uncap such charges to reflect differing standards of accommodation. | Improves the capacity of the industry to meet the demand for residential high care services.<br>Improves the transparency of accommodation costs for residents and ensures that a bond reflects the actual cost of accommodation supplied. |

| *Current problem* | *Proposed reform* | *Main benefits of change* |
|---|---|---|
| ***Funding*** | | |
| *Co-contributions across community and residential care* | | |
| Consumer contributions, if allowed, vary and are not always related to cost of supply nor are they related to people's capacity to pay. | Rate of co-contributions to be determined by the Australian Government, and based on affordability and capacity to pay. | Consumer contributions will better reflect people's capacity to pay based on their wealth not just income. |
| | Where the care services provided are of a value above a set threshold (of around $100 per week), a comprehensive means test for care recipients' co-contributions will apply. | Below the threshold, a simpler test based on the age pension would be used for determining co-contributions. |
| Excessive or catastrophic costs of care could totally consume older people's accumulated wealth. | A lifetime stop-loss limit comprising 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. |
| *Assisting older Australians to pay for care and support* | | |
| Current arrangements provide an incentive for older people to sell their residence and 'over-invest' the proceeds in accommodation bonds. | Establish an Australian Pensioners Bond scheme to allow age pensioners to contribute proceeds from the sale of their primary residence. The bond is exempt from the assets test and income deeming rate, and can be drawn on to fund living expenses and care costs. | Pensioners have more choice in how they use their housing wealth. They can retain their pension benefits and access the bond to pay for care and other needs. |
| Financial products to access equity in one's home are limited in scope, expensive and not well supported by older Australians. | Establish an Australian Government backed equity release scheme to assist older Australians meet their aged care costs, whilst retaining their primary residence. | 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. |
| *Residential care for those of limited means* | | |
| Inadequate supply of residential aged care places for the financially disadvantaged. | Providers obliged to make available a proportion of their accommodation to supported residents, unless already exempted. | Ensures equitable access to residential care for those unable to pay for their own accommodation costs. |
| | Set on a regional basis, the obligation would be tradable between providers in the same region. | This flexibility will allow providers to pursue more efficient and innovative residential business models. |
| The Government subsidy for supported residents is inadequate. | The subsidy for approved basic standard of residential care accommodation for supported residents should increase to reflect the average cost of providing such accommodation. | The level of subsidy will sustain the commercially viable provision of supported accommodation (based on a twin room and shared bathroom). |

| *Current problem* | *Proposed reform* | *Main benefits of change* |
|---|---|---|
| *Scheduled prices, subsidies and co-contributions to reflect actual costs* | | |
| Government set prices do not fully reflect the cost of delivering services. As a consequence, the quantity and to some degree quality of aged care services on offer has suffered. | Regular, transparent recommendations from the new independent regulatory commission on the scheduled set of prices and related indexation, lifetime stop-loss limit, and approved basic standard of residential care accommodation. | 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** | | |
| *A single gateway into the aged care system* | | |
| Consumers face a complex and confusing array of entry points into the aged care system. | Establish an Australian Seniors Gateway Agency to provide information, assessment, care coordination and carer referral services, to be delivered via a regional network.<br>The Gateway Agency will facilitate the assessment of need and capacity to pay co contributions. | The Gateway Agency will make the aged care system easier to access and navigate for potential aged care recipients and will be more efficient because it will remove duplication of some services and provide greater care coordination. |
| *Care continuity and consumer choice* | | |
| At present, community care is provided in discrete care silos, and moving between these is problematic for consumers. | Replace current discrete care packages with a single system of integrated and flexible care provision. | Consumers will have better access to services appropriate to their needs as these needs change. |
| Consumers have limited choice about the mix of services they receive and the provider of those services. | The Gateway Agency will approve a set of services to individuals on an entitlement basis. Individuals may choose an approved provider or providers. | Consumers will be able to exercise greater choice about who provides those services. |
| | To support these arrangements, fund an expanded system of consumer advocacy services and provide care coordination and case management as needed. | Expanded consumer advocacy services and other supports will assist informed choice, particularly among vulnerable consumers. |
| *End-of-life care* | | |
| 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 case mix 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. |

| *Current problem* | *Proposed reform* | *Main benefits of change* |
|---|---|---|
| *Block funding of care and support services* | | |
| Many current programs that are block funding should receive funding through consumer entitlement commensurate with usage. But some will need to be directly funded. | Governments should only block fund programs where a detailed consideration of scale economies, generic service need and community involvement indicates there is a need to do so. | Direct funding would target a limited number of programs to ensure sustainability or where entitlement funding is not appropriate such as for wellness or social inclusion activities, some remote and Indigenous services. |
| *Improving the interface between aged care and health* | | |
| Limited integration of services between health and aged care service providers leads to inappropriate hospital admissions and care.<br>Current health services are not sufficiently responsive to aged care needs. | Promote the expanded use of in-reach services to residential aged care facilities and the development of regionally or locally-based visiting multidisciplinary health care teams. | Improve wellbeing of residents from not having to move between residential and hospital care, reduce cost burdens on the health system.<br>Teams will develop expertise in aged care, deliver more responsive services and attract health workers to this sector. |
| **Catering for diversity** | | |
| *Caring for special needs groups* | | |
| 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 negatively affect the wellbeing of the older person receiving care. | The proposed Australian Seniors Gateway Agency should cater for diversity by providing interpreter services and diagnostic tools that are culturally appropriate for the assessment of care needs. | Improved assessments of care needs and improved delivery of appropriate care for people from culturally diverse backgrounds will help enhance consumer wellbeing.<br>Newer diversity needs will be better recognised including gay and lesbian care recipients and refugees. |
| Caring for special needs groups can involve added costs, which are not fully reflected in scheduled prices and subsidies. | The proposed Australian Aged Care Regulation Commission, 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 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.<br>Help to ensure sustainable, culturally appropriate services. |

| *Current problem* | *Proposed reform* | *Main benefits of change* |
|---|---|---|
| **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 to meet the access needs of older people with functional limitations, for use when people wish to modify their house. | 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 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. |
| *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.<br>Differing state and territory retirement village legislation impose costs which deters investment. | State and territory governments should pursue nationally consistent retirement village legislation under the aegis of COAG. | Greater transparency in financial arrangements and residents' contracts.<br>Reduce a significant impediment to new investment in the industry. |

| *Current problem* | *Proposed reform* | *Main benefits of change* |
|---|---|---|
| **Workforce issues** | | |
| *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.<br><br>Carer support is currently administered in an ad hoc way across a number of programs and jurisdictions. | The Gateway Agency, when assessing the care needs of older people, should also assess the capacity of informal carers to provide ongoing support.<br><br>Carer Support Centres be developed from the existing National Carelink and Respite Centres to provide a broad range of carer support services. | Encourage a strong and sustainable community of informal carers.<br><br>Ensure carers access the services they, and those they care for, need and are entitled to receive.<br><br>Make respite and other services more easily accessible and responsive to the needs of informal carers. |
| *Improving employment conditions for the formal care workforce* | | |
| Inadequate funding and indexation mechanisms diminish aged care providers' ability to pay competitive wages. | Scheduled prices for aged care should take into account the need to pay competitive wages to nursing and other care staff delivering aged care services. | The payment of competitive remuneration for aged care workers should reduce the lack of parity and enhance the attractiveness of the aged care sector to employees. |
| 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 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 among medical, nursing and allied health students. | Increase the willingness of health professionals to enter the aged care sector. |
| *Improving conditions for volunteers* | | |
| Organisations face significant costs associated with organising, training and managing volunteers.<br><br>Activities can impose substantial costs on volunteers. | Scheduled prices for aged care should take into account the costs associated with: volunteer administration and regulation; appropriate training and support for volunteers; and reimbursement of volunteers' out-of-pocket expenses. | Reduce barriers to individuals volunteering and improve organisations' ability to harness volunteers. |

| *Current problem* | *Proposed reform* | *Main benefits of change* |
|---|---|---|
| **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.<br><br>A number of regulatory functions are undertaken by multiple jurisdictions, agencies and departments. This duplication creates confusion for providers and adds to regulatory costs incurred by the industry. | Establish a new regulatory agency — the Australian Aged Care Regulation Commission (AACRC) — with statutory offices and Commissioners for Aged Care Standards and Accreditation and for Complaints and Reviews.<br><br>Also to have responsibility for recommending scheduled prices, subsidies and rate of indexation, and administering prudential regulation. | Removes potential conflicts of interests, ensures greater independence of regulatory roles and, thus, establishes a more effective regulatory governance structure. |
| Complaint handling within DoHA creates conflicts of interest.<br><br>A complex management and accountability structure exists within the Complaints Investigation Scheme and the Office of Aged Care Quality and Compliance. | The Australian Aged Care Regulation Commission (AACRC) should handle complaints by consumers and providers in the first instance.<br><br>Appeals in respect of its decisions and those of the Australian Seniors Gateway Agency should be heard by the Administrative Appeals Tribunal (AAT).<br><br>Abolish the Office of the Aged Care Commissioner and give consideration to the establishment of an Aged Care Division within the AAT. | Create an independent complaints handling process which is separate from the funding and policy department.<br><br>Provide a separate mechanism to determine appeals at arm's length to both the proposed independent regulator and the proposed Gateway Agency. |
| *Publicising information about assessments of the quality care provided* | | |
| 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 quality assessments using the Community Care Common Standards, consistent with the current publication of quality of care assessment of residential aged care. | Assist providers and consumers in making informed decisions about the aged care services they supply or receive. |
| *Encouraging and enforcing compliance* | | |
| The range of enforcement options is limited, which in practice restricts their usefulness. | Provide a range of enforcement tools to the Australian Aged Care Regulation Commission to ensure that 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. |

| *Current problem* | *Proposed reform* | *Main benefits of change* |
|---|---|---|
| *Putting streamlined reporting requirements into place* | | |
| 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 (SBR). | Reduce unnecessary costs to providers while delivering timely reporting information to the regulator. |
| *Reducing the extent of some mandatory reporting requirements* | | |
| 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. |
| *Clarifying and simplifying jurisdictional responsibilities and harmonising some regulations* | | |
| 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. |
| **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. | The Australian Aged Care Regulation Commission should perform the role of a national 'clearinghouse' for aged care data.<br>Introduce measures to improve the usefulness, collection and public reporting of aged care data. | Provide a better evidence base for government policy and for decision making by providers, care recipients and their families.<br>Improve transparency within the sector. |
| **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. |

# 1 About the inquiry

## 1.1 Background to the inquiry

Australia's population, like that in many other countries, is ageing. This means 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 400 000 in 2010 to 1.8 million by 2050 (Treasury 2010).

The ageing of our population is largely in response to improvements in life expectancy. In 1983, a Australian female reaching the age of 65 could expect to live on average for another 18 years, while an Australian 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 have increased further — to 24 years for females and 21 years for males (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 Benevolent Society agrees, but 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 forty years. This equates to over 2.5 million older people 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 by 2050 (Treasury 2010).

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 (Treasury 2010). Clearly a productivity driven reform agenda will increase the capacity of the economy to meet the higher costs of aged care.

The older population themselves will, on average, be 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 the 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. (2010, p. 3)

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's recent White Paper — *Building the National Care Service* noted that:

> 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 decline in family support and informal carers and strong competition for workers from within parts of the health system.

Weakness 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:

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

## 1.2 The Commission's brief

In view of the well documented weaknesses of the current system and the future challenges, the Government asked the Commission (in April 2010) 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 program)
- 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. The final report will now be submitted to the Government in June 2011.

## 1.3 What is aged care?

Over recent times, the community and governments have broadened their approach to the care of older Australians. 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.

Within this broad approach, formal 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).

Most aged care is provided by informal carers (such as partners and daughters). 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 conditions, 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 (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 consisting of:

> … a wide set of services to people who, due to their reduced degree of functional capacity, physical or cognitive, have prolonged difficulties with performing Activities of Daily Living (ADLs) such as washing, eating, getting in and out of bed. Furthermore, in many cases, Instrumental Activities of Daily Living (IADLs) (such as housework, meals, shopping and transportation) are also hampered and require assistance. People most affected by a need for long-term care are those with (multiple) chronic illnesses, with (mental) disabilities, and older people. (2010, p. 4)

A 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:

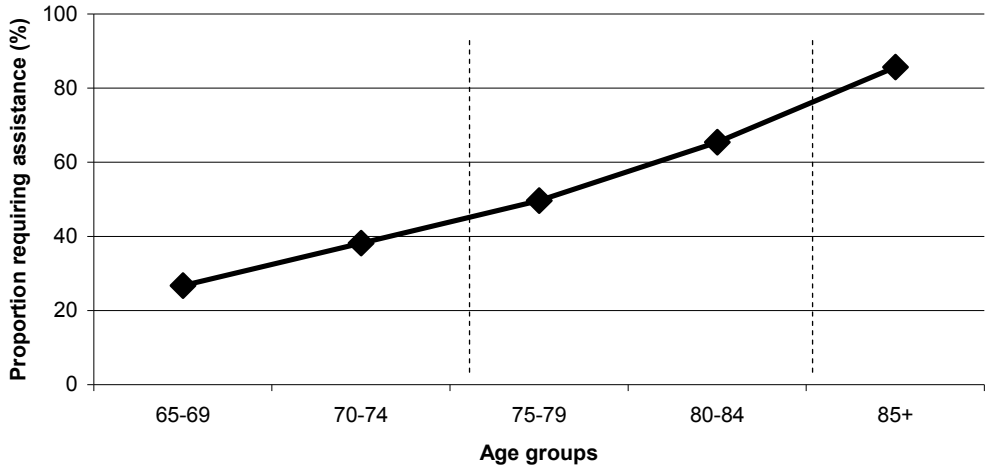
> … the system of activities undertaken by informal caregivers (family, friends and/or neighbours) and/or professionals (health and social services) to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences,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

The Department of Health and Ageing (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 (figure 1.1) can create a need for assistance with everyday living activities and, progressively, personal care. 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).

## Figure 1.1 Need for assistance by age of older person, 2003




*Data source*: 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).

## 1.4 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)

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.

## 1.5 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 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 older Australian's independence, 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.

## 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 World Health Organization 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 (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 (OECD 2005) 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 National Health and Hospitals Reform Commission 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 old age cohort.
- 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.

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; 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 available quantitative and qualitative evidence relevant to assessing the benefits and costs of the current system and options for reform. The Commission has also undertaken preliminary modelling and empirical analysis to assess indicative public and private costs and benefits of its proposals and how they might affect older Australians. This draft presents the initial results of this work. 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 B.

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 have also been generous in the provision of data to the Commission.

The Commission's initial views on an appropriate transition path from the current aged care system to a preferred system are set out in this draft report. The Commission will draw on feedback from participants and its own further analysis to develop a detailed transition path in the final report.

## Extensive public input

In preparing this draft 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 500 submissions.
- It met informally with a broad cross-section of interested parties within Australia, including: older Australians and their representative organisations; providers of community and residential aged care; health and aged care professionals and researchers including those in fields such as nursing, general practice, geriatrics, allied health and personal care. In all, the Commission undertook more than 150 visits.
- To gain a better understanding of various key issues, the Commission held roundtables on the topics of funding, the workforce, service delivery in rural and remote areas, accommodation, care and technology.

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. That inquiry is scheduled to release its draft report in late February 2011 and its final report in July 2011.

In its final *Caring for Older Australians* report, the Commission will recommend the most appropriate funding, assessment and service delivery arrangements for people with disabilities who are ageing, and older people who incur a disability. In defining an appropriate interface between the two systems, the Commission is mindful of the importance of the service provision being seamless for the person receiving care. Services should be drawn from the sector with the most relevant expertise, irrespective of the funding source.

The Commission will outline its preliminary preferred option on the split in funding between the aged care and disability sectors in the draft disability care and support inquiry report.

## 1.6 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 a perspective of aged care and how it is defined.
- 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 views and draft recommendations on:

- a proposed funding model (chapters 6 and 7)
- a new model for care and support services (chapter 8)

- care for special needs groups and other diverse groupings of older people (chapter 9)
- aged-friendly housing and retirement villages (chapter 10)
- carers and the aged care workforce (chapter 11)
- a new regulatory framework (chapter 12)
- deficiencies in aged care data and improved collection and dissemination arrangements (chapter 13)
- a transitional framework to support the implementation of the Commission's draft recommendations (chapter 14).

Additional supporting analysis is contained in appendices to the report. Appendices B to F 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 the states and territories 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 (see, for example, AIHW 2009a; DoHA 2009e; SCRGSP 2010b).

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 and 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[1]. 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.

[1] A more detailed outline of the history of aged care in Australia can be found in DoHA's sub. 482, p. 41.

In 1985, the Australian, 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 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) packages 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[2]
- 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[3] (which also specify the Government's aged care objectives — box 2.1).

2 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.

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

- The *Aged Care Act 1997* governs residential care, community care packages, Multi-purpose Services, 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).

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.

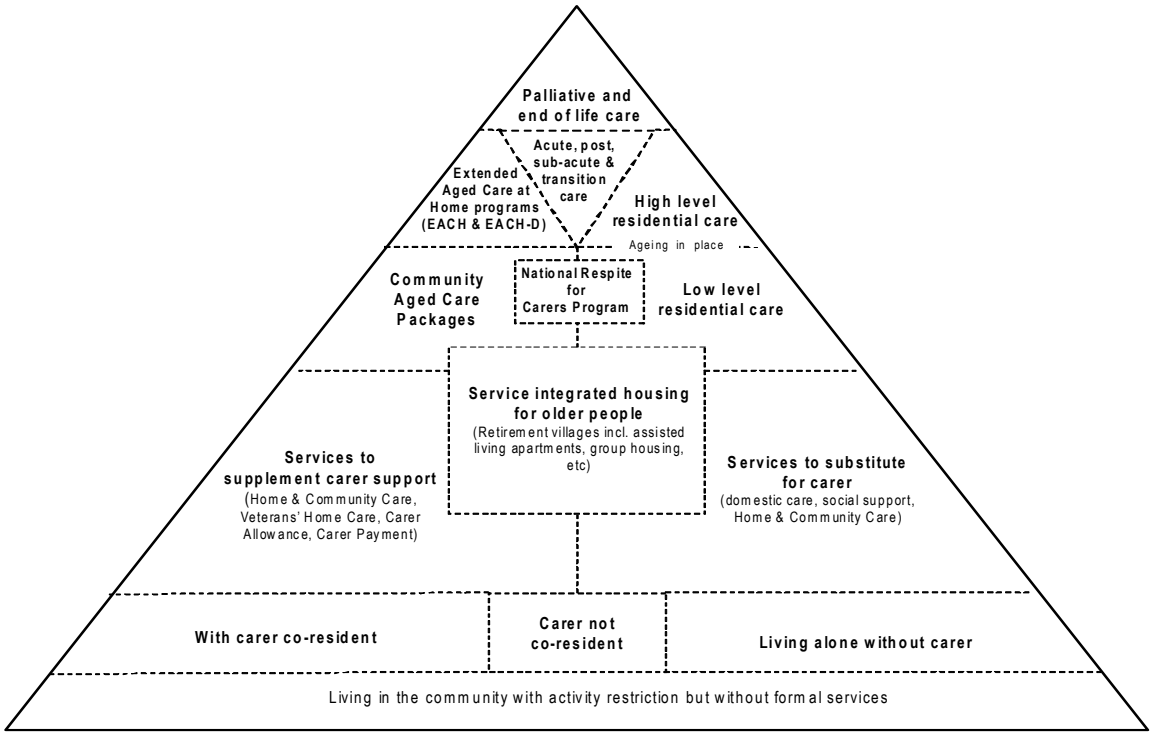
Objectives of the *Home and Community Care Act 1985*:

- 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., Consultant Gerontologist, Melbourne, pers. comm., 18 May 2010.

Most older Australians, including those who receive formal aged care services, live at home. As the 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 11). 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. The 2003 ABS Survey of Disability Ageing and Carers found that there were 240 000 people who were the primary carers of people aged 65 years and over (ABS 2004). The Productivity Commission (PC 2008) estimated that there were approximately 2.3 million people providing some level of informal care to the aged in 2006.

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 through 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]**

| *Program* | *Clients* |
|---|---|
| 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] | 69 600 |
| DVA Community Nursing[d] | 31 400 |

[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); the Department of Veterans' Affairs DMIS Service Item Cube (extracted 29 October 2010).

### *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 | × | 81.5 | 68.3 | 61.6 |
| Meals at home or a centre | 19.5 | × | × | 13.7 | 7.4 | 8.1 |
| Other food services | 0.6 | × | × | 21.4 | 35.3 | 34.6 |
| Transport services | 17.0 | × | × | 20.8 | 9.9 | 14.2 |
| Home or garden maintenance | 17.8 | 18.7 | × | 11.6 | 11.4 | 11.2 |
| Activity programs | 10.9 | × | × | 3.1 | 9.8 | 9.8 |
| Social support | 12.0 | × | ✓ | 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 | × | ✓ | ✓ | 11.7 | 18.0 |
| Counselling (carer) | 1.3 | × | × | × | × | × |
| Goods and equip. | 3.1 | × | × | ✓ | ✓ | ✓ |
| Home modifications | 4.3 | × | × | ✓ | ✓ | ✓ |
| Respite care | 2.2 | 8.3[b] | × | 4.4 | 32.2 | 44.0 |
| Linen services | 0.3 | × | × | 0.7 | 2.0 | 2.6 |
| Accommodation and related services | × | × | × | × | × | × |
| **Specialist services** | | | | | | |
| Nursing (home and centre) | 21.1 | × | 78.7 | × | 21.9 | 16.9 |
| Allied health/therapy (home and centre) | 19.5 | × | × | × | 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. × 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**

Research undertaken by 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 Institute considers this figure to be an underestimate.

About 85 per cent of the community care workforce were 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 has been 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*, funding 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).[4]

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 list of services). These programs offer a range of services similar to those available through HACC. In 2009-10, 69 600 veterans aged 70 years or over received VHC and 31 400 received Community Nursing.[5]

4 The component of HACC related to persons with a disability is excluded from the Agreement.

5 From the Department of Veterans' Affairs DMIS Service Item Cube, extracted 29 October 2010. 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.

### *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).

CACPs typically provide around five to six hours of direct assistance per week, primarily for home help (including meals and laundry) and personal care (including showering and dressing) (SCRGSP 2010b).

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 packages typically provide around 15 to 20 hours of assistance per week, while EACH-D packages are designed specifically for people who experience behaviours of concern and psychological symptoms associated with dementia (SCRGSP 2010b).

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).

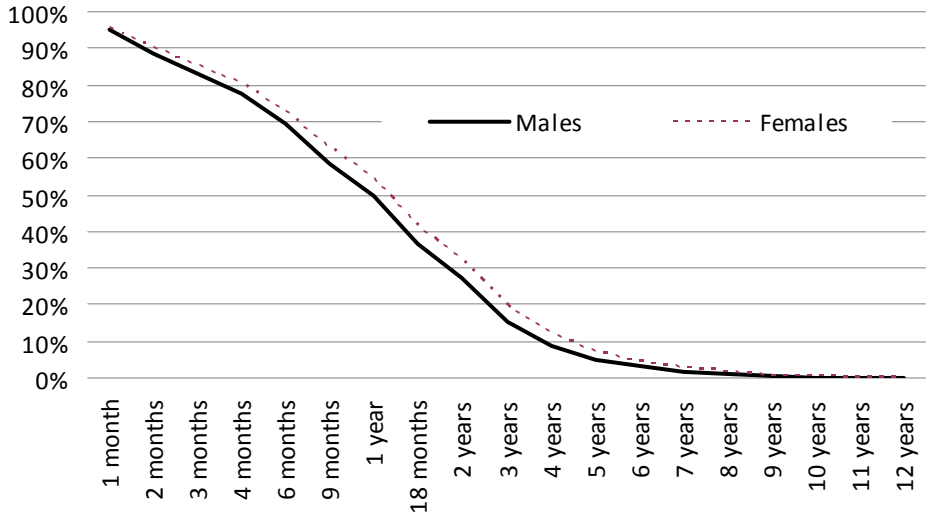
Most people do not receive community care services for an extended period of time. The median length of stay on a community care package for anyone who received community care between July 1997 and December 2009 was just under 12 months for males and 14 months for females.[6] However, there is considerable variation in the length of time people spend receiving services from packages (figure 2.2).

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

6 Data from the DoHA *Aged Care Data Warehouse* draws on administrative data sourced from the community care payments system.

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). 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). That 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 differ 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) 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 twenty 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

| Year | *Residential high care places* | *Residential low care places* | *Total residential places* | *CACP packages* | *EACH & EACHD packages* | *Total community packages* | *Total aged care places & packages* |
|---|---|---|---|---|---|---|---|
| 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); SCRGSP (2006); Pyne (2007); Santoro (2007); PC (2008).

### *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[7]. 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. Of these, 70 per cent received high level care (DoHA 2010n). In recent years, around 70 per cent were female and 55 per cent were aged 85 years or older.

7 '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.

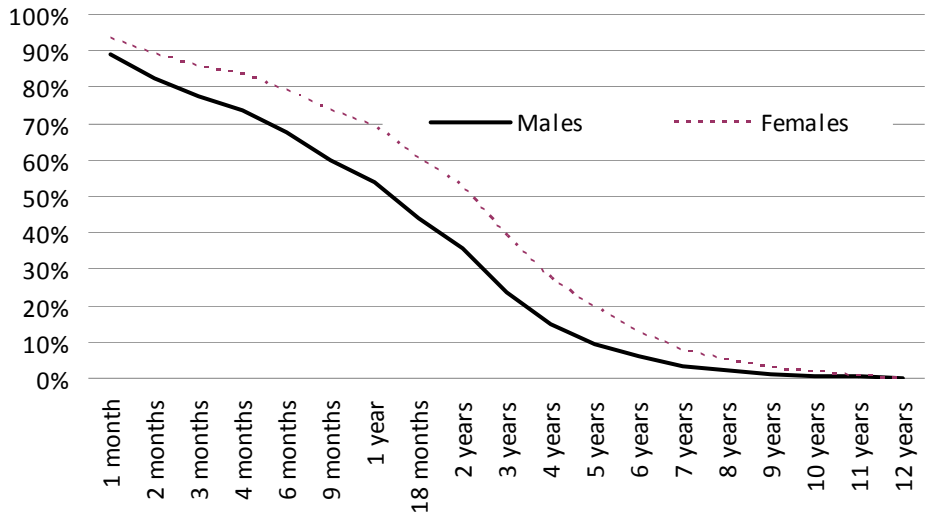
Generally, there has been a steady increase in the proportion of residents being classified as needing high level care. That is, an increasingly dependent and frail group of older people have been entering residential aged care. Between 1998 and 2008, the proportion of high care entrants rose from 58 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 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[8]. However, similar to community care packages, there is considerable variation in the length of time people spent in residential care (figure 2.3).

As at 30 June 2010, there were 2773 aged care facilities in Australia delivering formal residential care. Around 59 per cent of the beds were operated by NFPs; 35 per cent by commercial organisations; and 6 per cent by state and local governments (DoHA 2010). 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).

8 Data from the DoHA *Aged Care Data Warehouse*, drawing on administrative data sourced from the community care payments system. Data supplied 24 September 2010.

Assessments of older people for entry into residential care are undertaken by ACATs. An Aged Care Funding Instrument (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 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 (RCS), 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, Multi-purpose Services (MPSs) 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.

MPSs integrate 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, state and 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 to 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, p. 3). The RVA also estimate that the national penetration rate could increase to 7.5 to 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 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 2008-09, total direct government expenditure on aged care services was around $10.1 billion[9]. 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.

9 This figure includes combined Australian Government and state and territory government expenditure on aged care services, reflected in table 2.4, for 2008-09 only. The proceeding discussion in the text cites Australian Government expenditure on aged care services for 2009-10 as state and territory government expenditure for that year is not yet available.

Table 2.4 **Government expenditure on aged care services, 2008-09[a]**

| *Expenditure component* | *$ million* |
|---|---|
| Assessment and information services[b] | 93 |
| Residential care services[c] | 6 654 |
| Community care services[d] | 2 935 |
| Services provided in mixed delivery settings[e] | 397 |
| **Total** | **10 079** |

[a] 2009-10 data is not available for combined Australian Government and state and territory government expenditure amounts for aged care services. [b] Assessment and information services include only Australian Government expenditure. [c] Residential care services include DoHA and DVA (including payroll tax supplement) and state and territory governments' expenditure. [d] 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. [e] 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 (2010b).

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 2010). 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 2008).

Government spending on CACPs was $510 million, with $306 million spent on EACH and EACH-D packages in 2009-10 (DoHA 2010). 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 2008).

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 2010).

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, 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 a full pensioner 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* — residents with assets in excess of $38 500 who enter high care may be asked to pay an accommodation charge. The charge increases to a maximum of $28.72 per day for residents with assets of just over $98 000.

*Accommodation bonds* — 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 $38 500 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 (this amount is fixed at the rate applying 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 home is exempted from the pension assets test for two years for people entering residential care (and longer if the person's partner is living at home). If a resident's former home is rented out to pay some or all of a periodic payment for an agreed accommodation bond, the former home and the rental income are exempt from the age pension assets and income tests for as long as the home 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).

*Source*: DoHA (2010n).

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 2010).

The average bond is now more than three and a half times that in 1998 (when the average new bond value was around $60 000), while 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

This section provides a broad overview of government regulation of the aged care system. A more detailed description is provided in Appendix E (Aged care regulation), and issues relating to aged care regulation are examined in chapter 12.

### 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.

### *Governance arrangements*

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. Its legislative functions are set down in the *Aged Care Act 1997*, the *Accountability Principles 1998*, and the *Accreditation Grant Principles 1999*, 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 community care programs and the HACC Program) must also be *approve*d under the *Aged Care Act 1997*, but are subject to a number of different quality standards and reporting arrangements. COAG-based negotiations are expected to agree to common standards through a National Quality Reporting Framework (NQRF) comprising:

- efficient and effective management
- access to services
- information and consultation
- coordinated, planned and reliable service delivery
- privacy, dignity, confidentiality and access to personal information
- complaints
- advocacy.

*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 community aged care packages 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*.

*Appeals*

The Office of the Aged Care Commissioner (OACC) has been established independently of DoHA. The Aged Care Commissioner (the Commissioner) is appointed by the Minister for 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 Commissioner may only make recommendations (generally to the Secretary of DoHA) when examining complaints. While the Commissioner is a statutory appointment, the Commissioner's officers are DoHA employees.

## 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), nurse practitioners and allied health professionals (see chapter 8 for a detailed discussion).

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 million 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 85 years and older. There will also be a temporary bulge in demand as the baby boomer generation reach this age.
  - While age specific rates of disability may have been declining slowly, the limited available evidence suggests any effect on reducing demand for aged care is out-weighed by the longevity effect as the rate of disability rises with age.
  - Longevity also brings a 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 from non-English speaking backgrounds who want services that meet specific needs
  - Aboriginal and Torres Strait Islander people who require culturally 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.
  - More 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 to enable 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.

The demand for aged care services depends on the number of older people needing care and support services and the quantity and cost of those services. Care needs are dictated by physical and mental health needs, and affected by preferences. Older peoples' preferences will be shaped by their cultural and linguistic background and the lifestyle they wish to have in their old age. The home and community in which an older person lives and the availability of family or friends to provide informal care will also affect demand, as will the type, quality and personal cost of the service on offer and the persons' capacity to pay. So too will policy settings that affect any of these factors or alternative sources of care.

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. An understanding of the broad drivers of demand for aged care services is important to: assess the types and quantities of services required; the capacities of carers, providers, and the workforce to deliver that care; and the cost of publicly funded subsidies for aged care.

This chapter explores each of these issues as set out in figure 3.1.

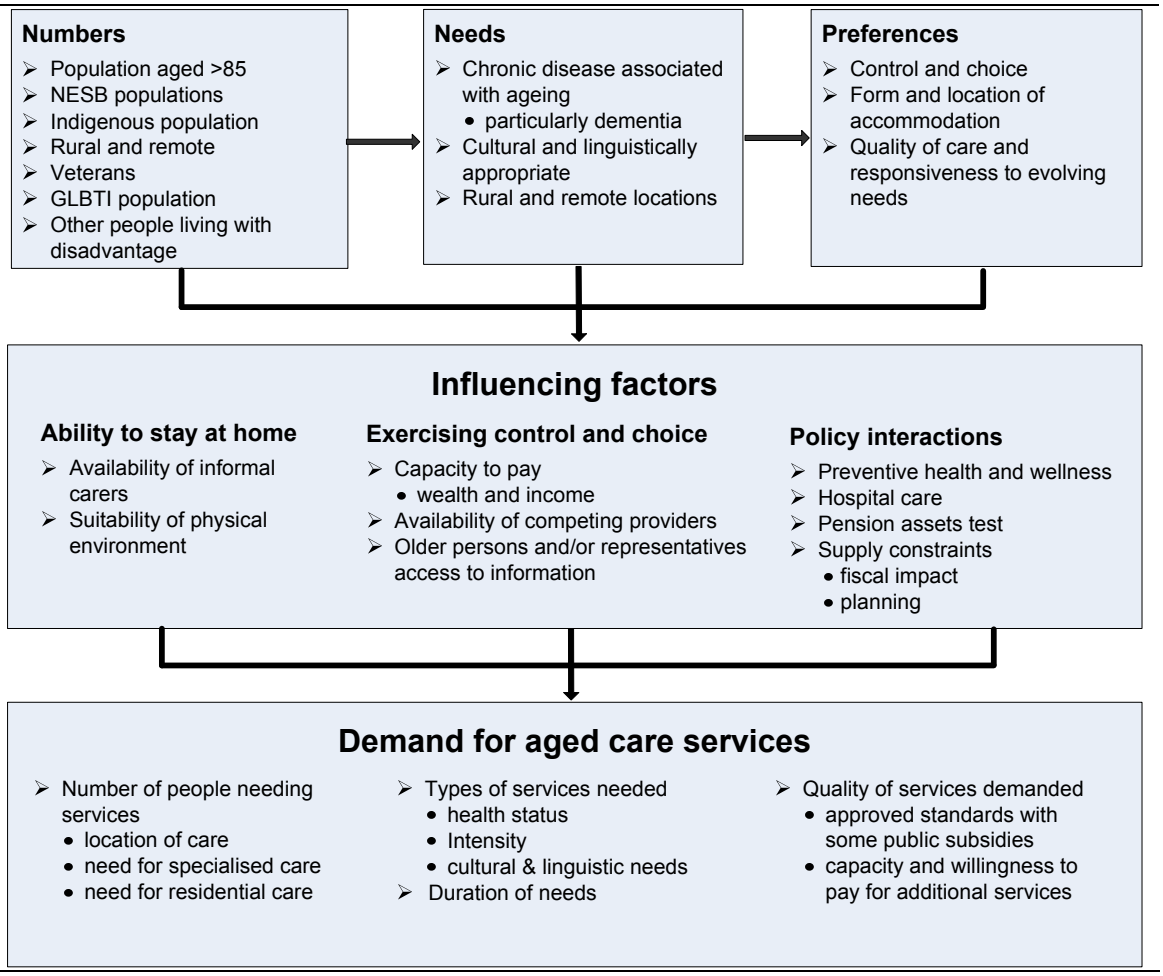
## 3.1 Population ageing and demand for aged care

The demand 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 million to just over 1.8 million (table 3.1). Much of this growth will occur after 2020. Moreover, the increase in the size of older cohorts is greater at older ages. For example, the number of centenarians is projected to increase almost fourteen fold by 2050 (table 3.1).

There are two effects at work. The first is the increase 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 (DoHA, sub. 482, p. 31). The second effect is the change in the growth rate of the population, particularly for the baby boomer generation. This cohort, born between 1947 and 1964, is the product of unusually high family sizes compared to the previous and subsequent generations (Gibson 2010).

As a result there is a progression toward a permanently higher proportion of older people as a share of the population, as well as a 'bulge' of baby boomers. This bulge will result in a higher growth in demand for aged care over the period 2030 to 2050 than would otherwise be the case.

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




## 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 | 21 487 000 | 23 584 000 | 25 645 000 | 27 744.000 |
| | 86.51% | 83.63% | 80.68% | 78.72% | 77.38% |
| 70+ | 2 092 000 | 2 950 000 | 4 143 000 | 5 286 000 | 6 232 000 |
| | 9.41% | 11.48% | 14.17% | 16.22% | 17.38% |
| 85+ | 365 000 | 53532 000 | 802 000 | 1 319 000 | 1 815 000 |
| | 1.64% | 2.07% | 2.75% | 4.05% | 5.06% |
| 100+ | 4 000 | 7 000 | 14 000 | 24 000 | 50 000 |
| | 0.02% | 0.03% | 0.05% | 0.07% | 0.14% |

*Source*: Data provided by Treasury.

In practice, there is little that governments can do to change the age profile of the population. The effect of higher fertility rates is very small, takes many years to work through, and is not readily influenced by government policies. Although migration has been a moderating factor on the overall demographic profile it has not prevented, and even at the present levels which are relatively high 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. With the increase in longevity there will be a growing number of older people in our population. Offsetting this trend are improvements in health and interventions that lower the age specific disability rates. The current trend in 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 such matters as the health of the population and medical advances.

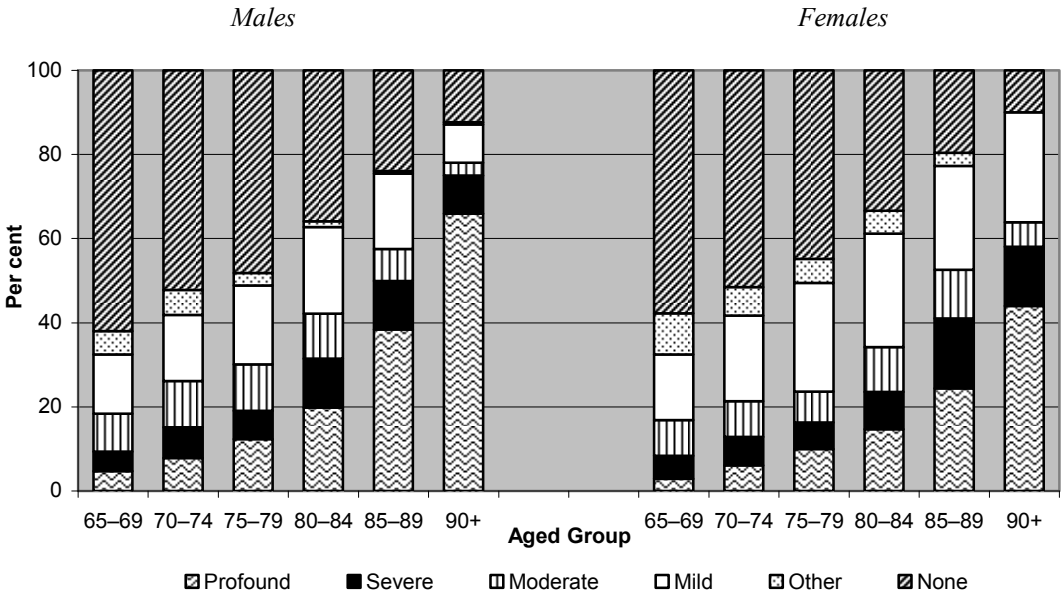
The international evidence on the likely net effects of longevity on disability rates is mixed (OECD 2007). Socioeconomic advances, including rising incomes, levels of education and living conditions, are linked to improvements in health and the functional status of older people (Cutler, Landrum and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

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).

Another source of evidence is the ABS survey of Disability, Ageing and Carers (SDAC) which 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 latest

SDAC survey (in 2009), 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, 2003**




*Data source*: Survey of Disability, Ageing and Carers 2009, table 2, ABS (2010).

The use of services by each age cohort provides another indicator of the level of age-related disability. The Australian Institute of Health and Welfare (AIHW) reports the usage of HACC, CACP, EACH and EACH-D packages and residential aged care per thousand people in the relevant age group (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 demand arising from age-related disability. Given the constraints within the planning ratios (chapter 2), these estimates may also not reflect demand for community care relative to residential care.

Overall, the rates of use of most services is roughly twice as high for the 85 years plus cohort than for the 75–84 years cohort.

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).

Assessing trends in disability is difficult. Both the Census and the ABS 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.

The SDAC was conducted in 1998, 2003 and 2009. Overall there was a statistically significant decline in the self-reported rates of disability for the population as a whole 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 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.

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 would be due to the higher share of aged

people who live with a disability being able to remain in their own homes, so a broader analysis of all formal care is needed to give a clear 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 appropriate sensitivity analyses, has highlighted that even relatively modest reductions in disability rates among the aged could have a significant impact on the demand for aged care (Treasury 2010, p. 145).

## The nature of disability may be changing

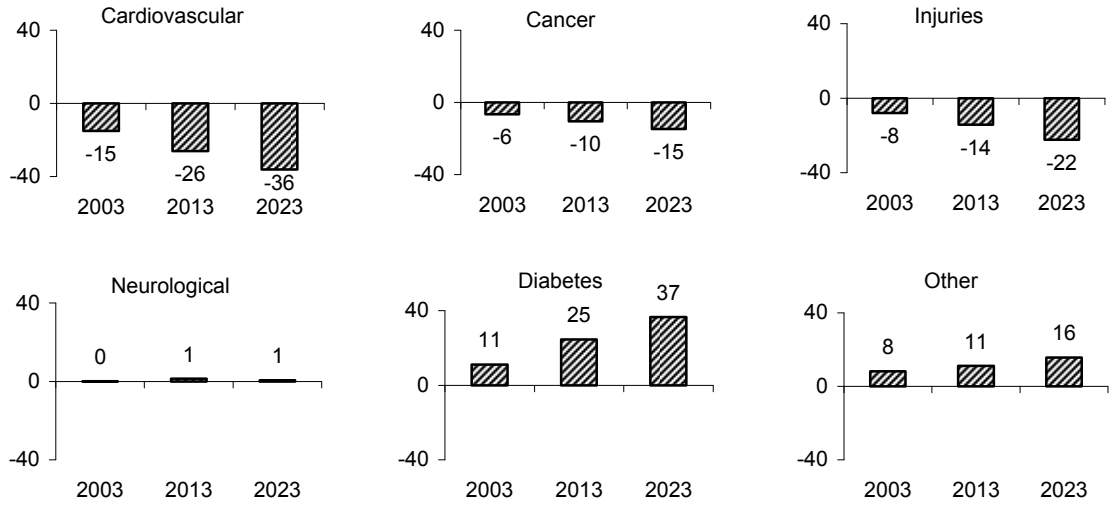
A consequence of increasing longevity is that the pattern of diseases that people experience changes. Improvements in lifestyles and better disease management have reduced the prevalence of many debilitating diseases. However, offsetting these gains is the marked increase in the prevalence of chronic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

Figure 3.3 **Percentage change in disability (PYLD) prevalence rates since 2003 for selected major causes in people aged 85 years and over, Australia, 2003 to 2023[a]**




**a** Prevalent years lived with disability (PYLD).

*Data source*: AIHW (2007b, p. 120).

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 Organisation (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 (2009, recommendations 55–56) recommended strengthening access to specialist palliative care services in residential and community care settings.

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. For example, at current prevalence *rates* of the various neurological diseases that can cause dementia (around 22.4 per cent for people over the age of 85), the number of people suffering from dementia is projected to increase from around 257 000 in 2010 (1.2 per cent of the population) to around 981 000 by 2050 (2.8 per cent) (Access Economics 2010a). 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.

The picture in relation to dementia and obesity induced diabetes is not, however, all negative. The disabling consequences may be mitigated by advances in treatment and prevention and cure in the future. Public health programs can also 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.

While these developments can result in a relative decline in demand for aged care services, this may not reduce pressures on overall expenditure. On the contrary, increased spending on health care is a precondition for lower disability (OECD 2006).

## 3.2 Communities with special needs are growing

The *Aged Care Act 1997* defines special needs groups for the purpose of promoting diversity in choice (see chapter 9). The growth in groups that are likely to have distinctly different needs will affect the relative demand for different types of services. The geographical location of people also matters as the efficiency of specialist service delivery will be affected by population density and distance. Although the sections that follow discuss each special needs group in turn, it is important to recognise that some older people may have several special needs and be counted in more than one group.

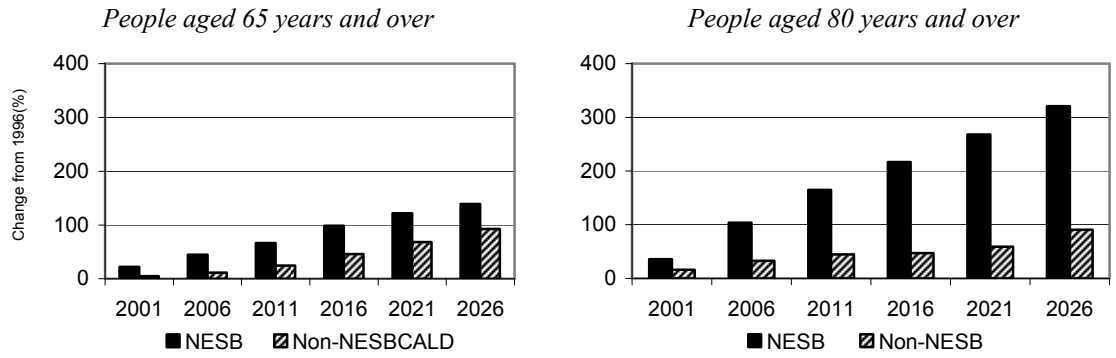
### Older people from non-English speaking backgrounds

Although communities from non-English speaking backgrounds (NESBs) have similar aged care needs to those of older people born in Australia, culture and language can add other dimensions to the provision of aged care (Howe 2006, p. 26).

The number of older Australians from NESBs is projected to increase substantially in the coming decades with growth 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 2016. This pattern of growth means that the 80 plus age group is projected to grow by over 300 per cent from 1996 to 2026 (figure 3.4).

Figure 3.4 **Projected increase of older Australians with and without non-English speaking backgrounds[a]**

Change from 1996

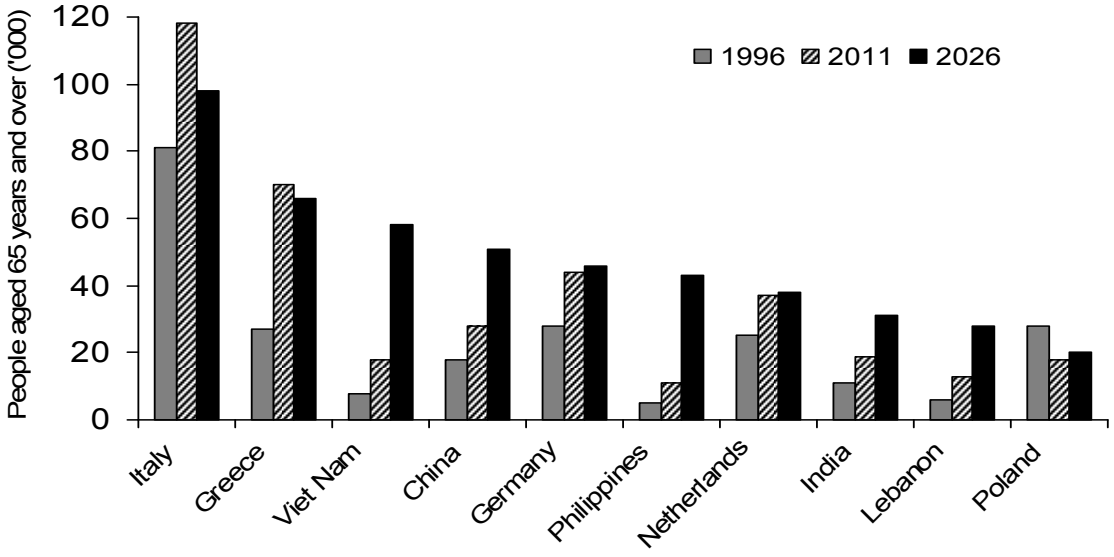



[a] Older people who do not have a culturally or linguistically diverse(CALD) background are either Australian-born or overseas-born but from the English-speaking countries.

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

Over this period, the diversity among Australia's older NESB population will increase, as different immigrant communities move into older age cohorts at different times (figure 3.5). 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.

Figure 3.5 **Projected numbers of older immigrants by selected countries**




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

There is considerable variation in where older people from NESBs live. At a state and territory level, Victoria is projected to have the most diverse NESB population as a proportion of those aged 65 years and over (28 per cent), followed by New South Wales (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 people with NESBs live in metropolitan areas, the NESB population is also widely dispersed across rural areas with concentrations in some rural towns (Howe 2006, p. 2).

The Ethnic Communities' Council of Victoria (2008, p. 3) has argued that these developments will require culturally and linguistically responsive, flexible and consumer oriented age care services. Services tailored in these ways recognise the benefits to the quality of life of older people of being able to maintain continuity with life patterns established at younger ages (Rowland 2007). Providing linguistically appropriate care to older NESB people suffering from dementia is particularly important as they often experience language reversion and forget their acquired English due to a cognitive impairment (Hogan 2004b). Access Economics (2006), in projections undertaken for Alzheimer's Australia, estimated that by 2050 6.4 per cent of people suffering 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.

Ethno-specific agencies are likely to find it easier to service the needs of the majority living in metropolitan areas than the smaller number in regional and rural areas. However, mainstream services are capable of meeting the needs of many NESB clients. As Howe points out:

> Many 'mainstream' services have adopted various strategies to enhance responsive(ness) to cultural diversity, most commonly by employing staff with a wide range of language skills and from cultural backgrounds of the local communities in which they work. (sub. 355, p. 18)

Moreover, a number of submissions suggested that many NESB older people prefer to receive services at home:

> Many NESB groups would rather care for their elders at home, rather than in a residential setting … NESBs leave residential care to the last possible moment when care needs are extreme … (DutchCare, sub. 128, p. 4)

> ECCV research shows that Australia's overseas-born seniors have strong preferences to stay living at home longer. (Ethnic Communities' Council of Victoria, sub. 169, p. 4)

This preference is reflected in the significantly lower use of residential aged care by older people from NESBs. For example, for the 85 years and over age group, the use rate of residential aged care per 1000 people for NESB people was 184,

compared with 238 for English speaking migrants and 248 for Australian born people in this age group. By contrast people in the NESB group tend to be over represented in community care (AIHW 2007a, table 43.1, p. 147).

## Aboriginal and Torres Strait Islander peoples

The care needs of older Aboriginal and Torres Strait Islander (ATSI) peoples are substantially higher than those of older non-indigenous Australians. For example, in 2006, 20 per cent of Indigenous people aged 55 years and over needed assistance with a core activity compared with 12 per cent for the same cohort of non-indigenous Australians (OID 2009). Because of a higher incidence of premature ageing, consequent on a generally lower health status, Indigenous people are usually considered to have aged care needs from age 50 onwards. For example, ATSI people experience a higher rate of dementia, however, they are less likely to receive a diagnosis or access services (Bogarty, sub. 45, p. 3). Moreover, there is some dispute about whether aged care services are an appropriate response to the health problems of Indigenous people in the 50–69 years age group (A Howe, sub. 355, p. 18).

Challenges relating to cultural appropriateness, geographical isolation, English-language proficiency, and greater needs for assistance, confront providers delivering care services to many Indigenous people. Although the wide spectrum of cultural and linguistic dimensions in older NESB communities listed above are similarly relevant, the issues are magnified in remote Indigenous communities. 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).

In 2006, 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 to care for older family members.

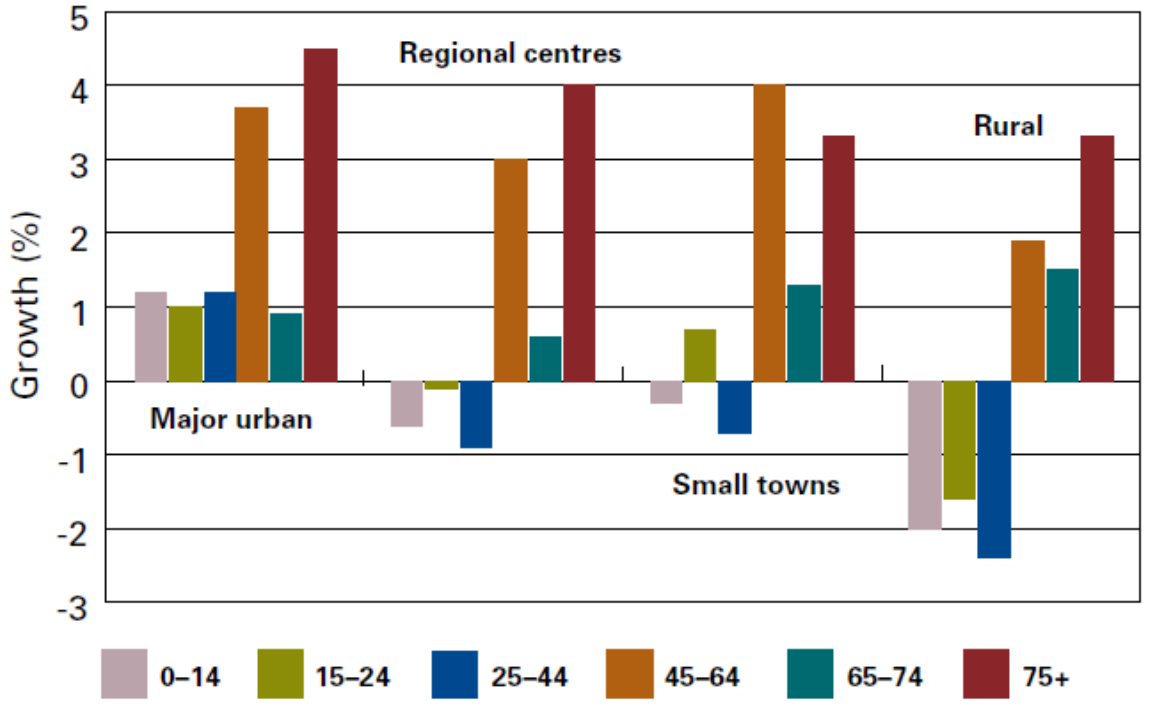
Australia's older Indigenous population is projected to grow more rapidly than Australia's total older population. By 2021, the older Indigenous population (aged 55 years and over) could more than double, from around 40 000 in 2006 to over 85 000 (ABS 2009). These estimates are based on the assumption that, over the projection period, life expectancy at birth increases by five years, by 2021 reaching 77.8 years for females and 72.1 years for males (from 72.8 years for females and

67.1 years for males in 2006). On the basis of these projections the demand for aged care services by Indigenous people will increase substantially.

## People living in rural and remote areas

On current trends, the population in rural areas (including small towns) is ageing more rapidly than in major urban and regional centres. 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. Ageing of those remaining in rural areas means that the older rural population is growing strongly — at over 3 per cent per year for the population aged 75 years and over (BRS 2008). This is despite significant migration of older people from rural to regional areas (figure 3.6).

Figure 3.6 **Average annual 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 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 relative to 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 2005, 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, 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.

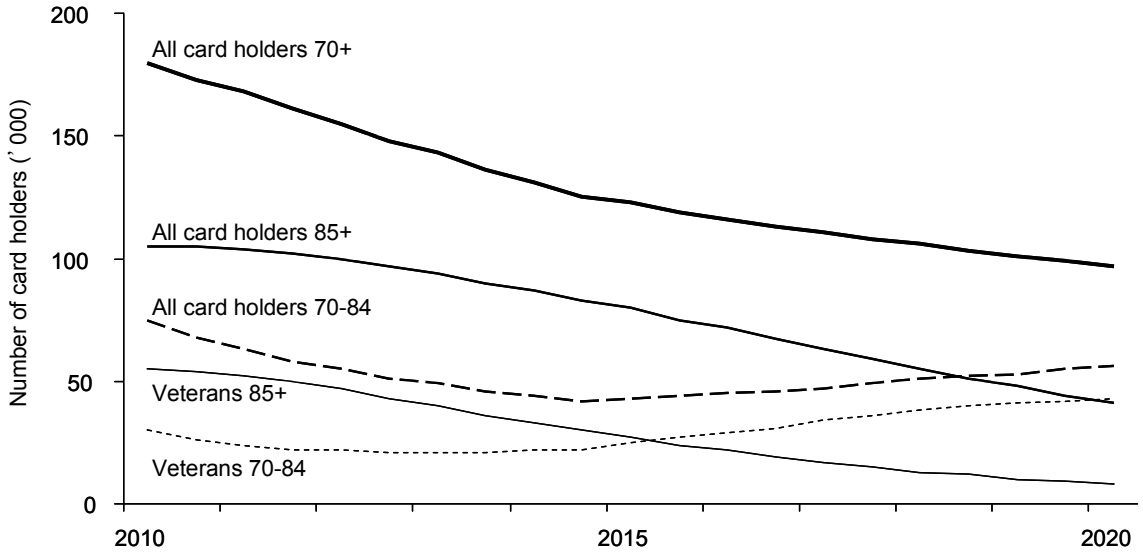
## Veterans

While 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, their numbers are trending downwards (figure 3.7).

From a clinical perspective, veterans are a distinct population insofar 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 markedly from the rest of the population (AIHW 2008a, p. 100).

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.

Figure 3.7 **DVA gold and white card holder projections**[a]




**a** Card holders comprise veterans, their dependents and war widows.

*Data source*: Department of Veterans' Affairs treatment population forecast, December 2009 version.

## Other special needs groups

The Social Inclusion Toolkit (Commonwealth of Australia 2009) identifies vulnerable communities as: homeless people; children at risk of long term disadvantage; Indigenous Australians; people living with mental illness or disability; communities experiencing concentrations of disadvantage and exclusion; jobless families, including the long-term unemployed and the recently unemployed ('the vulnerable unemployed'); and low skilled adults who are at greater risk of unemployment. Of these categories, the main groups of older persons not already discussed are homeless people and those living with a disability.

As with Indigenous people who experience multiple disadvantage, these groups of older Australians may need age-related care at a younger age, or a higher level of care due to disability, than the general population.

### *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 one year, the prevalence of homelessness could be three to five times that on any one night (Wright and Devine 1995).

Older homeless Australians, who are typically financially and socially disadvantaged, generally find it very difficult to access mainstream aged care service. In many instances, they are reluctant to seek out services or to assert their right to care. Winteringham (2009, p. 6) claims that older homeless people may not recognise that they require care and support and, with poor access to aged care, the most common outcome is premature death — often in the most appalling circumstances.

The trend in homelessness for older people is not known, and will largely depend upon policies other than aged care. The particular challenges facing policy makers and aged care providers in enabling homeless people to access services are discussed in chapter 9.

### *People living 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 are 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 disability are likely to have special needs as they age and at the same time retain responsibility for caring. While all carers should be assisted by services such as respite care to continue to undertake this role, this is particularly important for carers who themselves are experiencing age associated frailty. The physical demands of caring may require carers to seek an assisted living place sooner than they otherwise would have done (see chapter 11). But it is quite likely that they will want this to accommodate the person they are caring for in addition to themselves. This has implications for the type of accommodation these carers will demand as they age.

*Other special needs that affect demand*

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, is likely to place additional demands on residential care for more flexible accommodation arrangements for couples.

Gay, lesbian, bisexual, transsexual 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).

## 3.3 The effect of changing preferences on demand

While demographic projections provide a useful foundation for assessing the future magnitude of demand for aged care by groups with different types of needs, this is clearly not the whole story. 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 (see, for example, Boldy et al. 2009; Leeson, Harper and Levin 2003; Tanner 2001). And the baby boomers have experienced much greater capacity than previous generations to fulfil their desire for independence and control and to be able to satisfy their preferences.

### The nature of aged care accommodation and its location

As older people are less able to care for themselves, the majority prefer to remain, and be cared for, in their own home. This preference is reflected in a number of submissions, and is summed up well by Just Better Care:

> The majority of older Australians want to receive care and age in place in their own homes; a decision generally supported by their families and loved ones. (sub. 131, p. 1)

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 length and quality of time spent living at home, rather than in residential aged care, can be enhanced through:

- the availability of community-based services that provide care needs in the home (chapter 8)
- aged-friendly design and assistive technologies (chapter 10)
- the availability of informal care services from family and friends (chapter 11).

The current trend to ageing at home has been driven by preferences, and by belief that community-based services offer a saving of public funds through reduced demand for residential care. In part this is due to the structure of the current financial support for residential accommodation (see chapter 2). It is also in part due to the greater involvement of informal carers in the home, although at some point care becomes more expensive, and less efficacious, to provide at home (Howe et al. 2006).

As examined in chapter 8, there are different private and public costs and levels of effectiveness in delivering care and accommodation in community and residential care settings. A more transparent allocation of care costs and greater co-contributions for those who can afford it, will impact on the relative demand for the differing forms of care and the settings in which they are delivered.

Baby boomers appear more mobile than previous generations and more likely to live in variety of settings, either leased or owner-occupied (Baptcare, sub. 212, p. 12; Amaroo, sub. 98, p. 6). 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, p. 3). There is also some evidence that the age of entry to retirement villages is increasing, with the RVA reporting industry analysis that found:

> People are now moving into retirement villages later in life and often staying for longer periods because many of their care and support needs are met within a village. Residents are therefore departing more frail and delaying (or even negating) a move into higher levels of aged care. (sub. 424, p. 9)

The growth in retirement villages has had knock-on effects for community based aged care services. Many retirement village residents are ageing at home, with some receiving care services to remain independent. The growing number of older people

concentrated in congruent living arrangements provides scope for potential efficiency gains in delivering community care services (RVA 2007).

## Quality and the tailoring of services to meet demand

Quality means different things to different people. Many older people and their informal carers assess quality in subjective terms based on perceptions of how respectfully they are treated and the attention paid to their expressed preferences, as well as the ambience of their surroundings. For example, most older people will have preferences over their daily timetable or their menu, or who provides them with care services, and for them quality includes having control or choice over these aspects of their care.

### *Demand for greater consumer control and choice*

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 (Ergas 2006; Quine and Carter 2006; Fujitsu Australia and New Zealand 2007). 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)

Baby boomers have also become accustomed to more choice across a wider range of goods and services than previous generations. Commenting on this, Dowding and John (2008) observed:

> In virtually every area, the private sector offers more options than in the past and so people might come to expect choice from the public sector too — and making the choice experience more common across all social groups. (p. 12)

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.

*Choice requires supply to be able to respond to demand*

In reality, the scope for choice is limited by a number of factors. First, providers can only offer choice, or for there to be a choice of providers, where it is financially viable for them to do so. This depends not just on the level of public and private funding, but the costs of providing different options, particularly in 'thin' markets. Greater diversity could increase the unit cost of supply if the potential for economies of scale are reduced.

Second the client, or their carer, must have a capacity to make an informed choice, especially where the choice will have a significant effect on their wellbeing. Third, some have suggested that there is little real opportunity for older people to exercise choice once having entered a high care facility. However, the potential to be able to move can empower the resident to demand a better service from their current provider.

Finally, the preferences and needs of consumers will change over time. Indeed some people will, for periods, require no services yet at other times have high levels of demand. The aged care system needs to be able to respond to those changes in a timely manner by allowing periodic or consumer initiated reviews.

These issues are explored in chapter 8.

## 3.4 The influence of informal carers on demand

As discussed above, the ability of older Australians to remain at home depends on their own health, the suitability of their home and local community environment, the availability of family and friends to provide informal care, and access to formal community-based services.

The importance of the physical environment for ageing at home is discussed in chapter 10. The home and local environment affect the demand for formal aged care services as it influences the risk of falls and other accidents, access to transport and services, and the capacity to undertake activities of daily living. The availability of

informal carers is of even greater importance. And this supply is in turn affected by the formal care support services available (see also PC 2008).

## Demographic factors are reducing the ratio of informal carers 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 to 2.7 per cent over the same period (see chapter 6). While a widening of the traditional working age 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 (see, for example, 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 elderly 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 likely to decrease the availability of informal carers. Currently, 44 per cent of persons aged 65 years or older live by themselves (ABS 2005).

Against this trend, the increasing number of partners that are living longer could increase the availability of informal carers. According to the 2003 SDAC, partners comprise 34 per cent of all informal carers (ABS 2004). 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 willingness to provide informal care may also be declining

Increasing female workforce participation may compound the anticipated shortage of potential informal carers. That said, most 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. The proportion of women working part time has increased from 37.6 to 45.2 per cent between 1986 and 2006 (ABS 2007c). This need not be incompatible with performing a caring role. The 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 to 34 and 45 to 54 who are carers compared with those who are not carers (AMP and 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 (see, for example, Johnston 1995). 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, notes that there is considerable variation in the extent to which people accept family obligations. In his 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. (de Vaus 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 NESBs.

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 (see chapter 11).

### Effects on demand for formal care

Several analysts have used various approaches to explore the future availability of informal carers and, regardless of which metric is 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 their 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)

## 3.5 The influence of income and wealth on demand

The ability to exercise control and choice depends very much on how the private and public funding for aged care services is structured. There are also limits on what

public funding will support. Making a co-contribution for subsidised services can empower consumers to demand better services. Individuals have the greatest ability to exercise control and choice where they (or their representative on their behalf) purchase services additional to those included in the approved standard or assessed entitlement.

Choice itself can make an important contribution to wellbeing, and it can act as a discipline on providers to encourage quality and cost effective provision (see chapter 4). But the effectiveness of choice depends on the capacities of the older person or their representative to be well informed about the availability and quality of care and its cost. (As discussed, the relative decline in the availability of informal carers could undermine some older people's ability to exercise choice effectively). Offsetting this, people may plan more for their old age care and be willing to seek professional advice (for example from an aged care broker) where they will be paying for at least a proportion of this care.

The baby boomer cohort has 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 afford 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 these trends are 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

| | *Cash deposits*[a] | *Shares* | *Equity in own home* | *Equity in rental property* | *Super-annuation* | *Total net worth* |
|---|---|---|---|---|---|---|
| | % | % | % | % | % | 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. 21–2).

## 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 (currently aged 45 to 65) 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 and NATSEM 2007, p. 18).

The HILDA survey data provides some indication of the distribution of assets for individuals over the age of 65 (table 3.4). In general 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 the 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

| *Decile* | *65+* | *75+* | *80+* |
|---|---|---|---|
| 10th | 4 500 | 5 200 | 6 000 |
| 20th | 82 634 | 44 000 | 32 220 |
| 30th | 149 404 | 130 350 | 122 637 |
| 40th | 200 003 | 180 000 | 185 515 |
| 50th | 252 900 | 221 860 | 220 430 |
| 60th | 314 800 | 280 000 | 272 300 |
| 70th | 411 760 | 352 358 | 344 120 |
| 80th | 610 160 | 500 750 | 518 602 |
| 90th | 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.

The impact of savings and the capacity to pay for aged care is discussed further in chapter 7.

## 3.6 Effects of other policy areas on 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 pension assets test is analysed in chapter 6. Policy changes in this area have implications for savings and the willingness to utilise 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 could 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

Many '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 be more appropriately cared for 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 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. Elements of the reform agenda include:

- facilitating greater access to primary health care providers and geriatricians for residents of aged care homes (NHHRC 2009, p. 23, recommendation 52)
- strengthening access to specialist palliative care services for all relevant patients across a range of settings, with a special emphasis on people living in residential aged care (NHHRC 2009, p. 23, recommendation 55).

## Implications of planning for 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, the planning ratios will 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, by year 2011. This 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 those HACC services which are block funded.

Planning ratios do not necessarily reflect the level of demand. In 2009 fewer bed licences were taken up than were made available, and some bed licences have been

handed back. There are reports of unusually high vacancy rates being experienced by some residential care providers (see for example, Anglican Care, sub. 49; Fronditha Care, sub. 436; Cook Care, sub. 442). This decline in occupancy rates has not affected all services, as DoHA note in their submission: 'It is still the case that two in five aged care homes are operating with occupancy rates above 98 per cent' (DoHA, sub. 482, p. 55). The lack of take up may also reflect difficulties in raising capital to invest in new high care beds under current funding arrangements rather than a decline in demand (Toohey and Ansell, sub. 464, p. 3).

Demand has also been managed through the use of means tested co-contributions. While for some programs these are set by government, in others providers can set co-payments based on their assessment of the consumer's capacity to pay (see chapter 5). The effect of the price to the consumer on their demand is uncertain, especially in the presence of substantial subsidies. Hogan (2004b) 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. (p. 94)

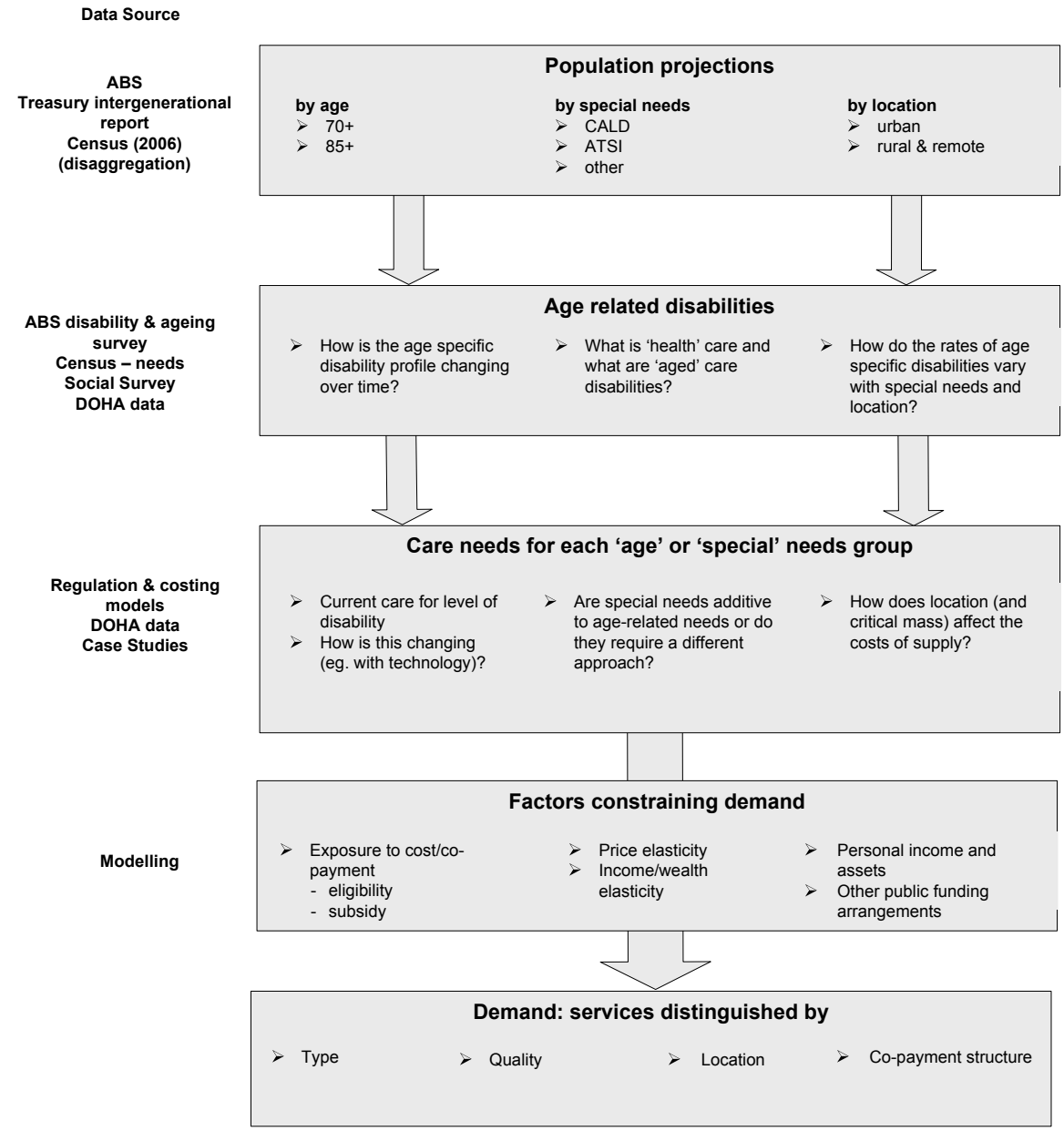
Means tested co-contributions complicate the analysis further as they can distort the choices older people make about accessing care (see chapter 6).

## 3.7 Calculating the trends in demand

Treasury (2010, p. 57) has projected that Australian Government spending on aged care as a proportion of GDP could increase from 0.8 per cent in 2009-10 to around 1.8 per cent by 2050. Importantly, Treasury estimate that population ageing accounts for two thirds of the projected increase in real per capita expenditure on aged care.

Working out the impacts of all the various factors on demand is complex. Figure 3.8 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.

Figure 3.8 **Data needed to make projections for the demand for various services**




## Managing demand

Government can manage the level of demand for subsidised services that is met by dictating their supply. Planning processes to determine the appropriate quantity to supply would ideally take all the factors discussed above into account in determining the appropriate ratios of each type of service in each location. This is

difficult to do and in any case needs change over time, so such planning will inevitably lag changes in demand.

An alternative is to allow the market to respond freely to demand for the different types of services in each location. For providers to be able to invest in and deliver services they need to know the likely level of subsidy for each type of service, as well as the population characteristics that affect demand in each location. Given the managed nature of the market, much of this information can only be efficiently collected and collated by DoHA. The importance of more publicly available information for the functioning of a market for aged care services is discussed in chapter 13.

Private providers will not provide services where it is not profitable (or, for the not-for-profit (NFP) providers, at least financially viable) to do so. In some areas the level of demand will be too low to sustain competition in services, or even for services to be provided without additional subsidies. Yet subsidies can reduce the efficiency of the market. Efficiency is driven by effective consumer discipline, which requires that consumers can exercise real choice, and is enhanced when people pay for their own services. And there is nothing in the functioning of a market that will ensure equitable outcomes when people have different capacities to pay. Fair and equitable outcomes will depend on directing subsidies to those who lack a capacity to pay for the aged care services they need.

In addition, as long as government is a major funder of aged care services it needs to manage the fiscal costs of meeting its obligations to eligible clients. To do this government must be able to influence the use of subsidised services. Currently government controls this use through eligibility criteria, quantity restrictions and price (chapter 2). Under a more market based system, government would still need to control eligibility and negotiate on the prices of services in setting its subsidies. These issues are central to this inquiry and are taken up in the following chapters.

# 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 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 care and support for older Australians should aim to:
  - promote independence, wellness and the continuing contribution of older Australians to society
  - ensure that all older Australians needing care and support have access to person-centred services that can adapt as their needs change
  - be consumer-directed, allowing older Australians to have choice and control over their lives
  - treat older Australians receiving care and support with dignity and respect
  - be easy to navigate — Australians need to know what care and support is available and how to access those services
  - assist informal carers to be able 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. 83, p. 4)

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. 3)

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 care. A number of participants' 'visions' are presented in box 4.1.

The vision and principles put forward in *Leading the Way: A New Vision for the 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. The 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. 5)

## Box 4.1 **Participants' visions for future aged care and support**

The National Aged Care Alliance'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. 4)

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:

> 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 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. (sub. 25, p. 3)

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 12).

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 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 indictors 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 is 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.

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 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 impacts
- 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)

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 forward a broad wellbeing framework comprising several domains under three broad categories — physical, mental/emotional and social (sub. 252, p. 8).

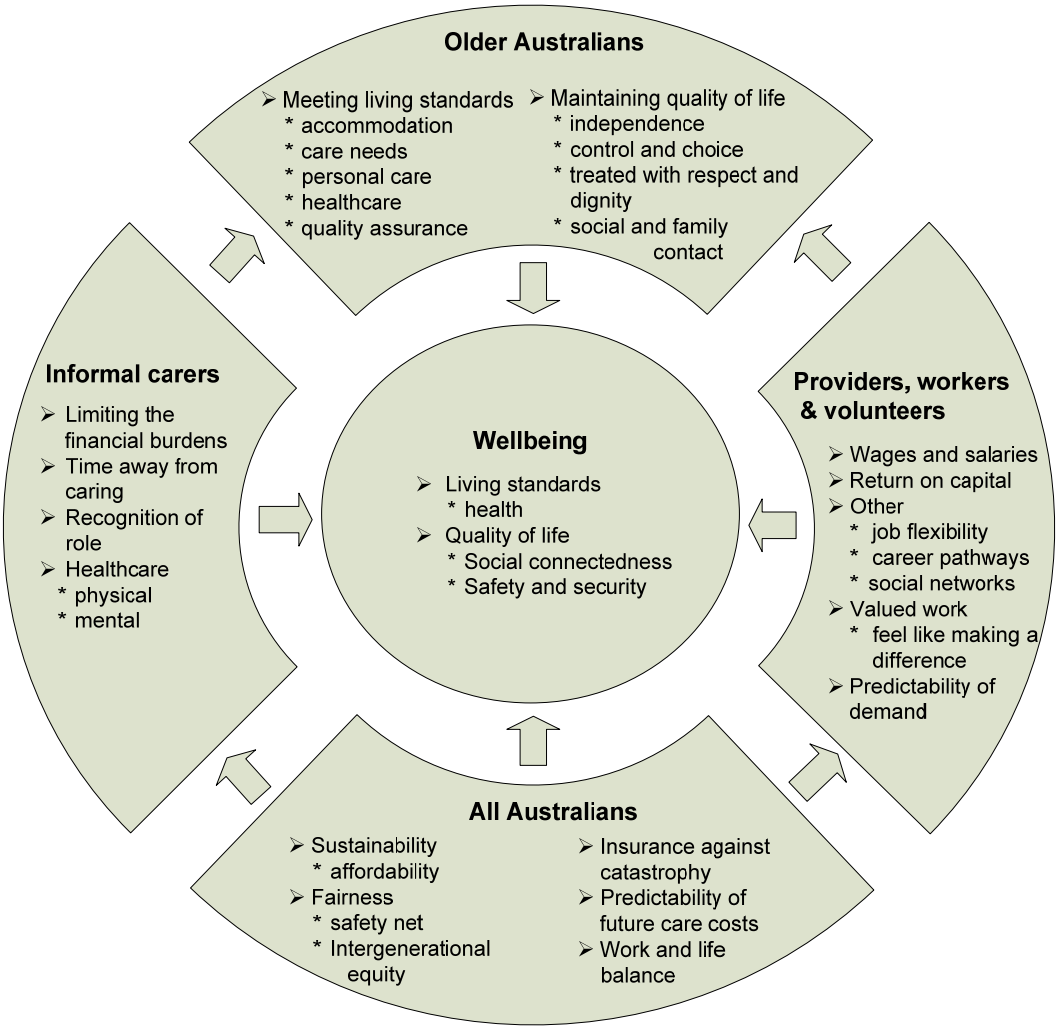
Measuring wellbeing, however, is not easy because it involves making value judgements about what aspects of life are important to an individuals' wellbeing (knowing that people value outcomes differently) and what matters to society. As the Australian Treasury said:

> … 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.

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).

Figure 4.1 **Factors influencing wellbeing in the context of aged care**




## 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 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. National Seniors Australia 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, change 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 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 eighty-year-olds is likely to be less similar than those of two ten-year-olds.

Because people age in unique ways, the needs of older people will vary quite markedly, depending on functional capacity, physical and mental health, culture and language and the built environment which they live in. Support and care should, therefore be flexible enough to recognise diverse needs and be able to adapt the services provided accordingly. 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)

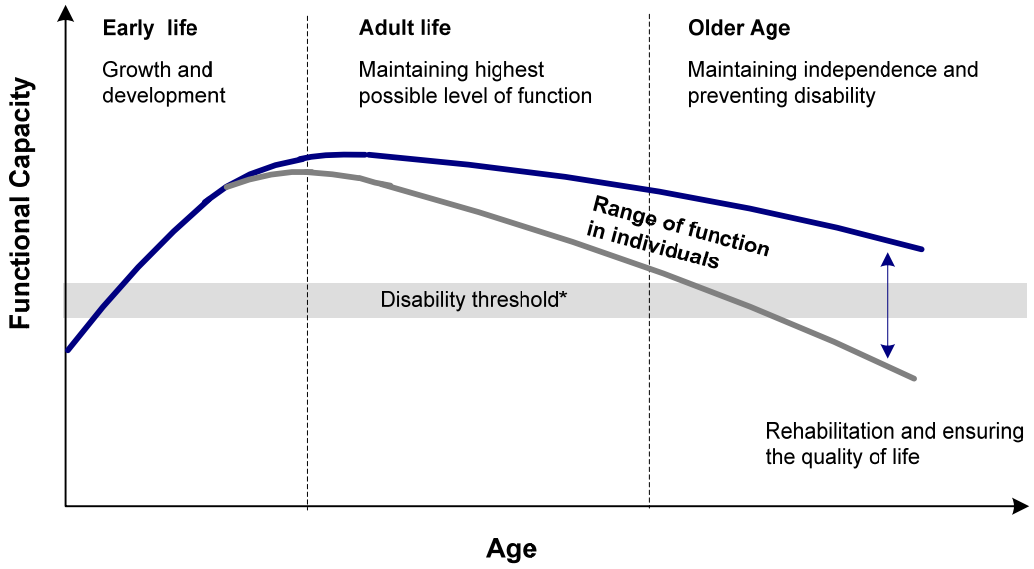
National Seniors Australia argued that an aged care system:

> … 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)

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 well being, this is where the notion of choice is most useful. (sub. 461, p. 3)

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).

This points to the importance of a person-centred (rather than program-centred) approach to providing care and support.

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)

## Care and support should be person-centred.

*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 had 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 dignity. They want to remain active in their communities and close to their families, friends and neighbours. (DoHA 2009, p. iii)

Recent focus group research also showed that older Australians living in Victoria had a strong desire to remain independent as they age (Victorian Government, sub. 420, p. 9).

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 may not only enhance their 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 and 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**

Alzeihmer'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. 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. (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. 14-15)

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. The 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. 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, J 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. 2-3)

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 who value 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).

*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. Older Australians receiving care and support 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 4.3). The Australian Government has a social inclusion agenda in relation to older Australians.

### Box 4.3 Social connections and wellbeing – participants' views

The Victorian Government:

> Older people still want to be connected, contributing, and cared for. (sub. 420, p. 10)

New South Wales 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, pp. 13-14)

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)

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 or unhappy 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)

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 dealt with in chapter 10.

## 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.

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 11, McKenzie et al. 2009; ABS 2008a; Access Economics 2009b). A number of participants to this inquiry spoke about the effect caring has on carers' lives (box 4.4)

- 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.

### Box 4.4 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 Probets:

> 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)

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. (2009, p. 212)

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, 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 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*

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 11).

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 levels of involvement of the not-for-profit sector 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 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 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 not to raise costs without a commensurate decline in risk. These costs are not just financial in nature. Regulation that erodes choice and control, reduces the recognition of 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. (DOHa, 2010, 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, are 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.*

DRAFT RECOMMENDATION 4.1

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

- ***promote 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***
- ***treat older Australians receiving care and support with dignity and respect***
- ***be easy to navigate — Australians need to know 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* (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 these 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
- *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 and better ways of producing goods and services. It can also refer to the ability to adapt quickly, and at low cost, to changed 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 covers:

- *fiscal sustainability* — the extent to which financing arrangements can accommodate projected changes in the number of older Australians (both 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.

## Table 4.1 Some indicative outcomes measures against proposed objectives of Australia's aged care system

| *Objectives* | | *Some indicative outcome measures* |
|---|---|---|
| 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 | ⇨ | 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 — Australians need to know 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. |

The next chapter assesses the current aged care system against these indicative outcome measures.

# 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. 4)

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. Section 5.1 looks at access, continuity of care, choice, and unmet demand; section 5.2 considers pricing, subsidies and co-contributions, and section 5.3 examines regulation. Section 5.4 provides an overall assessment of the scope for improvements in efficiency and the need for further reform for the system to be sustainable.

## 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 ensures 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 one participant, 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. (J. Masso, 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).

Data from the National Data Repository 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**

| | *Mean days* | *Median days* | *Percentage 'on-time'* |
|---|---|---|---|
| *Priority 1 (<48 hours)* | | | |
| 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** |
| *Priority 2 (3 to 14 days)* | | | |
| 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*: National Data Repository (2009).

Table 5.2 **Length of time between ACAT referral and first face-to-face contact**

All referrals, 2007-08

| | *Mean days* | *Median days* | *90$^{th}$ percentile (days)* |
|---|---|---|---|
| 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*: National Data Repository (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 services (hospital beds). 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, were that funding to increase without a commensurate increase in aged care service availability, there would be greater numbers of older people who have been assessed as eligible, but who cannot access an available service.

## Access to care services

Most low-intensity support services (mainly 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 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 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 (table 5.3). The only exception is for entry into high-level residential care, where 56 per cent of eligible clients access this service within one month of their ACAT approval.

Table 5.3 **Length of time between ACAT approval and entry into a care program**
2008-09

| | *High care* | *Low care* | *EACH* | *EACH-D* | *CACP* |
|---|---|---|---|---|---|
| Less than 2 days (%) | 10.2 | 3.9 | 6.1 | 6.6 | 4.7 |
| Less than 7 days (%) | 26.3 | 10.4 | 12.2 | 15.1 | 11.2 |
| Less than a month (%) | 56.3 | 31.0 | 33.2 | 45.6 | 38.6 |
| Less than 3 months (%) | 81.2 | 61.4 | 61.6 | 77.6 | 71.1 |
| Less than 9 months (%) | 96.7 | 91.9 | 92.3 | 97.8 | 95.4 |
| Average time (days) | 23 | 63 | 62 | 35 | 45 |
| Total number (program entrants) | 29 254 | 23 523 | 2 479 | 1 633 | 16 583 |

*Source*: SCRGSP (2010b).

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**

2008-09

| | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *Tas* | *ACT* | *NT* [a] | *Aust* |
|---|---|---|---|---|---|---|---|---|---|
| High care | 59.1 | 60.2 | 52.4 | 46.3 | 55.0 | 51.8 | 44.5 | 19.7 | 56.3 |
| Low care | 29.1 | 35.6 | 31.2 | 27.2 | 25.8 | 37.7 | 23.8 | 21.7 | 31.0 |
| EACH | 32.0 | 23.0 | 38.5 | 44.3 | 34.1 | 33.7 | 26.1 | 63.0 | 33.2 |
| EACH-D | 43.4 | 43.9 | 46.2 | 55.6 | 34.6 | 53.1 | 60.0 | 70.6 | 45.6 |
| CACP | 29.9 | 36.4 | 50.5 | 56.4 | 33.6 | 38.1 | 29.6 | 40.6 | 38.6 |

[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 (2010b).

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 such as 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, E. 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 concern about respite for those caring for 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)

## 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)

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.

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

| | *Community care* | | | *Residential care* | | *Total* |
|---|---|---|---|---|---|---|
| | *CACP* | *EACH* | *EACH-D* | *Low care* | *High care* | |
| NSW | 27 | 19 | 63 | 35 | 50 | 36 |
| Victoria | 45 | 23 | 54 | 37 | 49 | 42 |
| Queensland | 33 | 22 | 41 | 33 | 47 | 37 |
| South Australia | 27 | 22 | 36 | 28 | 55 | 36 |
| Western Australia | 30 | 24 | 44 | 34 | 41 | 35 |
| Tasmania | 47 | 38 | 76 | 56 | 53 | 53 |
| Northern Territory | 29 | 88 | 85 | 52 | 32 | 38 |
| ACT | 24 | 21 | 33 | 32 | 44 | 31 |
| **Australia** | **32** | **22** | **51** | **35** | **49** | **38** |

*Data sources*: NDR (2009); DoHA (2009e).

While a gatekeeper plays an important role in controlling access to public subsidies, aged care services must 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 6 and 8.

## Continuity of care

Restrictions on the number and scope of services that providers can offer also reduces 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 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 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 not willing to change carer, are not willing 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, S. 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 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 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. (P. 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 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 general practitioners (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. (sub. 330, p. 1)

Further,

> 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.

## 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 Department of Health and Ageing (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) who highlight:

> 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 pension rate). Baptistcare (WA) explained the reaction of consumers to the inconsistent pricing of community care services:

> The complexity of the aged care system … has lead 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 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 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 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 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 $38 500). The level of the accommodation bond is based on a resident's assets and does not necessarily relate the quality of the accommodation.

The average level of accommodation bonds charged by providers exhibit substantial variations (table 5.6). These variations do not necessarily reflect the underlying costs of providing the accommodation that these bonds relate to. 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 $28.72 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 |
| *All sectors* | *176 625* | *200 362* | *215 175* |
| **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 |
| *All sectors* | *246 755* | *257 796* | *292 744* |

*Source*: DoHA (2010z).

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. 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.

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 the 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 most recent aged care approval round for 2009-10, 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; Elliot 2010).

For services that charge accommodation bonds, pricing restrictions and time limits on the retention amount affect the capacity of 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)

Underfunding 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

> 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 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 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. (Catholic Health Australia, 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 11.

### *Differences in the taxation treatment between for profit and not-for profit-providers*

The Commission's study *The Contribution of the Not-for-Profit Secto*r (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 costings 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 — Cook Care Group (sub. 10), Woodville Nursing Home (sub. 298), Tickled Pink Aged Care (sub. 301), Martindale et al. (sub. 304), Spakia (sub. 306), Pakary et al. (sub. 308), Salisbury Private Nursing Home (sub. 310), and Aged and Community Care Victoria (sub. 408).

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 Henry tax review recommended that FBT concessions for NFPs be phased out over 10 years (Henry Review 2010). The Australian Government rejected this recommendation.

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. Given the low salaries in the sector, the extent of advantage offered to most workers by packaging options is likely to be small, but the arrangements may provide a greater advantage in attracting and retaining managers. 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 age 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, COTA argued that the emphasis on process rather than outcomes has resulted in 'excessive paper trails' (sub. 337, Attachment 6, p. 7).

In a similar vein, 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, M. 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 heath services, music

therapy, nutritional care (Dieticians Association of Australia, sub. 371), and grief counselling and spiritual support (Villa Maria Society, sub. 395).

Excessive paperwork has also been 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 11). Additionally, the increased use of electronic records offers scope to significantly reduce the burden of documentation, but critically requires that regulatory authorities and providers accept and embrace technology.

### 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 compulsory 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).

### *Police checks*

In April 2006, the Australian Government strengthened its police check regulation to make it mandatory for all staff, regardless of whether they only have supervised access to care recipients, to have a police check. The resulting effects on compliance costs were regarded by many in the industry as non-trivial and on-going. In addition, external legal advice is sometimes required to make assessments as to whether or not a certain type of criminal record constitutes the barring of an individual from employment.

Aged and Community Services (ACS) NSW & ACT questioned the overall effectiveness of police checks in aged care for a number of reasons:

- The majority of perpetrators of abuse of older people do not have criminal records and, so, would escape detection if seeking employment in the industry. The reliability of overseas documentation regarding criminal records is variable … In addition, there is no provision for alerting the approved provider should an employee be convicted of a serious offence during the term of employment.
- Some potential and actual employees are disadvantaged by the lack of discretion afforded by the legislation … There is no consideration whether the conviction is relevant to employment in the aged care sector.
- The industry believes that current requirements have a disproportionate effect on Aboriginal and Torres Strait Islander people who have higher rates of criminal convictions than the rest of the Australian population. Cultural disadvantage can be reinforced by further restricting employment opportunities in the industry …
- It is costly to comply with police check requirements. Where the approved provider pays, this becomes a significant cost especially during a period of high staff turnover. When responsibility for payment of the checking fee is passed on to the employee, it can be prohibitive and a deterrent for seeking employment in the industry. (ACS NSW & ACT 2010, p. 3)

In addition, such checks could lead to greater complacency and less concern with monitoring staff's engagement with clients.

These amended regulatory requirements were not subject to the usual Regulatory Impact Statement process because DoHA's preliminary assessment of the regulatory proposal assessed it as having no/low business compliance costs and no/low impacts on business and individuals or the community. The Commission has previously argued that:

> The police check regulation could have benefited from the application of this compliance cost tool — because its results could have informed its design and achieved the same objectives with less compliance costs on business. (PC 2009a, p. 44)

### *Reporting of missing residents*

Approved providers are required to notify a resident's family, the police and DoHA's Office of Aged Care Quality and Compliance (OACQC) of an unexplained absence of a care recipient from a residential aged care facility which the provider is sufficiently concerned about. This amendment requiring OACQC to be notified was introduced following a number of reports of older people going missing from residential aged care facilities.

While acknowledging there was a case for providers to report missing residents to OACQC, the Commission (PC 2009a) suggested it would be less burdensome on providers if they were given more time to report missing residents and that OACQC adopt a more risk managed approach by allowing different reporting time periods depending on a provider's record on missing residents.

Mandatory reporting of missing residents was not raised as an issue in submissions. However, ACS NSW & ACT said that:

> The necessity of notifying the Office of Aged Care Quality and Compliance of reports made to Police has created additional administrative procedures for approved providers that appear to have no benefit to the resident, the industry or the Department.
>
> The Office of Aged Care Quality and Compliance follow-up of reports adds additional scrutiny and stress for the provider, further stretches the resources of the Office of Aged Care Quality and Compliance, adds no value to Police procedures, the care of residents and provides no comfort for families. (2010, p. 7)

### *Compulsory reporting of assaults*

Since 1 July 2007, all aged care providers must report (within 24 hours) all allegations or suspicions of resident physical abuse to both the police and OACQC. Discretion is, however, provided where the resident concerned (the alleged perpetrator) has been assessed as suffering from cognitive or mental health impairment.

While the Commission (PC 2009a) acknowledged that these amendments may be appropriate, it also noted that a thorough analysis of the benefits and costs of the regulation was not undertaken prior to the amendments being legislated. ACS NSW & ACT (2010) indicate that the impact of the legislation on reducing and responding to alleged assaults is unknown as there has not been reliable data published on:

- the number and type of alleged assaults reported
- the outcomes of investigations by the police and OACQC
- the proportion of reported assaults proceeding to trial
- the number of convictions.

In its submission, Baptistcare considered that:

> While the Department's Guidelines state that investigation of incidents of alleged assault are the responsibility of the police, as is the case for assaults involving residents with assessed cognitive or mental health impairment, it would be more efficient to rely on the Agency audit processes to ensure appropriate systems are in place to ensure appropriate reporting and management of assaults and that the systems are used. (sub. 426, p. 11)

### *Unannounced visits by the ACSAA*

In the 2006 Budget, the Australian Government introduced a policy which requires that each residential aged care facility receives at least one unannounced visit each year. In addition, in March 2008, the then Minister for Ageing announced that in 2008-09 ACSAA would undertake 7000 visits (either announced or unannounced) to residential aged care facilities. This equated to around 2.5 visits per facility per year.

As well as unannounced visits by ACSAA, the Complaints Investigation Scheme also makes unannounced visits. In 2007-08, 1145 unannounced visits were made from a total of 3127 visits that year.

The Commission (PC 2009a) noted that there does not seem to be a widespread problem of sub-standard care in the aged care industry. Indeed, in 2008 and 2009, 98.4 and 97.6 per cent of providers, respectively, were compliant with accreditation standards (ACSAA 2008, p. 26 and 2009, p. 27). Accordingly, the rationale for increasing the number of ACSAA visits to 7000 is not clear.

While both random and targeted unannounced visits should be part of the visits program of a regulator, the Commission has previously outlined that the focus should be on targeted visits (PC 2009a). Targeted unannounced visits should be

made to those facilities that meet certain risk profile parameters. And to reduce the burden on providers, only a small proportion of facilities should be subject to random unannounced visits.

A. Howe (sub. 355) suggested that reducing the frequency of full site audits from three years to every 4–5 years would free up resources for ACSAA to undertake more frequent support visits. Her analysis of sanctions from 1999 to 2008 showed the non-compliance is rarely identified at site audit visits and mostly identified during unannounced support visits.

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 has signalled that it will give consideration to changing the visits program as part of its broader review of accreditation processes (the Walton Review (2009)). The Commission is also incorporating the findings of the Walton Review in its deliberations and recommendations in chapter 12.

### *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.

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 (Australian Government 2009a). However, it has yet to announce any other significant initiatives in this regard.

## 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**

| *Objectives* | | *Areas for improvement* |
|---|---|---|
| To promote 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<br>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<br>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<br>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 | → | Regulations and planning ratios can limit the capacity to providers to offer greater choice.<br>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 — Australians need to know 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.<br>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.<br>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 Council on the Ageing (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)

Inadequate subsidies, according to a number of providers, 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 residential 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 Survey of Disability, Ageing and Carers (SDAC) reports on the extent to which needs are met for people over the age of 60 years living in households. In 2003, 5.7 per cent of those needing some form of assistance with personal activities reported that their needs were not met at all, while just under 20 per cent reported that their needs were only partly met. For self care, the proportions were 10 per cent and 5 per cent respectively, suggesting that once in the system, self care needs are more likely to be fully met than needs such as mobility or cognitive or emotional support (ABS 2004, table 22). The results on this section of the 2009 SDAC survey should be available in early 2011.

## 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 chapter 8.

## 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 5.3).

## 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)

NHHRC'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 *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.

# 6 Paying for aged care

**Key points**

- Australian Government spending on aged care is projected by the 2010 Intergenerational Report to increase from 0.8 to 1.8 per cent of GDP over the period 2010 to 2050. This increase in spending could be paid for by increasing taxes and/or reducing government spending in other areas.
- But there is the question of whether there is a more efficient and equitable way to raise the necessary funds. There is also evidence of increasing strains on the aged care system under the current funding regime.
- Addressing inefficiencies in Australia's aged care system can reduce the rate of growth in government spending but is unlikely to be sufficient to prevent future tax increases. The public expenditure burden could also be lessened by requiring higher co-contributions from care recipients who can afford to pay.
- Funding arrangements could be improved by separating the costs of aged care (accommodation and living expenses, personal and health care) and applying funding principles consistently across care settings. This would allow prices to better reflect underlying costs, enable better targeting of subsidies to those most in need, and overcome inconsistencies and inequities between different forms of care.
- Accommodation costs and everyday living expenses are reasonably predictable and should be the responsibility of individuals, with a safety net for those of limited means.
- For accommodation charges to reflect the cost of the service, regulatory restrictions on the number of community and residential care places and price controls need to be removed over time. Providers should offer a periodic charge and accommodation bonds that are equivalent to that charge. All accommodation charges should be published.
- While the majority of older Australians will require some form of care, only a minority will require extended periods of intensive care. Individuals should contribute to the more predictable and manageable costs of their care, but not be exposed to excessive costs associated with extended periods of intensive care. A risk pooling mechanism would overcome this potential exposure.
- Government expenditure could be controlled through a rigorous assessment of need, the resource levels for approved services, the standard for basic accommodation and the co-contribution schedules.

With many more Australians living longer, there will be a sizeable increase in the *quantum* of people requiring care and support over the next 40 years. Australians also have increasing expectations about the type and quality of care they want to receive in their old age. Further, due largely to increased longevity, there will be a growing proportion of older people with complex care needs. Each of these factors translate into unavoidable increases in spending on aged care services. Without changes to the current funding arrangements, this will mean a much larger aged care bill for governments (with the Australian Government being the largest contributor, chapter 2).

Going forward, the challenge is to come up with a system for funding that:

- achieves the objectives sought from providing support and care (chapter 4)
- is affordable for older Australians and taxpayers
- is fair between generations
- improves the basis on which individuals contribute to the cost of their own care.

The efficient use of resources will also be essential to optimise the cost-effectiveness of funds directed to aged care.

This chapter first looks at whether the funding arrangements are sustainable over the longer term (section 6.1) before unpacking the concept of 'aged care' and addressing the questions — who should pay and what should they pay for (section 6.2). Sections 6.3, 6.4 and 6.5 look at applying the funding principles in practice to accommodation, everyday living and care, to secure more equitable and efficient funding arrangements across care settings. The next chapter examines alternative (or additional) ways of funding aged care and enabling individuals with the capacity to pay to contribute more to the cost of their care.

## 6.1 Are existing funding arrangements sustainable?

Although there is some uncertainty about the future costs of aged care, projections in the 2010 Intergenerational Report are that Australian Government spending on aged care is likely to increase from 0.8 to 1.8 per cent of GDP by 2050 (Treasury 2010). The significantly higher government spending projected for aged care could be paid for by diverting spending from other areas and/or by increasing the average tax burden.

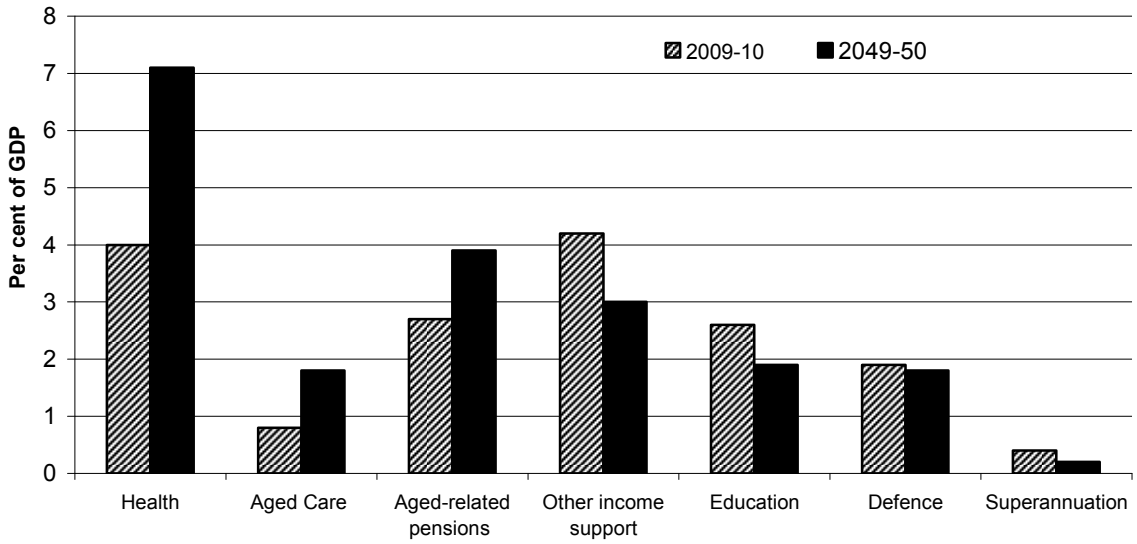
This in itself should not be a problem provided the community considers that taxpayers' money is well spent and that the distribution of funding responsibilities and tax burden between taxpayers and users and between generations is fair. But, there is the question of whether there is a more efficient and equitable way to fund aged care.

It is also true that if there is strong productivity improvement, growth in real GDP will mean a wealthier community with greater capacity to meet the additional costs associated with an ageing population. This points to the importance of continuing policy reforms to lift Australia's productivity performance and thereby more fully exploit the nation's potential for improved living standards (see, for example, PC 2010a). Stronger productivity growth will help to meet the fiscal demands of a pay-as-you-go financed system, although it is unlikely to obviate the need for tax increases and/or a reassessment of government expenditure priorities.

Population ageing, however, is not only expected to increase government spending on aged care, but also spending on health and aged-related pensions. Government spending on health is projected to increased from 4.0 to 7.1 per cent of GDP and age-related pensions from 2.7 to 3.9 per cent of GDP by 2050 (figure 6.1). However, the rate of growth in the proportion of GDP is projected to be highest for aged care expenditure (125 per cent compared to 78 per cent for health and 44 per cent for age-related pensions). In other areas, such as income support payments (excluding aged-related pensions), education, defence and public sector defined benefit superannuation, government spending is projected to decline as a share of GDP. Even so, overall increasing age-specific costs, combined with demographic change, mean that total government spending is expected to rise significantly as a share of GDP.

The increase in government spending to support older Australians would be less of a concern if the working aged population was growing at a faster rate. But the demographic profile arising from increased longevity and the baby boom (chapter 3) means that, by 2050, it is projected that there will be 2.7 people of working age to support each Australian aged over 65 years, compared with 5 people today.

Figure 6.1 **Australian Government spending by category, 2009-10 and projections for 2049-50**




*Data source*: Treasury (2010).

## Intergenerational equity

Participants raised concerns about intergenerational inequities given a relative decline in the working age group and the fact that those requiring care in the future are expected to be the wealthiest older cohort yet (box 6.1).

A number of participants maintained that some of the public expenditure burden could be shifted onto those individuals with greater capacity to pay. For example, Alzheimer's Australia said:

> Currently, aged care in Australia is mostly publicly funded through subsidies or contributions financed indirectly from aged pension payments. In future, it may be necessary to increase the contribution of users who are able to pay. More older adults may have more capacity to pay than in the past due to increased retirement savings and wealth. (sub. 79, pp. 14-15)

Others argued that concerns about intergenerational wealth transfers may be overstated given the current exclusion of the family home from the age pension asset tests. For example, Ergas and Cullen maintained:

> The extent of the inter-generational wealth transfer … should not be exaggerated. An effect of Commonwealth funding of aged care is to protect the bequests made by long term care recipients to their heirs. The exclusion of the family home from the assets tests used in determining eligibility for aged care subsidies is of central importance in this respect, as the family home is the primary asset most older Australians own and are

in a position to pass on. As a result, the extent of the redistribution effected by the existing 'pay as you go' system depends on the degree to which the taxes used to cover current aged costs are correlated with the bequests that are being preserved. As that correlation seems likely to be quite high, the system may cause fewer intergenerational transfers than commonly thought. (2007, p. 13)

But, such intergenerational wealth transfers are only relevant for those who inherit assets.

To better understand the extent to which tax rates would need to increase to meet future public aged care costs, Hogan (2004a) estimated that if the projected increase was be to funded by taxpayers via a Medicare-style levy, the existing levy would need to more than double by 2043. Based on Australian Government spending on aged care increasing to 1.8 per cent of GDP by 2050, the Medicare levy would need to increase to 3.1 per cent to met this cost.

### Box 6.1 **Participants' concerns about intergenerational inequities**

Aged Care Association Australia and Deloitte:

> It is important to start by noting that current financing arrangements are not capable of supporting the expansion in supply that is needed. Currently aged care funding is financed from current tax payments. The changing demographics … will result in a significantly lower percentage of current tax payers to elderly requiring financing. It is also worth noting the substantial estimated intergenerational wealth transference generated from the sale of family homes and the question of whether this wealth should be applied to services for the elderly or simply continue to be a transfer from one generation to the next. (sub. 285, p. 5)

Aged and Community Services Australia:

> We know that the numbers of older people requiring services and support is increasing and that the numbers of taxpayers to fund the care is shrinking. We know also that the system is under increased pressure and is facing a serious threat to its overall sustainability. The status quo is not an option. (sub. 181, p. 8)

Anglicare Australia:

> It would appear that a call for people to accept a higher tax regime in order to ensure the well being of older Australians, now or in the future, is unlikely to fall on fertile ground at present. On the other hand, there is no doubt that as time goes by many more older Australians will be able to pay for the care and services that they want themselves, and would be prepared to do so. (sub. 461, p. 20)

Higher marginal rates of income tax risk creating disincentives for work. This would compound the effects of ageing on the supply of labour. Raising revenue through taxation also results in an inefficiency known as a dead weight loss (box 6.2). Hogan estimated that the higher rate of taxation implicit in doubling the Medicare levy would reduce GDP by around 0.4 per cent by 2042-43.

Importantly, population ageing will not happen over-night, with most of the baby boomers not entering their eighties for another two decades. This means that there is a limited opportunity to develop policies that increase people's capacity to pay for their own aged care and smooth out the costs of care associated with population ageing over time. The earlier that changes are made to funding arrangements, the more equitable they are likely to be from an intergenerational perspective. While there has been some 'rebalancing' of public and private funding of aged care in response to increasing cost pressures over the last decade or so (with users paying an increasing proportion of their care costs), this has largely been within a framework where taxpayers continue to meet most of the costs.

### Box 6.2 **The cost of funding government expenditure**

While government expenditure can deliver considerable benefits to recipients and to the broader community, it comes at a cost. This cost arises from the expense of collecting government revenue and from any distortions ('deadweight' losses and administrative costs, etc) introduced by the taxes, fees or charges used to generate the revenue. These costs vary with the nature of the tax, as does the effect on equity.

Taxes drive a wedge between the price suppliers receive and the price a purchaser pays that leads to them buying less than they would have without the tax. This can improve wellbeing if the purchase gives rise to adverse outcomes for others (known as negative externalities) or where people experience addictive behaviour, such as with alcohol and tobacco. But, more generally taxes that reduce consumption of preferred goods and services lower wellbeing, with loss of consumer surplus. The tax wedge can also distort firms' choices of inputs away from more efficient combinations. And over time the effects can be compounded as, for example, a tax on savings reduces the incentive to save, while a tax on wage income generally reduces the incentive to work.

The greatest deadweight losses, or marginal effective burdens (MEB), arise from taxes that create the largest price wedges and where demand and supply are highly price responsive and where the effects are long-lasting (taxes on investment or training). Taxes that are broad based and levied at a low and common rate result in the lowest distortions and hence the lowest deadweight loss for any level of revenue.

Estimates made for the Henry Review found that taxes on tobacco imposed a negative MEB (-8 cents per dollar), while those on wages and profits result in a positive MEB (of 24 and 40 respectively). The GST imposes a MEB of 8 cents per dollar of revenue, while insurance taxes have a MEB of 67 cents per dollar. While some caution should be applied to the estimates as they are based on stylised models, they suggest that deadweight losses are significant, and must be taken into account in assessing the net benefits of public expenditure. As should the equity implications of any tax.

*Source*: KPMG and Econtech (2010).

Part of the public expenditure burden could be shifted further onto individuals through increasing their share of the costs, rationing access and/or constraining service quality. Cutting or further rationing services that yield significant benefits to the community is clearly not a desirable option.

A significant hurdle to increasing co-contributions for aged care is the low incomes of many older people requiring care. Treasury projects that around 36 per cent of the pension age population will receive a full pension in 2047 (down from 55 per cent in 2007), while around 40 per cent will receive a part pension. The rate of self funded retirement is expected to increase only slightly, from 20 per cent in 2007 to around 24 per cent in 2047. These estimates, however, apply to the pension age population and not those aged 85 or older, among whom the need for aged care is concentrated.

Even so, as recognised by the OECD, the issue of sustainability relates to private expenditure as much as it does to public expenditure:

> … the issue of sustainability arises in relation to private as well as public expenditures. What may appear to be unsustainable in the future as a public contribution could drain the resources of middle-income families if similar costs had to be borne privately. (2005, p. 80)

A large proportion of older Australians, however, have sizeable assets, much of it in owner-occupied housing. This was acknowledged by some participants. Anglicare Australia, for example, said:

> Many of the people who will soon qualify as ageing will have significant assets and resources — property ownership in particular, superannuation, savings and investments — with which to purchase the care of their choice where it is available. (sub. 461, p. 8)

If older Australians could draw on their housing wealth, they could contribute more to the cost of their care. Being able to convert housing wealth into a income stream without necessarily selling the home, could also mean that they could afford to pay for additional services over and above approved care. Alternatively, Australians could be encouraged to save for their care costs or to take out insurance. These options are discussed in chapter 7.

## Scope for better outcomes with the same dollars?

Many participants to this inquiry raised concerns about the current institutional arrangements (including quantity restrictions through planning ratios and price controls) adding significant avoidable costs. As discussed in chapter 5, many of the current arrangements do anything *but* encourage competition between providers or provide incentives for innovation.

The Department of Health and Ageing (DoHA) said that while the planning ratios help manage the Commonwealth's fiscal risk:

> … they also create an artificial scarcity that limits the scope for competition, blunts pressure for efficiency and innovation and deprives consumers of choice. …The result is an industry structure which, while it does secure some important policy objectives (such as geographic equity of access), does not make the most efficient use of scarce resources. The consequence is persistent technical inefficiency. (sub. 482, p. 53)

Hogan (2004a) found that aged care providers could be around 17 per cent more efficient if they were to operate at the most efficient level (recognising that it is not possible to have all services operating at this level). This translated into providers being able to care for around 23 000 more people (at dependency levels in 2002-03). Hogan also estimated that costs could be reduced by a further seven per cent (or $470 million in 2002-03 prices) by making structural adjustments that improved the scale efficiency of the sector.

DoHA said that 'it appears that the level of inefficiency in the industry has not diminished since then' (sub. 482, p. 52). An analysis of trends in the level of efficiency in the residential care sector provided by DoHA shows that the average rate of efficiency across the residential care industry was reasonably constant between 2001-02 and 2004-05 but fell after the introduction of the Conditional Adjustment Payment (from 64 per cent in 2004-05 to 60 per cent in 2006-07) and remained at that level in 2008-09 (sub. 482, p. 52, table 7).

The Commission also heard many examples from individuals of their experience with the aged care system and providers that pointed to 'inefficiencies' and 'waste' within the system (chapter 5). Examples included multiple and inconsistent assessment processes, large compliance burdens associated with separate administrative and legislative obligations across multiple programs. DoHA acknowledged that there are 'significant issues of allocative efficiency in the current arrangements' (sub. 482, p. 50). In the context of continuity of care they said:

> … care funded under the Aged Care Act 1997 and care provided through low intensity interventions in the community, do not enable efficient and seamless transitions between care sectors or between services within a care sector, including enabling information and data to accompany the care recipient. This can result in repetition or omission. Similar issues arise at the interface of the aged care system with the acute, sub acute and primary care sectors. (sub. 482, p. 51)

Measures aimed at getting the different parts of the aged care system and the health care system to work together as more of a joined-up system are discussed in chapter 8. Removing unnecessary regulatory constraints and redesigning regulations that currently increase the cost of providing services and/or impair competition also

offer the potential for productivity improvements and enhanced efficiency (chapter 12).

A number of participants argued that aged care funding could be better spent investing in measures aimed at promoting independence, disease and fall prevention and early intervention. Alzheimer's Australia, for example, said:

> It has been estimated that if the onset of Alzheimer's disease could be delayed by five years, it would reduce the numbers of those with Alzheimer's disease by half (between 2000 and 2040) with significant savings to the health and care system. In order to move towards the goal of prevention, we need adequate investment in research into the causes of dementia, and support for preventative health initiatives. (sub. 79, p. 6)

Others suggested savings from greater promotion of independence and channelling people to short term wellness/restorative approaches (where appropriate). Banksia Villages, for example, said:

> One of the fundamentals that may assist to address the issue of the affordability of care for the ageing is to address the attractiveness of independency, primarily by promoting the benefits, facilitating the opportunities, and providing incentives to be independent. (sub. 467, pp. 17-18)

There is emerging evidence on the cost-effectiveness of preventative and early intervention measures and how they can improve the quality of life of individuals. For example, an evaluation of the Partnerships for Older People (POPP) project in the United Kingdom — a program of services for older people aimed at promoting their health, wellbeing and independence, and preventing or delaying their need for higher intensity or institutional care — found a:

- 12 per cent increase in health-related quality of life for those individuals receiving practical help
- 47 per cent reduction in overnight hospital stays and a 29 per cent drop in the use of Accident and Emergency departments. For every extra £1 spent on the POPP services, there was an additional £1.20 benefit in savings on emergency bed days (DOH 2010b).

Other international studies also show a positive relationship between receiving low-level community services and delayed or avoided entry into residential care. A systematic review and meta-analysis of 15 studies of home based support for older people found home visits reduce mortality and admission to long term institutional care (Elkan et al. 2001). Other studies show that the earlier older people receive community care services the longer the delay before residential care is required (Gaugler et al. 2005, Long et al. 2005, Stuck et al. 2002).

There is also emerging evidence that re-ablement or restorative home support programs — programs designed to help people 'do things for themselves' rather than 'having things done for them' — can delay or reduce the need for home care and other aged care services. A number of trials have found significant improvement in the independence of individuals who received re-ablement services when compared with individuals who had followed a 'conventional' homecare package. For example, a comparison of outcomes for a restorative home support service conducted in Western Australia — the Home Independence Program (HIP) — and the Home and Community Care (HACC) program found that older people referred for home care who received assistance under the HIP achieved better personal and service outcomes than those referred to standard HACC services (Lewin and Vandermeulen 2009). Similar outcomes for restorative home care programs have been found internationally (box 6.3).

### Box 6.3 Evidence on the effectiveness of re-ablement or restorative home support services

A United Kingdom study found that in three re-ablement schemes 53 to 68 per cent of people left the schemes requiring no immediate home care package, and 36 to 48 per cent continued to require no home care package two years after re-ablement.

A more recent UK report found that during the initial eight week period the cost of re-ablement (mean £1 640) exceeded that of conventional homecare (mean £570). However, over the course of the follow up period this was more than offset by higher costs of conventional care (mean £2 240) compared with post re-ablement (mean £790).

A United States study found that individuals' restorative home care episodes were shorter than usual care episodes and concluded that reorganising the structure and goals of home care can enhance the outcomes for clients without increasing health care utilisation.

*Sources*: DOH (2010b)*;* Tinetti et al. (2002).

Further evidence, however, is needed to answer questions such as what are the most effective types of restorative programs, who benefits most from the programs and what is the most effective duration and timing of restorative interventions. DoHA commenting on the allocation of resources between preventative and early intervention measures and care said:

> … the distribution of emphasis between … treatment and prevention, and between early intervention and ongoing care are currently determined largely by the history of program development rather than on the basis of evidence. There is a general consensus that prevention involves low levels of investment for significant impacts. (sub. 482, p. 51)

The allocation of aged care funds should be evidence based. Better monitoring and evaluation of programs will ensure that funds for government services are appropriately allocated between preventative and early intervention and care, as well as providing a basis for future policy direction. The value of building a better evidence base is further discussed in chapter 13.

Getting better outcomes from the same dollars could be achieved by reforming the aged care system. This would help contain upward pressure on aged care costs. But, this is unlikely to be sufficient to prevent significant pressure on the total aged care bill and avoid future increases in tax rates. Ergas and Cullen made a similar assessment:

> While reform can help ensure aged care provides 'good value' to consumers, the reality is that younger Australians face a future in which they will have to provide a potentially rising share of aged care costs. If it is a goal of policy to prevent future tax rates on income earners from having to rise substantially, some savings would need to be set aside now to fund aged care costs. (2007, p. 23)

Also, if subsidies for care and high care accommodation charges are currently under-funded, as discussed in chapter 5, then ensuring subsidies accurately reflect the cost of supplying care would mean a larger aged care bill. This again points to the need to consider ways in which each generation can better contribute to the costs of their own care in old age (chapter 7).

## 6.2 Who should pay and what should they pay for?

Allocating resources in a way that is 'efficient' and considered 'fair' are important design principles for funding aged care going forward (chapter 4). Participants spoke about the current 'ad hoc' and 'inconsistent' arrangements for aged care subsidies and user contributions, and the need to better align them across care settings. An important starting point for examining options for improving funding arrangements is to answer the questions:

- who should pay
- what should they pay for?

To answer these two questions, the components of what we know as 'aged care' need to be unpacked. Only then is it possible to consider the funding principles that should be applied to the separate components of care and the issue of who should bear the risks associated with aged care costs.

Although the distinctions are not always clear, there are, broadly speaking, four components to aged care:

- accommodation services (the equivalent of rent, mortgage payments and related expenses such as gardening and home maintenance)
- everyday living expenses (such as food, clothing, laundry, heating and cooling and social activities)
- health care (such as nursing, allied therapies and palliative care)
- personal care (the additional costs of being looked after because of frailty or disability).

There was wide support from participants for 'unbundling' or separating out the costs of aged care so as to support a more effective funding framework for the aged care system (box 6.4). For example, Catholic Health Australia said:

> … the separation of aged care costs between care and support, accommodation and living expenses is an important enabler for policies designed to give older people and their carers greater choice as to where they receive their care. Such a categorization of costs is also useful for developing policies on personal contributions towards the costs of aged care. (sub. 1, pp. 12-13)

The Henry Review also recently concluded that:

> For each of the different services available through the aged care system, the provision of assistance and the assignment of funding responsibilities are best considered separately, as these services can be provided both inside and outside the system. By 'unbundling' services and responsibilities in each component, assistance for aged care can be targeted most effectively. In particular, unbundling funding for care (both personal and health care) reduces the potential for cross-subsidies across different care types or between different users. (Henry 2010, p. 631)

## Accommodation and everyday living costs

Accommodation costs and everyday living expenses are reasonably predictable expenses of everyday life and are not especially associated with increasing frailty or disability. Older Australians living in the community (and Australians at other stages in life) are in general expected to meet these costs themselves and, as such, grounds for government subsidising these costs are weak, except for those of limited means. Indeed, the Government makes provision to cover the costs of these services for those unable to pay themselves via the welfare system (providing public housing/rental assistance and income support). Subsidy design for aged care accommodation should take into account any additional costs of providing accommodation in residential care facilities and income support and other safety net provisions that may be in place.

## Box 6.4 **Support for separating out the costs of aged care**

COTA:

> … separation assists with removing the distinction between community and residential support and care and would allow for a dollar value to be put on people's needs regardless of their setting of support or care. This in turn would give individuals more real choice on where they receive their support and care. (sub. 337, p. 19)

National Seniors Australia:

> NSA notes that there are suggestions for a distinct separation between the funding processes for care services and funding processes for accommodation/amenity in aged care. It is argued this provides greater opportunity to identify where the funding is going so that it can be better assessed and evaluated and would provide opportunity to remove the anomalies that currently exist between the allocation of funds to care and the allocation of funds to accommodation. NSA considers this has merit and should be seriously considered, particularly given that 'unbundling' provides scope for more targeted delivery of the funding; enables increased scrutiny of where funding is directed; and reduces the risk of cross subsidisation. (sub. 411, p. 15)

Anglicare Australia:

> By separating accommodation and care costs individuals can contribute to the overall costs in a more equitable way, with those with the financial means making a more meaningful contribution. This reform would also streamline the delivery of services and make the whole aged care system much easier to navigate for clients, residents and their families. (sub. 461, p. 26)

Australian Nursing Federation:

> … the separation of care and non care costs is highly desirable and indeed a viable option using the current funding model as the calculation basis, without any significant modification of the current system. (sub. 341, p. 93)

Australian Unity:

> Separation of the cost of accommodation from the cost of care service provision is already established in the delivery of community care into residential homes and retirement units and to some extent in low care residential services… extending this established principle to all aged care services will stimulate competition between providers and allow the varying preferences and wealth of clients to be better matched with service delivery. (sub. 265, pp. 6-7)

There was widespread support among inquiry participants for older Australians requiring care to pay for their own accommodation costs and everyday living expenses, with a safety net for those of limited means. For example, National Presbyterian Aged Care Network said:

> … older people should be responsible for their housing and living costs, with government support made available predominantly through the pension and rent assistance systems. (sub. 110, pp 3-4).

Aged and Community Services Australia:

> Paying for our own accommodation is a given at each stage of our lives. (sub. 181, p. 4)

Sundale Garden Village:

> The Government should remove itself from consideration of accommodation for anyone other than those who need a safety net. This reflects the reality of those in receipt of community care services, and would bring equity and social justice to all consumers seeking to access aged care services. It would also introduce a competitive structure to aged care services based upon consumer choice that does not exist under current legislation. (sub. 269, p. 32)

A number of participants argued that separating out accommodation costs would provide an incentive for the development of innovative housing options and promote increased choice for people requiring care. Helping Hand Aged Care, for example, said:

> Provision of accommodation and provision of care should be separated, so that residential facilities become an accommodation choice, rather than a 'compulsory extra' provided in tandem with particular types of care.
>
> The starting point should be that older people are able to provide/look after their own accommodation, regardless of the level of care they need. Residential care then becomes one of the choices they can make… This approach could then lead to the emergence of different types of accommodation options (eg as in Sweden; smart house units) and/or changes in the way existing accommodation options are accessed/used. (sub. 196, p. 5)

Hal Kendig argued that separating accommodation from care was a priority:

> A priority for the Commonwealth government is to 'unbundle' the residential care program into separating funding for accommodation and care. … This separation would provide more choice and independence for older people as they would not have to move into residential care in order to receive high levels of care. The Commonwealth would benefit because it would not have to pay for accommodation components of aged care for those individuals who can afford to meet their own accommodation costs.
>
> … New supportive accommodation models offer the advantages of age-concentrated, purpose-built accommodation to which care could be delivered flexibly and economically as needed by residents. (sub. 431, pp. 5-6)

## Health care costs

Basic health costs, in the context of aged care, largely consist of nursing, allied health and palliative care. They should be funded in the same way as other primary health care and should attract a universal subsidy (with co-contributions where appropriate). The distinction between health care and personal care, however, is not

always clear, so a practical approach needs to be applied to this principle. In particular, mainstream gerontological nursing should be funded as part of aged care. As with health services in general, individuals should be able to use their private resources to purchase aged health care services that are additional to the basic services that attract the universal subsidy.

## Personal care costs

The personal care component of aged care services is essentially about the costs of being looked after because of frailty or disability and include both assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs):

- 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
- IADLs relate to domestic tasks such as shopping, laundry, vacuuming, cooking a main meal and handling personal affairs (OECD 2008).

What is included in the 'personal care' component of aged care services, however, is contentious as the boundaries between living costs, personal care and health care are often blurred. For example, while food is a cost of everyday living, having someone assist with shopping and food preparation could be classified as 'care' (as the person is unable to undertake these tasks because of frailty or disability), or as an everyday living expense.

Care costs (personal and health aged care costs) vary depending on the needs of the individual and can range from less than $1000 a year (the average HACC client receives four hours of service a month) to over $50 000 for people with dementia (EACH-D packages).

While aged care costs are reasonably predictable at a population level, they are less so at the individual level. For example, it is difficult for anyone to anticipate whether they will need care and support in old age and, if they do, how intensive and long-lasting those needs will be. It is also difficult to know what kind of unpaid care will be available from family and friends if care and support is needed.

That said, it is reasonable to expect that, if you live long enough, you will need some form of care and support because of frailty. Lifetime risk estimates show that retiring Australians face a reasonably high probability of requiring care in older age. For example, 68 per cent of women and 48 per cent of men at 65 years of age will require some aged care services (CACP, EACH, EACH-D, Transition Care and permanent and respite residential care) at some time in their remaining life

(table 6.1). The likelihood of needing these services increases with age up to 95 years.

Table 6.1 **Lifetime risk of requiring aged care**[a]
2006-08

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

[a] Probability of ever using at least one of the following — residential aged care, community aged care packages (CACP) or extended age care at home packages (EACH or EACH-D).

*Source*: Data supplied by DoHA.

For females aged 65 years, the likelihood of entering residential care in their remaining lifetime was 54 per cent and for males aged 65 years it was 37 per cent. The likelihood of entering residential care increases with age, although the risk declines again for the very old — in 2007-08 for females the likelihood of entering residential aged care was highest during their early to mid eighties (likelihood of around 60 per cent) while for males the likelihood peaked during their mid to late eighties (around 48 per cent).

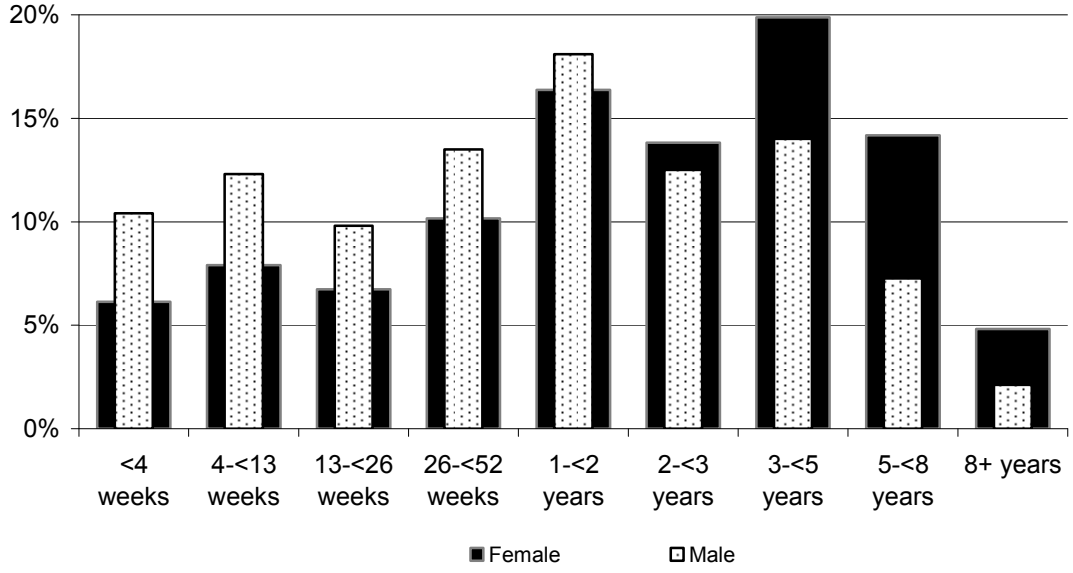
This suggests that some care costs should be considered a normal risk of growing old. And, because they are the more predictable and manageable costs of care associated with ageing, people should anticipate that they will contribute to those costs, except when they do not have the capacity to pay for care themselves.

Less predictable, however, is whether an older person will develop a chronic condition (such as dementia) or disability that requires intensive care for an extended period of time. As Wanless (The 'Wanless Report' on Securing Good Social Care for Older people in England) stated:

> The risks attendant with social care need are complex and difficult to measure. There is the risk of developing conditions or disabilities that in turn imply a need for social care. There is also the risk associated with how long people remain in poor condition, principally but not only in the cost of services. (2006, p. 223)

Only a minority of older Australians are likely to face extended periods of intensive care, and therefore could find themselves liable for very expensive — or catastrophic — costs of care. Around 14 per cent of women and 7 per cent of men entering residential care stay for between 5 and less than 8 years. Around 5 per cent of women and 2 per cent of men entering residential care stay for eight years or more (figure 6.2).

Figure 6.2 **Duration of stay in residential care**[a]




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

*Source*: DoHA *Aged Care Data Warehouse*, supplied by DoHA on 24 September 2010.

The fact that 'unpredictable' and potentially very high, or 'catastrophic' personal care costs are faced by a minority, points to the need for a risk/cost pooling or sharing mechanism. Some form of insurance (be it private or public), or a collective publicly funded system are the options for spreading this risk across the population. As the OECD recognised:

> There are significant uncertainties, in one's life time, about the need, duration, intensity and cost of long-term care. This provides a powerful rationale in favour of creating collective coverage mechanisms for long-term care. … Such mechanisms can ensure protection against the potentially catastrophic cost of care, which can place a significant burden on users, more specifically those living on low-income or with high levels of dependency. (2010, p. 14)

Such risks create a typical insurance problem, but currently the limited scope for risk-averse individuals to insure against the possibility of catastrophic costs (as they can for other potentially catastrophic costs, such as the loss of, or significant damage to, their house or car) results in a large welfare loss. And, as noted by Ergas (2010), as the prevalence of dementia rises and the distribution of care costs become more skewed, the welfare losses become more acute. Barr observed that:

> There are potentially large welfare gains if people can buy insurance that covers the cost of long-term care. (2010, p. 359)

To illustrate the potential welfare gains from insurance, if aged care costs were $30 000 a year and one in six people needed care for an average of two years, the

typical person would need care for one-third of a year, at a cost of $10 000. There are two ways a person could seek to finance the costs:

1. through buying insurance at an actuarially fair price. This would require a person to save enough to cover the premium for the average duration ($10 000)
2. by self-insuring where no insurance scheme is available, a person would need to save enough to cover the maximum potential duration of long-term care, say 10 years at $30 000 = $300 000 (based on an example provided in Barr 2010).

Voluntary insurance, however, is unlikely to work or be equitable or efficient because of problems on both the supply and demand side of the insurance market (chapter 7). The other options are compulsory insurance (which is examined in chapter 7), or the government acting as the 'insurer' by offering a stop-loss mechanism (see below).

One way the current publicly funded system could protect individuals from very high costs of care would be to have a stop-loss limit which could cut in either after a certain period of time of paying care costs (say after three years of intensive care) or after an individual had reached a cumulative level of 'out-of-pocket' payments (section 6.5). A key advantage of capping care costs to the individual would be to provide greater certainty for planning throughout life for aged care costs. As National Seniors Australia said:

> Older Australians want to know that they will be able to have affordable quality care in later life. (sub. 411, p. 13)

### *Where does that leave us?*

Some care costs are reasonably predictable and manageable (the high probability costs) and others less so (low probability, catastrophic cost events). In principle, the more predictable personal care costs should be largely the responsibility of the individual (based on a capacity to pay with a safety net for those with limited means), but there should be some mechanism in place for pooling the risk of the more unpredictable, and potentially catastrophic, costs of care.

## How much should individuals contribute to care costs?

In the Commission's assessment, there is a clear case for subsidising care for those unable to pay for care themselves (the safety net), and a case for protecting individuals from very high out-of-pocket costs of care (pooling of the 'tail' of the financial risk). What is less clear is how much individuals should contribute to the cost of the more predictable elements of their care.

A number of participants argued for universal access to subsidised care noting the parallels between personal care in old age and health care. For example, Catholic Health Australia said:

> … Medicare provides a precedent for the community meeting all or most of care costs, noting that an individual's aged care needs are unpredictable. (sub. 1, p. 13)

Others, however, were of the view that those who have the capacity to pay should pay for their own care costs. For example, a National Seniors Australia survey of more than 3200 seniors found that:

> … many people would be prepared to pay for high quality aged care, while wanting a safety net for those who cannot afford to pay. (sub. 411, p. 20)

Anglicare Australia said that a strong argument could be made that aged care is a 'public good', but supported the principle that:

> … people with considerable wealth or income make an appropriate contribution to their care. (sub. 461, p. 4)

Aged Care Association Australia and Deloitte also said:

> In principle, the primary financial role of the Commonwealth should be to finance care for those elderly Australians who are not in a position to themselves cover its costs. In that sense, the Commonwealth has, and must retain, a primary responsibility to ensure an adequate social safety net is in place. Conversely, those consumers who are in a position to cover their own care costs should do so, thus minimising the call on public expenditure and hence also minimising the need to impose distorting taxes so as to fund that expenditure. (sub. 285, p. 6)

The fact that it can be difficult to separate out health care from personal care suggests that there is a case for providing an entitlement for some services to everyone who has those needs. However, within Australia's health care system, the universal entitlement is limited to public hospital acute care and emergency department services. There are co-contributions subject to means-testing and a capped safety net for primary care services and pharmaceuticals. Ergas and Cullen noted:

> Commonwealth involvement in the funding of aged care arose at the intersection of the pension (and more generally, income support) and health care systems. From the former, it inherited an emphasis on means testing. From the latter came an emphasis on universality of access, tempered by quantity rationing (enforced through the restrictions on the number of places) and by reliance on significant co-payments. (2007, p. 10)

It may, therefore, be appropriate for some components of aged care to attract a universal subsidy (for example, those services closer to health care, such as palliative care), while others would be subject to means testing or specified co-contributions (such as low level assistance measures like domestic help). But too

great a focus of subsidies on those services closest to health care could ignore opportunities to help older people earlier, which in turn could lessen the risk of rising levels of need and higher costs to the taxpayer at a later stage. For example, early intervention measures such as installing hand railings could avoid an older person having a fall, requiring hospitalisation, and experiencing a further decline in functionality.

But providing care for free or with a high subsidy has significant fiscal implications for government and can reduce efficiency — which in turn would mean higher costs of providing the services (and this approach itself imposes a large burden on the public purse). And, it could see informal carers being replaced by more formal care.

Co-contributions can provide a test of how much individuals value particular services (provided they are not set too low), empower users to consider the value they place on services and encourage them to demand higher quality. Co-contributions can also be used to make the system progressive and encourage individuals to save for their aged care costs. The impact of any co-contributions on demand will depend on how responsive or sensitive care recipient decisions are to the effective service price — that is the out-of-pocket cost to the care recipient.

Means-testing seeks to ensure that those people with the capacity to contribute to their care costs do so. A feature of means-testing is that public funds are used as a safety net for those unable to pay for care themselves. Means-testing, however, can create perverse incentives including asset stripping by families prior to the individual requiring care. Administrative design can reduce the incidence of such behaviour.

### *International approaches*

Internationally, very different decisions have been made about where to draw the line between public and private responsibility for funding (figure 6.3). The OECD identified three broad types of arrangements for long term care:

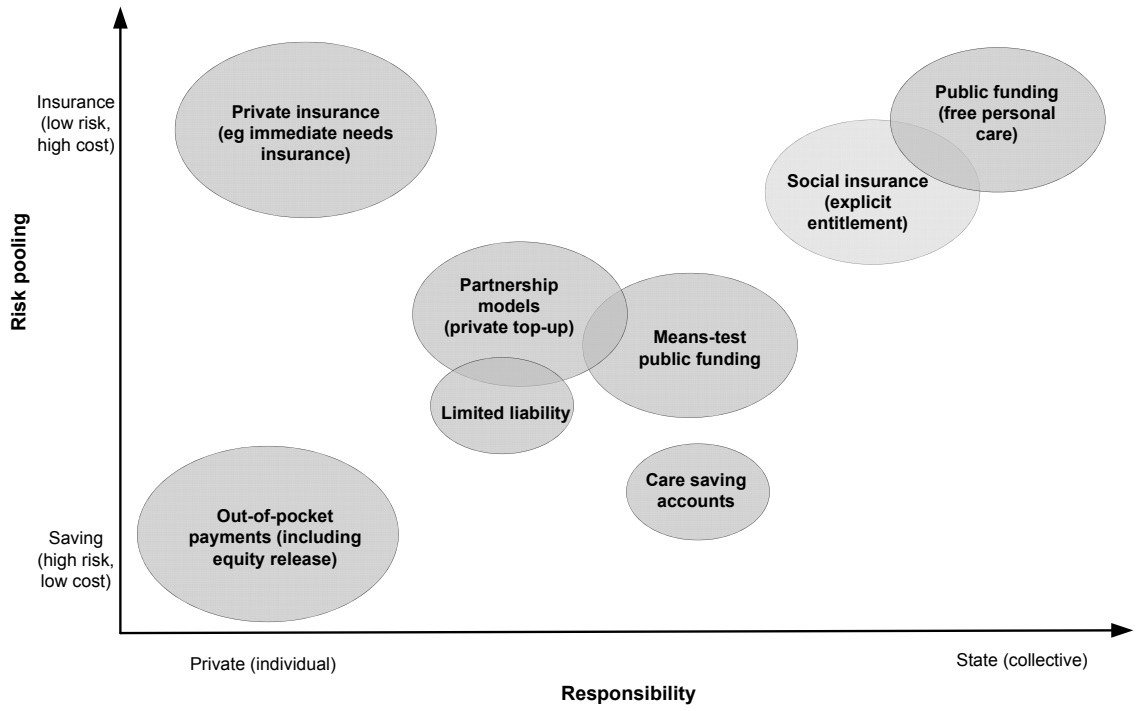
- universal systems where the majority of the population is entitled to publically funded care, with little need for private contribution. These include tax-based (such as Denmark, Sweden and Scotland) and insurance models (notably Germany, Japan and the Netherlands).
- mixed or progressive systems where there is some degree of universality, but also means-tested/income-related benefits. Under such systems a significant share of costs can be imposed on the individual. Countries with these systems include Austria, France and Australia.

- means-tested or safety net systems where there is minimal state intervention with support directed to those who lack the financial resources to pay for services. The United Kingdom and the United States are included in this category (2010a).

Long-term care systems across the OECD seem to be evolving in some common directions:

> At one end of the spectrum, means-tested, some safety-net approaches have been called into question, mostly on grounds of fairness and growing need. … At the opposite end of the spectrum, in comprehensive universal coverage countries, the range of services eligible for coverage has also been the object of scrutiny. (OECD, 2010, p. 18)

Figure 6.3 **Archetypal funding arrangements**




*Source*: Wanless (2006, p. 253).

All public coverage schemes across the OECD countries require users to share part of the cost of the personal care support they are entitled to, but countries differ in the method and level of subsidy relative to total costs of care. The three main approaches are:

- setting public subsidies and leaving individuals responsible for the difference between the subsidy and the cost of the service (Germany, France, Italy and Austria)

- flat cost-sharing — where cost sharing is a given percentage of care costs (for example, in Korea individuals pay 20 per cent of institutional care and 15 per cent of home based care; in Japan co-payments are 10 per cent of the cost of care)
- cost-sharing set according to income and sometimes assets of the care recipient.

A more detailed discussion of the different funding systems is provided in appendix C.

The bottom line is that there is no 'single' or 'right' answer to the question of how much individuals should contribute to the cost of their aged care (although they should not be exposed to very high, or catastrophic costs of care). In the Commission's view, where the balance between private and public responsibilities lies should be based on what is sustainable, considered equitable and 'fair' by older people and the community more generally, as well as what represents value for taxpayers' money.

DRAFT 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 (personal and health), everyday living expenses and accommodation.***

DRAFT RECOMMENDATION 6.2

***The Australian Government should adopt the following principles to guide the funding of aged care:***

- ***accommodation and everyday living expenses should be the responsibility of individuals, with a safety net for those of limited means***
- ***health services should attract a universal subsidy, consistent with Australia's public health care funding policies***
- ***individuals should contribute to the cost of their personal care according to their capacity to pay, but should not be exposed to catastrophic costs of care.***

Unpacking the different cost components of aged care makes it easier in practice to consistently apply the funding principles to the different types of care (community, respite, residential), to improve pricing signals to users and providers, and to better target subsidies to those in most need. Aligning care subsidies and charges between community care and residential care would facilitate more equitable choice and provide an incentive for providers and the government to drive service responsiveness and dynamic efficiency improvements.

The next sections look at what unpacking the different cost components and applying the above principles means in terms of changes to the current regulatory arrangements and examine options for improving funding arrangements.

## 6.3 Accommodation costs — applying the principles

Accommodation costs in community care are generally fully funded by care recipients. Rental assistance and social housing is available for those with limited means.

Currently the type of accommodation payment that older Australians pay for their entry to residential care depends on the resident's assessed care need at the time of entry. They can be charged either an:

- accommodation charge (for entrants to high care) or
- accommodation bond (for those entering low level care or those receiving extra services in high level care).

The level of the accommodation payment is determined according to a resident's assets. Accommodation supplements are paid to providers for residents in their care who have very few assets. Such supplements are appropriate in this context, because if the care recipients were in the community they would most likely be eligible for rent assistance (in addition to their pension).

### Accommodation charges

Residents of high level residential care (not on an extra service basis) can be asked to pay an accommodation charge if they have assets above the minimum asset level ($38 500 at 20 September 2010). The upper limit for any accommodation charge is regulated (currently the maximum amount is $28.72 per day at an asset level of just over $98 000). Accommodation charges are payable by high care residents for the entire period of their admission (with some exceptions), but cannot be charged for more than one-month in advance. Subject to agreement with an aged care provider, a resident can defer payment or make a payment from their estate. The aged care provider is entitled to charge interest on the unpaid amount. In 2009-10, the average accommodation charge for new residents was $22.51 per day (DoHA 2010n).

## Accommodation bonds

Bonds are effectively interest free loans to providers. Providers can also deduct an annual (capped) retention amount for the first five years of residence. The maximum retention amount is set by the government — for residents entering care during the 12 months from 1 July 2010 the maximum amount is $307.50 per month ($3690 for the 12 months). The retention amount does not vary while the resident lives at the residential care facility (for a maximum of five years). As for other residential care fees, the retention amount is negotiable below the maximum (with evidence presented to the Commission that some providers are willing to accept significantly lower or zero retention amounts in the case of a sufficiently large accommodation bond).

The balance of the bond is returned to the resident, or their estate, when they leave the residential care facility. The income from invested returns on accommodation bonds and retention amounts can be used by providers to meet capital costs or retire debt related to residential care, or to improve the quality and range of aged care services.

Residents can choose to pay an accommodation bond as a lump sum, a regular periodic payment (fortnightly or monthly) or a combination of both. Residents who have paid an accommodation bond and who are moving to high care can elect to roll over their accommodation bond.

## Accommodation charges don't reflect costs

The price charged for accommodation in residential facilities should reflect the cost of supply so that care recipients take into account the costs of provision in their decision-making (which in turn results in resources being allocated to the forms of accommodation that people value most). Regulatory restrictions under the current arrangements (price caps, maximum retention amounts, supply constraints on the number of allocated places) mean that the contribution that older Australians make towards the cost of their accommodation in residential care does not reflect the cost of the accommodation.

In ordinary high care the only payment option is an accommodation charge and the maximum charge is the same regardless of the room size, number of occupants, location and quality of fittings. This is a bit like charging the same rate for all hotel rooms across the country irrespective of where they are located and their star rating. A number of participants pointed to the lack of relationship between the accommodation charge and the cost of supply (and what that meant for choice of accommodation). Little Company of Mary Health Care said:

> It is illogical that the same (single) price applies to residential aged care in a fifty year old facility, with four bedded wards and multi- resident bathrooms as it does in a new, single-room with ensuite facility, and water views. (sub. 289, p. 22)

Ageis Aged Care Group also said:

> It is inconceivable that for 12 years we have had a system in place where residents and their families cannot pay for the standard of high care accommodation they want and deserve. (sub. 206, p. 3)

Having the same charge for accommodation is inequitable, limits care recipient's choice, provides little incentive for providers to compete on quality, and fails to provide an incentive for people to take into account the cost of provision in their decision-making.

Providers are handing back allocated places, beds that have been approved have not been made operational, and interest in aged care allocation rounds (ACAR) has diminished. A number of industry surveys also point to indicators that the financial returns on high care places are inadequate (box 6.5). In this context, Access Economics said:

> The ultimate consequence of a lack of industry sustainability is exit from taking up high care places or lack of commissioning of places taken up (ie, retaining them as provisional). This leads to overall service gaps and under-provision of care. Care needs are not met and the thinning in competition in the sector compromises the goal of efficiency also for remaining providers. (2009, p. 35)

Australian Unity spoke about the 'bleeding of capacity from the system', arguing that without action to support capacity building, residents will be unable to access appropriate care and 'a surge in hospital demand will be inevitable and with that higher per day care costs' (sub. 424, attachment 1, p. 7). Hogan also said the prohibition of bonds in high care:

> … impedes investment in that branch of the industry. Until this handicap is removed, the scope for making fully effective progress in efficiency and productivity will be marred at the expense of those who cannot secure or afford entry to extra service high care. (2004b, pp. 16-17)

The market is also responding to these pressures with strong growth in extra service places where bonds can be charged.

## Box 6.5 Participants point to evidence of insufficient returns on capital outlays in high care

Anglicare Australia:

> … the estimated annual difference between an average accommodation bond and an accommodation charge is about $12 846 per resident. … this annual shortfall for an average 100 bed facility with 70 high care residents equates to $899 220 or the funding required to construct 3.5 new residential care beds each year. (sub. 461, p. 26)

Toohey and Ansell identified some concerning trends:

> 1. An estimated 25 000 'phantom' beds i.e. places issued under ACAR over the last decade which have not converted to operational beds on the ground because of a lack of viable financing options.
>
> 2. Rapidly diminished interest by existing providers and new entrants in competition for new places in annual ACAR rounds. … most regions and states have been undersubscribed in recent years.
>
> 3. An unprecedented situation where existing, well established and highly respected providers have surrendered places to the Commonwealth because they are unable to viably construct and operate them. (sub. 464, p. 3)

Regis Group:

> …'extra services' places remain the only viable solution to obtaining capital. (sub. 237, p. 2)

Government of Western Australia:

> … the industry is currently funded by the Commonwealth Government at $109 000 per bed, whilst the average cost of construction ranges from $200 000 - $240 000. … Following the outcome of the 2007 Aged Care Approvals Rounds (ACAR) the Western Australian residential aged care sector was allocated only 644 out of a total 1006 places due to a lack of suitable applications from existing and new residential aged care providers. This represented 362 (36%) residential places available but not allocated. (sub. 412, pp. 1-2)

Deloitte's annual survey into the Australian Aged Care Industry found that three-quarters of the 137 respondents (managing around 700 facilities) had no intention of expanding their operations by acquiring pre-existing facilities and 61 per cent had no intention to undertake any new construction activity on existing facilities or build new facilities over the next five years (Deloitte 2010).

Bentleys 2009 survey of performance of more than 100 service providers operating approximately 350 residential aged care services found that more than 40 per cent of providers were operating at a loss.

Grant Thornton's Aged Care Survey of almost 700 residential care services reported that providers' average earnings before interest, taxation, depreciation and amortisation (EBITDA) in 2008 was $2 934 per bed per annum. The average return on investment for modern high care facilities with single bedrooms was around 1 per cent.

Stewart Brown's December 2009 survey of 380 facilities found that 39 per cent of high care facilities (22 per cent in June 2009) and 48 per cent of low care facilities (39 per cent in June 2009) achieved an operating profit.

## Bonds also don't reflect costs

Bonds, because they are only limited by an individual's capacity to pay (the only limit on the size of the bond is that it must leave the care recipient with a minimum of $38 500 in assets), and they are the only avenue of the market where providers have flexibility on price, have increased significantly in recent years. Bonds with new residents increased from around $58 000 on average in 1997-98 to almost $233 000 on average in 2009-10. Since 2004-05, the total value of accommodation bonds held by approved providers has doubled from $4.3 to $9.1 billion in 2008-09 — an increase of 20 per cent per annum. Since accommodation bonds are typically financed by the sale of the home, the growth in house prices is presumably a significant factor behind the growth in the size of bonds. To provide protection to the resident, there is a government guarantee of the bond for which providers are not charged (chapter 12).

The Commission heard evidence of very large bonds being paid (some well in excess of $1 million). Fortus (sub. 463, p. 6) cited the example of a Melbourne couple who were asked to pay bonds of $750 000 each, based on their home being valued at around $2.3 million. The Australian Guardianship and Administration Committee also presented evidence of high bonds being paid in recent years:

> All State and Territory members of AGAC have commented on the rapid acceleration, over the past 2 years in particular, in the amounts now being requested for accommodation bonds with sums of $550K to $750K and sometimes $1M+ now becoming somewhat of the norm rather than the exception. In NSW one approved provider has set its bond levels at between $500K to $2.6 million depending on the floor level and the particular rooms. (sub. 478, p. 1)

The average value of new bonds paid in recent years appear to exceed the estimated replacement cost of residential care places. Industry estimates of the average cost of construction for residential care beds ranged between $200 000 to $250 000. DoHA presented evidence to the Senate inquiry into residential and community aged care in Australia that the average construction costs for new or rebuilt aged care beds was $150 000 in 2009 (DoHA 2009h).

The Henry Review described the bond as a 'tax' rather than a user charge:

> The design of a bond is more like a tax, limited by people's capacity to pay, rather than a user charge, which would be limited by the costs of their accommodation. (Henry 2010, p. 636)

In 2008-09, anyone paying a bond of more than around $80 000 was paying more for their accommodation than those paying an accommodation charge. For the

accommodation charge to be equivalent to the average bond in 2008-09 it would need to have been more than $61 per day.[1]

For providers who offer both low care (or extra service high care) and high care, people who pay large bonds are cross subsidising those who pay the capped high care charge. Cross subsidisation creates inefficiencies in meeting the capital requirements of ordinary high care places as the financing of high care places depends in part on admissions into low care or extra service high care places. This situation is unlikely to be sustainable in coming years as demographic trends suggest that demand for low care places will continue to decline. The weakening incentives for investing in high level residential aged care services must be addressed if there is to be adequate investment.

The different accommodation payments are also inequitable because they are based on the level of assessed care need (high or low) and capacity to pay, not the cost of supply. As Sundale Garden Village said:

> The existing capital funding system is structured in such a way as to have part pensioners in low care facilities (hostels) potentially cross subsidising millionaires in high care. (sub. 269, p. 32)

Other participants pointed out that the different accommodation payments discriminate against older Australians who are least well off but who require residential care. As high-wealth care recipients paying bonds are more financially rewarding to providers than lower-wealth care recipients, this provides an incentive for providers to cherry pick (with some providers readily acknowledging that they do, chapter 5). One participant, relaying his experience on seeking a residential care place for a parent, said:

> I was told that there was no maximum fee and that it depended on the assets.
>
> I asked if she had a house worth $1 000 000 would they take all of that. I was told that would be very unusual but yes they would take that into the equation. They would not give me a 'retail' price for the room. … I don't feel it is fair for villages 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. (sub. 58, name withheld pp 1-2)

Hogan also observed that the distinction between extra service high care (where bonds can be sought) and ordinary high care:

> … brings a remarkable discrimination. Those with substantial assets may effectively buy their way into high care by offering substantial bonds. Those lacking substantial

[1] Assuming forfeited interest of one year at 8.74 per cent ($18 612) and the maximum retention in 2008-09 of $292.12 per month, the annual (pre-tax) cost to the individual providing a bond of $212 958 was $22 301.53 or $61.27 per day.

wealth — not only pensioner and part-pensioner residents but also those of relatively modest wealth — are not able to offer anything to support the provision of services for them. *Thus the discrimination is against the less well-off in Australian society*. [Author's italics] (2007, p. 2)

## Higher charges or bonds for high level care — what is the solution?

The equity, efficiency and sustainability of residential care could be improved by placing low care and high care on an equal footing in terms of access to charging arrangements to meet capital requirements.

### *Increase the regulated daily accommodation charge?*

One option is to increase the daily accommodation charge for high care so that the charge is adequate to cover average capital costs. But, with any new cap there is the risk of getting the price 'wrong' and it would need to be appropriately reviewed and/or indexed over time. And an average capped charge cannot accurately reflect the actual building costs of residential care in different regions nor would it allow older Australians to pay different accommodation charges for accommodation of different quality/with different features (a room with a view would be the same charge as an older room without a view). Some participants identified problems with this option. Aegis Aged Care Group, for example, said:

> To increase the cap is not appropriate because it restricts what can be built and takes away resident choice. (sub. 206, p. 4)

Uncapping the daily accommodation charge so that it can reflect the building costs across different regions and allow variation based on varying quality and features would be more in line with a user-pay approach. Anglicare Sydney supported such an approach noting that:

> The accommodation charge should not be regulated by Government. It should be set by the market so that people willing and prepared to pay for a higher standard of accommodation may choose to do so, whereas others may be content to pay for more modest accommodation. However, those with limited or no capacity to pay should have their accommodation costs subsidised at a fair and reasonable level. (sub. 272, p. 9)

Under this market price option, costs to care recipients and taxpayers (the accommodation subsidy for supported residents) are likely to be higher, but consumer choice and industry sustainability would be enhanced. Care recipients, however, would continue to be charged differently according to the level of assessed care need (high or low care). There is a concern that, as providers could charge what the market would bear, care recipients could be exploited and those with a lower capacity to pay will miss out. This is a greater concern in the short

term particularly in areas where there is limited competition. But in the longer term, provided that the accommodation subsidy is adequate to cover the cost of supply, there is likely to be improved access as providers are more likely to build new places with higher returns on accommodation.

### *Bonds for high care?*

The majority of participants saw the extension of bonds to high care as the 'solution' to under-investment in high level residential aged care services, and for removing the artificial distinction between high and low care (box 6.6).

#### Box 6.6 **Support for removing restrictions on bonds**

Australian Unity:

> Abolish the restrictions on high care bonds (and abolish 'low care' and 'high care' categories in residential and community aged care, as outlined below) to encourage investment in residential aged care by investors and operators. (sub. 265, p. 7)

ECH joint submission:

> On the question of accommodation payments, the government has offered no justification for its refusal to allow accommodation bonds to be charged for all residential care. By contrast, virtually every other review and inquiry into aged care in recent years has supported the lifting of regulatory restrictions in this area. (sub. 453, p. 12)

Clubs Australia:

> There is a need for providers of both high care and low care to be able to utilise and benefit from accommodation bonds, and the current restrictions on charging an accommodation bond for high care should be removed. (sub. 197, p. 28)

Older People's Reference Group:

> The disparity between an average bond of more than $200 000 for low care, while none applies for high care unless 'extra services' is provided, cannot be justified in the long run. (sub. 25, p. 10)

Aged Care Association Australia – South Australia:

> We propose that, subject to an indexed asset value which would be excluded from any payment, all people entering residential aged care, whether as high or low care recipients, would have the option of paying a refundable deposit for their accommodation, a payment which equates to an agreed deposit, or a combination of these. (sub. 309, p. 6)

Blue Care:

> Remove restrictions on high care bonds, including retentions, and deregulation of bed supply should follow in the longer term. (sub. 254, p. 4)

A survey of providers undertaken by Hynes Lawyers reported that 88 per cent of respondents said that approved providers should be able to ask any resident who can afford to pay an accommodation bond to do so.

Some participants, including National Seniors Australia, raised concerns about the extension of bonds to high care:

> Government and industry have raised the possibility of requiring bonds from high care residents. NSA believes this is a short-sighted approach to a bigger issue which requires planning ahead to meet increasing costs in aged care generally. NSA believes that accommodation bonds may be part of a suite of funding choices for consumers, but are not the only option. In fact, such bonds can be disadvantageous to some consumers, particularly those entering residential aged care for very short periods of time. (sub. 411, pp. 15-16).

Community concerns about extending accommodation bonds to ordinary high care places have in the past been a major stumbling block to reform in this area. In 1997, the Government proposed accommodation bonds for high level care but the proposal was quickly backtracked as the baby boomers (supported by various stakeholder groups) revolted at the prospect of losing control over their inheritances. A more substantial concern relates to care recipients having to pay large up-front bonds when they are expected to only need high care for a short period of time (for example, the very frail or those entering residential care for end-of-life care).

### *Choice in payment options for accommodation*

A system that provides flexibility and choice in terms of the form of accommodation payment acknowledges that one size does not fit all — someone entering high level care with dementia may (or may not) have the prospect of an extended period of time in care while someone else entering care may require palliative care and not expect an extended stay.

Many participants called for choice in accommodation payment options:

> … because the life time savings of many Australians is in the form of home ownership, flexible payment arrangements will be necessary to cater for individual circumstances. (Catholic Health Australia, sub. 1, p. 13)
>
> Residents need to have a means to be able to choose how they contribute towards their accommodation costs. We need flexible high care accommodation payment arrangements. There will be further pressure on the Aged Care Sector with current and future generations having higher expectations of choice, flexibility and responsiveness in how they use and access aged care services. (Anglican Care, sub. 49, p. 2)
>
> … people should have options for how they pay for accommodation in a residential aged care facility. Options could include paying rent, deferred contributions from

estates, a refundable lump sum which in effect is a loan, or other negotiated arrangements. (Aged and Community Services Australia, sub. 181, p. 4)

Residential aged care accommodation could be funded by daily, weekly or monthly rental payments, a lump sum, a deferred payment, or some combination of these options. Such an approach would be consistent with an aged care system that offers flexibility and choice. But, the payment options need to operate such that they generate income comparable to the returns earned on a lump sum payment which recovers the cost of accommodation (rather than including a large tax element arising from the artificial scarcity created by supply constraints).

Providers require a reasonable rate of return on the capital cost of providing residential care facilities. Provided the returns are the same for the different payment options (after allowing for differences in transaction costs, risks of non-payments, etc.) providers should be indifferent between how care recipients pay for accommodation (and care recipients would have a range of payment options available to them).

As discussed earlier, older Australians entering low care and 'extra service' high care already have the option of paying a lump sum bond or an equivalent periodic payment or a combination of the two, but care recipients' take-up of the periodic payment option has been low (table 6.2).

Table 6.2 **Method of payment of bonds**

Percentage of all bond-paying new residents

| *Method of payments* | *2004-05* | *2005-06* | *2006-07* | *2007-08* | *2008-09* | *2009-10* |
|---|---|---|---|---|---|---|
| Lump-sum | 91.8 | 91.2 | 91.1 | 91.0 | 89.3 | 89.6 |
| Periodic payments | 4.5 | 3.8 | 3.6 | 3.1 | 3.5 | 4.1 |
| Lump-sum and periodic payment | 3.7 | 5.0 | 5.3 | 5.9 | 7.4 | 6.3 |

*Sources*: DoHA (2009e, 2010n).

Low take-up of alternative accommodation payments can be explained by:

- providers' preference for bonds combined with constrained competition (arising from supply restrictions) which has allowed providers to offer care recipients little choice about the method of payment
- income and asset tests within the broader welfare system (the age pension in particular) which create incentives for residents to pay lump sum bonds
- evidence that clients are not well informed about their payment options (box 6.7).

## Box 6.7 Complexity of bonds and importance of information

Some participants suggested that, notwithstanding the interactions with the age pension test, the 'complexity' of the bond arrangements and insufficient information about payment options meant that people were paying large bonds thinking this was their best option. Fortus, for example, said:

> Not enough prior education is available to residents and their families in understanding Bonds. For example, many aged care providers recommend the family home is sold to pay for a lump sum Bond. Consumers are often unaware Equity Release can be accessed to pay for the lump sum and/or periodical payments. Additionally they are unaware that if all/part of the Bond is paid periodically and ongoing, the family home may be rented out and the house is exempt from the Assets Test and the rental income from the Income Test for the purpose of the Aged Pension. (submission 463, p. 4)

When a person enters a residential care facility, their home is not counted as an asset for age pension purposes for up to two years (longer if a spouse or partner continues to live there). However, as long as a resident continues to pay part or all of the accommodation bond via a periodic payment and rents their former home, the value of the home is not counted in the age pension asset test nor is the rent received counted as income. As such, there is some incentive for care recipients to agree to pay some of the accommodation bond by periodic payment. To illustrate, consider the following cameos for a resident with a $1 million home:

- Cameo 1: sell the home and pay an accommodation bond of $1 million
- Cameo 2: pay an accommodation bond of $150 000 and invest the remaining $850 000 in an interest bearing asset
- Cameo 3: retain the home, rent it out and pay a $150 000 bond payable by monthly instalments over five years.

As shown in the table 6.3, large bonds can result in poorer outcomes (compared with the other options) for taxpayers and the care recipient/bequest.

### Table 6.3 Big bonds = poor outcomes for taxpayers + individuals[a]

| | Cameo 1 *($1 million bond)* | Cameo 2 *($150 000 bond, invests $850 000)* | Cameo 3 *($150 000 bond , rents home pays monthly instalments)* |
|---|---|---|---|
| Provider receives | $103 068 | $41 294 | $30 485 |
| Care recipient | $4 241 | $38 974 | $45 864 |
| Bequest | $996 310 | $996 310 | $1 026 310 |
| Taxpayers pay | $18 619 | $0 | $6 864 |

[a] Assumes that the resident stays for one year and a borrowing cost by the RACF of 8.5 per cent, no transactions costs on the sale of the home and does not account for the cost to the Government of the pension health card.

*Source:* Productivity Commission estimates.

Bonds are particularly attractive to providers as a form of accommodation payment because they allow providers to offset bank debt with zero interest debt. The benefits to providers from negotiating large bonds can be significant. As shown in table 6.4, the interest that can be earned on $200 000 is around $17 000 a year. As Hogan put it:

> The use of accommodation bonds is attractive to boards and management compared with charges because of their contribution to the capital needs of the aged care entity; whereas accommodation charges simply meet the costs of servicing the capital which still must be raised and, most importantly with debt, repaid. Accommodation bonds offer a self-replenishing means of funding. (2004b, p. 1)

Table 6.4 **High bonds — an attractive option for providers**

| *Bond* | *Interest*[a] | *Retention* | *Total* |
|---|---|---|---|
| ($) | ($ pa) | ($ pa) | ($ pa) |
| 100 000 | 8 500 | 3 690 | 12 190 |
| 200 000 | 17 000 | 3 690 | 20 690 |
| 300 000 | 25 500 | 3 690 | 29 190 |
| 400 000 | 34 000 | 3 690 | 37 690 |
| 500 000 | 42 500 | 3 690 | 46 190 |
| 600 000 | 51 000 | 3 690 | 54 690 |
| 800 000 | 68 000 | 3 690 | 71 690 |
| 1 000 000 | 85 000 | 3 690 | 88 690 |

[a] Assumes an interest rate of 8.5 per cent per annum as a conservative estimate of borrowings costs.

*Source*: Productivity Commission calculations.

Some participants suggested that the ability of older Australians and their families to 'negotiate' payment arrangements, including the size of a bond, is questionable. The Australian Guardianship and Administration Committee, for example, said:

> The ability of a consumer to 'negotiate' a bond amount is clearly often questionable at best given the often emotionally charged nature of a consumer's move from home to aged care; the general pre-requisite need to sell a family home and to pay an accommodation bond. (sub. 478, p. 2)

Another constraint on the negotiating power of care recipients are the quantitative restrictions which enhance the negotiating power of providers by allowing them to charge what the market will bear.

Constrained competition can be addressed by reducing and ultimately removing controls over the number of places that currently reduce competition and restrict consumer choice. As discussed in chapter 5, many participants to this inquiry pointed to the costs associated with supply constraints and a number of recent

reviews have argued the need to remove the restrictions on the number of community care and residential places.

DoHA also acknowledged the costs associated with supply constraints:

> Fundamentally, the planning ratios help manage the Commonwealth's fiscal risk. However, they create an artificial scarcity that limits the scope for competition, blunts pressures for efficiency and innovation and deprives consumers of choice. This, in turn, means that suppliers face little threat of displacement and limited competitive pressure to be efficient, although the regulatory constraints placed on provider's incomes do not provide some incentives to achieve efficiencies. Market power is intensified locally because consumers seeking a place, especially in high-level care, often doing so as a time of emergency, and usually have preferences as to the location of the facility. These features further increases the market power arising from rationing, and add to the blunting of pressures for efficiency. (sub. 482, p. 52)

The Commission proposes the removal of restrictions on the number of community care packages and residential care beds as well as removal of the distinction between high and low care, with appropriate transitional arrangements to support this reform (see chapter 14). This will improve providers' ability to respond to the needs of users and facilitate greater choice of facilities where care can be provided. Price regulations could be gradually relaxed as the level of competition in the sector increases (price regulations are currently in place to prevent the abuse of localised market power).

As competition reshapes the market, this should place downward pressure on bond prices and result in increased choice for care recipients. Deregulating supply will, however, increase the risk profile of providers and therefore the required return on investment, a point made by DoHA:

> Currently aged care is seen as relatively low risk investment, and hence investors require a relatively low return in their investment given the security offered by the needs based planning arrangements (limited competition) and the guarantees associated with a government income stream. Reform to improve the efficiency of the industry through greater competition would increase the risk of the industry and hence the required rate of return. (sub. 482, p. 54)

It is often argued that removing supply constraints on bed numbers and community care packages would place a greater measure of fiscal risk on the government. However, the Commission maintains that the government could still control its expenditure on subsidies through the criteria used to assess eligibility for approved care, the level of resourcing of care, and the co-contributions required from recipients of care (chapter 8). Indeed, DoHA acknowledged the role of the ACATs and means-testing in keeping the system sustainable:

> The legislative framework of the Aged Care Act, and in particular the requirement for an independent assessment of need by Aged Care Assessment Teams, helps support sustainability by targeting services to those with greatest need. The Act's means testing arrangements for residential care also assist in this regard, both by altering the balance of public/private financing and by ameliorating the issue of moral hazard and provider induced demand. (sub. 483, p. 60)

### *Interaction of bonds with the age pension assets test*

But, constrained competition is only part of the story. The preparedness of some older Australians to pay large bonds is also driven by them wanting to meet the asset test for the age pension. They have an incentive to pay a large bond as, like the family home, the bond does not count towards the age pension asset test. This overcomes a concern of many older Australians currently in receipt of the age pension, who if they sold their house and invested the capital, may no longer be eligible for a pension or part pension (with its attendant benefits, including lower co-contributions for aged care services).

Older Australians can be convinced to pay a large bond because it can mean they can not only receive the pension (full or in part) but they can also reduce their care fees (residential care costs are income tested and full pensioners do not contribute to care fees in residential care). Currently around 90 per cent of all permanent residents in residential care receive a pension (Centrelink or DVA pension).

A number of participants raised concerns about what large bonds mean for taxpayers and the sustainability of the aged care system. Anna Howe, for example, said:

> … the exemption of bonds from the Age Pension assets test has lead to bonds becoming a mechanism for avoiding the means test, and comes at a considerable cost to taxpayers. … Residents of aged care homes who are left with few assets, and hence little income from those assets, will not only qualify for a part or full Age Pension, but will also avoid having to pay means-tested fees. Providers can be seen as 'double dipping' by maximising interest earned on bonds, possibly well in excess of the Accommodation Charge, at the same time as receiving subsidies for care and basic daily fees paid from the Age Pension. (sub. 355, p. 25)

Uniting Care NSW/ACT also said:

> … interaction with the pension means test makes it attractive for residents to trade-off higher entry bonds against lower daily fees. This creates opaque, poorly targeted transfers between taxpayers (who bear the costs of increased pension entitlements that result from higher bond payments) and providers of care (who benefit from the reduced price elasticity of demand with respect to entry bonds). While this also occurs in low care, the consequences are especially perverse in high care, where it creates a degree of taxpayer subsidy of extra service places (as only extra service providers can charge

bonds, and hence benefit from the transfer). It is difficult to believe that any of these outcomes would be intended or desirable. (sub. 369, p. 22)

Overall, the incentives under the current arrangements encourage large accommodation bonds for three reasons:

- to maximise the size of the age pension received by the care recipient
- to minimise the cost of care for care recipients
- to maximise revenue for providers.

To the extent that these three objectives are achieved, the taxpayer picks up the tab.

There is also the prudential risk from the accommodation bond regime that is currently taken up by the Australian Government, as it acts as an unsecured creditor for residential care providers (and in turn provides a guarantee to older Australians purchasing a bond). These arrangements impose further costs on taxpayers. The Government has recently committed $21.8 million over the next four years to support enhanced protections to further safeguard the more than $9 billion of residents' life savings held in aged care accommodation bonds by approved providers (DoHA 2010g).

### *Where does that leave us?*

Essentially the accommodation bond instrument together with how it interacts with the pension means test means that the care recipient and the provider will *not* be indifferent between payment options, but will be strongly biased towards bonds, and bonds that exceed the cost of supplying the accommodation. To avoid distorting choices between accommodation payment options, the incentives shaping choices for care recipients and providers need to be neutral.

## Some solutions

### *A first best option*

A first best option would involve having a means test for the aged pension that treated income and assets in a consistent manner and did not exclude particular assets (such as accommodation bonds and owner-occupied housing). Such an approach would recognise that individual wealth is made up of both income streams and assets and that, arguably, it is unfair to treat people with the same wealth, but with different mixes of income and assets, in different ways. The Pension Review Report (Harmer 2009, p. 121), said that 'means testing needs to target payments in a

way that does not induce inappropriate behavioural responses, and which is seen as fair and equitable'. The exemption of accommodation bonds from the asset test for the pension appears to be inducing behavioural responses that are costly to taxpayers.

The Henry Review also acknowledged that different treatment of wealth under current means-testing arrangements reduces 'fairness'.

> Within the current two-part means test — the income test and the assets test — some assets are assessed under both tests, while other assets are assessed only under the assets test. This results in people receiving different levels of government payments even though they have the same level of wealth. This reduces the fairness of the means testing system. (Henry 2010, p. 533)

The Henry Review recommended a 'comprehensive means test' for determining access to income support payments that included deeming an income on most assets. And, while the Review recommended that accommodation bonds and owner-occupied housing continue to be exempt from the comprehensive means test, they did recommend a cap be applied to the exemption for owner-occupied housing as a way of increasing the fairness of the means test. The Commission's terms of reference for this inquiry does not seek comment on the appropriateness of means testing for the age pension or the behavioural responses the test may invoke. A review of the aged care system is not the window through which options for age pension reform can be explored.

### *Alternative options*

In the context of the present means test arrangements for the age pension, the Commission has considered alternative or second best options, including:

- not allowing bonds
- placing a cap on the size of the bond
- changing incentives so that choices relating to the form of accommodation payment are less distorted.

#### *Not allowing bonds*

The option of not allowing bonds and only permitting daily, monthly or other periodic payments would remove some choice and flexibility for care recipients and their families. Entry into a residential care facility often involves a significant rearranging of the financial affairs of the care recipient. Many older Australians and their families are attracted to making a single lump-sum payment (particularly if

they have sold their home), recognising that they will have some of that capital returned at the end of their stay (typically returned to their estate).

While the assets of older people entering residential care could be invested elsewhere, given that the assets will be earning a return, older Australians who were entitled to the age pension when living in the community could lose part or all of their pension on entering into residential care (while the owner-occupied home is exempt from the pension asset test, the assets from the sale of the property are not exempt unless in an accommodation bond). This is not dissimilar to the disincentives age pensioners face when they sell their home and buy a less expensive (but often more appropriate) home, as the surplus usually becomes an assessable asset.

Not allowing bonds, while permitting providers to charge the equivalent of an accommodation charge for all forms of residential care that covered the costs of supplying the accommodation, would largely address the cross-subsidisation and 'cherry picking' problems under current arrangements. The beneficiaries of this option are taxpayers because more older Australians would be paying for their aged care costs and fewer would be entitled to the age pension. It would also address the inequities between users of high and low level care.

The main problems with this option are that it affects some older people's eligibility for the age pension and reduces the accommodation payment choices for care recipients.

The Commission is not attracted to this approach.

*Should bonds be allowed, but with a cap?*

A cap on the size of the bond could be a single dollar amount, but ideally in setting a cap, consideration should be given to reflecting variations in accommodation costs by location and amenity.

A fixed limit would be simpler and the limit could be set based on the average construction costs for new or rebuilt aged care beds as determined by DoHA or an independent body. Such an arrangement would remove the incentive for consumers and providers to agree to very large bonds. Residents could, however, top up the capped bond by periodic or other payment methods, to meet the price to be paid for higher standards of accommodation.

A single capped amount carries the risk of getting the cap 'wrong' (so the price charged for accommodation does not reflect supply) resulting in the same problems

that arise from the capped accommodation charge. An average capped amount also cannot accurately reflect the actual building costs of residential care in particular regions.

Capped bonds, if they are to reflect different building costs across different regions and allow variation in price based on varying quality and features, are complicated and could be open to criticism. The Australian Guardianship and Administration Committee said:

> Placing a 'cap' on what can be charged is highly problematic due to the multiplicity of factors that could be involved, however an independent test of 'reasonableness' appears to be appropriate to implement. (sub. 478, p. 2)

One option would be to only allow providers to charge for accommodation using an advertised daily rental charge for calculating the cost of accommodation. This would vary by regions and the quality of the accommodation, but in itself presupposes a limit on the daily rental charge.

A capped bond places a limit on the assets that can be exempt from the pension test and therefore results in different treatment of assets for those receiving care in the community and those receiving care in residential care.

On balance, the Commission is not attracted to this as a stand-alone-solution.

*Changing incentives so that choices about payment are not distorted*

One option for ensuring that accommodation payments reflect the cost of supply *and* are equally attractive to care recipients and providers is to limit the amount providers can charge for a bond, to be the equivalent of a periodic accommodation payment that is commensurate to the cost of the accommodation supplied.

To ensure transparency and maximise competition, providers would be required to publish their daily accommodation charges, and an accommodation bond equivalent. This would improve transparency of accommodation payments and older Australians' understanding of accommodation payments in residential facilities. The daily charge for those needing short term (including episodic) stays could be the same as for longer term stays (with additional 'turnover' costs of entry and exit if necessary), much the same as a hotel often charges a lower daily rate for a longer stay. Bond retention amounts would be abolished.

Such an approach would mean that accommodation payments would reflect variations in building costs for residential facilities in particular regions and reflect different quality/features without requiring valuations of each and every facility.

The Commission is attracted to this option as it would make transparent the 'price' of accommodation, provide flexibility on payment options, and provide an incentive for providers to be neutral between receiving periodic charges or bonds.

With accommodation bonds reflecting the cost of accommodation, rather than their ability to pay, some pensioners selling their homes to go into residential care or a retirement village could find themselves with surplus funds that would not be exempt from the pension test (so they could lose part or all of their pension). This could act as a significant disincentive for older people to move to more 'appropriate' accommodation for their care needs. As Australian Unity argued:

> According to current Centrelink arrangements, retirees moving into a retirement village are penalised for selling their existing house to move into a retirement village, since the equity released from the family home is added to their assets and decreases their pension amount. This has led to a tendency among pensioners to 'arrange' their finances in such a way that they can retain assets/income to pass on and maximise the pension.
>
> The government should, in fact, be rewarding pensioners to better use their own income to maintain their own health and wellbeing, where it is possible for them to do so. (sub. 459, p. 1)

Chapter 10 discusses the broader welfare and health benefits from living in age appropriate accommodation. There can also be savings made from the delivery of care in congruent and age-friendly accommodation. There are sound public policy reasons, therefore, to remove such disincentives.

A number of submissions proposed schemes to increase the mobility of older Australians by exempting certain investments from the age pension asset test. For example, Australian Unity (sub. 265 and 459) proposed the introduction of a 'Seniors Living Scheme' to facilitate the downsizing from the family home to more appropriate seniors housing. The Financial Planning Association of Australia (sub. 376) proposed that there should be an exemption for all lifetime annuities from the age pension assets test.

One option, favoured by the Commission, is to establish a pensioners bond scheme, provided or backed by the Government that would be available for age pensioners selling their homes. Under this arrangement any surplus funds from the sale of the home could be invested in the government scheme — effectively an Australian Pensioners Bond. It would offer an alternative (or supplement) to an accommodation bond and be exempt from the age pension assets test. Older Australians using this facility could draw upon it to fund their day-to-day living expenses and their aged care costs. Bonds would be free of entry, exit and management fees. The Government could guarantee the capital of the bond and maintain its real value through indexation at the consumer price index rate.

The Government could directly provide the product, or contract the private sector to do so. But if the latter, the liability should stand on the Government's balance sheet. The Pensioner's Bond scheme would only be available to age pensioners who wished to sell their own home.

## But what about 'supported residents'?

Participants raised concerns about services being maintained in areas of social need if there is to be an easing of planning ratios and bed licences. For example, Mercy Health said:

> The deregulation of bed licences, and the removal of the socio-demographic allocation model, is likely to lead to an increase in the number of beds provided in areas of relative affluence, to the detriment of lower socio-economic areas. (sub. 215, p. 10)

To ensure equitable access to residential care for those people unable to pay for their own accommodation costs, subsidies should be set at a level that ensures that providers are willing to provide a place to these residents. Currently DoHA determines a proportion of supported, concessional and assisted residents for each region. Aged care services in a region are expected to accept an appropriate proportion of supported (including concessional or assisted) residents to meet these levels. Providers receive an accommodation supplement (previously known as the concessional resident supplement). For facilities with more than 40 per cent of supported residents, the accommodation supplement is at the full rate. For those facilities with 40 per cent or fewer supported residents, a 25 per cent discount is applied to the accommodation supplement. Some extra service licensed providers are exempt from this requirement.

To maintain aged care places for the financially disadvantaged and those in rural and regional areas (on equity grounds) after the planning restrictions are eased, mandatory requirements for providers to make places available for supported residents could continue. But some participants were critical of the current mandatory requirements. Aged Care Association Australia SA, for example, said:

> The claimed intention of this policy is to ensure equity of access for supported residents, however the policy unfairly penalises facilities which cannot meet the ratio target, and works perversely to restrict access to different potential residents in different situations. (sub. 309, p. 5)

Melbourne City Mission:

> We are regularly moving backward and forwards across this 41% threshold level, at times achieving only 38% to 40.7%. In these situations, the Supplement rate that we currently receive is only $12.31 per day rather than the $18.82 full rate. This represents

a 35% penalty. For Melbourne Citymission, the annualized impact of this penalty is $42,000. (sub. 173, p. 22)

Anglicare Sydney:

> The current system of stepping concessional supplements acts as a disincentive; there needs to be a sliding scale increasing the supplement in smaller steps – eg every 5% - and continuing above 40% to between 60% and 80%. This would act as an incentive for those of us not for profit providers, who work with socio economically disadvantage groups, to widen the aged care support for these groups and still be able to maintain financial viability. (sub. 272, p. 8)

The requirement to have more than 40 per cent supported residents in a facility to have access to the higher rate of supplement means that the accommodation payment is based (to some extent) on the proportion of supported residents rather than the cost of supplying the accommodation. The different subsidy rates are also likely to distort providers' decisions about supported residents. As Hogan said:

> For many providers there must be a selection bias favouring concessional and assisted residents because the incremental cost of not having at least 40 per cent of residents in those two categories is so drastic. … This means the principle of equality of access for all those seeking entry to aged care facilities is set aside. Subject to the expectations of death occurring in the resident population, the likelihood is for management to aim for a ratio of at least 43 per cent in the larger RACS having more than 60 beds and obviously higher in the ones with fewer residents because the cost of dropping below the 40 per cent ratio is so dire. A fundamental strategic need in the immediate years ahead is for full funding of the concessional and assisted residents so the 40 over cent requirement may be abolished. (2004b, p. 14)

The supported resident payment should be a clearly defined payment for the accommodation costs (based on the costs of supplying a basic room) for those unable to pay for accommodation themselves, that provides an sufficient return on investment for providers. This should ensure that providers continue to provide places to those unable to pay for accommodation themselves and remove any distortions.

What is crucial is that the accommodation payment made by the Australian Government be sufficient to meet the full cost of providing an approved basic standard of accommodation — potentially this could be a two bed ward with a shared ensuite. An independent body would need to make transparent recommendations to the Australian Government on the subsidy rate for an approved basic standard of residential care accommodation on a regional basis (where there are significant cost variations across regions). The accommodation subsidy would also need to be adjusted over time based on independent evidence on building costs and regional differences.

The accommodation subsidy may also need to vary according to the age of facilities. For example, a higher rate for new facilities and a lower rate for existing or older facilities. *The Commission seeks participants views on such an approach.*

One option is to make the requirement for supported residents a 'tradeable' obligation between providers within the same region (the Australian Government would continue to set the level of the obligation on a regional basis). This would allow some facilities to have a higher proportion of supported residents while other facilities may not to have any supported residents.

An alternative approach would be to incorporate supported accommodation places in particular regions into a competitive tendering system with bids sought on the amount of government subsidy needed for capital and operating costs to provide a service. Such an approach was suggested by Toohey and Ansell:

> Abolish the provisions relating to mandatory requirements of places to financially disadvantaged persons in favour of a Commonwealth tender processes (externally managed by organisations experienced in government tenders) for the provision of a required numbers of places within existing or new facilities for a period of time consistent with economic viability. Tenders should be assessed on the basis of economic efficiency and the standard of care and accommodation guaranteed for residents. (sub. 464, p. 8)

Under this approach, the market would determine the value of the government subsidy, which would eliminate the need for an independent body to determine the appropriate value of the subsidy by region (where there are significant regional cost variations).

*The Commission seeks participants views on these options.*

Because of concerns about the adequacy of current pricing incentives to provide a sufficient number of beds for supported residents, the Commission proposes that the present supported resident scheme (but with accommodation payments for all supported residents adequate to meet the cost of providing the basic standard of accommodation) be retained until at least it has been reviewed as part of the third stage reforms, five years after implementation (chapter 14). However, to improve the scope for providers to tailor services to different client groups, facilities should be able to trade quota obligations with others in the same region so that some facilities could operate below their target and others could provide a more specialised service to needy groups.

The Australian Government should also review the current size of the quotas for supported accommodation in each region to ensure they reflect the current level of need for such places.

Over time, with the accommodation subsidy provided by the Government for supported residents matching the cost of accommodation, the Commission expects increased competition among providers with specialisation in services to particular client groups.

The five year review should assess developments under the new aged care system, in the context of the increased accommodation charge, and recommend whether the supported resident scheme should be continued or replaced by a tendering mechanism where there is a competitive market of service providers — chapter 12 of the Commission's study *The Contribution of the Not-for-Profit Sector* (PC 2010b) provides guidance on appropriate issues that should be considered by the Government when contracting services.

Transitional issues associated with relaxing supply constraints and price controls are further discussed in chapter 14.

DRAFT RECOMMENDATION 6.3

***The Australian Government should remove regulatory restrictions on the number of community care packages and residential bed licences over a five-year period. It should also remove the distinction between residential high care and low care places.***

DRAFT RECOMMENDATION 6.4

***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 retention amounts on accommodation bonds. The Government should require that those entering residential care have the option of paying for their accommodation costs either as:***

- ***a periodic payment for the duration of their stay***
- ***a lump sum (an accommodation bond held for the duration of their stay).***
- ***or some combination of the above.***

***To ensure that accommodation payments reflect the cost of supply, and are equally attractive to care recipients and providers, the Australian Government should require that providers offer an accommodation bond that is equivalent to, but no more than, the relevant periodic accommodation charge. Accommodation charges and their bond equivalents should be published by the residential aged care facility.***

DRAFT RECOMMENDATION 6.5

***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. This would not apply to existing providers who are currently not obliged to make accommodation available to supported residents.***

***Over the first five years, the obligation would be tradable between providers in the same region. After five years, the Australian Government should consider the introduction of a competitive tendering arrangement to cover the ongoing provision of accommodation to supported residents.***

DRAFT RECOMMENDATION 6.6

***The Australian Government should establish an Australian Pensioners Bond scheme to allow age pensioners to purchase a bond from the Government on the sale of their primary residence.***

- ***The bond would be exempt from the age pension assets test and income tests and would be indexed by the consumer price index to maintain its real value. All bonds would be free of entry, exit and management fees.***
- ***Age pensioners could flexibly draw upon their bond to fund living expenses and aged care costs.***

DRAFT RECOMMENDATION 6.7

***The Australian Government's contribution for the approved basic standard of residential care accommodation for supported residents should reflect the average cost of providing such accommodation and should be set:***

- ***on the basis of a two-bed room with shared bathroom***
- ***on a regional basis where there are significant regional cost variations.***

A further issue is the approach to charging for accommodation for shorter stay transitional residents such as those using facilities for residential respite, transitional care, rehabilitation and sub-acute care. For residential respite, daily or weekly accommodation charges could apply. For those services more closely aligned to health care, the costs of accommodation could be included in a total care package of costs that are largely publicly funded — drawing on the policy adopted for acute care in public hospitals.

## 6.4 Everyday living expenses — applying the principles

Community aged care services can, where needed, provide some assistance with everyday living, such as food preparation and housecleaning. Residential aged care facilities provide care recipients with meals, laundry and cleaning services, either at a standard quality or 'extra service' level. All residents of aged care facilities who receive the standard service for activities of daily living pay the same fee, regardless of means, equivalent to 84 per cent of the single age pension.

'Extra services' or lifestyle extras (such as increased food choices, newspaper delivery, massages, etc.) attract an additional extra service daily amount. This charge reduces a provider's residential care subsidy by 25 per cent of the extra service fee they charge clients (box 6.8).

### Box 6.8 About extra service places

Around 310 residential aged care facilities (or 8 per cent of all residential aged care homes) provided extra service places in 2010. 83 per cent of extra service residents were high care and 17 per cent were low-care residents.

To be approved for extra service status, an aged care service must offer a significantly higher standard of accommodation, food and services than the average standard in an aged care service that does not have extra service status.

The benchmarks are met by providing a list of extra service choices that providers can offer. Providers must score at least 60 out of a possible 100 points in order for the significantly higher criterion to be satisfied, and must achieve minimum scores in the three categories of accommodation, food and services. Each category allows points to be earned for innovation and special features. There is also a mandatory requirement in regard to building standards.

Extra service fees can vary for different places in an aged care facility, for example, a provider can set a higher fee for a bigger room with a private bathroom, but the average daily extra service fee across all extra service places in the facility must be more than $10.

If a resident is occupying an extra service place, their care subsidy is reduced by 25 per cent of the approved extra service fee for that place. For example, if the extra service fee for a place is $20 per day, the Government subsidy for a resident receiving extra service care will be reduced by 25 per cent or $5 per day. Effectively, then the extra service amount is $25.

*Sources*: DoHA (2009f, 2010h).

And, as discussed above, a further regulatory implication is that if a high-care resident receives extra services their provider can charge them a bond for their

accommodation. Such funding arrangements can act as a disincentive to use extra services, although with constrained supply, some Australians are agreeing to buy an extra service place because an alternative is not available.

No more than 15 per cent of places in each state or territory can be approved as extra services and there are caps on the maximum proportion of places that may be extra services in particular regions. Providers must also have their prices approved by DoHA and can only change the prices they charge once every twelve months.

Catholic Health Australia described extra services as:

> … a flawed and unsustainable concession towards choice in a system of rationed supply. Choice should not be reserved for a minority; its delivery begets even more regulatory complexity and perverse outcomes. Funding individuals eligible for assistance under the *Aged Care Act 1997* on an entitlement basis, allowing people choice of services and who delivers them and lifting restrictions on what services providers can offer, is a much more effective model for the provision of aged care services. (sub. 217, p. 13)

Blue Care, commenting on the supply restrictions for extra services, said:

> The regulation of extra services, rather than allowing supply to be determined by the market, has resulted in market imperfections with over supply in some market catchments, and deprivation in others. (sub. 254, p. 10)

BlueCross (sub. 441) recommended that the daily care fee for pensioners remain at the current percentage of the pension, but that the daily living expenses fee for non-pensioners be uncapped and negotiated between the care recipient and facility operator. Others, such as Aegis Aged Care Group argued that while residents should continue to pay for the daily cost of living with their pensions, or equivalent, they 'should be allowed to pay for additional services as required without those services being classed as 'extra services' in distinct facilities or distinct parts of the facility' (sub. 206, p. 2).

The Commission considers that the minimum regulated daily charge could remain for all residents. However, care recipients should be able to negotiate for services (type, quantity and quality) that are additional to those covered in the basic daily fee. The Commission's proposed independent body (draft recommendation 12.1) should also assess and provide transparent advice to the Australian Government about the appropriateness (or otherwise) of charging 84 per cent of the age pension for basic living expenses.

In a less regulated market, aged care providers would be able to better respond to the preferences of a wider range of care recipients. Restrictions on the purchase of additional services not only means that individuals may not be able to purchase

services they value but it also stifles competition in the delivery of higher quality services. The Commission recommends the removal of the extra service category so that any recipient wanting additional everyday living services can purchase them.

DRAFT RECOMMENDATION 6.8

***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.***

## 6.5 Care costs — putting the principles into practice

### Personal and health care

Many older Australians receiving care make some contribution to the cost of their personal and health care (whether in the community or in residential care), with co-contributions dependent on means testing using income and assets tests.

#### *Co-contributions in community care*

The Australian Government and the state and territory governments have developed a draft National HACC Fees Policy (which sets out principles and explanatory notes) to provide a consistent framework for collecting fees. However, there appears to be little consistency in the application of the principles across the states and territories. For example, in Victoria care recipients are charged low level fees if their income is less than around $33 000, while in Western Australia those with income below $45 000 are charged the lowest level fees (table 6.5).

Scheduled fees for services also vary between the states — for example, the suggested scheduled fee for respite for someone with income above $71 000 in Victoria is $29.40, while in Western Australia for someone with income above $50 000 the schedule recommends full cost recovery.

Table 6.5 **HACC income ranges and scheduled fees for selected services, Victoria and Western Australia, 2010**

| | *Victoria* | | | *Western Australia* | | |
|---|---|---|---|---|---|---|
| | *Low* | *Medium* | *High* | *Level 1* | *Level 2* | *Level 3* |
| Individual | <$33 233 | >$33 233 <$71 343 | >$71 343 | <$44 922 | <$44 923 <$50 000 | >$50 001 |
| Couple | <$54 044 | >$54 0144 <$95 374 | >$95 374 | <$73 047 | >$73 048 <$80 000 | >$80 001 |
| Domestic Assistance (per hour) | $5.30 | $13.10 | $28.40 | $8.00 | $10.00 | Cost recovery |
| Personal care (per hour) | $3.90 | $7.90 | $32.50 | $8.00 | $10.00 | Cost recovery |
| Respite (per hour) | $2.60 | $3.90 | $29.40 | $8.00 | $10.00 | Cost recovery |

*Sources*: Victorian Government Department of Health (2010); Western Australian Government Department of Health (2010).

Care recipients receiving several support services per week from one or more HACC providers are protected from paying excessive fees by applying a 'fees cap'. In Western Australia the fee cap is $56.00 per week for care recipients on the lowest income range and $138.00 per week for the highest income level. HACC fees are lower than those set for Australian Government care packages (table 6.6).

Table 6.6 **Aged care services funding by funding source**

| | *Average public cost per recipient in 2010* | *Average private contribution per cent* [a] | *Average Government share per cent* |
|---|---|---|---|
| Residential high care | 51 550 | 26 | 74 |
| Residential low care | 20 150 | 53 | 47 |
| EACH packages | 39 250 | 4 | 96 |
| EACH-Dementia packages | 43 450 | 4 | 96 |
| CACPs | 12 700 | 10 | 90 |
| HACC | | 5 | 95 |
| Other Australian Government programs (for example, National Respite for Carers) | Variable | No compulsory contribution | 100 |

[a] Earlier estimates provided by DoHA to the Senate Finance and Public Administration Committee Inquiry into Residential and Community Aged Care in Australia suggested that the average private contribution for community care packages was around 16 per cent for CACPs and 5 per cent for EACH and EACH-D packages.

*Sources*: Henry (2010); DoHA (2009h, 2010e, 2010n)

The recently released 2008 Community Care Census reports that the average private contribution for CACPs is around 10 per cent of the cost of supply and around 4 per cent for EACH and EACH-D packages. The majority of care recipients (90 per cent) paid a fee for a packaged care service. There are small variations in the overall proportion paying fees across these programs:

- 89 per cent of CACP recipients
- 94 per cent of EACH recipients
- 95 per cent of EACH-D recipients.

The average fee paid overall by packaged care recipients was $29.01 per week — $27.86 for CACP, $36.61 for EACH and $36.51 for EACH-D (2010c).

Full age pension care recipients cannot pay more than 17.5 per cent of their income for an Australian Government provided community care package (around 90 per cent of community care package recipients received some form of government pension or benefit in 2008) (DoHA 2010e). While some services provided through community care packages may cover everyday living expenses (for example, meals), a flat rate of 17.5 per cent of pensioners' income is unlikely to reflect the cost of providing these services (services for which it would be appropriate to charge pensioners and that would be consistent with charges in residential care). However, if the services covered by a 17.5 per cent flat rate were for personal care services, this would involve charging for a service that the income of a full-rate pensioner is not designed to cover (and full pensioners in residential care are not required to contribute to personal care costs). Personal care costs represent a high proportion of the costs of EACH and EACH-D packages.

Clients with income above the full rate pension can be charged up to 50 per cent of that additional income for community care packages and the amount that can be charged is uncapped by the costs of care. As such, providers have an incentive to cherry pick wealthier recipients of care and face weaker incentives to provide care for the least well-off. If wealthier recipients pay for more than the cost of their care, they effectively cross subsidise lower paying recipients. This is inequitable and involves providers playing a redistributive role. The Henry Review questioned whether this was an appropriate way to ensure people with limited means can access care:

> Ensuring that people with limited means can access care would be more appropriately financed through broad-based taxes, rather than through an effective tax on care users. (Henry 2010, p. 640)

*Co-contributions in residential care*

In residential care, the Government pays a basic care subsidy which may be augmented with supplements, such as for oxygen and enteral feeding. Residents who have sufficient income can be asked to contribute to the cost of their care through an income tested fee. The amount of subsidy payable is reduced by the amount of the income tested fee.

The ACFI is used to determine the level of assistance for both personal care and some health care costs. The ACFI divides care into three domains and each domain has three funded levels. The subsidy paid to providers is the lesser of the sum of the amounts payable in each domain (activities of daily living, behaviour supplement and complex health care supplement) and the maximum ACFI rate (currently $162.89 per day). For example, the cost of care for a resident assessed as requiring a high level of care for activities of daily living, a low level of care in relation to the behavioural supplement, and medium level of care under the complex health care supplement would be $137.26 per day or $50 099.90 per year (table 6.7).

Table 6.7 **Daily ACFI rates, 1 July 2010 to 30 June 2011**

| *Level of care* | *Activities of daily living* | *Behavioural supplement* | *Complex health care supplement* |
|---|---|---|---|
| Nil | $0.00 | $0.00 | $0.00 |
| Low | $30.32 | $6.93 | $13.64 |
| Medium | $66.03 | $14.36 | $38.86 |
| High | $91.47 | $30.25 | $56.11 |

*Source*: DoHA (2010o).

Residents with total assessable income above the full pensioner rate pay an income tested fee as a contribution towards the cost of their care. While an income rather than an assets test applies, the income test deems a certain rate of return on assets depending on the type of asset. The maximum income tested fee payable is calculated as $5/12^{th}$ of assessable income above the maximum income of a full single pensioner (DoHA 2010n). However, a resident's income tested fee cannot be greater than the lesser of:

- 150 per cent of the basic aged pension
- the cost of their care as determined by the ACFI (DoHA 2009e).

The cap on charges for personal care in residential care currently provides benefits to wealthier care recipients which are not available to their high wealth counterparts receiving care in the community. Taxpayers pick up the care cost bill for care recipients who, given their income levels, could pay more for the care. The Henry

Review recommended a consistent effective marginal tax rate for these costs of care:

> For higher income ranges, ..the total effective marginal tax rate can fall. … A more consistent approach to means testing would be to target a consistent effective marginal tax rate until these costs are covered. (Henry 2010, p. 638)

## Affordable care costs for people needing care and taxpayers

As discussed in chapter 4, care costs need to be affordable both for people needing care and for taxpayers. Care recipients should not contribute more to their care costs than the cost of having the care provided and care subsidies and co-contributions should be consistent across community and residential care. But, as acknowledged by DoHA, under current arrangements:

> There is [also] considerable dissonance between the approach taken to fees and means testing in the Home and Community Care Program and in the Commonwealth's packaged community care and residential care programs. (sub. 482, p. 50)

For there to be consistency between co-contributions for community and residential care, there needs to be a consistent test on an individual's capacity to pay. Many participants called for a move away from providers determining older Australians' ability to pay for community care costs and for contributions to be determined by government (as for residential care). For example, Blue Care said:

> The government should give strong consideration to operationalising means-testing and administration of client payments for community care (and possibly other care services) through the social welfare or Medicare system, rather than at the service interface. (sub. 254, p. 54)

Some participants noted the difficulties that providers have in determining care recipients' capacity to pay. Catholic Community Services, for example, said:

> … service providers face challenges in gauging a client's 'actual' ability to pay. These challenges include clients who are asset rich but cash poor, those who refuse to contribute, those who refuse to disclose their financial situation and those who have many additional costs such as medication and allied health interventions. The current system requires case managers / coordinators to make a judgement call on whether to reduce or waive fees. … The Australian Government has well-established systems for means-testing which is used to assess eligibility for pensions and other benefits. (sub. 256, p. 2)

And Catholic Health pointed out that inconsistent means testing results in poor targeting:

> Consistent with CHA's view that those that can afford to should contribute towards the cost of their care and support services, it will be necessary to introduce nationally

> consistent income testing for these services. This would make the provision of these services more affordable for the community, allow available public funds to be directed to those most in need, and would not impede further growth in the private market for these services. (sub, 271, p. 21)

The limited extent of means-testing for community care and poor targeting of support also increases the cost to taxpayers. DoHA expressed concern about what this could mean for demand for community care over time:

> … the different means testing treatment of community and residential care will, over time, induce greater demand for community care, as recipients of that care are not required to bear as a large a portion of the cost as they would be required to bear if they were receiving residential care. (sub. 482, p. 61)

To facilitate greater consistency in the approach to means-testing and determining co-contributions across community and residential settings, the Commission proposes that means-testing of care recipients' contributions to care costs in both settings should be undertaken by Centrelink and coordinated by the proposed Australian Seniors Gateway Agency (chapter 8). This should not only improve equity, but also provide the scope for subsidised services to be better targeted to those with the greatest need.

But consistency in co-contributions within community care and across community and residential care also requires consistent assessment and entitlements across all care settings. While residents currently in residential care are assessed against the ACFI and providers receive subsidies based on the assessed care needs, in community care each of the three community care packages only offer a single subsidy level. As discussed in chapter 8, the Commission is proposing a new layered funding instrument — the Aged Care Needs Assessment Instrument (ACNAI) — that would assess individuals needs and consistently apply entitlements (based on need not whether care is provided in the community or in residential care). A person who requires care and support would go through the single assessment process. The assessment would identify the person's care and support needs and link to this the government's set of scheduled fees (taking into account additional costs associated with location, special needs, etc.). Co-contributions would be set based on the person's capacity to pay.

The introduction of the ACNAI should overcome the inconsistencies in assessment of need and the single financial capacity test similarly overcome inconsistencies in co-contributions for care services across care settings. The ACNAI is discussed in more detail in chapter 8.

*What basis for determining co-contributions for care costs?*

Co-contributions for aged care should be linked to a person's financial capacity to contribute to the cost of their care, with a greater contribution from those better able to pay. A person's capacity to pay is shaped by their income and wealth. The majority of older Australians' wealth is held in their home (box 6.9).

### Box 6.9 **Older Australians' capacity to pay for care**

Wealth projections suggest that by 2030 older Australians will own around 47 per cent of total household wealth, although they will only make up around 19 per cent of the population. This suggests that asking younger Australians to pay higher taxes to fund aged care, while also being required to save more to fund their own retirement, is inequitable. So what is the capacity of older Australians to pay for their care?

Data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey conducted in 2006 shows that the medium net worth of households headed by a person aged 65-75 years was $443 000 and $332 000 for households headed by a person aged 75 years plus. The primary residence makes up most of this wealth — the 65-75 years median household holding 79 per cent of their net worth as a primary residence increasing to 90 per cent for the median 75 years plus household (RBA 2009).

The HILDA data provides some insight into the distribution of household assets for older households. Currently only 2002 data is available, but this estimated that the bottom 10$^{th}$ percentile of households headed by a person aged 75 plus had $17 200 in assets, those in the 30$^{th}$ percentile had $145 400, those in the 70$^{th}$ percentile had $380 600, while those in the 90$^{th}$ percentile had $828 000 (in 2006 dollars). As the net worth of the median household had grown by almost 29 per cent from 2002 to 2006, these numbers are likely to be similarly higher.

The ABS Survey of Income and Housing in 2007-08 found that average (mean) weekly household income declined with age after retirement up until 80 years plus. In 2005-06, dollars average weekly disposable income fell from $516 for households headed by a person aged 65–69 years to $433 for the 75–79 year households, but rose to $454 for the 80 years plus households. This pattern remains the same even after adjusting for housing costs. It has, however, changed over time. In 1988-89, the oldest households had the lowest average weekly disposable income, while the 75–79 year households were slightly above the average for the 65–69 years households.

The average income data tends to overstate the capacity of the median household to pay as it includes the tail of the distribution — the high wealth and high income households. And capacity to pay, once people move towards the end of their lives, is better defined by their wealth rather than their income.

*Sources*: HILDA Release 7; RBA (2009); Heady, Warren and Wooden (2008); Bradbury and Gubhaju (2010).

As discussed earlier, the means test for the age pension includes an asset test where the value of the owner-occupied home or an accommodation bond is excluded. The question is whether the pension asset test is the appropriate test for subsidised aged care services. The Henry Review recently argued that:

> … charges for the costs of care should be set so they do not harm income adequacy in retirement and are consistent with pension means testing. …Following the approach in the income support system, means testing should not be designed to force the drawdown of assets, but instead target the income from assets. (Henry 2010, p. 637)

The aim of the pension asset test is to assess individuals' (potential) income from their assets and is designed so as not to erode the value of people's assets. When becoming eligible for a pension, most people can look forward to another 15 to 20 years of independent living with no need for aged care services, so allowing people to retain their home and income earning assets makes sense. But, as people move towards the end of their lives (typically the time they require aged care) the logic of excluding particular assets (the home and accommodation bonds) from tests for public subsidies weakens considerably. And, a different approach to subsidising care and support for people who are disabled can be justified on the grounds that people who acquire a disability often have had no or less opportunity to accumulate wealth to meet their costs of care (particularly if a disability is acquired early in life). Older people, on the other hand, in many cases will have accumulated assets over their life time.

In principle, people with the same wealth but different combinations of income and assets, should be treated the same way. But, as discussed earlier, the age pension income/assets tests are well accepted and already in place, so from a pragmatic perspective, moving to a more comprehensive means test for subsidised aged care services can only be justified if it makes a considerable difference to the equity and sustainability of the aged care system.

HILDA data shows that in 2006, 14 per cent of full pensioners had assets in excess of $500 000, while 13 per cent had less than $6 000 (HILDA 2010). As such, a system that uses the pension test for determining co-contributions is likely to be considerably less equitable than one that applies a more comprehensive means test for subsidised aged care services. And, because of a limited aged care budget, there will be fewer resources to pay for care for those people with the least capacity to pay.

Noting that the majority of older Australians will continue to receive either a full or part pension looking out to around 2050 (table 6.8), the Commission considered three options:

- all people receiving a full pension or part pension would receive the full rate of subsidy, with self-funded retirees receiving a lower rate of subsidy
- people receiving a full pension receive the full rate of subsidy, those on a part pension receive a lower rate, and self-funded retirees receive the lowest rate
- a comprehensive means test (includes the family home, accommodation bonds, and the Commission's proposed Australian Pensioners Bond) with three levels of subsidy based on the level of assets. Those with assets below the median of $350 000 receive the full subsidy (the age pension asset test also allows non-home owners assets of $313 250 for a single pensioner and $389 000 for a couple for full pension, as at 20 September 2010). Those with assets below the 80$^{th}$ percentile of $550 000 receive the mid rate of subsidy, while those with assets above the 80$^{th}$ percentile receive the lowest rate of subsidy.

Table 6.8 shows the shares of older Australians that would be eligible for the three different levels of subsidy under the three options. This is very much a preliminary calculation, but it is indicative of the lock-in of adopting the pension test for aged care subsidies.

Options 2 and 3 start with a fairly similar ratio, but they diverge over time. It should be noted that, as those at the older end of the retirement age spectrum are more likely to have lower assets, the pension tests in options 1 and 2 will understate the shares that will be eligible for full and mid level subsidies.

Table 6.8 **Older Australians eligible for various subsidies under different eligibility criteria**

| *Rate of subsidy* | *Option 1 Pension test* | *Option 2 Pension and part pension test* | *Option 3 comprehensive means test* |
|---|---|---|---|
| | % | % | % |
| **2010** | | | |
| Full | 83 | 55 | 50 |
| Mid | 0 | 28 | 30 |
| Low | 17 | 17 | 20 |
| **2030** | | | |
| Full | 77 | 39 | 23 |
| Mid | 0 | 38 | 22 |
| Low | 23 | 23 | 55 |
| **2050** | | | |
| Full | 76 | 36 | 15 |
| Mid | 0 | 40 | 10 |
| Low | 24 | 24 | 75 |

*Source*: Commission estimates, based on Treasury projections.

Initial cost projections undertaken by the Commission shows that using the pension test for aged care costs is the least sustainable option for taxpayers. Applying a comprehensive means test, on the other hand results in the percentage of older Australians eligible for a full care subsidy declining from around 50 per cent in 2010 to around 15 per cent in 2050, with those on the lowest rate increasing from around 20 to 75 per cent.

The Commission proposes the use of a comprehensive means test for determining care recipients' co-contributions. The comprehensive means test would involve a combined income and asset test (including owner-occupied housing, accommodation bonds and the Commission's proposed Australian Pensioners Bond) with care co-contributions based on assets above a minimum threshold level. The asset threshold could be set at the threshold for the non-home owner asset test for the full-rate age pension.

While the Commission is convinced of the desirability of a more comprehensive means test to determine co-contributions by recipients of approved care services, it also recognises the need for a proportionate approach. For both ease of administration and consistency, the Commission proposes that the same scale of co-contributions should be applied across all care services (with those having the least financial capacity paying the lowest co-contribution). Yet, many care recipients will only receive very small amounts of basic support services within their own home. Currently, recipients are not required to disclose the value of their home for the purposes of either the age pension or for determining co-contributions for care services. To propose a new comprehensive means test on low levels of support service may seem disproportionate and, given administrative costs, inappropriate.

However, the currently applied co-contribution arrangements are not appropriate even for low levels of care services as they are often arbitrary in nature, lacking any obvious rationale and any relationship to a person's capacity to pay. The Commission considers that the proposed comprehensive aged care means test should apply across all care services but recognises that in respect of small levels of care a simpler test of an older person's financial capacity to make co-contributions would be more appropriate. Such a test could adopt a person's age pension status — full pension, part pension or self-funded retiree. The threshold below which this simpler approach would apply could initially be set at the level where the combined value of approved care and support services would be less than $100 on average per week. The appropriate amount, and adjustments could be advised by the Commission's proposed new independent regulatory commission (chapter 12).

Certain services, irrespective of their value, nominated by the Australian Government (for example, home modifications) could be subject to the comprehensive aged care means test.

It is recognised that there could be some discontinuity at the threshold, with older people requiring care and support that exceeds the threshold being subject to the comprehensive means test and paying a higher rate of co-contribution. *The Commission invites feedback on the balance between achieving consistency in co-contributions and a proportionate approach.*

### *Easing the way*

Under the proposed comprehensive means test there will be older people who lack the income to meet their care costs. Some participants raised concerns about people on low incomes not being able to access services because of the costs of care. Full pensioners and low income older Australians receiving care in the community, for example, are unlikely to have sufficient income to pay for their care costs, despite their overall wealth, and this points to the need for financial products that allow the unlocking of equity in homes and deferred payments. The need for such options was acknowledged by Aged Care Association Australia and Deloitte:

> … domiciliary care provided in the family home obviously cannot be funded through the sale of that home, though there may be ways other than sale of unlocking the consumer's equity in his or her home. (sub. 285, p. 7)

Catholic Health Australia also said:

> Copayment policies … have to take into account that the lifetime savings of most Australians are in the form of home ownership. The illiquid nature of this asset can constrain payment options for individuals, with potentially adverse financial consequences if lack of flexibility does not allow choice of payment arrangements that suit personal financial circumstances and objectives. (sub. 217, p. 32)

As discussed in chapter 7, the Commission acknowledges a role for the government to provide a means by which older people can use their accumulated wealth to contribute to their aged care costs. Consequently the Commission is proposing the establishment of a government-backed aged care equity release scheme which would enable older Australians to draw down on the equity in their home to contribute to the costs of their aged care and support.

### *A stop- loss for 'out-of-pocket' care expenses*

On both equity and efficiency grounds, the Commission considers that while everyone with the capacity to pay should contribute to the cost of their care, older

Australians should not be faced with having to pay for very high or catastrophic costs of care.

Intensive care for extended periods of time is very expensive. Under a system of co-contributions, those with the highest care needs and a capacity to pay face the highest costs. The Commission proposes that, combined with new co-contribution arrangements, a stop-loss mechanism be put in place to protect individuals against very high out-of-pocket expenses for aged care, recognising that voluntary insurance arrangements to do this are not really feasible (chapter 7).

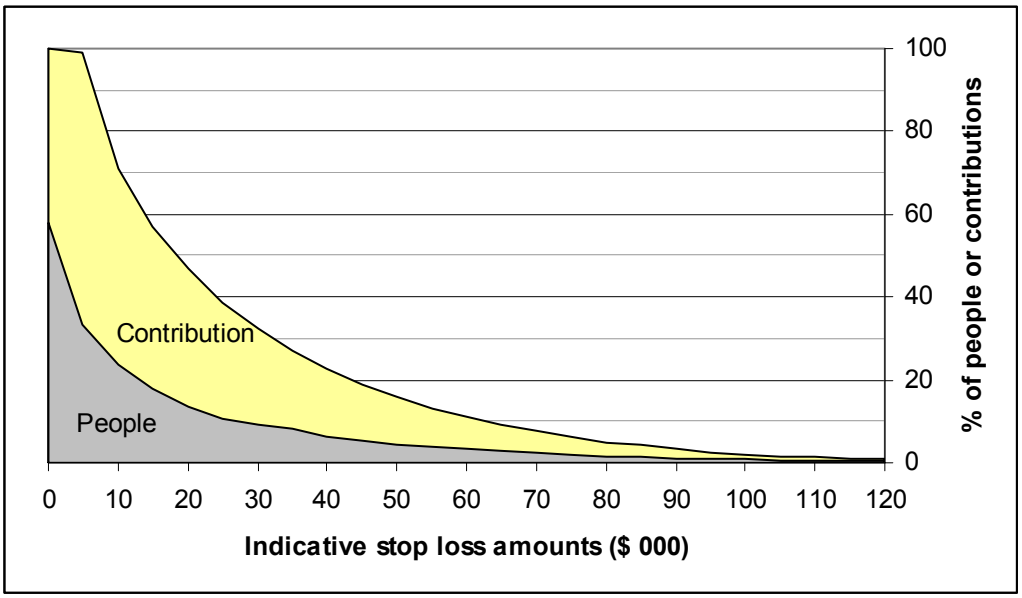
There are a number of ways that a stop–loss arrangement could be implemented. It could cut in either after a certain period of time of paying care costs (for example, after paying the cost of intensive care for a number of years), or after an individual had made a specific level of financial payout.

The United Kingdom recently announced a National Care Service which supports universal entitlement and protection from catastrophic costs of care. Commencing in 2014, anyone staying in residential care for more than two years would receive fully subsidised care after the second year (HM Government 2010).

Annual and lifetime limits should apply only to approved care services. Amounts above these limits would be a *de facto* insurance scheme as any very high out-of-pocket expenses for subsidised aged care services would be fully publicly funded. This suggests that limited liabilities should be based on a whole of life basis rather than an annual basis. In the Commission's view, the stop-loss should cut in at the same point for everyone.

Based on the explorative costing analysis of the Commission's proposed arrangements, which assume co-contributions for care ranging from 5 to 25 per cent (see next section), a stop-loss that covers 10 per cent of private contributions would need to be set at around $60 000 (figure 6.4). That would mean that older Australians requiring close to the highest level of care and who were paying the highest assumed co-contribution rate of 25 per cent of their care costs, would take around five years to reach the stop-loss limit. Taxpayers would pay for all remaining care costs once a care recipient had reached the stop-loss limit (appendix D).

Figure 6.4 **Projected percentage of care recipients expected to reach indicative stop-loss amounts**




*Data source*: PC estimates.

Any specified financial limit would need to be indexed. The Commission's proposed independent regulatory commission should recommend on the most appropriate form and rate of indexation (chapter 12).

Some of the practicalities associated with a stop-loss arrangement include:

- when the clock starts ticking for the stop-loss, which would be linked to when people are assessed or start to receive services (this could be facilitated via the proposed gateway and the Aged Care Needs Assessment Instrument)
- proof of purchase of services (receipts from care recipients, electronic records)
- a record keeping system.

## A new care co-contribution regime

In designing a co-contribution regime it is important to balance the incentives generated by requiring people to contribute an amount for a service (when people pay for, or contribute a material amount for a service they are more likely to value the service and demand quality) with the benefits that the service provides. A number of participants raised the possibility of co-contributions (if set too high) being a deterrent for people to access services, which could mean that older people would not access care or seek less care than was appropriate. For example, South Eastern Migrant Resource Centre said:

> When costs are prohibitive for those at the disadvantaged end of the care spectrum, there is a delayed drain on the public health system. Problems that could be dealt with earlier and less expensively develop into more costly and drastic health difficulties. (sub. 126, p. 3)

Australian Meals on Wheels also said:

> If our meal price to clients rise to a level where clients cut their spending and reduce the number of meals they need to sustain their nutrition requirements, their health will be compromised and the likelihood of requiring higher and more expensive hospital care is inevitable. (sub. 209, p. 1)

This reinforces the need for the design of the co-contribution regime to take into account the variability of the capacity of older people to pay. But, there is also a trade-off to be made between targeting (the more steps there are in a co-contribution scale the better the targeting and equity of the regime) and the complexity of the regime. The fewer the steps in a co-contribution scale the easier it is to apply and the easier it is for people to understand.

The level of co-contribution could also be varied for different types of services to encourage the take up of some services relative to others. Under the current arrangements health care is highly subsidised. One option is to vary the subsidy according to how close the service is to health care or to exempt some services (such as restorative programs) from co-contributions. This approach could see a lower subsidy for basic support (such as transport and home maintenance), a higher subsidy for personal care, with the highest subsidy for health care. The total number of levels of subsidy available would depend on the specified service types and the number of levels in the capacity to pay test. For example, even if there were only three levels in each, there would be 9 levels of co-contribution to be administered. Unnecessary complexity should be avoided.

To overcome the complexities and discontinuities between the levels of co-contributions made by care recipients for HACC, CACPs, EACH, EACH-D and residential care, the Commission is proposing a new single national co-contribution regime which would apply across all approved basic support and care services, irrespective of whether they are delivered in the community or in a residential aged care facility. Under such a regime, the co–contribution would vary according to the price of the service and the person's financial capacity to pay (as discussed above).

The Commission prepared preliminary projections based on a range of co-contributions. The guiding principles for the projections of the care co-contribution regime were that:

- co-contributions to care costs are consistent regardless of the care setting

- no one should pay more than the cost of their care
- those with limited means only make a small contribution, generally comparable with current arrangements.

As a base case, the Commission assumed co-contributions for care ranging from 5 per cent for the low income low asset group to 25 per cent for the high income high asset group. The Commission assumed that anybody with an annual income below $20 900 and assets below $313 250 in 2010 would pay no more than 5 per cent of their care costs. These thresholds are currently used to determine the eligibility for a full age pension for a non-home owner. For every dollar in income or assets that a person has above either of these thresholds, they are assumed to make a larger co–contribution to their care costs, until they reach the maximum care co-contribution rate for someone with an income of a least $42 000 and assets of $420 000.

For CACP type services, as an example, the maximum co-contribution of 25 per cent of care costs would be paid by someone with an annual income of over $58 000 and assets below $313 250 or by someone with income under $20 900 with assets in excess of $1.6 million.

For the base case, the indicative projection is that 67 per cent of aged care users in 2050 would be paying a co–contribution that covered no more than 15 per cent of their basic care costs. The Commission's preliminary projections for this scenario are set out in box 6.10. The indicative cost projections are explored in more detail in appendix D.

### Box 6.10 **Indicative cost projections**

The Commission prepared preliminary projections of its proposed new aged care arrangements (encompassing key recommendations throughout this report) and compared these to the 2010 IGR projections.

IGR projected that the future cost of aged care would be 1.8 per cent of GDP in 2050. The Commission's scenario is based on more recent information on aged care usage rates and the cost of care places. The Commission also assumed that community care fees and basic daily living expenses in residential care would increase in line with the single age pension.

The Commission examined the impact these assumptions would have on the IGR estimate. To do this, the Commission first replicated the IGR methodology and came up with the same cost estimate for 2050. Applying the updated usage rates and per place care costs, the Commission projected that the public cost in 2050 would be 1.5 per cent of GDP — a scenario the Commission termed the 'revised IGR projection'.

The Commission's projections for the cost to taxpayers of its proposed new aged care arrangements were 0.8 per cent of GDP in 2010 and 1.9 per cent of GDP in 2050 — 27 per cent higher than the revised IGR projection for that year. Some key assumptions for this projection were that:

- care recipients would be responsible for their accommodation and everyday living expenses (with safety net provisions)
- care co-contributions would range from 5 to 25 per cent of the cost of care
- co–contributions would be based on a comprehensive means test
- the number of care recipients would more closely reflect underlying need.

The Commission also looked at the impact of increasing the maximum co-contribution to 35 per cent — the indicative projections suggest that under this scenario the cost to taxpayers would be reduced by 0.1 per cent of GDP in 2050.

These cost projections are discussed further in appendix D.

*Source*: Commission indicative projections.

## A body for determining costs of care and accommodation

A major concern of participants to this inquiry was the appropriateness of indexation arrangements for determining the cost of care and accommodation on which government subsidies are based.

The Commission considered indexation arrangements as part of its inquiry into nursing home subsidies and found that, with other sources of income for providers largely tied, inadequate increases in subsidies after allowing for efficiency improvements would, in one way or another, compromise the delivery of quality

care. While not putting forward a view on the most appropriate indexation methodology, it recommended that:

> Basic subsidy rates should be adjusted annually according to indices which clearly reflect the changes in the average cost of the standardised input mix, less a discount to reflect changes in productivity. (PC 1999, p. 97)

This approach recognises the importance of both ensuring subsidies accurately reflect the cost pressures faced by the aged care industry and providing an incentive for providers to look for ways of improving their productivity.

There was widespread support among participants of this inquiry for the establishment of an independent body to determine the cost of care and annual indexation methodology, a role analogous to the proposed Independent Hospital Pricing Authority for the National Health and Hospitals Network (box 6.11). A transparent methodology was also seen as particularly important. Blue Care, for example said:

> Implement a transparent method of estimating input cost increases that is relevant to the residential aged care and community care sectors and capable of being subjected to external scrutiny and review. (sub. 254, p. 3)

The Commission proposes the establishment of an independent regulatory commission (draft recommendation 12.1) which would, as one of its functions, recommend the costs of delivering care (community and residential) and providing a basic standard of accommodation for supported residents. Care recipients' co-contributions should be regularly reviewed by the government based on transparent recommendations from the proposed independent regulatory commission.

DRAFT RECOMMENDATION 6.9

***The Australian Government should:***

- ***prescribe the scale of care recipients' co-contributions for approved care services which would be applied through the proposed Australian Seniors Gateway Agency (draft recommendation 8.1)***
- ***set a comprehensive means test for care recipients' co-contributions for approved care services. This test should apply the age pension income test and the non-home owner asset test (including any housing assets, such as the primary residence, accommodation bonds and the proposed Australian Pensioners Bond). The comprehensive aged care means test would apply where the approved care services have a combined value of around $100 or more on average per week (the 'comprehensive aged care means test threshold') and all home modification services***

- ***adopt for approved care services below the comprehensive aged care means test threshold, a test for determining car recipients' co-contributions for such services which relies simply on pensioner status.***

***To facilitate greater consistency in co-contributions across community and residential care, comprehensive aged care means testing to determine care recipient contributions to care costs in both settings should be undertaken through the proposed Australian Seniors Gateway Agency (draft recommendation 8.1) by Centrelink.***

***Care recipients' co-contributions should be regularly reviewed by the Australian Government based on transparent recommendations from the proposed Australian Aged Care Regulation Commission (draft recommendation 12.1).***

### Box 6.11 Widespread support for an independent body to determine costs and appropriate indexation

Aged Care Association Australia and Deloitte:

> What is needed is an independent mechanism for calculating an appropriate economic cost of care & personal services and levels of hotel and accommodation services. The task of undertaking this cost assessment should be allocated to an independent Authority or Commission (ie consider the possibility that that function be undertaken by the new Hospital Pricing Authority) for the ongoing evaluation, calculation and administration of this cost mechanism. This can then serve to be the price setter, whereby Government as purchaser, can determine the level of services it will fund and to who it will fund into the aged care system. (sub. 285, p. 13)

Blue Care:

> Establish an independent body to benchmark each year the true cost of care including regional variations and to estimate input cost increases and the required level of indexation of subsidies.
>
> Adjust the accommodation supplement over time based on independent evidence as to building development costs, clinical and community norms regarding standards of accommodation and regional disparities. (sub. 254, p. 4)

Catholic Health:

> … because the fees and subsidies reflected in the current ACFI rates are historically based and indexed to minimum wage adjustments, they do not reflect contemporary care practices, standards or labour market conditions. The reforms, therefore, should provide for periodic independent reviews of the cost of care to inform the setting of care subsidies and fees, undertaken by a body such as the proposed Independent Hospital Pricing Authority. (sub. 217, p. 14)

DRAFT RECOMMENDATION 6.10

***The Australian Government should set a lifetime stop-loss limit comprising the care recipients' co-contributions towards the cost of government-subsidised 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.***

DRAFT RECOMMENDATION 6.11

***The proposed Australian Aged Care Regulation Commission (draft recommendation 12.1) should make transparent recommendations to the Australian Government on the scheduled set of prices for care services and the required level of indexation, the lifetime stop-loss limit, and the price for the approved basic standard of residential care accommodation. The Commission should monitor and report on the cost of care, basic accommodation and the stop-loss limit.***

# 7 Options for broadening the funding base

**Key points**

- Australians will have to pay more for the care of older Australians as our population ages. Finding the right balance between public funding and private funding is a sensitive and complex task. The burden of funding should be equitable and the mechanisms should be efficient in their design and application.
- There are a number of options for broadening the existing taxation and user contribution funding base for aged care — increased private savings (aged care saving accounts and quarantined higher superannuation contributions), equity release products and insurance (voluntary or compulsory).
- Increasing private savings to fund the private costs of aged care is not an efficient way of funding these costs. Some older people will save too much while others will not save enough. Private savings redistribute resources across a person's life, but do not allow sharing of the risks of incurring aged care costs across the population.
- Many older Australians have built up assets over their working life that could be drawn on to pay for the more predictable and manageable costs of care. But equity release products can be complex and there is nervousness about current privately offered products. The Commission supports introducing a government-backed equity release scheme, under which amounts could be drawn down to cover aged care costs.
- Voluntary insurance is unlikely to work in anything but a very modest way because of problems on the supply and demand side of the insurance market. That said, with a stop-loss mechanism along the lines of that proposed by the Commission, there could be a role for private insurance, to cover the more predictable and manageable costs of care.
- There are many similarities between the current tax-funded system supplemented by a stop-loss mechanism and compulsory insurance — both involve risk pooling (to protect individuals from catastrophic costs) and progressive mechanisms for raising funds. Access to care is based on need, rather than ability to pay. But, there are significant design and transitional issues (and costs) with moving to a compulsory insurance model.
- At this stage, given the characteristics associated with aged care, the Commission is not convinced that a compulsory pre-funded insurance scheme would represent an improvement over the pay-as-you-go tax financed system supplemented by higher co-payments and a stop-loss mechanism.

The current funding arrangements for aged care are supported by two pillars — a dominant taxpayer funded pay-as-you-go subsidy pillar and a user pay pillar. Under these arrangements, taxpayers bear the full financial risk associated with the public subsidy, including rising unit costs and the effects of population ageing on overall care costs. A number of analysts (Howe and Sargeant 1999, Fine and Chalmers 1998, Myer Foundation 2002, Ergas 2010) and participants to this inquiry (Bethanie Group, sub. 407; Melbourne CityMission, sub. 173; Medibank Private, sub. 250; National Seniors Australia, sub. 411) suggested the need to consider a third funding pillar. For some, the case for an additional pillar rests on concerns about fiscal sustainability. Others contend that, with population ageing, marked intergenerational inequities can arise under the current system.

There are several options for broadening the funding base for aged care. They include:

- increased private savings (aged care savings accounts, quarantined higher superannuation contributions)
- drawing down housing equity (equity release products or an income contingent loan)
- insurance — voluntary or compulsory.

This chapter looks at each of these options with a focus on the incentives they create and their implications for economic efficiency, equity (including intergenerational equity), simplicity and sustainability. Assessments of the merits of these options will be influenced by the relative importance attached to each of these considerations. However, a complete assessment should also balance the merits of any new arrangements with those of the existing funding base.

Section 7.1 examines the use of savings accounts and superannuation. Section 7.2 looks at the use of home equity to help individuals contribute to their care costs, while section 7.3 examines the possibility of using insurance.

## 7.1 Saving accounts and superannuation

Aged care saving accounts and the use of superannuation funds to cover the private costs of aged care were two ideas put to the inquiry for encouraging individuals to save for their 'later-life' care costs (and in turn taking some of the pressure off taxpayers). Alzheimer's Australia NSW, for example, said:

> … consideration should be given to creating a form of Healthy Ageing Savings Account (HASA) or similar mechanism to fund aged care. This account should be

considered in addition to current Medicare levies and superannuation arrangements. (sub. 455, p. 5)

Mercy Health said:

> A greater emphasis should be placed on increased superannuation contributions, both employer and personal contributions to better position people to support themselves and their health needs in their latter years. Even with greater superannuation contributions, there will be a significant percentage of people who will be unable to pay for the services that they require. (sub. 215, p. 8)

Accumulated savings represent a form of pre-funding for future aged care costs. As such, they provide a mechanism for lessening the future call on public funds. They also help address concerns about perceived intergenerational inequities by evening out the burden of paying for care into the future. But it is difficult for any individual to determine the amount of savings required to meet their aged care costs. In particular, people who face catastrophic costs of care would be unlikely to have saved enough to cover these costs, whereas people who save for care by making higher contributions to a quarantined account but do not subsequently require aged care, will have forgone the benefits of higher consumption or other forms of savings. As Deeming and Keen pointed out, it is 'socially inefficient' for everyone to save for the possibility of needing long-term care in older age:

> Saving for long-term care is not an efficient option for individuals. Not everyone will need long-term care, therefore it would be unrealistic and socially inefficient for everyone to save to meet the average cost of needing care, let alone the maximum cost. (2001, p. 84)

Private savings, because they do not permit risk pooling, are unable to facilitate the redistribution of resources between individuals according to need (or provide protection from catastrophic costs). As Glendinning et al. argued:

> Private savings approaches are not likely to provide equal resources for equal needs. They redistribute resources across the life cycle, but do not redistribute from those with lesser to those with greater needs for long-term care. They are more costly for women; as women face a higher risk of needing care, they need higher savings than men. Savings approaches would not be widely affordable and moreover, involve no pooling of risk. (2004, p. 4)

Barr also said:

> Self-finance (i.e. financing long-term care out of personal savings of a long-term care savings account) is an inferior solution. Where someone is risk-averse the possibility of pooling risk is welfare-enhancing. (2010, p. 372)

As such, private savings are best suited to cover everyday living and accommodation costs and contribute to basic support and care costs that are more modest and predictable. The unpredictable and potentially catastrophic costs

associated with intensive long term care (which have a relatively low probability) are better suited to some form of insurance or stop-loss arrangement.

Having individuals pay for some of the more predictable care costs from private savings could provide an incentive for the greater use of preventive and early intervention measures. International evidence on healthy ageing savings accounts suggests that these accounts can encourage individuals to be more conscious of the costs of their care and to take greater responsibility for their health (box 7.1). The Aged Care Association of Australia (ACAA) and Deloitte's also argued that a private savings option could reduce concerns about moral hazard (or over-use):

> … if consumers are using their own savings to finance care, moral hazard in care decisions may be reduced, which is likely to be especially important for domiciliary care. (sub. 285, p. 8)

**Box 7.1 Healthy Ageing Savings Accounts (HASAs) — international experience**

A review of international experience with HASAs suggests the following lessons:

- *Accounts encourage efficiency.* A case study of Discovery Health in South Africa found efficiency gains as members were more conscious of cost when paying from personal savings, since marginal cost is explicit.
- *Accounts deliver better health outcomes* particularly if coupled with wellness programs (e.g. screening, health checks, vaccinations, lifestyle modification) and rewards (flyer points etc) as people take greater responsibility for their health.
- *Lower income groups take up accounts*, potentially more attracted to saving for their own needs rather than pooling risks through insurance. In the US, a third of accounts have been taken up by previously uninsured people and around 40 per cent of accounts were taken up by people with incomes below the median.
- *Incentivisation* is necessary to overcome moral hazard in relation to saving; in New Zealand a HASA product failed due to a lack of tax-deductibility.

*Source*: Access Economics (2009b).

Some participants suggested that dedicated aged care saving accounts would need to be additional to current superannuation. Because there are no restrictions on how superannuation income is spent, the concern is that older Australians may have an incentive to spend their retirement incomes on other less essential items and fall back on the public safety net to cover the cost of their care needs. In this context, Access Economics argued that:

> This moral hazard underpins the need for a parallel, complementary private saving mechanism. (2009, p. 37)

And, looking forward while Australians are likely to have larger superannuation and other asset balances when they retire (chapter 6), increases in average life expectancy will mean that the assets have to provide income for a longer period of time (box 7.2). In this context the Henry Review said:

> As the superannuation guarantee scheme matures, cohorts of older people should have larger assets balances available to them at retirement. However, these assets will need to provide an adequate stream of income over a person's retirement, the duration of which is uncertain for individuals. The expected increase in average life expectancy is likely to add to this risk. Further, the use of aged care services is particularly intensive for people aged 85 and upwards, once many have been in retirement for 20 years or more. (Henry 2010, p. 642)

While quarantining part of an individual's superannuation funds for aged care would lessen the scope for early draw downs prior to needing to contribute to the costs of aged care, it would also constrain consumption choices. And, for those individuals who do not require care in old age, they are likely to leave behind larger bequests than they might otherwise have chosen. As ACAA and Deloitte's put it:

> … consumers may be forced to leave higher bequests than they would otherwise have chosen to do. This excess bequests distortion (and the associated reduction in life-time utility) is obviously especially large if the mandated savings level is set in line with average expected life time care costs while the distribution of those care costs is bimodal or in any event, highly skewed (so that many consumers will experience costs well below the mean, while some others will experience costs many times the median). (sub. 285, p. 8)

### Box 7.2 **Retirement — funds for around 20 years required**

Retirement and retirement expectations have changed dramatically over the last 100 years. When the age pension began in 1909, the maximum payment was 12 per cent of male average weekly earnings (10 shillings per week). Only half of all people born lived to age 65 years and of those who lived to 65, their life expectancy was another 11.3 years for men and 12.9 years for women. Because of strict means testing and other eligibility criteria, few received the pension — just 23 000 or 28 per cent of those aged 65 years or more.

Today, 87 per cent of men and 92 per cent of women live until age 65 and can expect to live for around a further 20 years (18.7 years for men and 21.5 years for women). The introduction of compulsory superannuation in 1992 ensures that everyone working as an employee will have something saved for their retirement. That said, more than three-quarters (77 per cent ) or 2.3 million older Australians currently receive either the age pension or Department of Veterans Affairs Service Pension.

*Sources*: NATSEM (2009); Harmer (2009).

A compulsory aged care savings account is likely to be more distortionary than unrestricted superannuation as it can only be drawn on for aged care expenditure (or if unused, left as a bequest), while superannuation can be used for any purpose once it is accessed.

Compulsory saving imposes a deadweight loss as it distorts decisions about which savings vehicles to use as well as between consumption and savings. In particular, younger people may be less able to invest in their preferred mode of savings (for example, owning their own home, which is a tax effective savings vehicle and offers social benefits).

As a compulsory savings mechanism already exists in the form of the superannuation levy, the administrative costs of expanding savings in this way would be minimal (although not necessarily the administration costs of quarantining them). Medibank Private noted that such an approach could be implemented with relative ease, but also noted the additional burden on the working population.

> Advantages of this model include the relative ease of management if the scheme is aligned with current mandated superannuation contributions. However, this model relies on the working population who may feel they are already overburdened with taxes related to retirement and future needs. (sub. 250, p. 10)

Some participants suggested the need to provide subsidies or tax incentives to increase the attractiveness of making extra savings to cover the potential costs of aged care. However, such subsidies perform poorly on equity grounds as they offer the greatest benefit to those with the greatest capacity to save (being also those most likely to have the capacity to contribute to their own aged care in the future). And, without compulsion, subsidies for saving for aged care are unlikely to significantly increase overall savings for aged care costs. As Barr put it:

> Many people realize that they need to save more for their old-age security and intend to do so — but somehow it never happens. (2010, p. 370)

The challenge is to provide people with incentives to save in their preferred savings vehicles to fund both their retirement and the predictable costs of their aged care. The more generous the safety net for aged care, the lower the incentive to save for these likely, but not certain, costs. But a reasonable safety net is required in order to ensure that all older people have access to an appropriate quantity and quality of care.

An alternative approach is to change people's attitudes toward funding their aged care. There is currently an incentive to save in assets, notably the home, that deliver a service as well as a store of value, especially if this asset is tax free. Under the Commission's proposed stop-loss limit, individuals will have greater certainty about the maximum cost of care and therefore a greater incentive to ensure adequate

savings/income to cover the predictable costs of care (section 6.3). Also, in the vast majority of cases, older Australians have built up assets over their working life that could be drawn on to pay for their costs of care.

The least distortionary approach would be for these assets to be available to pay for aged care — especially if the liquidation of these assets is structured so that their owner could continue to use the asset, while drawing against it to pay for aged care costs (see below). A comprehensive means test for making aged care co-contributions, combined with a mechanism that would allow people receiving care to continue to enjoy their assets while they can do so, could form the platform for a change in attitude towards accepting responsibility for contributing to one's own aged care costs.

## 7.2 Drawing on housing equity to pay for care costs

Accessing housing equity is a contentious issue, yet most Australians recognise that the home is the principle means of long term savings. From participants' input into this inquiry, there seems to be a growing sentiment that many Australians could tap into the wealth they have tied up in their primary residence to pay for aged care costs. The Little Company of Mary Health Care, for example, said:

> Given that approximately three-quarters of older people in Australia own their own home, this most important source of funding cannot be ignored. (sub. 289, p. 22)

Toohey and Ansell also called for action to:

> Further broaden the choices for residents to meet the costs of their accommodation and services beyond lump sum refundable deposits including the option to levy deceased estates for an agreed amount incurred in the provision of aged care. These agreed deductions, over and above any government subsidy, can include costs for the provision of extra nursing and personal care where the resident and/or the family feels that such care is necessary or desirable. (sub. 464, p. 8)

ACAA and Deloitte said:

> Many elderly Australians have limited assets and income, and a substantial share of what assets they own involve the family home. While that home can be sold at the time of entry into residential care, it may not be so readily sold if only one member of a couple is going into care. Moreover, domiciliary care provided in the family home obviously cannot be funded through the sale of that home, though there may be ways other than sale of unlocking the consumer's equity in his or her home. (sub. 285, p. 7)

As discussed in chapter 10, the vast majority of Australians aged 65 and over (just over 83 per cent) own or are buying their home. And, looking forward, older cohorts are likely to have significantly more wealth in real terms. Kelly (2002), for example, estimated that the share of Australia's total family net wealth for those

aged 65 and over is likely to increase from around 22 to 47 per cent between 2000 and 2030.

Equity in housing can be released by selling and moving into something less expensive, with the balance being used for other purposes (see chapter 6 for a discussion covering a proposal for an Australian Pensioners Bond to protect eligibility for the age pension). Alternatively, housing equity can be drawn down via an equity release scheme or an income contingent loan. Equity release schemes allow people to borrow against the equity in their home with no (or limited) repayments made until the home is transferred to another person. An income contingent loan is broadly comparable to an equity release scheme and, as described by Chapman, works in the following way[1]:

> An individual entering a nursing home, for example, would be allowed to borrow funds using her/his home or other assets as collateral. A given sum of money provided by the government, say $100 000, could be set aside and drawn down over time to cover the costs of nursing home care. At the end of the person's time spent at the nursing home, in most cases meaning the death of the individual, the remainder of the loan would be returned to the individual's estate, which has a debt equivalent to the original amount borrowed. This debt would be considered to be a debt of the estate. (2006, p. 2)

The advantage of schemes that draw on housing equity is that they allow people with housing assets to meet the costs of extra spending, including spending on aged care, without having to sell their home to finance it. These schemes can be an attractive option when a partner goes into residential care while the other remains in the home, or to fund care while remaining in the community.

For those older people with limited superannuation (including most of the current cohort of those aged 85 or older), access to housing equity could improve their capacity to pay for their own care. This would allow the government's funding of care to be more generous for those with less capacity to pay (and/or reduce the tax burden on future generations), and provide greater choice for older Australians. That said, the potential market for equity release products is limited by the value and condition of the homes of older people (an issue particularly for many people living in rural and remote areas).

There are two broad ways to release equity:

- reverse mortgage — where the equity in a home is used as security to borrow money. The loan can be taken as a lump sum, a regular income stream, a line of credit, or as a combination of these. The amount that can be borrowed is linked

[1] Australia's higher education contribution scheme provides an example of an income contingent loan arrangement.

to the person's age. No repayments are made on the money borrowed until the home is sold.

- home reversion — where a proportion of the equity in the home is sold (usually up to a maximum of 50 per cent). A lump sum payment is received in exchange for a fixed proportion of the future value of the home. The proportion of the future value of the home belongs to the scheme provider, but is only paid to them when the home is sold (ASIC 2010).

Both products are available in Australia, but generally only for people aged 60 years or over. Reverse mortgages are the most common product, while home reversion schemes are relatively new and only available in certain areas of Sydney and Melbourne (ASIC 2010).

Equity release products can be complicated financial products and there is some nervousness about them amongst consumers. This may explain the low take up rates to date. As AMP Capital Investors said:

> Reverse mortgages have been available in Australia for some time now, however their attractiveness for investors has been slow to develop. (sub. 342, p. 10)

A number of participants expressed concerns about the use of equity release products for aged care. The Financial Planning Association of Australia, for example, said:

> While reverse mortgages or equity release products have the potential to significantly improve the quality of life of older people with few assets other than the family home, they have significant risks and are not suitable in all cases. Such loan products are very complex, are commonly very expensive, and the FPA is concerned that existing laws do not adequately protect consumers. (sub. 376, p. 5)

Medibank Private also said:

> Many current private equity release schemes have not offered good terms to homeowners and there is an opportunity for the private sector to offer better product packages with government support. (sub. 250, p. 10)

A recent Financial Planning Association of Australia member survey highlighted a number of concerns about reverse mortgage products including:

- clients' ability to comprehend how the critical features and risks of the products may impact on them in the future, particularly when conditions and circumstances change
- future uncertainties (interest rates, property values and longevity) impacting on the suitability of the product
- beneficiary discontent
- high implementation costs for the product

- the long-term, irreversible nature of the contract (sub. 376, pp. 5-6).

Reverse mortgage products can expose home owners to financial risks, largely because of a number of 'unpredictable' factors including interest rates, real estate prices and life/independence expectancies (box 7.3). As the Australian Housing and Urban Research Institute (AHURI) said:

> Reverse mortgages can yield cash quickly but they are complicated and can expose vulnerable homeowners to potentially serious financial risks. These risks include: negative equity; rising interest rates; falling property values; and default conditions that could, for example, trigger immediate loan repayment and negate 'no negative equity' guarantees. (Bridge et al. 2010, p. 8)

Box 7.3 **The risks of equity release products**

The Australian Securities and Investments Commission (ASIC), an independent Australian Government agency responsible for consumer protection in financial services, notes that while equity release products can provide benefits, they also have significant risks:

- They can be difficult to understand.
- They can be relatively expensive compared to other types of loans with regular payments.
- If you breach certain terms and conditions you may have to sell your home and replay the loan.
- If your property values don't increase as much as you think, or if they fall, you might end up with less money than you expect when you sell your home.
- Your circumstances and financial views might change as you age — if you release too much money now you may find you do not have enough later on.

Because of compound interest and fees (and not making any repayments), the amount owed on a reverse mortgage can grow very quickly. What is owed can end up being more than the value of the home. Most reverse mortgages protect against negative equity by putting a limit on how much can be owed with a No Negative Equity Guarantee (NNEG), but not all reverse mortgages offer a NNEG.

*Source*: ASIC (2010).

Reluctance to reduce the 'kids' inheritance' can be a further barrier to the use of equity release products. A survey of 7000 Australians aged 50 years and over undertaken by the AHURI, however, suggested that concerns about leaving inheritances are less evident with older Australians. AHURI concluded that:

> The attitudes of many men and women towards inheritance has shifted as to what previously would have been considered 'the right thing to do' in terms of traditional obligations and responsibilities to their children. Our data strongly suggest that many

> older people's attitudes have taken on more of those of their Baby Boomer children; that is 'put yourself first'. The desire to bequeath assets to the next generation seems to be significantly diminishing. (2005, p. 13)

And, the market for reverse mortgages in Australia has experienced some growth in recent years corresponding with the property boom. A Deloitte study commissioned by the Senior Australians Equity Release Association of Lenders (SEQUAL) found that as of December 2009, the market in Australia consisted of just under 39 000 reverse mortgages with total outstanding funding of $2.7 billion and an average loan size of just under $70 000. The number of reverse mortgages more than doubled between 2005 and 2009 (table 7.1).

Table 7.1 **Number of reverse mortgages, outstanding market size and average loan size, 2005-2009**

| | *2005* | *2006* | *2007* | *2008* | *2009* |
|---|---|---|---|---|---|
| Number of reverse mortgages | 16 584 | 27 898 | 33 741 | 37 530 | 38 788 |
| Outstanding market size ($ billions) | $0.85b | $1.51b | $2.02b | $2.48b | $2.71b |
| Average loan size ($) | $51 148 | $54 233 | $60 000 | $66 150 | $69 896 |

*Source*: SEQUAL (2010).

What is unclear, however, is whether reverse mortgage products are being used to fund aged care or to fund other consumption (Access Economics 2010c).

Internationally, the uptake of equity release products by older home-owners has been relatively low. The complexity of schemes, limited information and the failure of providers in the past, have been factors contributing to the hesitation of consumers to use these products (appendix C). According to the OECD:

> … in most countries, [reverse mortgages] are still scarcely used, including because they require a relatively high degree of household financial education. Even in the United States, where the reverse mortgage market has developed rapidly in recent years, it remains very small. (2005, p. 51)

## Is there a role for a 'public equity release' scheme?

There are a number of reasons why government involvement in equity release products might be justified to assist older Australians to contribute to their aged care costs including:

- information asymmetries — the evidence suggests that older Australians lack the information about how such schemes work and they have poor financial literacy. In the context of Debt Free Equity Release Products, Access Economics argued

that information asymmetries arise due to the relative infancy of the market, which means that both consumers and investors have insufficient knowledge about the product and are unable to make informed decisions. Also, many consumers and investors may be unaware of the product.

- older Australians may be vulnerable to exploitation and hence may need protection. AHURI found that people typically make the decision to investigate or take out a reverse mortgages when they experience an unexpected change in their circumstances and/or an ongoing shortfall between their income and their expenses (Bridge et al. 2010). As Access Economics said: 'government should be mindful above all of the vulnerable circumstances of the older Australians' who are most likely to consider such products (2010c, p. 31)
- equity release products can be costly to set up and this can be problematic if the amounts required for aged care are small (and not suited to the drawing down of a large lump sum)
- for people on pensions, equity release products may not be suitable as pensioners could be made worse off by drawing down equity in their home (because of how the income stream is treated for the pension eligibility test).

The Australian Government could play a more active role by simply providing information about equity release products and educating older Australians about the role such products can play in paying for retirement activities and services. To a large extent, however, the Government is already active in providing information (ASIC provides information to consumers about equity release products, alerting people to potential risks and providing scenarios for different circumstances, box 7.3).

A public scheme could play an important role in inspiring confidence in equity release products and stimulating market development, although it could also crowd out the further development of private schemes.

Internationally, some governments have sought to increase the attractiveness of equity release products. For example, the New Zealand Government has put in place an interest-free 'Residential Care Loan Scheme'. Under the scheme, the government advances funds to a rest home, on the client's behalf, for residential care services received by the client. The purpose of the scheme is to assist older people who, because they own their home and have assets above the applicable asset threshold (and therefore are not eligible for a care subsidy), are obliged to pay for the cost of care services.

The higher uptake of government-sponsored schemes, relative to private provider schemes, in the United States also suggests that the added security from government backing can help dispel nervousness about using the products (appendix C).

A government backed (but not necessarily operated) equity release scheme may be more acceptable to older people. Such a facility could take a charge over the equity in an older person's home (up to a maximum percentage, say 40 per cent) and draw against this to help finance their accommodation and care costs. To avoid gaming, any sale or transfer within five years of entering a residential aged care service could be deemed as being included in the asset test at market value.

Alternatively, the Government could expand the existing Pension Loans Scheme to allow small regular sums of money to be drawn down to cover care costs. The Pension Loans Scheme is an equity release scheme offered by Centrelink which allows older Australians to draw an age pension or top-up their part pension using their home equity (box 7.4). The scheme is currently not available to people on the full rate age pension and only allows relatively small amounts (fortnightly payments) to be made available rather than one-off large payments.

An equity release scheme such as the Pension Loans Scheme that allows small payments, so that payments accumulate over time, is less likely to be a product that will be attractive to private operators. A small loan at the outset that grows over time is unlikely to be offered by the market without a large upfront fee.

Any proposed government backed equity release scheme would need careful design to ensure its acceptance in the community, drawing from the experience of private and government-backed reverse mortgage schemes and the Pension Loans Scheme.

DRAFT RECOMMENDATION 7.1

***The Australian Government should establish a government-backed Aged Care Equity Release scheme which would enable individuals to draw down on the equity in their home to contribute to the costs of their aged care and support.***

## 7.3 Insurance for aged care

Aged or long term care insurance (LTCI) would cover care services not covered by Medicare or private health insurance. Such insurance would pool the risk of aged care costs across those participating in the scheme. As discussed in chapter 6, given the unpredictable nature of incurring very high aged care costs, there would be welfare gains from having a mechanism in place that pools these costs. A number of participants acknowledged the advantages of a pooled funding approach. Laurel Hixon, for example, said:

> The need to focus on insurance options stems from the fact that certain aspects of aged care represent a textbook case of an insurable event in that the probability of needing care is low and unpredictable while the cost of that care is high.

> Australia should be prepared to have in place strategies that anticipate the future demand for aged care and mechanisms to spread the financial risk of aged care over the *widest possible population and over time*. (sub, 328, p. 2) [original emphasis]

Box 7.4 **Pension Loans Scheme — how it works**

People of age pension age (or their partners) who cannot get a pension because of their income or assets (but not both), or those who only receive a part pension, can access capital tied up in their assets under the Pension Loans Scheme. The Pension Loans Scheme is not available to people paid the maximum rate of pension.

The Pension Loans Scheme is a voluntary arrangement which provides support in the form of a loan, for a short time or for an indefinite period. It is paid in regular fortnightly instalments. Compounding interest is charged on the balance of the loan and calculated on a fortnightly basis. The Pension Loans Scheme loan must be secured by real estate owned in Australia.

Features of the Pension Loans Scheme include:

- No Negative Equity Guarantee (a guarantee that no matter how long the loan runs, the borrower can never owe more than the value of the security)
- minimum age 65 years or pension age if less
- capped at the maximum age pension plus pension supplement and rent assistance
- underwritten by the Australian Government
- available Australia-wide
- available as an income stream only
- interest rate fixed by the Minister.

An example of how it works: Tim has a property valued at $210 000 which he offers as security for his loan. As he wants to be sure that he has the flexibility to move into a retirement village when the need arises, he nominates a guaranteed amount of $85 000 for that purpose. His eligibility for payments under the Pension Loans Scheme is based on $125 000, the value of his property less the guaranteed amount.

*Source*: Centrelink (2009).

While voluntary insurance would allow risk-averse individuals to insure against the possibility of high care costs, 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 (box 7.5). As Barr put it:

> There are potentially large welfare gains if people can buy insurance that covers the cost of long-term care. However, technical problems — largely information problems — face both the providers of insurance and potential buyers. These problems on both the supply and demand sides of the market suggest that the actuarial mechanism is not well suited to addressing risks associated with long-term care. (2010, p. 359)

Box 7.5 **Voluntary insurance — problems on the supply and demand side of the market**

While voluntary insurance would allow risk-averse individuals to insure against the possibility of high care costs, problems on the supply and demand side of the market limit the extent and coverage of such insurance, including:

- a lack of knowledge about the risk of needing care and competing priorities (mortgages, childcare costs). Also difficulty in predicting care needs and framing an acceptable level of coverage
- affordability problems for consumers arising, in part, from the limited number of people likely to take out insurance which in turn increases the costs of premiums. Individuals also tend not to think about purchasing insurance until late in life, and the later in life the insurance is purchased the higher the premiums. The greater risks of requiring aged care for females — related to their morbidity and mortality profiles — means they will face higher premiums
- low incentives to insure because of existing safety net mechanisms and uncertainties about future age care policies
- the unpredictable nature of future care costs and life expectancy for any individual makes it difficult for insurers to calculate appropriate insurance premiums
- adverse selection problems — people with the worst health profiles and highest likely future care costs are most likely to buy insurance. If insurers are unable to set differential premiums, a common rate premium would discourage potential lower-risk purchasers. Identifying people more likely to claim aged care benefits involves more than assessing their health and future probability of becoming disabled as availability of a carer or preferences of individuals and their families towards using paid care can also determine whether a claim is made.

While insurers can counteract some of these problems (by requiring co-contributions or limiting what can be claimed) this further reduces the attractiveness of insurance.

*Sources*: PC (2003); Barr (2010); OECD (2010); Gleckman (2010).

Internationally, private insurance plays a relatively small role in financing aged care.

- In the US, where insurance is voluntary and privately provided, less than 10 per cent of the population aged 65 years and over are insured for aged care, despite the presence of tax incentives.
- In Germany, private insurance is available for high-income individuals and as supplemental coverage for all. Participation rates are less than 10 per cent.
- In France, 25 per cent of people over the age of 60 have private insurance.

Myopia in planning for the risk of dependency, failure to recognise the potential risks of needing care into the future, and the high cost of care are factors explaining the relatively small size of the private long term care insurance market in the above countries (OECD 2010).

It is often argued that governments could provide tax incentives to improve the attractiveness of private insurance. However, the merits of providing such incentives are frequently contested because incentives largely involve transfers from taxpayers to policy owners who would have purchased insurance anyway rather than inducing people who otherwise would not have purchased insurance to take out insurance. Further, where incentives are provided as tax deductions rather than rebates, they provide disproportionately large benefits to those with high taxable incomes.

Under a stop-loss taxpayer model where the Government covered costs above a nominated cap, there could be a role for private insurance as the government would be taking on the 'long risk' that individuals and insurers are less willing to accept. As the OECD notes, supplementary private insurance would be considerably more affordable for individuals:

> Supplementary private insurance could play a stronger role in the future to cover private cost-sharing. Private insurance on top of a basic universal public insurance, for example to pay for the cost of accommodation in nursing homes, covers a risk that is easier to calculate and therefore to insure for the private insurance industry compared to full coverage of the risk of care needs in old age. And it is more affordable for private households. (2005, p. 14)

With a government funded stop-loss mechanism in place, insurance is really a form of pre-saving for the more predictable costs of aged care. Hence, there is an added issue of prudential regulation to ensure that the insurance policy can be redeemed when it is needed, a long time into the future. While voluntary insurance may complement other forms of funding it is — for the reasons outlined in box 7.5 — unlikely to provide an adequate funding mechanism for a large share of the population. Nonetheless, the Commission would argue against any unnecessary legislative restrictions to personal insurance being offered by the private sector.

An alternative approach which addresses these problems is compulsory insurance.

## Compulsory insurance

Compulsory care insurance can be provided publicly or privately, although it is usually discussed in terms of public provision and referred to as social insurance. Compulsory contributions under a social insurance scheme are typically collected

via a levy on income and put into a designated (hypothecated) fund. In contrast, contributions under a private compulsory insurance arrangement would typically be collected as premiums related to an assessment of the underlying insured risk and placed in an insurance pool as reserves to meet subsequent claims.

As with voluntary private insurance, compulsory insurance represents a pre-funded approach to funding the costs of aged care. By extending coverage, compulsory insurance provides a more effective risk pooling mechanism that, in principle, provides individuals with an assurance that funds would be available if needed.

Over the past decade or so, a number of commentators and key stakeholder groups have suggested introducing compulsory insurance, usually in the form of social insurance, to broaden the funding base for aged care (box 7.6).

Box 7.6 **Past interest in compulsory care insurance**

Over the past decade or so, many commentators and stakeholders (including those representing providers, consumers and workforce groups) have listed compulsory insurance among the possible options for raising the level of funding for aged care through increased user contributions.

In the late 1990s, interest in social insurance was kindled following the public backlash against substantial increases in user contributions — the proposal to introduce accommodation bonds in high care (Fine and Chalmers 1998, Howe 1999).

In 2002, the Myer Foundation suggested a pre-funded social insurance scheme, funded by a compulsory premium on national wages similar to the Medicare Levy, could be introduced to enable individuals to contribute more to the costs of their care when they can afford to. Although the 2004 *Review of Pricing Arrangements in Residential Aged Care* did not include a social insurance scheme among its recommendations, many participants to this review did raise this option, including 24 peak industry members of the National Aged Care Alliance (NACA 2003). Participants to the Senate (2005) Inquiry into Quality and Equity in Aged Care, including Aged and Community Services Australia on behalf of 10 other peak industry bodies, also proposed that the scope for a social insurance scheme to broaden the funding mix, such as that currently operating in Japan, should be investigated.

More recently, in recognition of the growing pressure on the taxation system, the Henry Review (2010, p. 641) recommended the Commission consider the 'potential for insurance to play a role in helping to fund aged care as Australia's population ages'.

Despite the seemingly significant level of in-principle interest, past reviews have been unable to determine whether a compulsory insurance scheme would represent a significant improvement over the existing arrangements.

Howe, for example, observed that:

> Current aged care funding relies on only two 'pillars' — taxation revenue and user charges. Adding a pillar of social insurance would add a third pillar and so strengthen the whole of the funding arrangements. In particular, by providing a source of forward funded capital, social insurance would serve as a buffer against downturns in the wider business cycle for aged care investment, and in turn, marginally moderate the business cycle.
>
> A social insurance approach to aged care funding in Australia is highly consistent with and would complement both the Medicare Levy and the Superannuation Guarantee that are already in place. Both have proved 'painless and popular' taxes with the community, and a social insurance scheme for aged care could be expected to gain similar acceptance. (2003, p. 8)

A number of participants to this inquiry also supported a compulsory insurance type scheme, many suggesting an increase in the Medicare Levy (box 7.7).

A well designed compulsory insurance scheme for aged care could offer several advantages:

- because compulsion means that risks are fully shared, individuals would be protected against catastrophic costs and there would be enforced savings for predictable costs
- spreading the costs of aged care across a wide range of individuals would address the adverse selection and information problems associated with voluntary insurance, which in turn helps improve affordability
- if contributions to the scheme are means tested and proportional to income (as with the Medicare levy), a broad cross-section of individuals would be covered under the scheme, with contributions from those on higher incomes effectively extending the benefits available to low income participants.

As Barr observed:

> while compulsion makes politicians nervous, it has economic advantages, including:
>
> - It recognises the evidence from behavioural economics that people do not always make decisions in their own self-interest.
> - It avoids adverse selection, since good risks cannot opt out and bad risks cannot choose to buy inefficiently large amounts of cover.
> - A system that is compulsory allows some redistribution; thus it is possible to charge a contribution to x per cent of earnings, respecting ability to pay' (2010, p. 317).

Box 7.7 **Some participants supported the introduction of a Medicare type levy and compulsory insurance**

Melbourne CityMission:

> The Government should examine introduction of an Aged Care Levy in the taxation system, as a social insurance levy similar in function to the Medicare Levy ... Australia currently has transparent mechanisms to help fund the public health system and citizens' retirement. Why not introduce an Aged Services Levy in addition to the Medicare Levy? (sub. 173, p. 21 and p. 23)

Baptcare:

> Baptcare agrees that many people may not have adequate superannuation for their needs in the long term or may choose to utilise their superannuation payout to live well for the period whilst they are fit and healthy. To combat this, we suggest the Government extend the Medicare levy to cover aged care costs. This could be applied to all taxpayers, with an additional impost on high-income earners who do not choose to take out private insurance for aged care costs, such as the longevity insurance products suggested by the Henry Review. (sub. 212, p. 30)

Medibank Private:

> Mandated social insurance to cover the costs of independent living and aged care services. The benefits of this model include the development of a sense of individual responsibility to fund aged care needs as well as the benefits of sharing costs and pooling risk at a population level. However this model requires that premiums be set at a high enough rate to ensure future sustainability of the scheme and is a long term strategy which relies on people in the transition phase having assets to draw on to support their ageing care needs. (sub. 250, p. 10)

Blue Care:

> Blue Care **recommends** that the government considers introducing social insurance by an increment to the present Medicare levy … to close the present residential aged care funding gap of some $1 billion. We estimate that the required increment at around 0.15% to 0.2% (percentage points). In the longer term, the increment could be increased to meet the rising cost of care of the ageing population. (sub. 254, p. 16) [emphasis in original]

Another argument advanced in favour of a compulsory insurance scheme is that it can smooth intergenerational transfers. In this regard, younger generations may be more prepared to support older generations who have contributed to the cost of their own aged care costs. But as Ergas said:

> … if incomes are rising, the welfare cost of reducing current consumption exceeds that of reducing future consumption. Moreover, the reduction in current consumption would be greater for the transition generation, as it would have to cover both the costs of care for current, unfunded, consumers and provision for its own care costs. Indeed, if the real rate of return is less than the 'biological rate of interest' (i.e. the sum of population growth and productivity growth), then a PAYG scheme is generally efficient.

> The mere fact of moving to a funded scheme therefore need not increase welfare. Whether it does depends on its impact on efficient risk-allocation and service provision, and on its overall effect on savings. (2010).

In the case of aged care, the opportunity to smooth the higher costs associated with the bulge of the baby boomers has largely passed.

It is also often argued that hypothecation of funds provides greater protection from the vagaries of the government's budget process, as money can be more securely ring-fenced than through simply increasing taxation. But, hypothecation can also introduce rigidities in the way funds are allocated and it does not necessarily provide a guarantee about the level of specific funds available (Barr 2010, OECD 2010a). The appropriateness of hypothecation needs to be considered having regard to the specific characteristics and policy objectives of the service sector under consideration. While there are arguments for and against hypothecation of funding, this debate is secondary to the question of the appropriateness of having a social insurance scheme for aged care.

Advances in medical and assistive technologies over time as well as potential changes covering other variables have the capacity to alter the future cost profile for aged care in ways which are inherently hard to predict. If the contribution rate (premium) is set too high, there will be excessive savings (reserves) relative to the future costs of care while if set too low, additional funds would be required from general tax revenue (or higher premiums).

## International examples of compulsory insurance

A number of OECD countries — Germany, Japan, Korea, the Netherlands and Luxembourg — have adopted dedicated social insurance arrangements for long term care services (table 7.2). Common features of the arrangements include:

- separate funding channels for LTCI and health insurance, but with the same social insurance model
- mandatory participation for the whole population or a large section of the population (for example, in Japan everyone over 40 years of age)
- predominantly financed through employment based payroll contributions, but seniors can also be asked to pay contributions. A share of the cost is funded out of general taxation in most countries (OECD 2010b).

Table 7.2 **Universal LTCI schemes in OECD countries**

| | *Introduced* | *Financing sources* | *Contributions* | *Eligibility* | *Benefits* |
|---|---|---|---|---|---|
| Germany | 1995 | Payroll and income-related contributions | 1.95% payroll tax (additional premium of 0.25% for those with no children)<br>Paid by all working age and retired population<br>Approx 11% opt out and are obliged to buy private insurance | Needs based assessment regardless of age | In-kind or cash at user's choice |
| Japan | 2000 | General revenue (45%)<br>Contributions (45%)<br>Cost-sharing (10%) | Paid by over 40 year old population<br>Individuals aged 40-64 years pay 0.9% of wages. | 65+ assessed as needing LTC<br>40+ with certain diseases | In-kind |
| Korea | 2008 | Tax (20%)<br>Payroll contributions (45%)<br>Cost-sharing (15-20%) | Paid by working-age population through contributions to health insurance.<br>National Health Insurance contributions set at 5.08% of wages, 4.78% goes toward LTC | 65+ assessed as needing LTC<br>Younger people with geriatric diseases. | In-kind or cash |
| Netherlands | 1968 | Payroll and income-related contributions<br>Means-tested copayments | Contribution rate is based on income.<br>Paid by working-age and retired population (all citizens over 15 years with taxable income) | Disabled assessed as needing LTC, regardless of age. | In-kind (institution)<br>Cash (home, personal budgets) |
| Luxembourg | 1999 | Taxation (about 45%)<br>Contributions<br>Special tax | Paid by working-age and retired population. Contribution set at 1.4% of income | Disabled assessed as needing LTC, regardless of age | In-kind and/or cash, at user's choice |

*Source*: OECD (2010b).

Under Germany's insurance scheme, insurance premiums are means-tested and paid for through payroll tax. Around 90 per cent of the population is covered by the scheme, with the remainder opting for private insurance (high income earners, the self-employed and civil servants have the option to take out LTCI with a private provider). The government determines eligibility for aged care services and makes all capital investment for residential aged care facilities (Arntz et al. 2007). Eligible

beneficiaries can opt for a cash payment (at a lower value), in-kind professional services (worth nearly twice as much), or a combination of the two.

Japan introduced a LTCI system in 2000. The scheme is funded by a combination of general tax revenue and income-related premiums (payroll tax) levied on those over the age of 40. Anyone over 65 years of age in need of care (eligibility for care is determined by the government) is granted access as are people aged 40-plus suffering from age-related disabilities such as stroke or Parkinson's Disease.

LTCI was introduced in Korea in 2008, covering people aged 65 and over assessed as needing care and younger people with geriatric diseases. The working-aged population contributes around 5 per cent of wages to the National Health Insurance scheme, 4.78 per cent of which goes towards LTC. The government pays subsidies equal to 20 per cent of contribution receipts and care recipients pay an out-of-pocket contribution of between 15 per cent of the cost for in-home services and 20 per cent for care in institutional services.

For details of the schemes in the Netherlands and Luxembourg see table 7.2.

The OECD observed that as a share of GDP, long-term care spending is around the OECD average of 1.5 per cent for those countries who have adopted LTCI models, apart from Korea (0.3 per cent) and the Netherland (3.5 per cent).

Both the German and Japanese schemes have begun to face increasing cost pressures because contributions have been insufficient. In Germany, contributions were raised in July 2008 from 1.7 to 1.9 per cent of gross salary for people with children (of any age) and from 1.9 to 2.2 per cent of gross salary for people without children. Featherstone and Whitham said:

> Both Germany and Japan … are struggling to ensure long-term financial sustainability of these systems. In Japan, costs of care have escalated and, in 2005, they excluded hotel costs (care home accommodation as opposed to care home nursing costs) from the benefits package. Currently lowering the minimum age of contribution to 21 is under consideration. The German system now only covers about half of the cost of institutional care, leaving some older people forced to pay out-of-pocket to cover their long term care. (2010, p. 29)

## Designing and implementing a compulsory insurance scheme

Moving to a compulsory insurance scheme would be a big change from the current aged care arrangements and would raise significant design and transitional issues.

In designing a compulsory scheme, policy makers would need to resolve a number of important questions:

- What costs should be covered — only care costs or also accommodation and every day living expenses?
- Whether the scheme should be administered by the public or private sector, a single insurer or multiple insurers?
- If provided by the public sector:
  - would the contribution rate be based around a hypothecated levy with a flat rate or a progressive income-related rate?
  - would the contribution rate be imposed on the entire working-age population or only those above a certain age?
  - how would the scheme deal with non-tax paying individuals or those not in the workforce?
  - what level should the contribution rate be set at, how would it be adjusted as expected future costs change and how would fund surpluses be distributed or shortfalls be funded?
- If provided by the private sector:
  - should the premiums to be paid be mandated by the Government or subject to conditions set by Government as with private health insurance?
  - should premiums to allowed to vary on the basis of risk?
  - what regulatory framework is needed for the operation of the insurance scheme and to manage contingent liabilities for government should an insurer fail, or if coverage falls short of expectations?
  - how would equity issues be addressed if premiums rather than a flat rate or income related rate was used?
  - what regulatory mechanism would be used to enforce compulsion and how should premiums be collected?

There may be significant operational and administrative efficiencies which can be achieved by having a single insurer. And, at least, in principle, a single insurer would have a greater capacity to impose strong disciplines on service providers to encourage cost effectiveness and efficiency. In contrast, a multiple insurer arrangement offers scope for competition between insurers which may promote greater efficiencies and a more dynamic market over time. A private insurance market would have to be highly regulated and government would need to subsidise insurance for those who could not afford to purchase cover.

In the Commission's, view whether the economies of scale and buying power of a single insurer would outweigh the potential dynamic efficiencies of multiple insurers is an empirical question, about which there is little evidence. More

fundamentally, the regulatory regime required to underpin a compulsory private insurance system for aged care may well undermine the scope for efficiency gains, and it is highly likely that government would, in effect, become the insurer of last resort.

### Similarities between a tax-funded scheme and compulsory insurance

There are many similarities between the current aged care tax-funded system supplemented by a stop-loss mechanism and compulsory insurance — both involve risk pooling (to protect individuals from catastrophic costs) and can involve progressive mechanisms for raising funds. Access to care is based on need, rather than ability to pay.

But, as noted earlier, the introduction of a compulsory insurance scheme for aged care would also raise significant transitional issues. A key one relates to how to treat different age cohorts relative to the likely timing of prospective demands by their members for aged care services. For those who have already retired, or are nearing retirement, the magnitude of their accumulated contributions under any scheme is likely to be small relative to their potential draw-downs. Hence, the scope for compulsory insurance to handle the population bulge associated with the ageing of the baby boomers is arguably becoming limited.

*At this stage, the Commission is not convinced that a compulsory insurance scheme, in the context of aged care, represents a significant improvement over the pay-as-you-go tax financed system supplemented by higher co-payments by those with the financial capacity to make them and a stop loss mechanism (to achieve risk pooling) for the high costs of care.*

*Accordingly, the Commission seeks feedback on this assessment together with participants views on the advantages and disadvantages of introducing a compulsory insurance scheme to broaden the current funding base for aged care.*

# 8 Care and support

**Key points**

- Older Australians find the current aged care system difficult to navigate. Care services are limited and community care packages are relatively inflexible.
- A single agency that provides information, assessments and care coordination would help older Australians and their families make informed choices. Such services should be delivered through a network of regional centres.
- While most older people receive timely assessments of care needs and access to services, there are significant delays for some.
- Care assessments should be streamlined and more nationally consistent, with the resourcing of assessments linked to the level of anticipated need.
  - There should be a range of options for completing lower level assessments for basic support services, including through face-to-face consultations, over the phone or via the internet.
  - For higher levels of care need, a reformed and coherent system of assessment is required that builds on the current approach of the Aged Care Assessment Teams.
- A model of care and support based on assessed needs and service entitlements which are tailored to those needs, rather than providers funded for approved places and packages, will significantly enhance the delivery of continuous care.
  - The care model should comprise building blocks of basic support, personal care and specialised care that meet the changing needs of individual older Australians, together with carer support services.
  - Consumers should have choice of providers, with initial care coordination and more intensive case management available where warranted and requested.
  - The role of publicly funded care advocacy will need to be expanded, as will restorative care and rehabilitation.
- There is a strong and increasing preference for ageing at home.
  - The removal of quantity restrictions on the supply of care will allow services to be delivered more widely in all types of accommodation.
  - A greater role is likely for the delivery of palliative and end-of-life care in people's own homes and in congregate care settings.

Participants to this inquiry argued that there are significant opportunities to improve the provision of publicly subsidised care and support services, and that an expanded focus is needed. Strengths and weaknesses of the current system were analysed in chapter 5. Many submissions proposed that the purpose of the aged care system should be to assist the physical, emotional and social wellbeing of the person, and provide opportunities for purposeful interaction with community and family. The Commission's wellbeing framework developed in chapter 4 recognises both the importance of these objectives and that a publicly funded system must also be sustainable.

In the Commission's view, there is a need to develop an aged care system that better allows the principles of wellbeing to be reflected, particularly in the ways in which information, assessment, care and support are provided for older Australians. As with the current system, this new model would retain a strong emphasis on respect for the individual and their role in society, but it would also allow them a degree of control and self determination that is not always possible in the current approach.

The proposed model removes the constraints on supply of services, so people assessed as needing services will have access to these services. This makes the assessment of needs and the coverage of the system (which defines the services that are subsidised and their resourcing) central to managing the fiscal cost of the aged care system.

This chapter sets out the main features of the new system, and discusses the Commission's proposed reforms in:

- information, assessment and care coordination services (section 8.1)
- arrangements for improving care continuity and enhancing consumer choice (section 8.2)
- several other areas, including palliative and end of life care and funding arrangements for some basic support services (section 8.3).

Improvements in care quality resulting from implementation of the proposed reforms are discussed in section 8.4.

## 8.1 An aged care gateway: information, assessment and care coordination

For many older Australians and their families, the first time they access the aged care system is to search for information about what services are available and what they might be entitled to (and often this is at a time of significant stress). They told

the Commission that the current aged care system is difficult to navigate. They used terms such as 'complex', 'confusing', 'fragmented', 'overwhelming' and 'uncertain'. They stated that attempts to make the best decisions about care services are 'time consuming' and 'bewildering'.

To quote the daughter of two elderly parents who had worked in the community care sector for over 20 years:

> Our family navigates the complex interfaces between the HACC, Veterans' Health, Centrelink and Commonwealth community aged care support systems. While I would be considered a well informed consumer, this navigational act is at times overwhelming. (Dianne Beatty, sub. 413, p. 2)

National Seniors Australia argued that:

> The complex and myriad regulatory regime results in confusion for the consumer and stifles innovation. Also, there is little coordination between the structured components of the system and the informal support networks. This makes it difficult for older Australians to plan and take responsibility for their own care. (sub. 411, p. 18)

This section explores the 'front end' of the journey for older people who need formal care and support. There are three broad stages of this front end which, if reformed, could greatly help older Australians to retain control over their lives.

- The first stage requires information to be more readily available and easily understood. Information needs to be made available at both the community level and at a level which is specific to the needs of individual older people.
- The second entails the development of simpler and more accessible assessment processes, with self-navigation wherever possible to reinforce personal control. A single integrated assessment service would: help older people understand and make choices about their own care and support needs; determine their eligibility for subsidised services; inform them of their required co-contributions; and provide them with a set of care and support entitlements which they can take to approved providers.
- The third involves access to services from approved providers once the entitlements have been determined. Often these services can be accessed directly by the consumer or with the aid of an informal carer. But, where necessary, assistance may be required through the provision of low level care coordination or, in some cases, more intensive case management.

## Information services

Independence and self-control is built on a strong foundation of understanding one's own needs and the availability, quality and cost of services that are relevant to meeting those needs. Information is critical to building this foundation (box 8.1).

Box 8.1 **Participant's views on information — accessible and useable?**

ACH Group:

> In the new aged care older people and their families and advocates should be able to get information more easily — information should be independent, comprehensive, accessible by all in a diverse society, have many outlet mediums and backed up ways in which people can see how things work (e.g. resource centres). This information should enable older people to assess their own needs and to assist their access to services and supports. (sub. 111, p. 5)

COTA:

> Work has already started on [improving information] with the allocation of $36 million in new investment for the 'one stop shops' but there needs to be a greater sense of urgency around ensuring the information elements … are pulled together in a way that facilitates individuals accessing the services they need. (sub. 337, p. 43)

Older People's Reference Group:

> Unless people know what their choices are, how can they make good decisions? It should be much easier to understand what care programs are available in the community and in residential facilities. Less jargon, more accountability, more public information and more access points are needed. Local councils are well placed to provide details of options in their areas. General practitioners, and especially the proposed new primary health centres, are also suitable points of information. (sub. 25, p. 4)

Health Consumers Association of the ACT:

> Information and communication is essential … We need information that helps with decision making; this means taking into account one's health status, hobbies and interests, community and family connections and financial means as well as lifestyle preferences. (sub. 326, p. 4)

There are significant challenges in providing effective information for older Australians. People turn to care and support services, in the main, when they are experiencing an increase in their frailty and, for some, a reduction in their cognitive capacity. Information is often sought in stressful circumstances, such as the loss of carer support or during recovery from an acute health episode. Information for this group, as for various disadvantaged groups, must be comprehendible and accessible. Many do not have a ready familiarity with the internet but most have telephones. Importantly, partners, family and other informal carers who help them to navigate the system need to be able to clearly understand and explain the benefits and costs of the various care and support options to those in need.

In the Commission's view, both healthy ageing and equitable access to aged care services have equity and public good characteristics, and there is a case for public funding of an information platform that assists with both. On efficiency grounds, a streamlined approach to information provision reduces the costs incurred by those seeking the information, makes it easier to ensure the information is accurate and up to date and warrants investment in making access user friendly.

The information platform needs to be targeted at two main levels:

- broad community education about healthy ageing and Australia's support and care arrangements, to help people plan and prepare for their own and their parents later aged care needs
- specific information that helps older people and their carers to find and choose the particular services that can meet their immediate and ongoing needs.

### *Community education*

Many people do not plan, at any level of detail, for their final years and end of life. However, individuals in a well informed community can take action ahead of time to prevent or delay a decline in independence and wellbeing. A community where people have a broad understanding of 'the aged care system' including their own funding responsibilities, and entry points for specific inquiries, will be more prepared when the time comes that they or their parents require aged care services.

In adjusting to ageing and maintaining wellness, older Australians, their families and carers can benefit from information on issues such as how to:

- respond and adapt to changing personal capacities
- adjust their lifestyles in an orderly manner, starting with preventative measures to maintain active, healthy and engaged lives
- rehabilitate and restore functionality after an adverse event.

There is an expanding number of organisations and sources of information that promote positive ageing — for example, information is provided by health insurers, retirement villages, care providers and superannuation funds. Peak ageing and aged care bodies such as COTA Australia, Alzheimer's Australia, National Seniors, Carers Australia and Palliative Care Australia also disseminate information. This information is spread across the system and tends to be targeted to particular groups or individuals. In the broad, they offer general guidance on how older people can maintain or enhance their wellbeing. They cover one or more issues such as mental and emotional functioning, physical health, strength and nutrition, socialising, engagement in the community and financial planning.

Government agencies also maintain positive ageing websites, ranging from the Commonwealth Department of Health and Ageing's (DoHA's) website, agedcareaustralia.gov.au, to local government information services.

Access to and use of information remain key issues. Information needs to be tailored where possible to a range of contexts, and to be readily accessible, for example, for use in local communities by general practitioners (GPs) and community health centres, in acute care emergency departments and discharge centres, in public libraries, and by community workers. Given that many older Australians do not have access to, or are unfamiliar with, the internet, this information needs to also be available via telephone information lines and well-known shopfronts such as Centrelink, Medicare Offices and Post Offices.

The information platform should provide a basic set of information on healthy ageing approved by industry peaks or expert bodies. It could also provide a portal for accessing the wider array of information.

There is a particular role for contextual information that makes people aware of the service delivery framework. There is also a need for relevant information to be made available much earlier in the journey towards and into receiving care — such as information on moving to more appropriate accommodation.

### *Individual information needs*

In accessing and moving through the aged care system, older people need increasingly specific information which is tailored to their individual circumstances.

A common theme in submissions and past research is that this information should be relevant, current and accurate. A study by Cheek et al. found that:

> … older people and their families reported difficulties with accessing information and knowing where to get that information. They reported being confused by the available information, particularly due to the use of jargon and acronyms and the complexity of the system, and they often did not know what information they needed until the situation arose … Participants also expressed concern that the provision of inappropriate information often set up unrealistic expectations. (2005, p. 22)

Accurate and timely information is particularly needed on the availability of specific support and care services, and the availability of subsidies and eligibility for those subsidies.

As noted, there is already a well developed network of government information portals and services in place. But there is a clear need for consolidation to ensure that information services (such as the current Commonwealth Respite and Carelink

centres, the Agedcare Australia web-based information service, the seniors.gov.au website, HACC funded information services, and information provided by ACATs) all feed off, and are linked to, an overarching single information platform. This would give consumers far more clarity about where to begin when looking for authoritative information. However, a common single information platform does not imply a single way for older Australians to discover information about aged care and healthy ageing — the one set of information should be available through many outlets.

The proposed information platform would provide both general information on the aged care system and information more specifically tailored to individual circumstances. The platform would be region-specific and contain information on contacts for assessment services and on the availability, quality and cost of services delivered locally by approved providers. The nature of a proposed aged care access gateway that would provide this information is discussed further below.

The Commission notes the recent announcement of funding over four years in the 2010-11 Commonwealth Budget for the establishment of a series of aged care 'one-stop shops'. If development of these is to proceed, the information services provided within these outlets should be built on this broader consolidated information platform and such centres could form part of, or be directly connected to, the proposed gateway agency detailed below.

## Assessment

Accurate assessment of a person's care needs is a necessary precondition to the delivery of appropriate care. The complex nature of many older people's underlying health status, together with the often vexed circumstances in which assessments take place (for example, immediately after a health event), mean that assessment can be a critical transition point. As Davis, Dorevitch and Garratt state:

> Frail, older people with multiple problems and co morbidities, particularly those not under the direct care of geriatric services, are at risk of adverse outcomes. Appropriate assessment is required to address the complexities of health needs. Hence, the cornerstone of contemporary care for older people is assessment. (2009, pp. 168-169)

As discussed in chapter 5, participants to this inquiry identified several problems with the current assessment process.

### *Current arrangements*

Aged care assessment services, as they currently operate, have evolved from, and are an amalgamation of, various arrangements that developed in individual states and territories. In the case of Home and Community Care (HACC) services, which are block funded, older and frail people (or those with a disability) who are having difficulty undertaking tasks of everyday living can directly contact local HACC providers. Thus, there is self-screening, often prompted by health professionals, older friends or by community information campaigns.

There are national guidelines for HACC service standards which have been agreed to by all jurisdictions. However, there is significant variation in their operation, and in the charging regimes for these services. Individual HACC providers undertake their own assessments, and determine the provision of care according to need and to the financial capacity of the provider to accept more clients.

Access to Commonwealth subsidised care packages (Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH), Extended Aged Care at Home Dementia (EACH-D)) and residential care requires an assessment through the Aged Care Assessment Program.

While there is a 'national' program, Aged Care Assessment Teams (ACATs) operate in different systems across the jurisdictions. In South Australia, for example, many assessments are carried out by Domiciliary Care services, with ACATs mainly being involved where residential care is the most likely outcome. The Aged Care Assessment Services in Victoria are mainly located in Extended Care Facilities (formerly known as geriatric hospitals), with several in Community Health Centres.

The ACAT assessment instrument which is used to determine the level of care that a prospective client is entitled to in the community or in residential care differs from the funding instrument (the Aged Care Funding Instrument (ACFI)) which is used by residential care operators.

### *Assessment issues*

The current assessment system's strengths include its multi-disciplinary approach and nation-wide coverage. However, there are a number of significant problems with structures, outcomes and variability and the Commission sees reform as necessary.

Individuals requiring care, their families and representative bodies were critical of the need to go through multiple assessments and eligibility tests ('I have to tell my story over and over again'). One participant reported that her mother had been assessed 16 times over a period of five months (Dianne Beatty, sub. 413). COTA also said:

> Older people (and their families) often express frustration at having to go to separate services for information, screening, assessment and access to services. They have to make separate trips, separate phone calls and have to give the same information many times over. The current system of information and referral is under-resourced and quite fragmented, often resulting in people accessing the wrong services for their needs, and/or experiencing long delays that can be extremely detrimental. (sub. 337, p. 13)

DoHA also identified the multiple and inconsistent assessment processes under the current system as an area of inefficiency:

> There are … significant issues of allocative efficiency in the current arrangements. For example, in (low intensity) community care, clients can face multiple and inconsistent assessment processes as they are referred to different organisations depending on their care requirements. In addition, service specific assessments may not be designed to identify other issues that the client (and their carer) may be experiencing therefore reducing the chances for appropriate and timely referrals within the system. (sub. 482, p. 50)

Participants also noted that in some areas there are long waiting periods for assessment. For example, Just Better Care said:

> 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)

HammondCare commented on access delays and the resulting costs, which included sub-acute care, primary care and palliative care costs. They argued that the devolution of sub-acute care services into the aged care system would provide constructive competition and consumer choice in a critical area of health:

> Access to hospitals and primary care is comparatively easy. You present to an acute hospital environment and wait; you present at a GP surgery. While 'wait times' are often publicly criticised, Australians receive hospital and primary care in a comparatively quick and efficient manner.
>
> The same cannot be said for aged care. Aged Care Assessment teams cannot meet demand in a timely fashion. This means that there are delays of weeks and months for an older person to be assessed. Such delays increase the likelihood that a prospective client or resident for an aged care service will be admitted to an acute hospital while waiting for an aged care service. The irony of this dichotomy is that hospital places cost more than aged care places. (sub. 168, p. 3)

Participants also expressed concern that individuals were not being assessed for their needs, but rather against their eligibility for the services that were available (see, for example, Embracia, sub 439; Baptistcare (WA Baptist Hospitals and Home Trust Inc., sub 426)). Helping Hand Aged Care argued that:

> Even many proponents of entitlement-based, single entry/assessment systems advocate extensive assessments relying heavily on complex tools which, again, divide people's lives up into 'domains' or 'components'. We need to move to assessment which determines a broad entitlement and places equal value on self-assessment - what the older person and their family say they want/need ie build consumer choice and control in at the earliest point. (sub. 196, p. 4)

A further concern of providers was the number of inappropriate admissions to either low or high care through the ACAT assessment process. In this context, Mission Australia said:

> Reforms are required to review the process of ACAT assessments for older people requiring formal care. Currently the ACAT assessments are not validated and the assessment may take just two hours. There is a feeling that the Department of Health and Ageing does not trust the assessment process of the residential aged care facilities. Residential aged care facilities conduct assessments over a four week period and as such are likely to be more accurate due to the longer assessment process yet must be validated. (sub. 117, p. 3)

Lack of consistency of needs assessments was raised by many participants — particularly operators of residential care establishments. Catholic Health Australia, for example, quoted a provider as saying:

> Our organisation provides community packages across a number of ACAT regions and we are experiencing considerable variability in ACAT assessment for packages across the regions. As a result we have underutilised packages in some areas and waiting lists in others. This suggests that there is considerable room for improvement in the consistency of assessments. (sub. 217, p. 29)

Aged Care Queensland Inc. also said:

> There is a perceived lack of consistency between Aged Care Assessment Teams (ACAT) across Queensland. Members advise that ACATs have different approaches to responding to referrals, managing waiting lists, interpreting ACAT guidelines and assessing clients. (sub. 199, p. 17).

Inconsistencies were also observed between HACC providers within and between states, and also between HACC and ACAT assessments. A further problem raised by some participants is where ACATs have different cultural backgrounds to the client base they are serving, which can influence how they undertake assessments and what services they recommend.

In the Commission's view, there is a need for a national assessment process that results in consistent care and support entitlements for those assessed as needing care, irrespective of what state or territory they are located in. A single (or joined-up) assessment process is likely to result in better outcomes for individuals and produce savings for the community. This process must provide a common set of tools for assessment of aged care needs, and a mechanism to ensure that these are applied in a consistent manner by people with the appropriate skills.

### *Assessment tools*

A national standard suite of assessment tools (see, for example, box 8.2) should aim to achieve outcomes that:

- promote independence and build on an older person's strengths
- identify restorative options that accord with an individual's own aspirations
- identify when a more in-depth assessment is needed
- provide adequate follow up, with timing depending on the nature of the assessment
- use electronic records, attached to a more detailed e-health record, where possible
- support other aspects of care facilitation, such as identifying the need for a care coordinator to help with making appointments with care providers and helping choose an appropriate provider, linking health and care providers and arranging transport.

This suite would be structured to enable a single initial assessment as a foundation, with various triggers that indicate the need for more complex assessments where required.

#### *Base assessment*

The first of the tools in the national assessment suite would provide a base assessment of an older person's core functions such as their ability to undertake instrumental activities of daily living (IADLs), activities of daily living (ADLs), their care setting and level of informal carer support.

The base assessment form could be filled out directly at a shopfront, online, by mail, or by phone to the gateway agency by the older person alone or with the assistance of their carer, GP or other health care professional.

Box 8.2 **A possible new suite of assessment tools**

In considering the possible nature of a new suite of assessment tools, and in order to supplement its own analysis on this topic, the Commission contracted Applied Aged Care Solutions Pty Ltd (AACS) to provide an independent report on a new care and assessment model. Their report is available on the web in appendix B of this report.

The approach proposed by AACS includes the following key elements:

- A system involving a central agency and hubs, which would provide a range of services including triage; information provision; management of needs identification; initial care planning including goal setting; actioning, coordination and monitoring of care plan; and provision of independent advocacy for the clients.
- A layered funding model involving a base subsidy varying across low to very high levels of need; together with layered 'supplements' covering specialist areas (e.g. dementia/behaviour/mental health, health/nursing/continence, palliative care, rehabilitation) and 'care support' needs. The proposed supplements are aligned to the current specialist high care programs (CACPs, EACH, EACH-D) but the funding that would be allocated will only be directed at the 'marginal cost' in these areas over and above what is already taken account of in the base layer payment.

The Commission seeks further comment on the approach proposed in the AACS report.

The base assessment process could also be used as an opportunity to assist an older person with advice on healthy ageing, falls prevention and care coordination. Preliminary care plans (including preventive measures), in consultation with the care recipient (and family), could be established. This would be an opportunity for the older person to express their preferences for how their assessed services were delivered.

As appropriate, this base assessment would be sufficient to determine whether the older person would receive an entitlement for basic support, such as home care, meal preparation and transport services. It would constitute a direct referral to providers of those services, together with eligibility for a government funded subsidy (which would be additional to the user's co-contribution). It would draw largely on the best practice formats currently used under the HACC program.

*Further assessment*

The base assessment would also act as a screening tool for the gateway agency assessor to determine whether there is a need for a more comprehensive second-stage assessment. Regionally based multidisciplinary teams would undertake any further assessment using more sophisticated assessment tools. The assessment

would usually lead to determining a person's entitlement to personal care and specialised services. If not undertaken as part of the base assessment, a person's financial capacity to make a co-contribution would also be assessed.

For someone whose initial assessment was a consequence of hospitalisation, follow up assessments should take place in their longer-term accommodation.

Each assessment, and the information it generates, would build on the electronic records of earlier assessments. This record would establish a case history of support and care as a basis for care coordination and, if required, case management.

*Carer assessments*

Assessment can play a critical role in leading to services which assist not only care recipients but also their carers. Several submissions discussed the importance of including carers at various stages in the assessment process. Carers Australia argued that:

> … broad consideration should be given to the introduction of carer assessments in the aged care sector as an innovative approach to supporting carers in the aged care system… carer assessments would take into account the needs and opinions of carers regarding the support they require and would provide a clear process, with standards across the sector. This simple introduction could easily provide a tangible reflection of a conceptual change in the sector. (sub. 247, p. 16)

COTA stated:

> There should be separate carer assessments undertaken at both the basic and complex stages of a person's support and care assessment. This carer assessment needs to occur as soon as possible after the person they support and care for is assessed. If the person is in hospital the carer must not be assessed until the person returns home.
>
> The carer assessment is the basis for a support and care plan for carer/s needs. The assessment identifies the carer's needs for training, support and respite.
>
> Carer entitlements can apply whether or not the person they support and care for is actually receiving services but would need services if the carer was not there. This is important as a carer may need support when the person they are caring for has refused services. (sub. 337, p. 28)

Alzheimer's Australia WA said that:

> … consideration of the needs and well-being of the caregiver are necessary components of a comprehensive dementia needs assessment. This approach is likely to facilitate and encourage more timely access by people living with dementia along their dementia journey to suitable services. (sub. 345, p. 10)

A consistent theme in submissions was that some form of comprehensive carer assessment can provide fuller information about both the care circumstances of older people and information on a broad range of their carer's needs.

Under the revised assessment arrangements proposed by the Commission, there would be several points at which carer assessments would take place:

- as part of initial and more comprehensive assessments for older people receiving care, with detail being collected on current carer/s, and the nature of support they provide
- via a separate more detailed process of negotiation of support for the carer. This would involve assessing and providing for carer's needs in relation to dedicated services such as income support, advocacy, education and training, counselling and emergency respite.

This would build on the foundation of several initiatives already underway, including the development of the revised Australian Community Care Needs Assessment and the Carer Eligibility and Needs Assessment.

Broader measures to support the role of carers, including the development of specialist carer support centres, are discussed in chapter 11.

## Care coordination

In relation to care coordination, the main functions to be performed by care planners were described in general terms in several submissions. For example, one participant emphasised the need for planners with local knowledge, stating.

> They would know what services were available. They would have all the data about local operators at their finger tips and national figures for comparison. They would be in a position to give expert local support and advice. They would provide the glue to coordinate hospital, disability services, nursing home and community. (Michael J Wynne, sub 368, p. 48)

Care coordination services should be provided at a number of points within the reformed system. Care coordination in the form of a preliminary care plan should be available to older people upon entry into the system through the access gateway. The more detailed assessment should include identifying whether further and more intensive case management services are needed.

In the case of individuals receiving care in the community, these services could be provided by independent agents along similar lines to those case management services currently provided under the Community Options Program (box 8.3). Many community options providers could be well placed to offer such extended case management services. Case management would also continue to be provided in residential care facilities as part of the suite of services on offer by the residential care provider.

Box 8.3 **The Community Options program**

The Community Options Program is a service funded under the Home and Community Care Program (HACC). It provides individually tailored services to support people with complex needs wishing to remain at home in their local community.

There are a range of services offered in the program. They can include case management (coordination and monitoring of support); domestic assistance (support with household tasks); personal care (support with showering/medication); social support (support with shopping and accessing the broader community); transport to medical appointments and recreational activities; and respite.

*Source*: Footprints in Brisbane Inc. 2010.

## A single national care gateway

A number of organisations provided thoughtful and detailed proposals for reforming information, assessment and care coordination services. One key element in several of the proposals was the need for a single gateway or portal of some form, so that older people did not have to navigate between a complex array of possible entry points into the aged care system. The Commission notes that there is a strong agreement as to the broad design of a new system.

One of the more comprehensive proposals was that offered by COTA Australia. In essence, it advocated a two-level system, the first being a multi-purpose gateway for promotion, information, screening and basic referrals, and a second specialist Care Assessment Service for more complex assessments (box 8.4). The Commission has drawn heavily on this model for its proposed reforms.

Blake Dawson proposed a similar consolidated approach, focused on the concept of what they called Senior Living Centres. They stated that:

> We submit that the service that conducts professional assessments of the care and accommodation needs of older Australians should form the base for a broader service that also provides (sub. 465, p. 40):

(a) case management services, for those individuals who qualify for fully or partly funded services and their families and carers on an on-going basis;

(b) information and advice for all older Australians and their families and carers who are considering senior living issues, options and services (irrespective of whether any qualify for fully or partially funded services);

(c) introduction and assistance with access to senior living social activities and networks;

(d) introduction and assistance with access to accommodation and care providers.

### Box 8.4 Information and Assessment – COTA's Gateway proposal

COTA Australia (COTA) argued the need for an aged care gateway, with a number of key services offered through this improved entry point.

**The Gateway**

The key initial functions performed by the Gateway would be to:

- undertake promotion of positive ageing and awareness of availability of support for older people
- provide people with information on relevant support and care services
- undertake basic screening and assessment to help direct people to the most appropriate services
- make direct referrals to basic support and care services and to more complex assessments for those with higher needs.

In COTA's view, the Gateway would be a valuable entry point for first time users of the aged care system, and be a point of continuing referral for individuals as they move into and out of the system across time.

**Care Assessment Service**

COTA also proposed the establishment of a Care Assessment Service, drawing on features of ACATs, that would provide:

- a national specialist service, separate from health and aged care providers, that uses a standard set of assessment tools and processes
- comprehensive assessment prior to receiving more complex levels of support and care

COTA argued that provision must be made for the assessment decisions made by the service to be appealed by users.

*Source*: COTA Australia (sub. 337, pp. 12-15).

A further key feature of Blake Dawson's proposed approach was a greater local devolution of these service locations.

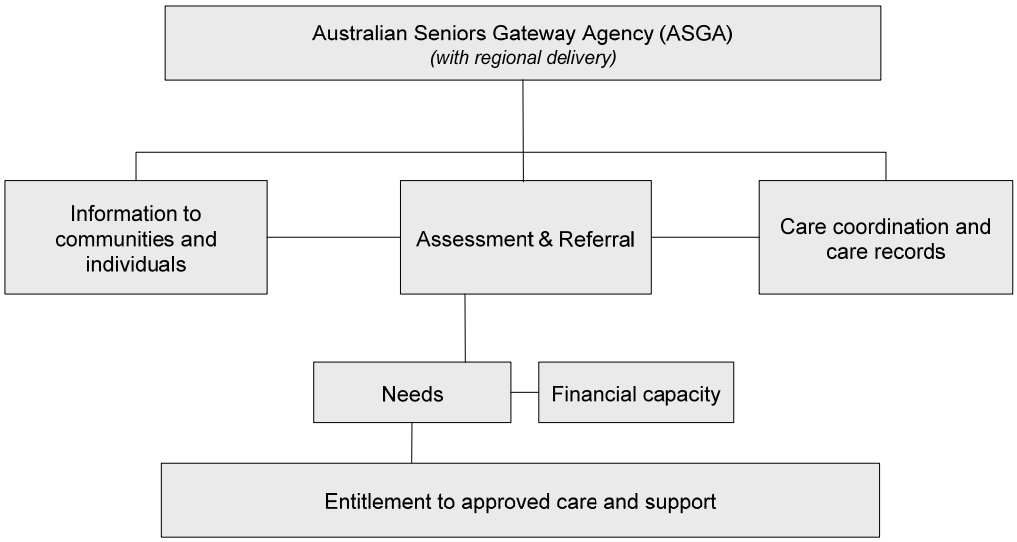
There have been several recent initiatives by the Australian Government and by the Council of Australian Governments that relate to the concept of a gateway. They include the Commonwealth's aged care 'one stop shops', the transfer of full responsibility for the Aged Care Assessment Program to the Commonwealth in 2012-13, and broader pursuit of consolidation of service delivery. While these initiatives go some way towards a more unified approach, in the Commission's view there are good grounds for going further and introducing a comprehensive, centralised gateway which provides information, assessment and care coordination services. The Commission's proposed gateway would be more streamlined and easier to navigate. It would be more efficient, by replacing a range of currently disparate elements in the system, including:

- assessments for low level home-based services (currently undertaken by individual providers, whether they be local councils, charities, community organisations or others who are funded under the HACC program)
- higher level assessments (currently performed by ACATs) — and the overheads in each state and territory which administer ACATs
- the Commonwealth's Respite and Carelink Centres – which would be disbanded (with some elements reconfigured into new specialist carer support services)
- a number of websites maintained by various government agencies.

An integrated gateway agency would require additional initial funding to further develop an electronic data base and other key infrastructure. However, there would be longer run savings because duplication could be reduced, as set out above. The agency would be separate from the DoHA, and would take over all related operational activity from this department. The Commission's proposal is shown in figure 8.1, and includes provision for the assessment process to arrange for assessments of financial capacity to make co-contributions (chapter 6).

Importantly the Australian Seniors Gateway Agency proposed in draft recommendation 8.1 would deliver its services through a regional network of Gateway Centres, each of which would provide information, assessment and care coordination. While in many cases these would be directly administered by the Agency, regional Gateway Centres could be operated on a contract basis by other government or non-government agencies, should the Australian Government determine that this would be the most efficient and effective way to operate them. These regional centres could become the basis for the one-stop shop outlets currently proposed by the Australian Government.

Figure 8.1 **Australian Seniors Gateway**




The Commission recognises that many older Australians and their carers will be able to directly access privately provided services and other government supported services such as those that enhance social engagement and inclusion, or primary and preventative health care, without the need to access the proposed Gateway. But for government subsidised aged care and support services, the Gateway will be the new streamlined access point.

Gateway assessors would determine the service entitlements of older people (and inform them and providers of the price the Government has set for the services). For those entering residential facilities, this entitlement would replace the initial ACFI assessment currently undertaken by providers. Providers would have the opportunity for subsequent assessment reviews in the event of a material change in a client's condition, and the results of subsequent assessments would be reviewed on a risk managed basis. The Gateway assessors will also arrange for an assessment of the consumer's capacity to pay.

For care costs valued at less than an average of $100 per week, the financial capacity would be determined based on the consumer's pension entitlement. Above that threshold a more thorough financial capacity assessment will be undertaken by Centrelink as detailed in chapter 6.

DRAFT RECOMMENDATION 8.1

***The Australian Government should establish an Australian Seniors Gateway Agency to provide information, 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 also 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, with the level of assessment resourcing varying according to anticipated need.***
- ***An aged care needs assessment instrument would be used to conduct assessments and an individual's entitlement to basic support, personal care and specialised care, and carer support. Assessments of financial capacity to make care co-contributions toward the cost of the services would also be arranged.***
- ***Initial care coordination services would be provided, where appropriate, as part of the Gateway. If required, case management would be provided in the community or in residential aged care facilities by an individual's provider of choice.***

***The Gateway would be established as a separate agency under the Financial Management and Accountability Act 1997.***

## Care records

Electronic records of an older person's needs assessment and service usage were considered by participants to be important for improving the quality of care of older Australians. For example, the Business Council of Australia said:

> … the adoption of unique health identifiers and electronic sharing of health information — the current e-health measures — are fundamental to making the provision of health and aged care services seamless while improving quality and patient safety. (sub. 274, p. 11)

The Australian Medical Association also said:

> The multidisciplinary nature of care that older people need — general practice, acute, emergency and sub-acute care — will be improved by the application of an electronic medical record. In particular, electronic discharge summaries and electronic medication management systems have the capacity to improve communication between health care professionals and across care settings, to improve continuity of care and reduce the potential for adverse events.(sub. 330, p. 11)

Other participants noted the scope for electronic records to remove inefficiencies. For example, Uniting Care Australia said:

> E-health monitoring and support and single health records would streamline processes and help reduce red tape and ultimately ensure a higher level of care through more accurate record keeping. (sub. 406, p. 13)

Some progress has already been made in developing and integrating electronic records in aged care. In this context the Commission notes recent announcements by DoHA of further progress in rolling out the electronic Aged Care Client Record (eACCR) (DoHA 2010b).

Further development and rollout of electronic records has been recommended by several recent reviews, most notably the National Health and Hospitals Reform Commission (NHHRC). In its final report, the NHHRC proposed:

- increased use of electronic clinical records in aged care homes, including capacity for electronic prescribing by attending medical practitioners, and providing a financial incentive for electronic transfer of clinical data between services and settings (general practitioners, hospital and aged care) subject to patient consent
- that hospital discharges include timely provision of good information on a person's hospital care to the clinical staff of their aged care provider, subject to patient consent. (2009, p. 23)

In the Commission's view, linked electronic records would avoid the need for older people to repeat the same basic information to multiple sources. The initial questionnaire would provide the base information for any further assessments. There would be protocols for who could update the information as care needs changed. The relevant information, subject to agreement from the client, would be attached to an e-health record and be made available to all approved and relevant health professionals and care providers.

## 8.2 Improving care continuity and enhancing consumer choice

Older Australians need a seamless range of services to assist them with ongoing care and support or rehabilitation if they become increasingly frail, lose the support of their partner or other carer, or suffer a significant health event. Services should be coordinated with their existing care services, with their primary health providers and with hospitals if they have had an episode of acute care.

Continuous care has for some time been a major goal of aged care planning and provision. The Organisation for Economic Co-operation and Development, for example, stresses the importance of continuous care in achieving better health outcomes and greater wellbeing for older people, particularly for those in the community (OECD 2005, p. 11).

Providing for genuine continuity of care is not easy. The change in an older person's care needs is not always progressive. While many people's care needs do increase gradually, others may have episodic changes in need, followed by periods of rehabilitation and then a reduction in care need. There is also an increasingly diverse spectrum of care needs apparent among older Australians. As Uniting Care Ageing NSW put it:

> … in addition to … variation (in the *level* of care required), there is also increasing variation in the *nature* of the care required, with a focus on wellness and prevention involving a move from care in its most conventional, narrow sense to a wider concept that includes a broad range of interventions that are neither therapeutic nor essentially assistive… There is also variation in the *duration* for which care is required, also due to differences in the duration of various kinds of intervention … Finally, and related to these, there is growing variation in the range of *settings* in which it is desirable to provide care. (sub. 369, p. 14)

Further, there are considerable differences in the types of care continuums required by older people depending on their health status (for example, older people who have suffered a stroke or who have dementia, as shown in table 8.1). A system that meets such diverse and changing needs requires flexibility, effective communication and an absence of gaps between care programs, personnel and contexts.

## Recent reforms of note

Recent b reforms to aged care have, in part, been predicated on the need to provide greater care continuity. For example, the National Health and Hospitals Network Agreement of 19 April 2010 announced considerable changes to arrangements for the funding and administration of aged care programs, including the transfer of funding responsibilities for HACC. It also stipulated that:

> The Commonwealth and states share responsibility for providing continuity of care across health services, aged care and disability services to ensure smooth client transitions. (COAG 2010b, p. 49)

Table 8.1 **Interventions on a continuum-of-care for stroke and dementia patients**

| | *Potential benefits in the case of:* | |
|---|---|---|
| *Type of intervention* | *Stroke* | *Dementia* |
| Prevention through risk management | Yes | No |
| Controlling severity of symptoms through drugs | Limited | Limited |
| Restoring functioning through drugs | Limited | No |
| Restoring functioning through physiotherapy | Yes | No |
| Occupational therapy to help patient to help themselves | Yes | No |
| Advice and help to enable patient to help themselves | Yes | Very limited |
| Advice and counselling to family carer | If necessary | Essential |
| Post-acute hospital care | Yes, where hospital treatment was required | Does not apply |
| Personal care service in own home | Yes, where symptoms severe but patient can remain at home | Yes when condition has become severe but patient can remain at home |
| Admission to long-term residential care | In severe cases where rehabilitation unlikely and home care not possible | Yes unless family carer can provide extensive palliative care |
| End-of-life care | In severe cases only | Yes |

*Source*: OECD (2005, p. 35).

Many submissions to the current inquiry commented favourably on the potential of these reforms to enhance the service continuum for older people. For example, the Aged Care Association of Australia (sub. 291, p. 30) stated that the reforms 'will now provide the Commonwealth with the opportunity to integrate HACC, community care and residential care into a seamless service offering'. KinCare (sub. 324, p. 3) stated that 'COAG decisions to shift the funding and administration of Health and Aged Care services to the Australian Government open new opportunities for integrating and streamlining services'.

## Control of care subsidy and choice of provider

Under current arrangements, public subsidies for aged care services are typically paid by the government directly to a limited number of service providers. In this supply constrained system, many people who are assessed as in need of care have to join a queue and take a funded care 'place' when it becomes available.

The care that is provided is generally a 'package' (other than for HACC), and the extent to which this fits an individual's care needs varies. This limited choice has led a number of analysts, as well as many participants to the inquiry, to call for reforms that provide subsidies to consumers rather than providers, as a means by which to promote a more consumer-directed approach to care.

### *Participant's views*

Participants expressed a range of views about the benefits and risks of moving to more consumer-directed care.

Among those supporting major reform, several argued that greater choice was likely to be expected by consumers of aged care in the future, and that the system would need to respond to this expectation. In this regard, Catholic Health Australia stated:

> There is a need to change the current highly regulated arrangements for the provision of aged care services in response to the higher expectations of current and future generations for choice, responsiveness and flexibility in the way they use aged care services, including choice over what services they receive, which accredited provider delivers the services and where they are received. (sub. 1, p. 10)

Personal control was also a key theme raised in support of more consumer direction. A number of participants expressed frustration at not being able to influence care decisions under current arrangements (box 8.5).

**Box 8.5 Participants express frustration at their lack of control and choice**

Ms Marjory Kobold:

> I was very surprised, after working in aged care for 20 years and knowing how it all works, at how little I could influence 'the system' to effect changes to improve my father's care. (sub. 450, p. 2)

Ms Dianne Beatty:

> I, and others, regularly fail in our efforts to provide sensible answers to my father's reasonable questions about the reasons for the plethora of rules, individuals and agencies with whom we have to deal. … they also are given little control or choice … and don't understand service rules and rigidities which prevent them from choosing their most desired support. (sub. 413, p. 3)

Comment sent to Aged Care Crisis:

> Eating is one of the few pleasures left to some elderly folk and where are the inspectors at the vital times. Why should the residents be fed at 4pm so staff can go home and not cost extra in wages? Ask anyone if they eat their dinner at 4pm. (sub. 433, p. 37)

A common point made was that a more consumer-directed approach to care would empower care recipients and informal care-givers. For example, the National Aged Care Alliance stated that there was a need for:

> … funding for care and support services linked to each recipient so that the recipient and their family can determine how and where they receive their care and support, including the option to control how their funding entitlement is used. (sub. 88, p. 6)

Many participants also argued that a consumer-directed approach would introduce more flexibility into the system and result in more appropriate care for the individual. In this context, Ms Pam Graudenz stated:

> As the population of older persons increase … the "one size fits all" is not going to be appropriate. There will be a need for more personalised and individual responses to the requirement for care. (sub. 70, p. 1)

The Home Nursing Group stated:

> In order to maintain their independence, older people require numerous different services in varying combinations at different times (e.g. home and garden maintenance, cleaning, meals, transport, medication checks/assistance, nursing care, etc.). This requires a flexible pool of funding available to buy different "baskets" of care for different people at different times. It also needs to recognise that "caring for the carer" will often be very important to ensure there is no deterioration in the health status for either partner. (sub. 6, p. 1)

However, there were a number of submissions that also highlighted the risks of moving to consumer-directed care (or CDC). Some argued that, on the basis of risks to frail and potentially vulnerable older people, a cautious approach was required, with an emphasis on a thorough assessment of a person's abilities to manage a care budget. In this regard, the National Foundation for Australian Women stated:

> There should be some capacity in appropriate conditions for direct control methods to be allowed, subject to assessment of the suitability of the individual or the carer to manage such budgets efficiently. (sub. 95, p. 34)

Other submissions raised concerns about price gouging and attempts to gain greater market share by providers. For example, Anna Howe stated:

> [Past findings suggest that] providers' interests in expanding greater choice of provider is driven in part by goals of increasing their share of service provision and funding, and that these interests may not always be the same as the interests of clients and their carers. (sub. 355, p. 3)

Other concerns raised included the scope for cost increases, the challenge of designing effective quality standards of care and whether entitlements for care would be appropriately spent.

Some participants focused on the limits of such an approach in regard to certain care levels or components of care. Several saw a greater opportunity to introduce choice for lower levels of basic support (such as community transport), but argued it would be inappropriate to provide greater choice at higher levels of personal and specialised care need due to the frail condition of people. Even for those higher levels, however, choice enables the older person to select a provider based on their cultural awareness, languages spoken, suitability of individual personal carers and timing of service delivery. Such choices enable older people to retain some control over their lives.

## Assessment of issues

The Commission considered a number of key issues around the possible benefits and risks of introducing greater consumer direction into aged care. As part of its consideration, it has paid particular regard to:

- international experience in providing greater consumer direction in aged care
- recent developments in enhancing choice in aged care and other sectors
- key design issues, including whether care entitlements would be provided in a CDC system via vouchers or cash
- possible supporting services to consumers in a CDC system (such as information, care advocacy and care planning)
- implications for the supply side, including the impacts on providers and on care infrastructure more generally of a move to CDC.

### *Overseas reform experience*

A number of OECD countries have sought to enhance choice in aged care by introducing consumer-directed initiatives (table 8.2). The experience in these countries has been previously discussed in PC (2008) and is also detailed in appendix C.

Table 8.2 **Personal budgets and consumer-directed employment of care assistants for eight OECD countries[a]**

| *Country* | *Personal budgets and consumer-directed employment of care assistants* | *Payments to the person needing care who can spend it as she/he likes, but has to acquire sufficient care* |
|---|---|---|
| Austria | | • Cash allowance for care |
| Germany | | • Cash allowance for care |
| Luxembourg | | • Cash allowance for care |
| Netherlands | • Personal budget for care and nursing | |
| Norway | • Care wage | |
| Sweden | • Carer's salary | • Attendance allowance |
| United Kingdom | • Direct payments | • Attendance allowance |
| United States | • Consumer-directed home care<br>• Cash & counselling | |

[a] Includes those countries that have experience with arrangements allowing users more choice and flexibility with regard to the way care is provided, and for which sufficient information was available.

*Source*: Lundsgaard (2005).

Some countries have offered older people personal budgets which, in some instances, allow them to directly employ personal carers. Other countries have provided older people with personal budgets which they can spend as they like, as long as they acquire sufficient care.

Evaluations of such schemes (see, for example, Carlson et al. 2007 for the United States; Witcher et al. 2000 for the United Kingdom; Miltenburg and Ramakers 1999 for the Netherlands) generally show that many participants report an increased likelihood of higher satisfaction with care arrangements and their lives more generally; and a decreased likelihood of unmet needs, care related health problems and adverse events.

However, despite the well documented advantages, participation rates in consumer-directed care are typically lower than the traditional agency-directed alternatives (Lundsgaard 2005). While these low participation rates may raise questions about the broader applicability of such schemes, as the Commission has previously argued (PC 2008, p. 117), it is important to understand that, at a broader level, even a relatively small number of active consumers switching between alternative services can induce providers to improve services and encourage broader innovation and quality improvement.

*Recent developments in enhancing choice*

Consumer-directed care has been used widely in Australia in other social service sectors, including disability and child care.

Enhanced choice through greater consumer involvement in the design and delivery of disability services has been a feature of services in this sector since the mid 1980s. The strengthened client focus in these services has sustained a range of consumer and/or family direct support programs over many years in a social policy area with many similarities to aged care. The disability services sectors in most states and territories now offer a variety of programs or trials designed to promote independence and choice (Laragy and Naughtin 2009).

Recent reforms of Australia's child care system have also enhanced consumer choice, and the sector now responds more freely to changes in demand instead of places being administratively allocated. Further, the range of eligible carers has widened to include grandparents, relatives, friends and nannies (FAO 2007).

Beyond these social policy areas, interest in improving consumer choice has been part of wider policy debates across other industries. In particular, from the mid-1990s, National Competition Policy reforms were partly directed at making Australia's infrastructure industries more responsive to changing consumer needs and preferences. For example, the removal of regulatory barriers and fixed pricing regimes in the electricity and telecommunications industries sharpened incentives that improved the quality of services and increased the uptake of new technologies (PC 2005c).

Greater consumer choice in aged care has also been proposed in the past, and there are some aspects of choice in the current system.

Previous reviews have supported the idea of linking subsidies in aged care directly to consumers. The Hogan residential aged care review (2004), for example, discussed vouchers and cash entitlements as a means to enhance consumer choice. The final report of the National Health and Hospitals Reform Commission also recommended that subsidies be more directly linked to people rather than places in aged care (NHHRC 2009, p. 22).

At present, there are more limited forms in which consumer choice applies in aged care. For example, the introduction of community care packages such as CACP, EACH and EACH-D allowed a limited number of older people to choose to be cared for at home rather than enter residential care. More recently, the Government announced the roll out of consumer-directed packaged care and consumer-directed respite care programs (box 8.6). These latter programs are focused on community care programs and have only limited applicability to residential care (focussed as

they are mainly on respite). In announcing the rollout of the packages, the Government stated that an evaluation will be undertaken to explore the potential for implementing the CDC model more broadly across Australian Government community care programs (DoHA 2010f).

Box 8.6 **The current consumer-directed care trial**

In May 2010, the Australian Government commenced an application process for the funding of a limited number of consumer-directed care packages and respite packages. Successful applicants for the packages were subsequently announced in mid 2010, with places initially allocated for a two year period (2010-11 and 2011-12).

A total of 500 (non-ongoing) consumer-directed care (CDC) places were provided under the Innovative Pool Program as part of the trial. These align roughly with the community aged care programs that the Australian Government funds (CACP, EACH and EACH-D). A further 200 consumer-directed respite (CDRC) places were also allocated in the first round with a focus on respite care provided under the National Respite for Carers Program (NRCP).

The model adopted for the CDC packages is an individual budget based on a needs assessment and administered on the care recipient's behalf by an approved provider for an agreed percentage of the allocated budget. An individual budget will: be allocated to the care recipient; be based on a care recipient's needs as assessed by the packaged care provider and agreed with the care recipient; follow the care recipient's assessment by an ACAT, which determines eligibility for a specific level of packaged care (eg, CACP); be held and administered by the packaged care provider for an amount agreed with the care recipient from the total budget; and be set for a one year period.

*Sources*: DoHA (2010f, 2010i).

### *Design considerations*

There are several main design options through which a consumer-directed approach might be introduced into aged care. These include:

- an assessed person having an aged care entitlement and choosing one or more services from a range of approved providers (perhaps with the assistance of an advocate or care coordinator funded by the Government)
- a voucher system where individuals choose an approved provider and negotiate a package of care given their care needs or
- a cash out option where people can take part or all of their assessed entitlement as cash and then purchase various services directly.

As international experience shows, the design features of any consumer-directed approach can be critical to uptake, quality of service, consumer protection and effectiveness.

*Cashing out an entitlement?*

Of the three broad approaches, the Commission has most concerns about a fully 'cashed out' system, where individuals receive a subsidy via cash or cheque and can determine to expend it in full in any way they see fit. Concerns include the possibility that individuals would underestimate the amount of their entitlement they would need to spend on care; and possible abuse of the funds by carers and relatives. A full cash out option in aged care would, in the Commission's view, be unlikely to be taken up by a majority of consumers initially. The vast majority of older Australians would more likely choose a package from an approved provider rather than cash out their entitlement.

However, under the revised arrangements, some small cashed out element for incidental expenses may warrant further consideration. The Commission will monitor progress of the Commonwealth's trials and assess feedback from participants.

Any expanded introduction of consumer-directed care would also need to have flexible arrangements in place so that consumers could choose to entrust their care to a single provider. This would ensure that older people who did not want to be directly involved in organising their services from several sources could take their entitlement to a single approved provider and receive a defined package of services.

Monitoring of quality of service would be a further vital consumer safeguard. The nature of this function is described in more detail in chapter 12.

*The role of support services (information, care advocacy and planning)*

The provision of relevant, current and accurate information will be critical in supporting greater consumer choice. Older people will require information on available services, alternative providers, quality outcomes and sources of further assistance. The reforms to information provision proposed by the Commission will assist in providing an accessible set of regionally-based information with which to inform choice.

Nevertheless, consumers may also require additional assistance to navigate the system and to plan their care needs. There are two different responses required. One is the provision of care coordination and/or case management services, as discussed

earlier, and the second is the provision of care advocates who represent the interests of the consumer.

In relation to care or consumer advocacy, much advocacy is undertaken by informal carers and family members. Nevertheless, there is a need for a more formal system of advocates independent of carers and family members.

The Aged Care Rights Service stated:

> An advocate is someone who stands beside a person and works solely on their behalf and at their direction. An advocate listens to their concerns, provides information and speaks on behalf of the person if that is what they want. Before taking any action, the advocate always seeks the person's permission. (sub 322, p. 1)

A number of submissions called for a system that built on existing publicly funded programs, such as the National Aged Care Advocacy Program, but with greater funding of these functions and wider availability.

The Commission acknowledges the importance of care advocacy functions in a system with greater choice, particularly in relation to vulnerable consumers. A balance would need to be struck in the proposed system between the need for adequate consumer support and the cost of any expanded publicly funded system of provision for advocacy. Nevertheless, this would appear to be a necessary precondition of any adequately regulated system involving greater consumer direction. Further detail on the proposed advocacy arrangements is provided in chapter 12.

## The Commission's model of care and support

The Commission has given consideration to a reformed model of care and support services which will provide greater continuity of care and empower older people to exercise greater choice. To achieve this, it is particularly necessary to move away from the current rigidly defined and discrete care packages (CACP, EACH and EACH-D). While the various main community and residential care programs are the result of considerable innovation historically, and have in many respects performed well in meeting the needs of clients, as discussed in chapter 5 problems remain in terms of service gaps and inconsistencies of funding levels and eligibility criteria.

A large number of submissions commented on the adverse effects these gaps have on care continuity and choice. For example, Blake Dawson stated:

> Our clients commonly raise concerns that the current distinction between low care CACPs and the high care EACH and EACH-D packages do not provide for a seamless

> transition from one kind of care services to the next for older Australians. (sub. 465, p. 28)

Hal Kendig called for reforms to remove service gaps, stating that a key priority:

> … is to develop a single, integrated care funding program after review of HACC services, Commonwealth packages and carer support, and the care component of current residential care programs. The aim would be to overcome the fragmentation, gaps, and inconsistencies of current programs that have evolved in an incremental, opportunistic way. A single, integrated care and carer support funding program would increase the capacity to deliver flexible, effective support in whatever ways are most appropriate for communities and individuals. (sub. 431, p. 6)

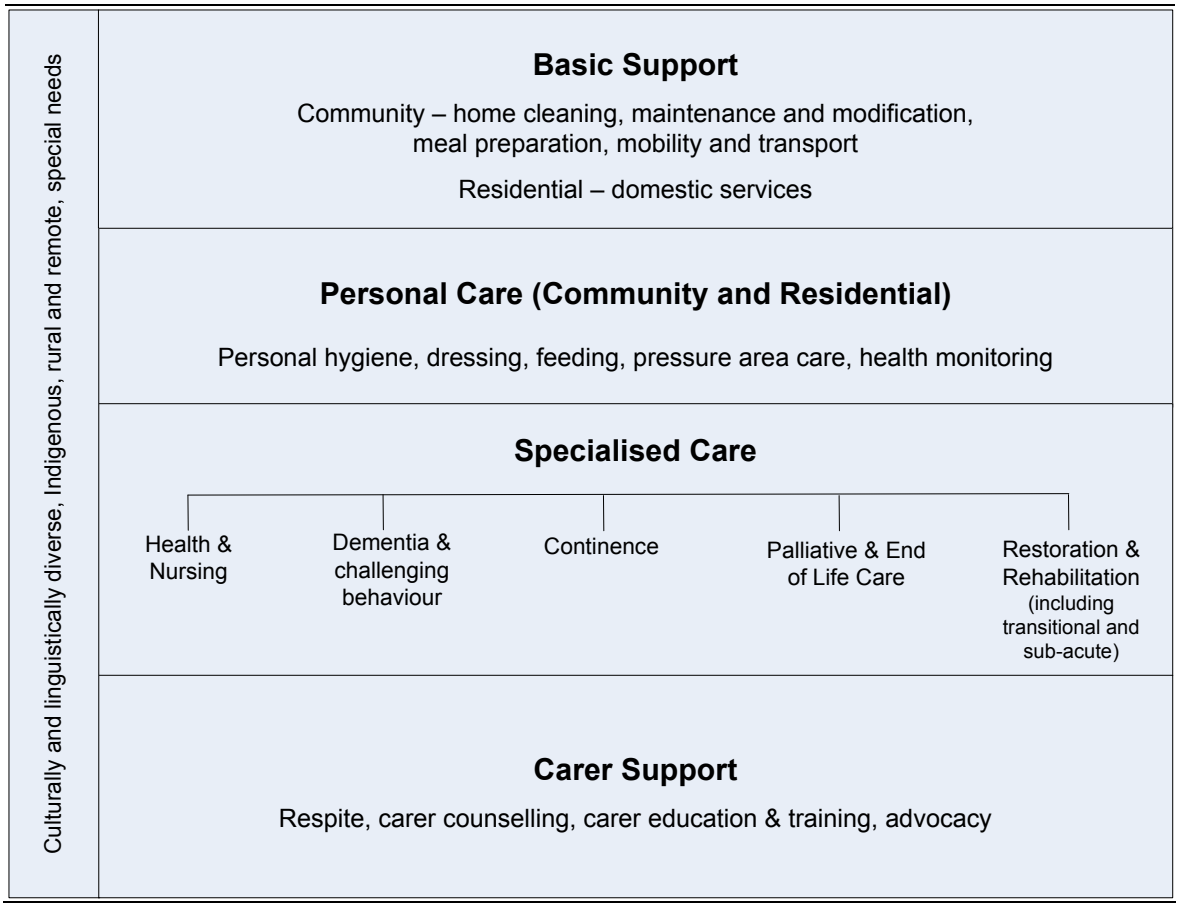
Many other submissions made similar observations about the need for a single, integrated and flexible system of care provision that applies equally in community and residential settings.

The reforms to assessment processes and to broader eligibility and funding arrangements outlined in this report will go some way towards improving consistency across programs. However, the Commission's view is that these should be accompanied by a broader move away from a focus on discrete care 'packages' to an emphasis on a more unified, seamless approach.

Given continued problems with a siloed approach to program design and resulting inconsistencies in eligibility criteria and care outcomes, it is proposed that the current system of packages be replaced with a single integrated system of care provision. This would deliver care services currently provided under HACC, Commonwealth funded care packages and the care component of residential care services. The main attributes of the Commission's new model of care and support are shown in figure 8.2. An important feature of the system is the translation of a needs assessment into a quantifiable group of care and support services that constitute a person's entitlement.

There are a range of possible options for this process, and these are outlined in a separate paper appended to this report at appendix B (Applied Aged Care Solutions 2010). The Commission is of the view that a building block approach to determining entitlement levels across community and residential care is required (figure 8.2). In the Commission's view, the gateway agency would draw on a range of services covering basic support, personal care, specialised care and carer support that best meet the assessed needs of the older person.

Figure 8.2 **Aged care and support: a building block approach**




There were a range of concerns expressed by inquiry participants about the effects of greater consumer choice on provider viability. While the Commission acknowledges these concerns, the introduction of greater choice will not threaten the viability of the majority of operators. However, unlike the present system, it is important for the supply side to be flexible to meet demand, and minimise queuing. In fact, greater choice will provide additional opportunities for efficient and innovative providers to attract more customers.

Approved providers would, in a reformed system, be selected by consumers to provide a service or range of services in accordance with their assessed entitlement. The price of those services ('the scheduled price') would be established by the Australian Government. As discussed, the consumer's co-contribution would be determined by the Gateway Agency. The consumer would pay their co-contribution to the provider and would sign across their subsidy to that provider.

There may also be provision for specific surcharges to be added to the scheduled price to reflect additional transaction costs of delivering care (eg. transportation in more remote areas).

It should be noted that consumers could also purchase additional services from such providers (or any others), over and above their government subsidised entitlement. The price of such additional services will be set by the market, with the consumer bearing the full cost of such services.

*To some degree, there will be scope for consumers' preferences to be taken into account by the gateway agency when assessing needs and determining service entitlements. And even when specifying approved services there would be scope for consumer choice - perhaps more so for basic support and respite, and less so for the more clinically based services. And as set out elsewhere in the report, consumers would have the freedom to choose their provider, making a judgement about the quality of service delivery being offered and the extent to which competing providers meet their preferences and expectations. The Commission seeks participant's further views on these issues.*

DRAFT RECOMMENDATION 8.2

***The Australian Government should replace the current system of discrete care packages with a single integrated, and flexible, system of care provision. This would deliver care services currently provided under Home and Community Care, Commonwealth funded care packages and the care component of residential aged care services.***

***The Australian Government should approve a range of care services to individuals on an entitlement basis, based on assessed need. Individuals should be given an option to choose an approved provider or providers.***

***The Australian Government would set the scheduled price of each service.***

***To support these revised arrangements, Australian governments should fund an expanded system of aged care consumer advocacy services.***

## 8.3 Associated reforms

There are several further reforms that, in the Commission's view, are essential to secure a more continuous care system. These include:

- delivery of care across different forms of accommodation
- improved provision of palliative and end-of-life care in congregate facilities and the community
- block funding of some community-oriented basic support services
- improvements to the interface between the aged care and the health and disability systems.

## Delivery of care across different forms of accommodation

Home and community care services play a major role in allowing older Australians to remain living in their own accommodation (ACG 2007, p. 14). Sandra Hills, CEO of Benetas, stated:

> If there is a lack of adequate care services available or people don't have their own social supports then the reality is that people often have no option but to move into residential care. (Aged Care INsite 2010, p. xx)

The provision of such care is a policy goal widely endorsed by the sector (NACA 2009, p. 4). Similarly, the sector is of the view that such care should be generally available to those in need of it, regardless of their type of housing:

> Where older Australians require support or care, they will: have access to services in their own communities and homes … [so that] Most people will receive care and support in their own homes, whether that is a 'family home' of long standing, or a retirement village, community or publicly owned housing, or a private dwelling chosen by people as their own later life housing option. (NACA 2009, p. 5)

However, some inquiry participants highlighted barriers which prevent care being delivered in certain types of accommodation: a situation which prevents some Australians wishing to age in their homes from doing so.

Lend Lease Primelife (sub. 76, p. 6) noted that the highly regulated supply of subsidised care packages means that retirement village residents do not get the same access to care services as those in residential care homes. Referring to this problem, Catholic Health Australia (sub. 1, p. 3) noted that reforms are needed to ensure '… access for all in need of care regardless of … where they live' and suggested the solution lay in:

> Aligning care fees and subsidies for people receiving care in their own home with those applying in residential care for people with similar care needs in order to allow fair and equitable choice. (sub. 1, p. 3)

ECH, Eldercare and Resthaven (sub. 100, p. 4) also argued for the need to align care fees and funding across residential and community care such that they are not linked to accommodation, and that the funding be portable across residential and community care to enable two-way movement between the client's preferred housing location.

National Disability Services (sub. 102, p. 7) drew attention to policy barriers to appropriate support that can distort older Australian's choice of accommodation. It referred to research (NDS 2009) that identified a range of barriers, such as community aged care packages not being available to group home residents and the variable access to services for people living in different accommodation types.

Barriers such as these limit the ability of some older Australians requiring care from continuing to live in their current housing. This situation is inequitable and, to the extent that it forces them to move into residential aged care (or hospitals) where care delivery costs are higher, it is also inefficient.

Where possible, access to care services should be neutral with regard to the type of accommodation in order to not distort the accommodation choice of older Australians and the efficient delivery of care.

The Commission proposes an orderly phasing out of supply restrictions over a period of five years (chapters 6 and 14). The primary aim of this reform is for older Australian's who have assessed entitlements to care services to be able to choose between competing approved providers.

A second benefit of the reform is that it would allow care services to be delivered widely in all types of accommodation, subject to appropriate co-contributions. Where care delivery would be significantly more costly because of the attributes of the accommodation and its location, it would be reasonable to limit its provision.

*As proposed in chapter 6, the Australian Government should remove quantity restrictions on care services. This would allow services to be delivered widely in the accommodation of choice of the clients.*

## Improved provision of palliative and end of life care

Ageing in the home, when combined with the demographic trends set out in chapter 3, has implications for the types of care and support services that will be needed in the future. In particular, there are likely to be pronounced increases in demand for a number of main care streams, including higher level congregate care for some services, broader care and support services such as respite care and, most importantly, community care.

With entry to residential care being increasingly confined to people at a higher level of frailty (with the major exception of dementia), there will be increased need for palliative and end-of-life care services to be delivered in both the residential and home environment.

Some participants claimed that the end-of-life care needs of older Australians are not being well met under the current arrangements for community and residential aged care (box 8.7). While it is often the preference of older people to die in their own homes, it was argued that there are limited options when it comes to receiving specialist care. Palliative Care NSW, for example, said:

> According to the literature, patients and families commonly express the wish to have their palliative care at home and wherever possible to die at home. The lack of available, appropriate and timely services often means patients and carers cannot achieve this goal. (sub. 445, p. 1)

Too often, older Australians are transferred to acute care hospitals for pain management and to die, due to insufficient expertise being available in the residential or home environment. Palliative Care Australia said:

> An expansion of aged care services for older people with chronic conditions will need to be complemented by an expansion of the capacity and competence of primary health care services to provide generalist palliative care for people living in the community and in aged care homes, supported by increased collaboration and networking with expanded specialist palliative care services. (sub. 77, p. 4)

**Box 8.7 Participants raise concerns about palliative care**

Palliative Care Australia:

> Access to, and the quality of, palliative care is diverse and inconsistent in residential aged care. Some aged care facilities enjoy ready access to primary care physicians well skilled in palliative care and to specialist palliative care physicians. Some facilities, particularly high care facilities, have systems in place to limit hospitalisations by providing care in-place. (sub. 77, p. 8)

Ms Jan Coat:

> Speaking from personal experience, (as a relative of a person who was in an ACF due to the need for palliative care) I acknowledge the dedication of carers. However, I am very concerned about the skill and available time for staff to provide this extremely complex and important end-of-life care. The fact that I was able to advocate on my relative's behalf was good for him however I am really concerned about all the other residents who don't have someone with the skills and knowledge to do this for them. (sub. 54, pp. 1-2)

Australian General Practice Network:

> … despite a plethora of effective programs there remains limitations in the knowledge of aged care staff about working within a palliative approach, associated with a somewhat adhoc approach to who receives education in this approach. There also remains limitations in the confidence and competence of some GPs to provide palliative care, which may be frustrated by limited access to advice and support from a palliative care specialist. These limitations can negatively impact the quality of care and end-of-life experience of patients. (sub. 295, p. 9)

In the Commission's view, there is a strong case for a greater role for residential and community care providers to deliver palliative care. Not only is this less expensive than services delivered in a hospital, but more appropriate care can be provided. Palliative Care Australia states that the current ACFI subsidy for palliative care is around one third of the amount that specialist palliative care services receive (sub. 77, p. 12).

Participants suggested expanding the ACFI to cover palliative care. Warrigal Care said:

> Expand the ACFI to include a hospital bed funding level to allow acute aged care residents to transfer to aged care facilities with their health service needs being met at the aged care home and a phased and diminishing level to return to the person's ACFI rate. (sub. 279, p. 2)

Residential and community providers should, in the Commission's view, receive appropriate case mix payments for delivering these services, which would reduce the strain on public hospitals.

DRAFT RECOMMENDATION 8.3

***The Australian Government should ensure that, through the Independent Hospital Pricing Authority, residential and community care providers receive appropriate case mix payments for delivering palliative and end-of-life care.***

## Block funding of some community oriented basic support services

There are several small programs that are essential to supporting people who wish to remain in their own homes that may warrant a continuation of block funding arrangements, at least for the short-term. Possible examples include community transport programs and meal delivery which are largely provided by community groups, draw on the services of volunteers and are part of each local area's social capital. Block funding (or direct allocation funding) would, in such cases, give providers some certainty in their planning and operations.

Block or direct allocation funding may also be appropriate in other circumstances, such as for pilots of innovative services or in rural and remote areas where markets might not support the provision of any service under self-directed funding (and where block funding might be cheaper than direct government provision). Such could be the case for multi purpose services and Indigenous specific services, and in other situations where a consumer-directed care model may not necessarily be the most effective means of ensuring consumer access.

The emergence of new programs that promote wellness, social inclusion and engagement may also warrant direct funding at least in part. Services that are provided on a group basis such as community activities or group fitness programs are more likely to fall into this category. They are also likely to be accessed directly by older people without the need to go through the Gateway or be in the nature of a referral from the Gateway rather than a specific entitlement.

Retention of block funding for certain programs would need to be firmly based on a consideration of issues such as the scale economies delivered by such programs, and the extent to which they service more generic needs across a large number of individuals. Conversely, in the case of programs where limited scale economies are apparent, and very individualised forms of delivery are required, a continuation of block funding may be more difficult to justify.

DRAFT RECOMMENDATION 8.4

***The Australian, state and territory governments should only continue to directly block fund programs where there is a demonstrated need to do so based on a detailed consideration of scale economies, generic service need and community involvement.***

## Improvements to the interface between aged care and health

A large number of participants highlighted problems with the interface between the aged care and health care systems. This was seen as a key factor in preventing older Australians from receiving appropriate and seamless care. For example, in its submission, COTA noted:

> ... the interfaces between aged support and care and the health system often work poorly and sometimes to the severe detriment of older people (sub. 337, p. 41).

Many submissions argued that the lack of coordination between health and aged care leads to inappropriate or avoidable admissions and care. For example, Blake Dawson (sub. 465, p. 23) stated that poor coordination leads to inefficiency because of overlapping and duplicated services and gaps in service provision, resulting in older Australians not receiving services they need.

United Care Ageing (NSW) stated:

> … the administrative and bureaucratic structures within which these services are provided differ, and the degree to which they are coordinated is very uneven. The result is that interventions that could be efficiently carried out in an aged care setting — for instance, for rehabilitation — are often carried out at what seems to be far higher cost in the health system (sub. 369, p. 17).

HammondCare also noted:

> The inefficiency and cost of moving residents between residential aged care and the providers of sub-acute services is significant (sub. 168, p. 2).

In the case of medication management, the Aged Care Association of Australia notes:

> … the inefficient systems used to administer medications result in aged care staff, GPs and pharmacists spending considerable time and effort on prescription writing, (including chasing new prescriptions when the current ones expire), owing prescriptions and double handling of excessive paperwork. Clearly this is an area for potential and significant productivity improvement for all three stakeholder groups. (sub. 291, p. 25)

There is considerable scope to increase the efficiency of these interacting systems through the use of information technology, such as the e-Health initiative (including e-prescriptions and e-transactions), that allows information to be shared and accessed in an efficient but safe way. The introduction of aged care electronic records was advocated earlier in this chapter.

Participants argued that it has been increasingly difficult to find general practitioners who are willing to visit residential centres and make home visits to community care recipients. ACAA stated:

> It is generally recognised that securing sufficient GPs to visit aged care residents is problematic in many parts of the country.
>
> There are a variety of problems ranging from small client numbers, poor remuneration, lack of consultation facilities, lack of GP confidence in treating the very old and lack of coordination of consultation times. (sub. 291, p. 23)

These issues are discussed in further detail in chapter 14.

### *Recent and further possible reforms*

The National Health and Hospitals Reform Commission (NHHRC 2009) proposed, and COAG (2010b) agreed to, reforms to the hospital system that will have the effect of increasing the demand for aged care resources. These reforms aim to reduce the extent to which hospitals provide care to older people that could be provided more appropriately in individuals' homes and residential aged care centres. Elements of the reform agenda include:

- facilitating greater access to primary health care providers and geriatricians for residents of aged care homes (NHHRC 2009, p. 23, recommendation 52)
- strengthening access to specialist palliative care services for all relevant patients across a range of settings, with a special emphasis on people living in residential aged care (NHHRC 2009, p. 23, recommendation 55).

The benefits of improved coordination between the sectors are likely to be significant. For example, HammondCare stated that an acute hospital bed in NSW costed $1223 per day compared with a HammondCare sub-acute hospital bed

between $650 and $900 and an aged care bed around $160 — a substantial difference as illustrated in table 8.3.

Table 8.3 **Acute care and aged care access and cost**

| | *Hospitals and primary care* | *Aged care* |
|---|---|---|
| Access to entry | Relatively easy | Relatively difficult |
| Cost to government | Higher cost (uncapped) | Lower cost (capped) |
| Cost to private health insurers | Private health insurance coverage | No private health insurance |
| Services offered | Accident and emergency | Residential care |
| | Acute care | Community care |
| | Sub acute care | |
| | Other primary health care | |

*Source*: HammondCare (sub. 168, p. 3).

In addition to direct cost savings to the health budget, other benefits include:

- improved wellbeing of residents not having to move frequently between residential and acute care (and benefits to partners and others)
- an increased capacity for residential facilities to deliver higher level services, with attendant benefits to staff from higher skill sets and a wider scope of practice
- synergies for other residents from the proximate delivery of sub acute services
- an additional revenue stream to residential providers, diversifying their risks.

The use of electronic medical records and improved discharge statements from hospitals could improve the coordination of care between the two sectors.

Improved coordination will go some way to increase the scope for sub acute services to be provided in residential settings. The proposals outlined in this report, which increase the flexibility of the aged care sector, reduce the burdens of regulation, encourage innovation, and establish a sustainable funding regime, will also assist to build momentum in this direction.

A further reform that would, in the Commission's view, have merit in this context is the expanded use of multi-disciplinary teams (so-called in-reach teams) that are able to call on residential facilities. Several submissions discussed positive outcomes from the use of these teams, which are generally run out of state and territory administered hospital emergency departments. For example, VincentCare stated:

> … we have found a particular pilot program which has now received ongoing funding, to be of benefit. "In-Reach" covering inner Melbourne and "Out-Reach" covering outer metropolitan region is a program which provides a specialised medical advice service

> which has assisted facilities by minimising the transfer of residents into hospital … The In-Reach/Out-Reach model has eradicated previous issues such as residents being discharged without a phone call to the facility, being returned without transfer information and requiring the facility to spend considerable time chasing up relevant information on behalf of the resident. (sub. 258, p. 21)

General Practice Victoria stated that:

> The (In-Reach) service … has been very positively received by nursing homes, GPs and hospitals. (sub. 235, p. 5)

The use of such teams has been trialled in limited form in Victoria (box 8.8) and internationally has also been used in Canada and the United Kingdom (see, for example, Szczepura et al. 2008).

The Commission believes there are significant benefits in the expansion of in-reach services and the development of regionally based multi-disciplinary aged care health teams. Such teams would better utilise the professional health workforce, create a more responsive health service and develop professional expertise in the area of care for older people. They could provide not only services to older people in residential care facilities, but also to those living in the community. Expansion of these approaches should be actively undertaken by all governments where evaluations prove that the net benefits are as significant as initial indications appear.

### Box 8.8 Clinical in-reach pilots in Victoria

The residential aged care clinical in-reach pilots were developed as part of the Victorian Department of Human Service's Winter Demand Strategy 2008. The aim of the in-reach pilots was to reduce the need for transfer of aged care residents to an emergency department if safe and appropriate care could be provided in their own home.

Each health service was given the flexibility to develop a program that accommodated existing strengths and capabilities and built on an existing service to utilise resources already available in the health service. Wide ranging, positive feedback from health services led to the extension of the pilots to run all year round and nine metropolitan and three regional health services were running the pilots in mid 2009.

An external evaluation of the pilots was completed in mid 2009. The evaluation found that the in-reach pilots met their main objective of assisting to avoid unnecessary travel of older patients to a hospital facility, were well regarded, accessible and met referrer (Residential Aged Care Services, General Practitioners and Ambulance Victoria) and hospital requirements.

*Source*: Department of Human Services (Victoria) 2009.

DRAFT RECOMMENDATION 8.5

***The Australian, state and territory governments should, subject to further evaluation, promote the expanded use of in-reach services to residential aged care facilities and the development of regionally or locally-based visiting multidisciplinary health care teams.***

## Interfaces with the disability sector

Concurrent with this inquiry, the Commission is undertaking an inquiry into disability care and support. That inquiry is scheduled to release its draft report at the end of February 2011 and its final report in July 2011.

The Commission received several submissions advocating an integrated system covering both disability and aged care. For example, Pam Webster wrote:

> Should Australia have an 'aged care system' as currently conceived, or could a broader conception of care and disability policy be more appropriate, with the needs of the aged being one part of this continuum?
>
> I believe the two Inquiries need to work together and look carefully at the benefits of developing an integrated system that will meet the needs of all Australians no matter when, at what age or how they develop the need for care and support (sub. 178, p. 1).

While both the aged care and disability sectors provide support for people with disability, there are significant variations in the philosophies and goals of those in each sector, the services that people with a disability use and their aspirations. There can also be a significant difference in expectations of those needing to use the services of each sector. Further, while the probability of acquiring a disability is low, this is not the case for aged care. Many people who live long enough can expect to require some level of assistance.

The Commission is particularly aware that many more people with disabilities are living longer, whilst many younger people are acquiring disabilities previously associated with ageing.

*Irrespective of the funding source or assessment arrangements, all people with a disability and all older people needing care and support should receive services appropriate to their needs, on a fair and equitable basis.*

People with disabilities should receive services from providers best skilled to meet their needs howsoever funded. So, for example, a person with a severe long term disability such as multiple sclerosis may be best served by specialist disability service providers to the end of life. On the other hand, people who acquire early

onset disabilities normally associated with ageing such as severe dementia might be best served by providers skilled in the support of older Australians.

There are several options for addressing the funding issues, including:

- Until a person reached the pension age, the disability sector could fund all of their disability needs. On reaching the pension age, the services for the person with a disability could be funded from the aged care sector. (An exception would be where the services were covered by an accident insurance arrangement.)
- On reaching the pension age, the disability scheme and aged care would share the costs of support. There would be several ways of doing this, but one model would be that the disability sector would fund the typical pre-pension age costs of disability and the aged care sector would fund any additional costs.

*The Commission will outline its preliminary preferred option in the disability care and support inquiry draft report, expected to be released at the end of February 2011.*

## 8.4 The issue of quality

Throughout this inquiry participants expressed views about the variable quality of care provided within the aged care sector. Indeed, the community is often rightfully concerned when they read and see media reports of poor quality services and even abusive circumstances. And it seems everyone has a personal story. Despite the myriad of regulations concerning quality standards and the much improved accreditation processes examined in chapter 12, there remains considerable variation in the quality of care delivered. Often quality is not related to the physical infrastructure, but to the attitude of staff and senior managers.

This variation in quality may have a number of causes including the current system which actively props up poorer quality operators who in a more liberated market might otherwise fail. Further, the ethos of the provider and the senior management's approach to quality of care are key determinants.

It is also the case that, to some extent, quality 'is in the eye of the beholder', especially relatives who have very differing expectations. Quality issues also arise through a lack of proper understanding and acknowledgement by staff and providers of the culturally diverse needs of consumers.

The Commission believes that the reforms proposed in this report will assist to promote high quality care, including:

- greater consumer choice and a more liberated market of service providers which should encourage high levels of quality care to be seen as a competitive advantage
- improved funding and consequential improved workforce conditions
- improved regulation and regulatory oversight, together with upgraded complaint handling processes
- greater recognition by providers, staff and trainers of the needs of culturally diverse groups and those with special needs
- increased access to consumer advocates.

# 9 Catering for diversity — caring for special needs groups

**Key Points**

- The Australian population is diverse and this is reflected in the needs and preferences of older people who require aged care services.
- A number of special needs groups are defined in the *Aged Care Act 1997* and associated principles for the planning and allocation of aged care places.
- An expected outcome of the accreditation standards is that providers of aged care services meet the needs and preferences of care recipients with special needs.
  - Not all special needs groups require extra services or higher levels of funding but require services to be respectful of, and responsive to, those needs including those arising from diverse ethnic and religious cultures and of gay and lesbian consumers.
  - Participants raised concerns about some mainstream aged care services discriminating against individuals with special needs because the higher costs associated with delivering appropriate care to them are inadequately funded.
- The aged care system should cater for diversity in all client groups by ensuring access to services for all older Australians that are delivered in a culturally appropriate manner, to the extent feasible.
- Staff need the skills to deliver appropriate care to individuals with special needs. Additional training for aged care workers caring for special needs groups is likely to result in better outcomes for care recipients.
- Language and consultation services could be extended so that older Australians from non-English speaking backgrounds can make more informed decisions about their aged care and can more effectively communicate so that their care needs are better understood and matched to their preferences.
- Providers of Indigenous services and services in rural and remote areas should be actively supported to ensure sustainable, responsive and culturally secure services.

This chapter evaluates how well aged care services are being modified and delivered in ways that meet the needs and preferences of clients with special and/or additional needs. It also looks at how special needs might be better met in a

reformed aged care system. Section 9.1 provides an overview of the diversity in the demand for aged care services, and sets out some principles for responding to this diversity. Other sections in this chapter explore issues relating to specific groups, including culturally and linguistically diverse communities (section 9.2), Indigenous people (section 9.3), veterans (section 9.4), the socially disadvantaged (section 9.5), the financially disadvantaged (section 9.6) and those living in rural and remote areas (section 9.7).

Some older Australians may have even more complex aged care requirements as a result of multiple special needs, such as a financially disadvantaged older person from a non-English speaking background, living in rural Australia.

## 9.1 Diversity in demand for aged care services

Aged care services are delivered in a variety of locations to a diverse population of older Australians from very different social and cultural backgrounds. The needs and preferences of some older Australians can be very different to those of mainstream care recipients. Some aged care services specifically cater for the needs of certain groups — for example, services designed to assist older Australians from specific cultural or linguistic groups. Over the next 40 years, there is likely to be an increasing number of older Australians with special needs (see chapter 3 for a discussion of these trends).

The *Aged Care Act 1997* (the Act) and its associated principles define a number of 'special needs' groups that are taken into account in the planning, allocation and transfer of aged care services (box 9.1). More generally, the aged care accreditation standards require providers to deliver services which take into account and meet the special needs of clients. Item 3.8 in the accreditation standards covers 'spiritual and cultural life', and has the expected outcome that 'Individual interests, customs, beliefs and cultural and ethnical backgrounds are valued and fostered' (appendix E). The capacity of a provider to cater for special needs is also considered in the determination of grant applications.

There are other groups with needs that differ in certain ways but who are not specifically identified in legislation. They include:

- y people with a disability who cannot live independently in the community
- ageing people with a physical and/or mental disability
- older gay, lesbian, bisexual, transgender and intersex people
- older refugees.

## Box 9.1 Special needs groups recognised in the aged care system

The Act recognises that some people have special needs that should be taken into account in the allocation and provision of aged care services. Specifically, the Act specifies the following special needs groups:

- people from Aboriginal and Torres Strait Islander communities
- people from non-English speaking backgrounds (NESB)
- people who live in rural and remote areas
- people who are financially and socially disadvantaged[1]
- people of any kind (if any) who are specified in the Allocation Principles.

Under the Act, the current and future capacity of providers to service the needs of special needs clients is taken into account in the allocation and transfer process (of places) and in the determination of grant recipients (either for capital, advocacy, community visitors and/or unforseen circumstances).

The *Allocation Principles 1997* identify the following groups of people as having special needs:

- veterans — people who have seen active service in the Australian Armed Forces and their widows
- homeless — people who are homeless or at risk of becoming homeless
- care leavers — people 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.[2]

*Sources*: *Aged Care Act 1997* and Allocation Principles 1997.

Aged care providers should satisfy the needs and preferences of their clients, but some older Australians may not be able to access services that can meet their special needs. This may be due to: a lack of awareness of special needs by providers; there being very few clients in an area having particular needs so providers have little incentive to cater for particular groups; and/or the higher costs that can be involved in meeting special needs.

Some participants raised concerns about the adequacy of the funding for special needs and that regulations can restrict the ability of providers to respond to the demands from some groups.

1 This includes homeless people and care leavers as identified in the *Allocation Principles 1997.*

2 This definition is used by the Care Leavers Australia Network (CLAN) which is a support and lobby group for care leavers (www.clan.org.au).

The benefits arising from 'special needs' status and capacity and commitment of aged care providers to effectively meet the needs of special needs groups were questioned (see, for example, Jo Harrison, sub. 190; Repatriation Committee, sub. 366). A number of participants argued that service providers should be required to report on how they meet the needs and preferences of clients with special needs, as such requirements are not clearly outlined in the current accreditation standards (see, for example, National Health, Aged & Community Care Forum, sub. 241). A review of the accreditation standards is currently being undertaken and some submissions argued for greater clarity of requirements in the standards.

Services that cater for particular needs can be highly sought after by clients in these target groups, and they are often willing to travel significant distances to access those services. However, it is often not practical or efficient to have specialist providers in every geographical area. As such, it is important that mainstream aged care providers have the capacity to provide appropriate aged care services to the increasingly diverse population of older Australians. However, a number of submissions to this inquiry suggested that many current mainstream aged care services may not be sensitive to, nor adequately cater for, the needs of clients with special needs (see, for example, The Aged-Care Rights Service, sub. 322; Alzheimer's Australia, sub. 79; Matrix Guild (Victoria) and Coalition of Activist Lesbians, sub. 397).

Under the reforms proposed in this report, there should be greater equity of access to aged care services for special needs groups because approved providers will be less constrained in the number and types of services they can offer. There will also be greater competition between providers, which should drive improved service delivery, including for those with special needs. However, there is a risk that a more market responsive system will not deliver services to particular groups who require more costly services unless these are adequately funded.

Regulations covering service provision can be used to ensure access to appropriate services for groups that might not otherwise be served. However, where these services are more expensive to provide, but no additional funding is provided, the result can be cross-subsidisation of these services. This distorts providers' incentives and is inequitable, especially where clients are required to meet a larger share of their own costs of care. Alternative funding and/or service delivery arrangements, such as targeted supplements, and more market based approaches, such as competitive tendering, could be more efficient approaches.

In principle, the delivery of aged care for special needs groups should:

- ensure access to services — reducing discrimination for those groups that age earlier than others, such as Indigenous Australians and the homeless, or those

who may be challenging for service providers, such as those with a behavioural condition

- support specialised models of care — ensuring providers have the flexibility to meet the preferences of some groups that require different aged care services because of cultural, religious or other values
- encourage service providers to tailor services to meet particular sets of needs and to create culturally responsive services such as through training packages to provide workers with specialised skills and understanding, and to ensure that policies and practices reflect such needs
- acknowledge the higher costs of service delivery or difficulties accessing capital for some services catering for large proportions of clients with special needs.

## 9.2 People from culturally and linguistically diverse backgrounds

The cultural and linguistic diversity of many older Australians is an important consideration in the delivery of appropriate aged care services. Compared to other older Australians, this diversity may be reflected in:

- attitudes to the elderly, expectations of family care giving, roles of women and support groups, and beliefs about health and disability
- beliefs, practices, religions, behaviours and preferences which can affect the propensity to use formal care services, including preferences for different types of food
- English language proficiency, which can affect access to information and services, communication of needs and participation in the wider community.

In the context of accessing and delivering appropriate aged care services, two significant broad groups of culturally and linguistically diverse people, are people from non-English speaking backgrounds (NESBs) and gay, lesbian, bi-sexual, transgender and intersex (GLBTI) people. The special needs status of older Australians from NESBs is set out in the Act and has long been a consideration in aged care policy and service development.

However, the needs of GLBTI people have only more recently been actively canvassed. The Commission has received representations in submissions that GLBTI people are a culturally diverse group with specific needs. Their issues are also discussed in this section.

## Older people from non-English speaking backgrounds

As discussed in chapter 3, Australia's population of older people from NESBs is expected to increase by over 40 per cent between 2011 and 2026 in line with the overall increase in the older population. By 2026, it is projected that one in four Australians aged 80 and over will be from a NESB (Gibson et al. 2001).[3]

While people whose main language at home is European will still be the largest group, those who speak Middle Eastern and Asian languages are expected to become increasingly important (Gibson et al. 2001).

The use of aged care services by older Australians from NESBs is different than for many other older Australians. They are relatively underrepresented in residential settings but overrepresented in formal community care services where they are supported by family and cultural groups (AIHW 2007a). However, there may be some variation in usage patterns across locations depending of the level of community support and the engagement of individuals with these services.

Some NESB communities in certain locations are well served by dedicated aged care providers (generally not-for-profit organisations arising from the respective community) that tailor services to particular groups, such as the Italian, Greek, Spanish, Dutch and Jewish communities. The standard of care provided by these organisations is generally high and, not surprisingly, these services are usually in great demand.

That said, most older Australians from NESBs access aged care services through the mainstream system. As part of the accreditation standards, mainstream providers are expected to deliver culturally appropriate aged care services to clients. However, some participants to this inquiry said that parts of the mainstream aged care system have difficulty delivering care that meets the needs and preferences of NESB clients. The main issues raised include:

- accessing easily understood information about aged care services in languages other than English to be able make informed choices
- being able to communicate needs and preferences to aged care staff and health professionals
- supporting culturally relevant social activities.

[3] Gibson et al. (2001) consider that cultural and linguistic diversity includes people who are proficient in English but come from a non-English speaking background. In this report, these people are considered as part of the NESB group.

More generally, participants want service provision, irrespective of the provider, that is both respectful of and responsive to differing cultural beliefs and practices, to the extent feasible.

### *Accessing information about aged care services*

Older Australians from NESBs may not be proficient in English and may require assistance navigating and understanding the aged care system. And some may revert back to their first language as a result of the ageing process. This reversion can pose several challenges to governments and providers in delivering appropriate aged care services. As described by the Multicultural Access Projects (Metro North Region):

> Language and communication issues are the most frequently raised barriers for people from CALD backgrounds to access community support structures and services. The provision of language support services, such as face-to-face and telephone interpreting services is vital for effective service provision. (sub. 379, p. 5)

The Department of Health and Ageing (DoHA) provides some language support for older Australians from NESBs and their carers. Information about the aged care system and aged care programs is translated in a limited number of languages and is available online and through information outlets (Respite and Carelink Centres, DoHA funded information services). There is also a telephone translation service and DoHA funds two programs specifically designed to assist in the delivery of culturally appropriate care to NESB groups — Partners in Culturally Appropriate Care (PICAC) and the Community Partners Program (CPP) (box 9.2) (DoHA 2009d).

The CPP helps older people from NESBs to access and discuss information about aged care services in certain languages other than English. However, the program is targeted towards the dominant language groups in each geographical area. As a result, it does not provide assistance in all languages and may not be available in all locations.

Some state and territory governments also invest heavily in language services for Australians from NESBs, but these services are not aged care specific and may not be suited to explaining the intricacies of the aged care system.

## Box 9.2 **Assisting providers to meet the needs of NESB clients**

The Australian Government administers two programs to assist the delivery of culturally appropriate care to older people from NESBs:

- Community Partners Program (CPP)
- Partners in Culturally Appropriate Care Program (PICAC).

Both programs were developed to assist older people from NESBs access care services, and improve the capacity of aged care services to respond to the differing needs of older people from culturally and linguistically diverse communities.

The CPP promotes and facilitates increased access by NESB communities to aged care service providers and support services. A number of state-wide projects link NESB communities with aged care providers to improve use of aged care places by older people from these communities.

PICAC coordinators work to improve the partnership between aged care providers, NESB communities and the DoHA. PICAC program outputs may include:

- identifying specific barriers to accessing care services for older Australians from NESB communities
- providing culturally appropriate training to care staff, including the dissemination of information and resources about best practice
- providing support for the development of new services, including ethno-specific and multicultural aged care services
- providing information to policy makers about important NESB issues.

*Source*: DoHA (2009d).

While these services provide older Australians and their carers with information, they may not assist them to understand the complexities of the aged care system (which can confuse even English speaking older people and their carers) nor shape consumers expectations about the range and nature of standards of care. As Independent Living Centre's Multicultural Aged Care Service (WA) said:

> Many older people from CALD communities are unfamiliar with the aged care system, with some cultural norms dictating that care is provided by family within the home and with little outside support. As such, there is a need for improved dissemination of information about aged care options to older people from different CALD communities, in a language and context that is appropriate to them. (sub. 139, p. 4)

Older Australians from NESBs may also be less aware of information about preventative and early intervention measures. Multicultural Access Projects, for example, said:

> … older people from CALD backgrounds are at greater risk for health consequences resulting from physical inactivity due to higher rates of sedentary behaviour (National

Ageing Research Institute, 2008). This may be a result of both a lack of knowledge and a lack of opportunities to participate in programs specifically designed for older people.

'I did not know that I can still exercise even though I have difficulties to move around, and that exercise can help me improve my condition' Comment from a Spanish lady in an information event, 31 March 2010. (sub. 379, p. 8)

The Commission's proposed Australian Seniors Gateway (draft recommendation 8.1), which is aimed at reducing the complexity of the aged care system, should assist older Australians from NESBs better understand the system and to access information about health and wellbeing and preventative measures. The proposed Australian Seniors Gateway will also be drawing on the regional presence of other agencies to deliver locally relevant information about aged care.

But, even with better access to information, older people from NESBs can find it difficult to communicate their care needs and preferences. As Fronditha Care said:

Even before entering care or receiving care in the community, elders of CALD background are immediately disadvantaged in their attempts to access services, specifically where the model of service provided does not accommodate for a different language or culture at an enquiry point, initial contact point or initial entry point. The results often is that needs are not accurately assessed or responded to, with people too often falling through the gaps. (sub. 436, p.5)

Appropriate assessment of need is critical to receiving the appropriate care which points to the importance of having access to interpreter services. But, as noted by Multicultural Access Projects, particularly for assessment and service planning, the engagement of the older person's family in the process can be an important communication strategy for understanding their needs and preferences (sub. 379).

Aged and Community Services Australia also pointed out that interpreter services can add significantly to service costs:

… as at May 2007, the Telephone Interpreter Service (TIS costings via personal communication) provides on-site translator/interpreter services during business hours at a rate of $141 for the first 90 minute block plus an additional $46 for each subsequent 30 minute block. These rates increase to $225 and $74 respectively outside of business hours. These are substantial costs considering the (highest) day rate per person in residential aged care was funded at around $175/day in 2007 (Government contribution plus client contribution) and make the provision of such services 'cost prohibitive.' Some ACSA members have estimated the cost of providing the listed components at between three and five per cent of total budget, with community care estimated to bear the largest expense. (sub. 181, pp. 38-39)

Other Australian Government agencies with a significant consumer focus, such as Centrelink and Medicare, provide a wide range of information and advice services in languages other than English. For example, Centrelink provides language and

interpreting services in 226 languages through external contractors and provides onsite interpreters in areas where demand for certain languages is high. Centrelink also employs multilingual staff who are paid a Community Language Allowance if they use these language skills in the course of their employment (Centrelink 2010).

To improve access, the proposed Australian Seniors Gateway could provide information about aged care services through the Department of Human Services (Centrelink, Medicare, Family Assistance Office). This would provide economies of scale in delivering comprehensive information in languages other than English. An integrated service could also reduce complexity for consumers, especially given that Centrelink is recommend to undertake financial assessments for aged care services (chapter 6).

### *Communicating needs and preferences*

Older Australians from NESBs and their carers also report that many mainstream providers have difficulty providing care staff that can communicate effectively with the care recipient. Poor communication can negatively affect the health and wellbeing of the older person receiving care (Multicultural Access Projects, sub. 379; Baptcare, sub. 212). Multicultural Access Projects suggested a partnership approach with culturally specific and multicultural services would secure better outcomes for care recipients:

> There are many culturally sensitive and competent practices which specialist services can implement to improve service delivery including identifying and involving other cultural specific and multicultural services early in the service delivery process. These partner organisations can then share their cultural and language knowledge and expertise as well as their connections with local community groups. Such a partnership approach will result in better outcomes for the target group as well as building capacity in the partner services. (sub. 379, p. 7)

Some submissions highlighted the difficulties that some NESB seniors have in accessing timely aged care services, particularly in the community. For example, North West Region CACP/ EACH/D /ACAS Forum (Melbourne) said:

> … currently the availability of culturally appropriate aged care services is much less than the demand. For example, in the Northern region, there are only 16 Chinese specific CACP packages, but there is a waiting list for 22 eligible clients. The waiting time is estimated to be over 2 years. A similar situation exists for Italian clients in the Northern and Western regions as the number of clients on the CACP and EACH waiting list doubles the number of packages allocated on an ongoing basis. (sub. 133, p. 6)

The Commission's proposal to relax supply constraints over time (chapter 6) is likely to facilitate the establishment of culturally appropriate aged care providers in

specific areas (subject to them becoming approved providers) and enable existing providers of specialist services to expand.

A further challenge is in attracting and retaining bilingual and multilingual staff who can communicate effectively with clients and satisfy any reporting and other regulatory requirements. In order to attract staff with relevant language skills or promote the development of bilingual skills within staff, providers could consider a language allowance (along the lines of that provided by Centrelink) if these skills are used in the course of employment.

### *Supporting culturally relevant social activities*

A number of submissions commented on the importance of providing culturally appropriate care to older Australians from NESBs. Multicultural Access Projects, for example, said:

> Older people from CALD backgrounds have reported to service providers that they are more likely to use a service that specifically targets their communities, and has workers and/or volunteers who speak their languages and understand their cultural needs. This is particularly important for older people who do not speak English well, although cultural awareness and understanding is extremely important for older people from CALD backgrounds who also speak English well. (sub. 379, p. 4)

Social activities and associated transport are considered particularly important in keeping older Australians from NESBs connected with their community. As the Migrant Information Centre (Eastern Melbourne) explains:

> It is our experience, and also indicated in the HACC service usage data, that CALD seniors utilise social support and planned activity groups offered through the HACC program at a higher level than their Australian counterparts. In particular there is a preference for ethno-specific or multicultural services of this type. (sub. 154, p. 1)

Targeted social activities by specific cultural providers, which promote social inclusion, are one of the strengths of the current aged care system. Such activities will be required to meet the growing demand for aged care services by the rapidly growing older population. These service providers could also offer culturally appropriate activities for older people from these backgrounds who reside in some of the mainstream care facilities which have little capacity to provide such services.

Access to transport, whether it be public or community-based transport can be important for promoting social inclusion. The Migrant Information Centre (Eastern Melbourne) considers that:

> Transport services should be more available and more flexible to travel across boundaries. With smaller CALD communities it is often necessary to travel further

distance to a preferred ethno-specific group which is not available in the local area. (sub. 154, p. 1)

## Gays, lesbians, bi-sexual, transgender and intersex (GLBTI) people

Cultural diversity is not only reflected in language, background, religious beliefs, values or social class. It can also be reflected in sexual preferences and gender identity. As such, GLBTI people have distinct cultural and support networks which have shaped their attitudes towards care giving.

Although there are no comprehensive projections of the number and distribution of older GLBTI people, a large increase in the demand for aged care services is anticipated by this group consistent with the ageing of the overall population (Harrison and Irlam 2010; GRAI and Curtin Health Innovation Research Institute 2010).

The recognition of sexual preference and gender identity within a cultural context has been relatively recent and this has important implications for the provision of aged care services for the current cohort. Many older GLBTI people have experienced considerable discrimination over the course of their lives and this may continue in aged care where their sexuality and/or gender identity are not recognised in the delivery of culturally appropriate services. As outlined by the GLBTI Retirement Association Incorporated:

> The literature of GLBT ageing discusses the impact of historical experiences of discrimination against GLBTI people. GLBTI people who are currently accessing aged care services have lived in an era where there was a real threat of losing their job, family and friends, and risking imprisonment and 'medical cures' if they disclosed their sexual identity (Barrett 2008) …
>
> McNair and Harrison (2002) found that major concerns for older GLBTI people were not about their health per se, but rather about institutionalised discrimination pertaining to sexual and gender identity. Concerns were also raised about how homophobic attitudes of institutionalised aged care facilities would impact on the quality of care delivered and the fear that this could result in elder abuse. (sub. 57, pp. 4-5)

Consistent with the objectives of the Act, and care delivered to other diverse groups and the mainstream population, the provision of aged care services should be respectful and sensitive to the needs and preferences of older people, irrespective of whether they identify as GLBTI people or otherwise. However, the Commission received several submissions claiming that some GLBTI seniors face difficulty in having their cultural diversity recognised and that many face discrimination in service delivery. For example, Jo Harrison said:

> There is a growing body of evidence regarding the extent to which GLBTI elders are experiencing discrimination, or fear of discrimination, within an industry which remains unaware and uneducated as to their special needs and unique concerns. (sub. 190, p. 4)

The GLBTI Retirement Association indicated:

> To date, clients' sexual orientation or gender identity remains largely invisible to service providers: an invisibility that impacts negatively on these clients' wellbeing, and is extremely relevant to the standard of care made available to this cohort. (sub. 57, p. 2)

Submissions also indicated that GLBTI seniors would like greater recognition of their sexuality and gender identity, and more culturally appropriate services in the aged care system through: a safe and inclusive environment; recognition and inclusion of partners in consultation and decision making; and ambience and sensitivity in decor and staff.

The Australian Government has recognised that some parts of the mainstream aged care system could be more culturally sensitive towards GLBTIs. DoHA has recently developed a pilot training initiative to increase awareness among aged care workers in NSW about GLBTI issues and about delivering appropriate care to GLBTI seniors (Plibersek 2010). This initiative will be delivered in partnership with ACON (Australia's largest community-based GLBT and HIV/AIDS organisation) and Aged and Community Services NSW and ACT. It is envisaged that the:

> … program will be evaluated; with a view to a more broad application of this training should it be successful. (ACON 2010, p. 1)

Initiatives that increase the awareness of GLBTI issues within the aged care industry, such as training for aged care workers, are important in creating a culturally appropriate environment for the delivery of aged care services. There should be further initiatives between DoHA and peak bodies to help create an aged care system that can better cater for and respond to the needs and preferences of GLBTI older people. Service providers have a special obligation to ensure both policies and practices acknowledge these needs and respond appropriately.

## 9.3 Aboriginal and Torres Strait Islander people

Indigenous people who identify as Aboriginal or as Torres Strait Islanders have a number of social and cultural attributes which need to be taken into account in delivering aged care services. The challenges in providing services to this group are compounded by their heterogeneous nature — there are around 200 different skin groups or language groups across Australia (Wayne Herdy, sub. 18). In addition,

there are marked differences in attitudes, cultural identification and needs, between Indigenous people living in many urban centres and those living in rural and remote locations. Like other special needs groups, a 'one size fits all' approach is not appropriate.

It is well established that older Indigenous people age earlier and have a lower life expectancy than the population overall (SCRGSP 2010a). The 2006 Census of Population of Housing reported that around 8.2 per cent of the Indigenous population are aged 55 and over and around 3.3 per cent are aged 65 and over compared to 24.3 and 13.2 per cent respectively for the total Australian population (ABS 2007b). The Australian Government acknowledges the lower life expectancy in the planning and allocation process by also including Indigenous people aged 50-69 (compared to the general population where planning is based on those aged 70 and over, chapter 2). In the Commission's proposed aged care system, where access to care is determined by eligibility, Indigenous Australians younger than 65 who have ageing related disabilities would remain entitled to assessment and services under the aged care umbrella.

Many Indigenous Australians have different attitudes towards the elderly and the roles of family care giving compared to non-Indigenous Australians. Culturally important issues in the delivery of aged care services to Indigenous people include:

- not wanting to leave their community to receive care services
- the communal nature of many Indigenous cultures which can act as a disincentive for individuals to participate in the formal delivery of aged care services as workers
- Indigenous people generally preferring intimate personal contact to be delivered by people of the same skin group and gender. This may increase care costs, especially where there is a relatively small service size.

Many aged care services for older Indigenous Australians are delivered through the mainstream aged care system and there are specific initiatives within mainstream programs to increase both the awareness of and access to culturally appropriate services. For example, the HACC Program has a special advisory body, the National Aboriginal and Torres Strait Islander HACC forum, which provides leadership and input on policy and planning to the national HACC program on Indigenous matters. Specific information for Indigenous carers is available through Commonwealth Respite and Carelink Centres. The National Respite for Carers Program has providers that tailor services to the needs of Indigenous clients.

Such an Aboriginal and Torres Strait Islander forum should be maintained to provide advice on the reformed care and support system recommended in this report.

In addition, the Australian Government provides flexible and culturally appropriate aged care services to Indigenous Australians through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (which is not funded under or required to comply with the Aged Care Act). Unlike mainstream programs, this program allows providers to deliver a mix of residential and community care services depending on the needs of the clients. While these programs meet the preferences of older Indigenous people by allowing them to stay in their community and connect with younger generations, consultations indicated that they can be difficult to establish.

There are currently around 200 aged care services directly funded by the Commonwealth that target Indigenous people and/or are in remote areas. Around 70 of these have a residential care component and 30 come under the Flexible Aged Care Program (ACSA, sub. 181).

Aged and Community Services Australia claims that these services have been 'vulnerable' because 'they are small and located in remote areas where staff are hard to attract and retain' (ACSA, sub. 181, p. 37).

The Consumers' Health Forum of Australia also noted that:

> Rural consumers stressed that programs for older indigenous people must involve known and trusted community members in their development and involve local indigenous workers in their implementation. (sub. 287, p. 4)

Research has highlighted the importance of appropriate and extensive consultation in the implementation of successful Indigenous aged care programs (Bin-Sallik and Ranzijn 2001).

Issues surrounding access to, and the provision of, culturally appropriate aged care services to Indigenous Australians include:

- attracting and retaining Indigenous workers to provide culturally appropriate services
- use of culturally appropriate assessment tools
- support to develop service capacity appropriate to meet their specific needs.

These elements are critical to the establishment of culturally secure services where Aboriginal and Torres Strait Islander people know that they and their culture are

respected and where they feel safe. This is irrespective of whether the service is mainstream or delivered by a specialist provider.

### *Attracting and retaining Indigenous workers*

The use of local Indigenous workers is important in providing culturally appropriate care to older Indigenous people as they can have a better understanding of the needs and preferences of older community members. Further, as noted by General Practice South (Tasmania), Indigenous workers who are also part of the local community can have wider responsibilities:

> Aboriginal aged care workers are different from non-Aboriginal because they are part of the community and therefore they're looking after their aunties and uncles, not just 'clients' that they can forget about when they knock off at the end of the day. (sub. 278, p. 26)

However, there are several important issues relating to recruiting and training Indigenous workers. The South Australian Government considered that:

> There is a need for significant investment in training to develop capacity of community workers to provide high quality service, and to support unpaid carers. (sub. 336, p. 16)

Aged care service providers also said that it can be difficult to attract and retain Indigenous aged care workers (Latrobe Community Health Service, sub. 220; Frontier Services, sub. 323). In addition, as highlighted by the Queensland Aged and Disability Association, there are restrictions on who can provide care:

> … Aboriginal and Torres Strait Islander communities are limited to who can provide care to the elders, as they require family members who they consider trustworthy to enter into the consumer's home, because of a concern for their safety and a sense of vulnerability. Due to local Aboriginal Lore it is often difficult for staff members from the community to provide care for certain members of the consumer group. An example of this is that a daughter in law is not to speak to her father-in-law; therefore due to communication issues she cannot provide appropriate care. (sub. 207, p. 10)

To develop capacity within Indigenous communities to provide aged care services, the Aboriginal and Torres Strait Islander Ageing Committee of the Australian Association of Gerontology argued that:

> A systematic and regular, adequately funded training program, appropriate for the needs of Aboriginal and Torres Strait Islander workers' learning styles, is urgently needed. Networking; on-the-job training; targeted training, specifically designed consistent with local/appropriate cultural elements; apprenticeship; and work experience have all worked well. Basic caring skills can be documented, observed and accredited: this offers a good pathway into the formal education system and flexibility for career progression. (sub. 83, attach. 1, p. 3)

Significant issues exist in respect of training remotely located staff. For many Indigenous people located in remote locations, travelling to distant training locations for extended periods is not acceptable. There is need to deliver training locally, including with the enhanced use of technology. The lack of housing in communities for staff and trainers is a recognised problem. This creates a barrier to meeting workforce needs within Indigenous communities.

Frontier Services also argued that the introduction of criminal history checks for aged care workers has affected the capacity of providers to employ Indigenous people in service delivery due to relatively high levels of interaction with the criminal justice system:

> Whilst Frontier Services recognises and supports the reasons behind such checks, we also appreciate that many potential employees are excluded from employment in areas of high demand because there is no right of appeal when excluded from employment for an offence that does not impact on a person's ability to provide competent levels of care for local, older people … Very often the offences of Aboriginal people are related to domestic issues and would not impact on their ability to provide care to older members of their communities.
>
> In many of the communities in which we work, the majority of residents are precluded from working in aged care because of criminal history issues. (sub. 323, p. 13)

In order to address current and prospective workforce shortages and offer more Indigenous people opportunities to work in aged care, consideration should be given to allowing approved and established service providers some flexibility in employing Indigenous people who they deem to be appropriate.

### *Use of culturally appropriate assessment tools*

Some tools used in aged care assessments, and to diagnose ageing related diseases in the mainstream population, do not work as well for Indigenous people because they are not culturally and linguistically appropriate. The development and use of culturally appropriate assessment tools increases the potential to accurately identify morbidities in target populations and ensure that the proper care is delivered.

For example, the Kimberly Indigenous Cognitive Assessment (KICA) tool has been developed and validated as an appropriate cognitive screening tool for older Indigenous Australians living in rural and remote areas. This tool has identified that the prevalence of dementia among Indigenous Australians is substantially higher than among non-Indigenous Australians (Australian Association of Gerontology, attach. 1, sub. 83).

Funding has been provided by DoHA to validate KICA in the Northern Territory and a variation of this tool is proposed to be developed for use in urban areas (Alzheimer's Australia 2007). Sufficient resources should be devoted to developing culturally appropriate assessment tools to reduce the incidence of misdiagnosis.

### *Support to develop service capacity*

During the consultation process, a number of providers indicated that Indigenous, rural and remote service providers would benefit from an ongoing support program which actively assisted them to develop and operate their services as efficiently as possible.

The Commission notes that the Australian Government allocated $42.6 million for the Remote and Indigenous Support Services initiative in the 2007-08 Budget. This initiative was intended to actively support these services by:

- improving the physical infrastructure of Aboriginal and remote aged care services
- more effectively developing and supporting care, management and organisational capacity, including day-to-day management, financial, governance and locum services
- developing a more sophisticated and shared understanding of service delivery models and quality frameworks in Aboriginal and remote aged care (ACSA, sub. 327).

However, Aged and Community Services Australia notes:

> … the implementation of the program has been delayed by 3 years. In addition the proactive supportive and capacity-building emphasis of the program has been watered down. Early this year the Department released a tender to establish a panel of people/organizations who could provide support services on an ad hoc basis. (sub. 327, p. 37)

The Commission considers that providers delivering services in rural and remote locations and to all Indigenous people should be actively supported before remedial intervention is required. Such support requires flexible, long-term funding models that are aimed at ensuring sustainability of service delivery and the building of capacity to enable local people to be engaged in the management and staffing of such services over time.

## 9.4 Veterans

Veterans are classified as a special needs group under the Act. In terms of the provision of appropriate aged care services, the Repatriation Commission noted:

> Veterans have specific social and cultural issues, which include:
>
> - personal hardships as a result of war service that can affect veterans and their dependants physically and psychologically
> - critical shared experiences outside those of the general community
> - identifying themselves as a distinct cultural group with distinct needs (e.g. commemoration of fallen comrades, observance of special days such as ANZAC day and Remembrance day, provision by government of healthcare and compensation for war caused illnesses/injuries). (sub. 366, p. 3)

There is some confusion as to what is meant by 'veteran' in the context of aged care services. The Act defines a veteran as '…a veteran of the Australian or allied defence force; or a spouse or widow/er of a person mentioned above'. However, the Department of Veterans Affairs (DVA) has a much narrower definition of veteran as someone who holds a DVA health entitlement card and/or a DVA pension card, or is a war widow/widower or dependent holding such cards (National Health, Aged and Community Care Forum, sub. 241).

Eligible veterans receive subsidised and high quality health and community aged care services through the entitlement scheme funded and administered by DVA (box 9.3). All veterans access residential aged care services through the mainstream system and are also entitled to access mainstream community aged care services.

Although eligible veterans and war widows/widowers represent around 16 per cent of aged care residents, only a small proportion of residential care facilities have a majority of DVA clients as residents. As such, DVA eligible veterans are widely dispersed among the majority of residential aged care facilities (Repatriation Commission, sub. 366).

In terms of ensuring that aged care providers are aware of the needs of veterans, DVA conducts:

> … a well-subscribed national series of seminars for residential aged care, community care and hospital providers, on what constitutes the special needs of veterans and war widows(ers), and how these might be addressed with the assistance of established Repatriation benefits and services. (Repatriation Commission, sub. 366, p. 3)

### Box 9.3 **Specific service programs available to eligible veterans**

There are a number of community care programs designed to meet the care and support needs of eligible veterans. These programs are not available to non-eligible veterans.

- *Veterans Home Care* — assists eligible veterans and war widows/widowers with low level care needs to remain in their homes for longer. It provides a wide range of home care services designed to maintain their optimal health, wellbeing and independence. Services include domestic assistance, personal care, safety-related home and garden maintenance and respite care.
- *Community Nursing Program* — provides services in a person's home to restore health following illness, allow a person to maintain the best level of independence, and/or allow for a dignified death.
- *Rehabilitation Appliances Program* — provides appliances for self-help and rehabilitation purposes, and surgical aids for home requirements. The aim of the program is to restore or maintain independence and to minimise disability or dysfunction. The types of appliances available under this program include: mobility aids, such as handrails in bathrooms and near steps, and medical aids, such as continence products.
- *HomeFront* — assists in the provision of minor home modifications and appliances to reduce the risk of falls and similar hazards.

*Source*: Repatriation Commission (sub. 366).

A number of issues concerning aged care services for DVA veterans were raised in submissions. Many of the issues overlap and are related to DVA's 'arms length' involvement in residential care that it provides funding for but does not administer or regulate. These issues include:

- the transition from community to residential aged care
- accreditation processes — including standard setting and evaluation
- DVA's role and accountability in relation to mainstream aged care services.

Eligible veterans receive different levels of care and support depending on their needs. Veterans access the majority of community care services through DVA, but can access mainstream services or a combination of both. Residential care is delivered through mainstream programs. As DVA veterans are treated differently in terms of their health and home support needs through community care, it is often confronting when they make the transition to residential care, where they are treated the same as other residents. As explained by the National Health, Aged and Community Care Forum:

> For veterans and war widows/ers who have had their health and community care needs met by DVA while living in their own home, often for many decades, this changes significantly on moving to residential aged care. This division of responsibility between DVA and DoHA is complex and difficult to understand for elderly veteran members and their families. Some members of the veteran community report that their experience of this transition of care can be disjointed and confusing, thereby adding greater complexity for elderly members of the veteran community in the transition process. (sub. 241, p. 4)

Similar experiences have been reported in cases where a DVA veteran decides to take a mainstream community care package (CACP, EACH or EACH-D) and they are no longer eligible for some services offered by DVA. For example, the North West Region — CACP / EACH/D / ACAS Forum (Melbourne) noted:

> Veterans' community clients are disadvantaged in regards to accessing normally eligible services via DVA if they are receiving care under an EACH or EACH-D package. (sub. 133, p. 7)

The Repatriation Commission acknowledges that the transition arrangements between DVA and mainstream services are less than ideal and can be disjointed and confusing for clients (sub. 366). DVA has responded to issues surrounding aids, appliances and allied health care by introducing flexibility and discretion in allowing high care residents to continue to use the equipment or service until it is no longer needed.

Other concerns arise from the perceived loss of 'special needs' status compared to the volume and quality of services previously received in the community and/or a lack of understanding about DVA's role in the aged care system.

Many DVA veterans and their families are also concerned about the role that DVA has in making mainstream aged care services accountable. However, the aged care accreditation standards, determined by DoHA, do not explicitly outline how the needs and preferences of veterans (and other special needs groups) should be taken into account when delivering appropriate aged care services. DVA is not responsible for mainstream aged care service provision and the investigation of complaints relating to the provision of aged care services is undertaken by DoHA through the Office of Aged Care Quality and Compliance.

Given the widespread reforms recommended by the Commission it is appropriate to consider whether the DVA assessment processes should be merged into the new Gateway regime. There appears to be no obstacles to the special needs of veterans being accounted for in the new assessment process. This is irrespective of whether specialist services funded by DVA continue for veterans.

*The Commission seeks participants views on these issues.*

## 9.5 Socially disadvantaged

There are number of older Australians who are socially disadvantaged or who have been at some point in their lives. In the context of aged care, social disadvantage may result in access difficulties or even exclusion from services. Such marginalisation can have an adverse impact on the wellbeing of these people.

A number of submissions report varying experiences in the ability of socially disadvantaged older people to access care and support. Anecdotal evidence indicates that there appears to be excess demand for services specialising in socially disadvantaged care recipients as many mainstream providers are reluctant to take on socially disadvantaged older people who may be difficult to control or have care needs which are not adequately funded.

While the Act defines people who are socially disadvantaged as a special needs group, there is no clear definition of their characteristics and needs. Adrienne McAllister, a member of an ACAT team in Queensland, has attempted to overcome this lack of clarity by elucidating what she considers to be the characteristics of the socially disadvantaged:

> … [T]hose who have an inability to relate effectively and appropriately with others, who lack an informal support network, who have a tendency for self isolation and who display challenging behaviours. They are described as having a long-standing history of social estrangement including estrangement from family and friends and they have limited social and informal supports. Social estrangement relates to the person's social and interpersonal skills where they can be belligerent, uncompromising, unrelenting, contentious and unappreciative. Challenging behaviours can include intrusiveness, verbal and physical hostility. The characteristics defined here limit a person's ability to access, or maintain access to, services. (2004, p. 100)

There are a number of types of social disadvantage which can be relevant to the provision of aged care services. Homeless people and care leavers are specifically identified in the Allocation Principles 1997. Submissions also indicate that there is an emerging cohort of ageing people with a disability who may be homeless (or at risk of becoming homeless) and/or care leavers. Carers Victoria indicated that there may also be an emerging issue with ageing refugees (sub. 292, attach. 1).

Many socially disadvantaged people age faster than the mainstream population and, as such, may require aged care services at an earlier age. In addition, socially disadvantaged older Australians are more likely not to have an informal carer available to provide assistance, which increases the demands on formal care services.

In terms of social inclusion, the Australian Government's vision is to build:

> … a nation in which all Australians have the opportunity and support they need to participate fully in the nation's economic and community life, develop their own potential and be treated with dignity and respect. (2009b, p. 2)

Initiatives targeting social inclusion as part of the provision of aged care services are especially important in ensuing that the socially disadvantaged are able to contribute to society, where possible, and feel relevant and valued for their contribution.

According to the Alliance of Forgotten Australians (sub. 486), many care leavers will require additional social support services (such as counselling and supported independent living arrangements) above that delivered by the mainstream aged care system. Having recently recognised care leavers as a special needs group (see box 9.1), the Australian Government is in the early stages of improving aged care services for this group (DoHA 2010l). It is developing a National Education Package to present service providers with the information and tools to deliver quality aged care services in a way that is appropriate and responsive to their needs. It is envisaged that this package will consist of a general information awareness campaign and a targeted care management package for assessors, care managers and care workers (Healthcare Management Advisors 2010).

Some providers have specialised facilities targeted at the homeless, usually partly funded through a grant from the respective state government. These providers indicate that funding under the Aged Care Funding Instrument (ACFI) does not fully reflect the costs of service provision to them. In the case of the homeless, Winteringham asserted:

> The primary difficulty in providing services to the homeless is that it is extremely difficult to make such services financially viable. As such it acts as a disincentive to aged care providers who may be considering providing services to the elderly homeless.
>
> **Neither the DoHA Capital or Recurrent funding models are suitable for the elderly homeless.** (sub. 195, p. 8) [emphasis in original]

For those with a mental disability, Southern Cross Care (Victoria) said:

> While the introduction of the Aged Care Funding Instrument (ACFI) has generally been positive, capacity to meet the needs of clients with mental illness or dementia has decreased. (sub. 266, p. 7)

While the Psychogeriatric Care Expert Reference Group stated:

> Current funding does not capture people whose behaviour is considered too difficult for mainstream aged care homes. The Behavioural Supplement under the Aged Care

> Funding Instrument (ACFI) was not developed with the expectation that aged care homes would be providing care to people with extreme behavioural disorders… In addition, funding under the ACFI does not reflect the need to engage, train and develop staff with special skills sets, including the need to employ Mental Health Nurses, nor does it reflect the higher staff ratios required to care for those with behavioural/mental health needs. (sub. 299, p. 3)

Many socially disadvantaged people may require higher than average levels of assistance with behavioural issues but not require significant assistance with activities of daily living nor have complex care needs. In addition, this group is generally financially disadvantaged, which restricts the capacity of providers to finance capital from bonds and extra service charges.

In recognition that some components of the ACFI may be set too low, the Commission is proposing that DoHA conduct an initial full and public benchmarking of pricing of care and support services in consultation with the industry and other stakeholders. The Commission is also proposing that, subsequently, the function of assessing and transparently recommending care prices be the responsibility of an independent regulator (chapter 6).

## 9.6 Financially disadvantaged

The Australian Government recognises that, on equity grounds, financially disadvantaged people should have equal access to quality aged care services they are assessed as needing. To achieve this, the Government contributes towards the cost of care services and accommodation and everyday living expenses through a complex system of direct subsidies and transfer mechanisms.

Over 85 per cent of HACC, community care package and residential care recipients receive government income support (AIHW 2010b; DoHA 2009b, 2010e), predominantly the age pension (full or part pensions) and veterans affairs pensions. In addition, over a third of residential care clients were receiving some level of financial support for their accommodation from the Australian Government.

Access to residential aged care is currently promoted through varying subsidies and quota requirements designed to ensure providers have a certain level of supported (and/or concessional) residents. For example, the accommodation subsidy paid to providers on behalf of supported residents is reduced if providers have less than a specific proportion of supported residents in a facility — this proportion is set by DoHA on a regional basis. Some residential aged care providers indicated that they cross-subsidise supported residents either within facilities or across their operations

(Community Based Support South Incorporated, sub. 275; Anglicare Sydney, sub. 272; The Salvation Army — Aged Care Plus, sub. 363).

Looking forward, there will continue to be a large proportion of financially disadvantaged older people requiring aged care services, despite Australia's superannuation reforms. While the Commonwealth Treasury projects that the proportion of full pensioners will decline from 55.1 to 35.8 per cent between 2007 and 2047, this will largely be offset by a significant increase in the proportion of part-pensioners to 40.7 per cent with those receiving no pension expected to increase only slightly (from 20 to 23.6 per cent) (PC 2008).

Based on submissions and consultations, there does not appear to be a problem with the funding of ongoing care services (that is, the ACFI and community care subsidy levels) for the financially disadvantaged. However, there is an issue regarding subsidies for supported residents in that they do not appear to cover the cost of accommodation services (chapter 5).

Some providers do not consider the supported accommodation supplement to be viable or sustainable. For example, extra-service providers are not eligible for supported resident supplements, regardless of the number of supported residents they serve, and have to cross subsidise these services. Other service providers are delaying decisions to replace ageing facilities and/or are not expanding their residential operations. Accommodation subsidies for supported residents should be available to all providers.

In principle, if the accommodation charge for supported residents is sufficient, providers should be willing to offer a place on the basis that it will provide sufficient return on equity to justify the investment.

The Commission considers that the supported resident quota obligations should continue for at least another five years, pending a further review of the reformed aged care system in the context of higher accommodation charges paid by the Government for supported residents. Under the Commission's proposed model, providers who specialise in providing services to the financially disadvantaged could also benefit from other service providers who wish to trade their supported resident quota obligations (chapter 6).

More broadly, many older Australians who are considered financially disadvantaged in the aged care system (that is, they are pensioners) may have a low income but are asset rich as a result of owning their own home (which is not taken into account in determining age pension eligibility). These older Australians have a capacity to contribute towards their care costs and meet their accommodation and everyday living expenses. In effect, current arrangements crowd out the targeting of

subsidies for financially disadvantaged older people with the greatest need. The Commission is proposing that older Australians with the financial capacity to contribute to their care, and meet their costs of accommodation and every day living expenses, should do so.

## 9.7 Older Australians living in rural and remote locations

Rural and remote areas generally do not have the population density or demand to sustain many types of aged care services that are available in urban areas. As a result, there are generally only one or two service providers delivering aged care services in many of these areas.

Submissions and consultations indicate that, while older Australians in rural and remote areas are generally able to access suitable aged care services, there are significant challenges in delivering services in these areas, including:

- the relatively high cost of establishing and delivering services
- difficulties in attracting and retaining suitably qualified staff
- difficulties in obtaining services from medical practitioners and allied health professionals to support the provision of aged care services.

### *Costs of service provision*

The key issue for providers servicing rural and remote areas is the relatively high cost of establishing and operating an aged care service compared to similar services in metropolitan and other regional locations. Despite relatively lower land costs, it is generally more expensive to build in rural and remote areas due to higher transport costs for construction materials and sourcing specialised construction skills.

The ongoing, non-staff costs of delivering aged care services can be considerably higher for rural and remote providers due to the costs associated with:

- transport of food and the cost of other basic services, such as power, water, fuel and communications
- fluctuations in occupancy rates (particularly for smaller, more isolated facilities) and the need to provide stable employment for staff
- costs associated with travel to clients in the delivery of community care.

In addition, older Australians in rural and remote communities often do not have high levels of income and assets from which aged care providers can draw additional payments, such as significant accommodation bonds or extra service fees (National Rural Health Alliance, sub. 277).

The Australian Government recognises that the cost of delivering aged care services is higher in rural and remote areas, and provides a 'viability' supplement reflecting the remoteness of the service, the number of occupied places and the proportion of special needs clients.

However, a number of submissions noted the increasing difficulty that smaller rural and remote aged care services have in remaining viable even with the viability supplement. For example, Presbyterian National Aged Care Network maintained:

> It is particularly challenging to run smaller aged care facilities or community care services in a financially viable fashion. A number of Presbyterian aged care services are smaller services, some of them in rural areas. In many cases, the smaller urban services are being shut to allow development of new buildings with more beds. This option is not present in rural areas. We acknowledge the government does provide a viability supplement for small rural residential and community care services which certainly makes a difference. However, the reality is many smaller services struggle to break even, even though they are vital components of their local economies as well as their communities. (sub. 110, p. 9)

Similarly, Aged Care Queensland contended:

> Queensland is one of the most decentralised states, making the provision of sustainable aged and community care services in rural and remote locations a real challenge. Financial viability is one of the biggest challenges for these providers as often they are faced with higher costs that are not adequately compensated by the current viability supplement. (sub. 199, p. 11)

Many aged care services in rural and remote locations, particularly residential services, are cross-subsidised from other activities (either in urban centres and/or community care and/or income from other sources including philanthropy).

To ensure that the aged care system operates efficiently, aged care services delivered in rural and remote areas should be funded at a level which has regard to the additional costs incurred in supplying the services. The Commission is proposing the development of an independent regulatory commission to recommend to the Australian Government the appropriate subsidies for providing aged care services. A further role for this body should be to determine the sustainable costs of service provision in rural and remote locations.

### *Staffing difficulties*

Staffing is another important issue for the delivery of quality aged care services in rural and remote communities. Providers report an inability to attract and retain suitably qualified staff. Staffing difficulties can be significantly more expensive to resolve in rural and remote locations compared to urban and regional centres due to:

- higher staff remuneration and other costs associated with temporary workers
- allowing employees to undertake the required level of professional development (including travel and staff back-fill)
- difficulty finding suitable and affordable accommodation.

Regarding higher staff costs, Frontier Services explained:

> … Other additional staffing costs not factored into the current viability funding are those related to the need to use agency staff. In remote Australia, agency staff are not able to fill a position day by day or week by week. They provide staffing over usually a minimum of a four week period and need to have covered, in addition to wages, travel costs and accommodation for that period. Short term accommodation is expensive and often very difficult to obtain, particularly in regions where our services compete for accommodation with the mining companies well able to meet the inflated market rates … It should be noted that there is no government funding to meet these costs. They are not covered in viability or indexation funding. (sub. 323, p. 12)

A further difficulty is providing competitive remuneration for similar work where there is multi-purpose service in close proximity which pays public sector rates (chapter 11).

In relation to staff accommodation, Southern Cross Care (WA) said:

> … most public sector staff in remote locations are provided with housing or housing subsidies … Aged care providers receive no realistic supplementation to take account of the real cost of operating in remote locations and are compelled to draw from reserves, should there be any, to remain competitive for staff. In Broome, in order to attract staff SCC invested $400,000 of its own resources to convert premises to staff accommodation. (sub. 432, p. 8)

The National Rural Health Alliance outlined the impact on registered nurses who work in rural and remote locations, and health professionals in general, of the National Registration and Accreditation Scheme:

> Special consideration should be provided for rural and remote aged care staff for career development … Continuing professional development requirements, now more clearly defined under the National Registration and Accreditation Scheme, will also impose particular challenges for health professionals in rural and remote areas. Local training opportunities and the availability of suitably qualified locums or back-up staff to

> maintain service provision levels during training sessions are in short supply in rural Australia. (sub. 277, p. 15)

The National Rural Health Alliance also proposed the development and expansion of e-learning and distance education programs to support staff development locally.

More broadly, Community Based Support South (sub. 275) indicated that the best way to attract and retain a suitably qualified workforce would be to train locals to provide services as these workers generally have a greater attachment to the local area and, as a result, are less likely to move away in the short term.

In the Commission's view, initiatives such as the Aged Care Channel and the development of regionally based aged care providers as Registered Training Organisations should be encouraged and supported as they are important in the creation of a sustainable aged care workforce in rural and remote areas.

In addition, some rural and remote aged care services may have difficulty attracting and retaining quality managers. As noted in chapter 11, good management is a characteristic of quality aged care services, and this is an important issue in rural and remote areas. Instead of attempting to 'parachute' in managers who often do not have a connection to the community and are unlikely to stay for the long term, providers should aim to develop local management talent.

### *Access to health services*

Other submissions noted the difficulty that some older Australians and service providers have in accessing health services in rural and remote locations. The National Rural Health Alliance highlighted the extent of difficulties that older Australians face both in community and in residential settings:

> Rural, regional and remote areas face serious shortages of doctors, dentists, medical specialists and allied health professionals, all of whom are needed for effective aged care. (sub. 277, p. 15)

The disparity in access to health services in rural and remote areas has been highlighted previously by the Commission in its *Australia's Health Workforce* report (PC 2005a). Despite a number of initiatives to improve medical and allied health services in rural and remote areas in response to that report, access to doctors and other health professionals is still relatively low compared to urban areas. However, the proportion of nurses has remained at a high level and is comparable to urban centres (DoHA 2008). The Commission considers that in rural and remote areas, team-based, multidisciplinary health service models are an important mechanism to attract and retain the services of health professionals.

The Australian Government has responded to the problems of accessing health and aged care services in many rural and remote areas through the expansion of Multi-Purpose Services. There were 129 Multi-Purpose Services in June 2010 with 3120 aged care places (DoHA 2010n). These services co-locate health (including acute) and aged care services in one place and provide economies of scale which enable services to be provided that would otherwise not be feasible. In addition, Multi-Purpose Services are able to offer health professionals a peer support environment and greater opportunities to undertake professional development.

The Commission notes recent initiatives by the Australian Government to fund capital development and expand these services to locations with a catchment of 6000 people (previously limited to catchments with less than 4000 people) as they are essential to ensuring these communities can access health and aged care services (Australian Government 2010f).

Notwithstanding these developments, Aged and Community Services Australia (ACSA) highlighted that:

> The MPS program has not undergone a national evaluation since its inception in the 1990s so it is difficult to determine whether the purported strengths of the model have been fully realised. (sub. 327, p. 35)

As an alternative, ACSA has proposed an integrated service model which would primarily focus on the wellbeing of the older person and could also offer a variety of other health and community services. An integrated service would be developed in conjunction with the local community so that it meets their needs and preferences. The Commission considers that the potential benefits from co-locating aged care services within integrated health and community services models should be explored. Irrespective of the multi purpose service model adopted, the aged care component needs to be operated in a manner that is consistent with contemporary aged care standards and practices.

DRAFT RECOMMENDATION 9.1

***The proposed Australian Seniors Gateway Agency (draft recommendation 8.1) should cater for diversity by:***

- ***ensuring all older people have access to information and assessment services***
- ***providing interpreter services to convey information to older people and their carers, to enable them to make informed choices***
- ***ensuring that diagnostic tools are culturally appropriate for the assessment of care needs.***

DRAFT RECOMMENDATION 9.2

***The proposed Australian Aged Care Regulation Commission (draft recommendation 12.1), 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 interpreter services (either within facilities or through telephone translators) for clients from non-English speaking backgrounds***
- ***ensuring staff can undertake professional development activities which increase their cultural awareness.***

DRAFT RECOMMENDATION 9.3

***The Australian Government should ensure that 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***
- ***funding models that are aimed at ensuring service sustainability and that recognise the need for the building of local capacity to staff and manage such services over time.***

# 10 Age-friendly housing and retirement villages

**Key points**

- Age-friendly housing and neighbourhoods have a significant effect on the health and quality of life of older Australians. The Australian, state, territory and local governments all have a contribution to make in these areas.
- Universal design standards are increasingly being applied to new private and social housing. Although there are significant benefits from applying these standards, and voluntary adoption should be encouraged, the higher costs mean that mandating their application for all new dwellings is not warranted at this stage.
- Most state and territory governments do not have clearly articulated policies for providing home maintenance and modification (HMM) services, or clear connections to the wider goals of ageing policy. A better evidence base to identify the benefits and costs of HMM and a more systematic approach to assessing the need, and providing support, for HMM assistance for the elderly is required.
- Some building standards (such as those for ramps) are inappropriate for residential modifications, and impose unnecessary costs and/or ineffective outcomes. New residential housing standards which address the needs of older people are needed.
- The development of age-friendly communities is receiving attention at all levels of government. A national approach could assist in spreading best practice.
- Stamp duty and the asset test for eligibility for the age pension create disincentives for older Australians to sell their dwellings and move to more appropriate housing.
- Older Australians who rent tend to have less security of tenure and less wealth than home owners, and are more likely to enter residential care. The provision of affordable housing which facilitates both independent living and the delivery of home based care for older Australians who have insecure tenure is thus a priority. Governments are playing a major role in meeting this need, but evidence suggests more support for housing and rental assistance will be needed to meet significant demand pressures.
- Legislation at state and territory level is inhibiting investment in retirement villages. Nationally consistent regulation appears warranted. However, aligning the regulation of retirement living options with that of aged care is not appropriate.

The vast majority of Australians aged 65 and over (around 83 per cent) own or are buying their home, while about 14 per cent are renting (table 10.1).

Table 10.1 **Housing tenure/landlord type for those 65 & over, 2007-08**

| *Tenure or landlord type* | *Number and proportion of households* | |
|---|---|---|
| | '000 | % |
| Owner without a mortgage | 1 332.5 | 77.9 |
| Owner with a mortgage | 92.7 | 5.4 |
| Renter | | |
| State/territory housing authority | 108.6 | 6.3 |
| Private landlord | 114.2 | 6.7 |
| Other landlord type | 20.2 | 1.1 |
| Total renters | 241.0 | 14.1 |
| Other tenure type[a] | 45.0 | 2.6 |
| All households | 1 711.2 | 100.0 |

[a] 'Other' forms of tenure including living rent free with other family members, and group households. This is more common with advancing age, reflecting in part moves to live with younger family members precipitated by increasing frailty and care needs.

*Source*: ABS (2009a).

The literature on ageing and aged care highlights the significant effect of housing and social inclusion on the health and welfare of older Australians (AIHW 2009a, p. 8; Holt-Lunstad et al. 2010). It also highlights the overwhelming preference of people to age in their own homes and communities (Benevolent Society 2008, p. 8). Both views were widely held among participants, for example:

> … the most important or crucial element to a Senior Australian maintaining their health, lifestyle and connection to their community is their housing choice. (Masonic Homes Limited, sub. 124, p. 7)
>
> The preference for the majority of people is to continue to live in their own homes and receive care in this environment. (Boandik Lodge Incorporated, sub. 99, p. 1)

Many submissions also referred to the reductions in health and aged care costs when people are able to age in their own homes and communities and so defer the time of their life at which they enter residential care (ECH, Eldercare and Resthaven, sub. 100, p. 6; AARP 2008, p. 5). These benefits can be substantial:

> Analysis of IRT's [Illawarra Retirement Trust] customers showed that on average, seniors living in a purpose built residential community require access to both Residential Aged Care (RAC) and Community Services (CS), later in life when compared with their community peers. When accessing RAC the difference is four years, whilst for those accessing CS the difference is two years. (IRT, sub. 356, p. 13)

Against this background, the chapter examines factors affecting older Australians' access to 'age-friendly' housing and communities (sections 10.1 and 10.2 respectively). The chapter also examines the availability and affordability of rental accommodation suitable for older Australians (section 10.3) and whether the current regulation of retirement living options is appropriate for the future (section 10.4). Finally, the chapter briefly examines how some regulations affecting residential aged care buildings are being changed (section 10.5).

## 10.1 Improving choice of age-friendly housing

Australia's ageing population, and older people's strong preference to stay in their own homes as long as possible, will increase the need for housing that supports independent living, and associated home-based care.

Submissions raised various issues that affect older Australians' ability to remain living in their home of choice. Prominent among these were:

- housing design which better meets the requirements of older Australians
- availability of home maintenance and modification services
- barriers to moving to a more appropriate form of housing
- access to care services across all types of housing (dealt with in chapter 8).

### Housing design

In recognition of the growing number and proportion of older Australians, with the attendant growth in age related frailty and disability, some participants proposed the development of building regulations which required accessibility features or that dwellings be built which could be easily adapted to achieve accessibility. This led to a call for mandated universal design standards to be embodied in the Building Code of Australia (BCA). For example, Physical Disability Australia Ltd argued for:

> … new, national legislation be enacted to ensure that all new homes are at a minimum accessible from the street and are built to accommodate future adaption and provision for people who may have mobility impairments. (sub. 96, p. 17)

This view echoes that of aged care organisations more generally, which have called for reform along the lines of 'mandatory adaptable, accessible and sustainable design standards for all housing' (NACA 2009, p. 6).

There is limited regulation to deliver accessible, visitable or adaptable private dwellings (box 10.1). The *Commonwealth Disability Discrimination Act 1992* prohibits discrimination against people with a disability, including discrimination in

access to public premises. Public premises under the Act include buildings to which the public has access, but not private premises such as private housing. Similarly, while there are disability access provisions in the BCA, they do not apply to Class 1 (detached homes, terrace houses, row houses) and Class 2 buildings (apartments).

### Box 10.1 **Definition of accessible, visitable and adaptable dwellings**

*Accessible dwellings* allow full access and use for all occupants and visitors.

*Visitable dwellings* allow everyone (including wheelchair users) to visit with dignity, including overnight, and for an occupant with a disability to reside temporarily. They would be expected, therefore, to have a no-step entry, wide doors and a wheelchair friendly toilet on the ground floor.

*Adaptable dwellings* should be visitable, but with additional provisions that enable the dwelling to be altered without major structural works and at a much lower cost to make it fully accessible and useable in the future.

*Source*: VCEC (2005, p. 117).

Mandated universal design standards to deliver accessible, visitable and adaptable private dwellings would improve independence and social inclusion for some older Australians and enhance their ability to age in their homes. They would also substantially lower the cost of retrofitting those dwellings to achieve these goals (Quinn and Judd 2010). However, the issue is whether the additional costs, if applied to all new dwellings, would be outweighed by these benefits.

Mandated universal design standards in the BCA would increase the cost of all new housing. A 1999 study for New South Wales estimated the initial cost to make a townhouse compliant with AS 4299 class C (a standard specifying certain minimum levels of accessibility) is 0.5–1.0 per cent of the total cost, and to build an adaptable single dwelling or townhouse could add between 1–3.6 per cent to the total cost (Hill PDA 1999, pp. 9–15 and pp. 18–27). More recent analysis shows similar results: the cost of including 12 'critical' design elements of AS 4299 in typical project homes adds 1–2 per cent to the initial cost (Landcom 2008, p. 7). For mid-rise dwellings, the cost could initially add 0.3–8.0 per cent to total costs (VCEC 2005, pp. 121–22).

While all new housing would incur these costs, only a proportion of those dwellings would deliver benefits to older Australians who occupied (or visited) them (although there would also be benefits for younger people with a disability). In assessing the benefits, the Commission notes that much is already being done in this space.

Of particular importance are the Liveable Housing Design Guidelines (box 10.2), launched in July 2010 by the then Parliamentary Secretary for Disabilities and Children's Services, the Hon. Bill Shorten MP. These guidelines were developed as an outcome of the National Dialogue on Universal Housing Design. The dialogue brought together the housing industry, the disability and community sectors, and governments. The housing industry has embraced these guidelines and developed a plan which includes an aspirational target of having all new homes meet the guidelines by 2020. The Commission supports this initiative.

### Box 10.2 **Liveable Housing Design guidelines**

The guidelines describe a number of core easy living elements that aim to make a home safer and more responsive to the changing needs of its occupants.

Universal housing design is housing that meets the needs of all people at various stages of their lives, including people with a disability and senior Australians. Enabling key living spaces and features to be more easily and cost effectively adapted to meet changing needs and abilities, means safer, more suitable housing. It can help increase social inclusion, improve health outcomes, and allow greater independence and increased opportunities for anyone experiencing disability.

Three levels of performance are detailed in the guidelines.

The first level, Silver, comprises six core Universal Housing Design elements and is intended to apply to all new homes. The second level, Gold, contains enhanced and additional universal design elements for new home construction. The Gold level elements are also eventually intended to apply to all new social and affordable homes that receive government assistance or funding for construction. The third and highest level, Platinum, is intended to be more of an aspirational set of guidelines for people wishing to design houses with optimum accessibility features in mind.

These voluntary performance levels can be applied to all new detached and semi-detached houses, terraces and townhouses and to new apartment dwellings.

*Source*: FaHCSIA (2010b).

In addition, the housing market is already responding to current and prospective demand from an ageing Australia and is incorporating accessibility and adaptability features in new housing targeted at this cohort. Landcom, a major NSW property developer, for example, aims:

> … to influence the design of mainstream housing so that a greater proportion of new homes built will be suitable for older people to live in for a longer period of time. We aim to include a proportion of universal housing in each of our projects wherever appropriate. (Landcom 2008, p. 5)

The Benevolent Society's planned accommodation complex in Bondi (an adaption of the 'Apartments for Life' developed by the Humanitas Foundation in Holland) is another example of this (ACIL Tasman 2009).

More generally, the retirement village industry — which currently houses more than 160 000 people, or about 5.3 per cent of those aged 65 and over (RVA, sub. 424, p. 15) — is fundamentally geared to providing purpose-built housing for older people. Industry projections are that the proportion of those aged 65 and over who will be living in retirement villages will increase to over 7.5 per cent in the next 15 years (sub. 424, p. 16).

New social housing is also substantially embracing design standards aimed at delivering age-friendly housing. The Australian Government's Social Housing Initiative, announced in February 2009, is providing funds to state and territory governments for the construction of up to 19 300 new social housing dwellings by 2011-12. Over 5300 of these dwellings are targeting older Australians, and in stage 2 of the initiative, some 16 500 dwellings will be constructed, with 99 per cent of these to comply with universal design principles (FaHCSIA, pers. comm., 9 August 2010). The Commission endorses this emphasis, particularly given the relatively high proportion of older Australians who are social housing tenants (in 2009, 102 000 or 29 per cent of all public housing tenants were over 65 years of age (OPAHA 2009, p. 3)).

In assessing the benefits compared to the costs, these developments suggest that, from the perspective of older Australians alone, mandatory application of universal design standards for all new housing is not warranted given the community wide costs. Nevertheless voluntary adoption should continue to be encouraged.

## Home maintenance and modification

Home maintenance and modification (HMM) services are primarily provided under the Home and Community Care (HACC) program, and aim to assist people to conduct their everyday living activities and remain independent. HMM services (box 10.3) are available to home owners, mortgagees or private renters who are ageing, have a disability, or care for someone at home who is ageing or has a disability.

### Box 10.3 The definition of home maintenance and modification services

Home maintenance and modification (HMM) services are defined as 'services that are designed to modify or maintain the dwellings of older people in order to enhance their safety, independence, identity and lifestyle'.

The four main service types identified are: structural modifications, non-structural modifications, repairs and improvements, and maintenance.

Structural modifications involve changes to the fabric of the home (e.g. widening doorways and passages and remodelling kitchens or bathrooms). Non-structural modifications are mainly concerned with installation or alteration of fittings and fixtures (e.g. grab rails and ramps). Repairs and improvements involve mending damaged or unserviceable elements of the home and surrounds, including steps, paths, floor coverings, roofs, lighting, and associated minor upgrading. Maintenance is work required on a recurrent basis to sustain the functioning and amenity of the home and surrounds, such as replacing smoke alarm batteries and garden maintenance.

HMM services are categorised as either direct, involving actual service provision, or indirect, involving such matters as information, advice, referral, assessment, brokerage, project management and financing.

*Source*: AHURI (2008, p. 124).

As an indication of the scale of HMM services delivered under HACC, in 2008-09 around 122 500 clients aged 65 or older received home maintenance services and about 30 000 received home modification services (DoHA 2009c, p. 25).[1] The total number and proportion of HACC clients receiving these services is shown in table 10.2.

[1] These numbers are indicative only because:

- the data does not cover all services (for example, some clients can opt out of having their data reported)
- not all HACC agencies required to report do so. Service levels may thus be higher than stated
- in Victoria, home modification is recorded as part of property maintenance (home maintenance).

Table 10.2 **HACC clients, assistance type by age group, 2008-09**

| *Assistance type* | *0–64* | *65–69* | *70 and over* | *Total* |
|---|---|---|---|---|
| | | Number of clients | | |
| Home maintenance | 19 479 | 10 991 | 111 543 | 184 026 |
| Home modifications | 4 611 | 2 629 | 27 430 | 34 670 |
| | | Percentage of age group receiving assistance | | |
| Home maintenance | 9.8 | 16.2 | 18.5 | 16.5 |
| Home modifications | 2.3 | 3.7 | 4.4 | 4.0 |

*Source*: DoHA (2009c).

Molineux, Rosenwax and Harmsen (forthcoming, p. 13) ascribe these variations as likely being due to differences in state or territory policy and programs, costing of services, and a lack of coordination of local service providers. Similarly, research by the Australian Housing and Urban Research Institute (AHURI) found:

> Under the HACC program the priority given to various service types can differ considerably from state to state, as have the organisational arrangements for service provision. One consequence has been that HACC-funded HMM services differ markedly from state to state both in their level of provision and the service structure. (AHURI 2008, p. 2)

HMM services can be instrumental in allowing people to continue to live in their homes and communities for longer. For example, the NSW Home Modification Information Clearinghouse found:

> … maintenance and modification interventions have been shown to be effective in decreasing accidents and injury with a reported seven-fold reduction in reported morbidity …. Further, lack of access to appropriate housing costs taxpayers and government especially if institutionalisation results …. (Bridge 2005, p. 6)

More recently, Molineux, Rosenwax and Harmsen (forthcoming, p. 21), in a report for the Western Australian Government, concluded:

> HMM services play a role in ensuring that older people and people who have a disability are safe in their home and surrounding environment, have access to the wider community and can remain in their home with as much independence as possible. This in turn can result in positive impacts on health and well-being for the individual and their carers. Furthermore, these can all have benefits for the community and local, state and federal governments.

Inquiry participants expressed similar views (box 10.4).

**Box 10.4 Examples of participants' views on the benefits of HMM**

Pam Graudenz:

> … for community care to be delivered effectively to older persons, Home Modifications are usually necessary. (sub. 70, p. 2)

Tech4Life:

> … simple home modifications can be the difference between safe and independent living for older people, or institutional care. (sub. 273, p. 1)

The Physical Disability Council of NSW:

> Home modification and maintenance schemes provide affordable, cost effective modifications and maintenance work for people within the HACC target group for people living in their own home or in private rental accommodation. These services allow people to live safely and independently in their own homes and reduce the need for premature admission to residential care facilities. (sub. 261, p. 6)

ACAA noted that home modification programs, as part of a general community care service:

> … support older people to retain their independence at home, help to prevent the need for more expensive services (such as hospital or residential aged care), and help people return home more quickly after a stay in hospital. (sub. 372, p. 18)

Participants also identified a number of problems with the provision of HMM services. Foremost among these were lengthy waits to be assessed for these services or to have those services provided once approved (Rosemary West, sub. 94, p. 1; The North West Region—CACP/EACH/D/ACAS Forum, sub. 133, p. 3; COTA Australia, sub. 337, p. 24; Motor Neurone Disease Australia Inc, sub. 147, pp. 5–6).

Delays in assessment were associated with inadequate levels of funding for assessment teams and shortages of assessment staff, such as occupational therapists in metropolitan and regional NSW (NSW HMMS State Council, sub. 268, p. 1; Occupational Therapy Australia, sub. 203, p. 16). Delays in services being provided were associated with a shortage of funds and a lack of service providers in some areas (NSW HMMS State Council, sub. 268, p. 1).

Inadequate funding and workforce shortages are general problems for the whole industry, and are discussed in chapters 6 and 11 respectively.

Although delays in assessment or service delivery are of concern, a comprehensive review of HMM services published in 2008 suggests they are not the norm:

> Most of the consumers who were interviewed reported that HMM organisations responded in a timely way to service requests, and that delays were experienced only

with major modifications. According to the consumers interviewed, delays were more the exception than the rule. (AHURI 2008, p. 139)

Accessibility to HMM services also has an affordability dimension. The NSW HMMS State Council raised concerns about the equity and sustainability of HACC HMM services under existing co-contribution arrangements:

> Currently, each HMMS sets their own Fees Policy in accordance with the National HACC Program Guidelines and Client contributions are collected from Clients on their ability to pay. Assessing a Client's ability to make a contribution is based on information provided by the Client. In essence it is an honesty system which is fraught with difficulty for the Service Provider and creates an inequitable subsidised payment system from one local planning area to another for the consumers.
>
> To ensure a sustainable system and one which is based on equity of access by all Australians a clearly defined assessment system of income and assets needs to be implemented by the Government for all HACC Services. (sub. 268, p. 4)

Chapter 6 discusses how co-contributions might be best assessed in the context of the Commission's proposed comprehensive approach to the provision of care and support.

Although there is some delivery under other programs (box 10.5), HMM services provided under HACC and community care packages constitute the bulk of HMM services provided for older Australians.

In a report on these programs, researchers from the AHURI network noted that HMM services lie at the intersection of health, community care and housing policies for older Australians, but found:

- while individual programs and organisations have clearly articulated objectives and policies, there is no overarching policy framework for HMM service provision at the national level or in most states
- there are limited integration and coordination mechanisms and processes to ensure that HMM organisations and programs operate as an integrated service system
- planning and development of HMM services is hampered by an absence of integrated HMM information systems[2] (AHURI 2008, p. 55).

[2] A coherent data set on HMM services would also assist in assembling the evidence needed to inform decisions on the appropriate level and distribution of resources devoted to HMM services.

## Box 10.5 **The main non-HACC HMM programs**

The Department of Veterans' Affairs provides a number of HMM programs across the country for veterans and their families.

State and territory housing authorities provide HMM services for social housing tenants. They may also provide loans to older people wishing to undertake home modifications. State and territory community health centres and hospitals also support HMM services in the context of hospital discharge programs, falls prevention programs and programs supporting older people with chronic illnesses in the community.

In addition, some states have unique HMM or HMM-related services or programs. Four are of particular interest:

- The Queensland Government's Home Assist Secure program, which funds a network of services providing home maintenance, repair and non-structural modifications to 50 000 consumers annually across the state.
- Also in Queensland, the Smart Housing and Home Access initiatives provide information on access and building issues for home-building professionals, developers, real estate agents and consumers.
- The Victorian Government funds the building advisory service (Archicentre) of the Victorian Chapter of the Royal Institute of Architects to provide free home inspections to older people and people with disabilities, including recommendations on maintenance, repairs and modifications.
- The NSW State Government supports a State Council to provide coordination and advocacy for HMM providers and supports a Research and Resource Centre at the University of Sydney (the Home Modification Information Clearinghouse).

Some home modification services are also available under state and territory aids and equipment programs.

*Sources*: AHURI (2008, p. 2, pp. 56-7); Medical Technology Association of Australia (sub. 187, pp. 31–2); Repatriation Commission (sub. 366, p. 6).

The report concluded that a coordinated and integrated policy approach to the provision of HMM services in Australia is needed in order to improve their effectiveness in achieving health, community care and housing outcomes in later life (AHURI 2008, p. 3 and p. 144).

To that end, the AHURI report proposed a national program with a set of objectives for housing, health and community care outcomes, linked to a national strategy for housing older people and a whole-of-government ageing policy. This approach would involve a lead agency in each of the Australian, state and territory governments, and a collaborative approach to policy and service provision between the two levels of government. ACSA and COTA, via their Older Persons Affordable Housing Alliance, support a national program (OPAHA 2009, pp. 4–5).

Within each jurisdiction a network of local and regional HMM organisations similar to those operating in NSW and Queensland (box 10.5) would be responsible for providing HMM services locally, linked to wider advice, information and referral services. These organisations could be responsible for HMM services funded by HACC, Department of Veterans' Affairs and health organisations, as well as services provided through the new national program.

The report also proposed a national approach to benchmarks for the levels of services to be provided, terms of eligibility and user charges, and the development of professional and technical expertise. The new arrangements would build on existing services and aim to incorporate the best features of schemes such as the Victorian Archicentre Home Renovations Service, the NSW Research and Resource Centre, and the Queensland Smart Housing and Home Access initiatives. (These best features could be identified by the research proposed below). Local services would draw funding from the new national program, the HACC program (or its equivalent in a new aged care system), client co-contributions and other sources in a manner similar to the way that the Queensland Home Assist Secure program now draws funding from both housing and community care sources (AHURI 2008, p. 144).

The Commission sees merit in an integrated national approach for aged care HMM programs and the other various HMM programs along the lines suggested.

DRAFT RECOMMENDATION 10.1

***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.***

Comments from submissions (noted above) raise questions about whether the level of funding for HACC HMM services should be increased and how funding might be better used to improve the efficiency and effectiveness of these services.

However, AHURI research suggests that the evidence available to inform decisions on these important matters is inadequate:

> The literature on Australian HMM policies and services is extremely sparse … Current service arrangements have a history of some two decades, but no systematic research evidence base to underpin policy development has emerged during this time. … Apart from a handful of highly focused studies, there is also no literature on the outcomes or cost-effectiveness of HMM provision in Australia. (AHURI 2008, p. 1)

> The system as a whole appears to be grossly underfunded, although it is difficult to verify this, given the lack of clarity around the objectives and benchmarks for levels of service provision. (AHURI 2008, p. 123)

Hal Kendig argued that further research was needed to improve the cost effectiveness of resources expended on aged care. This could include research into:

> How can aids and equipment be most effectively accessed, provided, used and funded — to maximise cost effectiveness? (This should cover the spectrum of aids from low to high tech and include home modifications) (sub. 431, p. 15)

A recent report on HACC HMM services for the Western Australian Government came to a similar conclusion, and recommended better evidence to inform policy:

> Research should be commissioned to further examine the effectiveness of HACC provided home modification and home maintenance services, and their economic outcomes … (Molineux et al., forthcoming, p. 37)

In view of the above, the Commission considers that Australian Government funding is warranted for research to provide the evidence needed to inform decisions on the appropriate level and mix of government funding for HMM programs and services. Moreover, this funding should be provided as a matter of priority. Marshalling existing research capabilities (such as the AHURI network and the NSW Home Modification Information Clearinghouse) would facilitate an early start on addressing this fundamental deficiency.

Chapter 12 also discusses this issue in the broader context of the proposed Australian Aged Care Regulation Commission facilitating more rigorous research and evaluation to inform aged care policy.

### *Problems with the standards on which modifications are based*

An emerging problem with home modifications is the difficulty (and cost) of getting modifications approved that do not comply with the BCA. This problem arises where building standards are inappropriate or do not address individual needs. In such cases, approval to deviate from the BCA might require:

1. engaging an accredited building assessor to seek 'deem to satisfy' provisions under the BCA
2. lodging a development application for the variation
3. two site inspections by council through the course of building the modification.

Inappropriate building standards for home modifications arise because the only Australian Standard for residential housing designed to meet the needs of people with a disability is the Adaptable Housing Standard AS 4299, which calls up

AS 1428.[3] However, AS 1428 requirements were not developed for older people or intended for private dwellings. The requirements within AS 1428 are derived from assumptions about the average dimensions of the 18–60 population and public access requirements. AS 1428 requirements are not linked to an evidence base of the capabilities of older Australians. Thus, an older person who is taller, shorter, wider or uses a mobility device that has a footprint outside the A80/A90 wheelchair template could be further disadvantaged in their own home under this approach (HMInfo Clearinghouse, pers. comm., 14 October 2010).

Resolving this problem requires that the building standards designed to address the needs of people with a disability or age related functional limitations be revisited with a view to making them appropriate for residential housing and be developed on the basis of a robust evidence base of:

- dimensions and capabilities of the 65 and over population
- dimensions and capabilities of contemporary disability aids (such as mobility devices).

New standards along these lines would provide individuals, who sought to build or modify a residential dwelling to cater for their access needs, with a more cost effective solution than is currently available.

Given its involvement in developing the liveable housing design guidelines, the Department of Families, Housing, Community Services and Indigenous Affairs would be an appropriate lead agency to oversee the development of new access standards for residential housing. In addition, it would be sensible for any new standards to be reviewed within three years of their introduction and thereafter to be subject to regular review to ensure their continued relevance and practicality.

DRAFT RECOMMENDATION 10.2

***For older people with functional limitations who want to adapt their housing, the Australian Government should develop building design standards for residential housing that meet their access needs. Those standards should be informed by an evidence base of the dimensions and capabilities of people aged 65 and older and of the dimensions and capabilities of contemporary disability aids.***

While reform along these lines would address the problem of inappropriate standards, it would not address the problem where modifying dwellings to new standards would be impractical and excessively expensive. In these circumstances, some compromise on a case-by-case basis is needed to achieve an affordable

[3] AS1428 is the Australian Standard for design for access and mobility, which provides design requirements for buildings encompassing the specific needs of people with disabilities.

solution that meets an individual's needs (and leaves them better off) even though it does not meet deemed to comply standards.

In the UK, where this situation arose on a sheltered housing project run by Pennine housing, the underlying issue was identified as the legal liability arising where modifications varied from building standards. In that instance, the issue was tackled by all concerned parties (for example, builder, designer, certifier and building owner) agreeing to share liability (HMInfo Clearinghouse, pers. comm., 10 November 2010).

*The Commission invites participants to comment on the difficulties in providing modifications where prescribed standards are impractical and to offer suggestions on how a compromise might be achieved in a cost-effective manner.*

## Barriers to moving to more appropriate housing

As people age and their needs change, their homes may become unsuited to sustaining their independence. For home owners, one option is to sell and move to housing better suited to the delivery of the support and care they need.

However, major regulatory (and associated financial) disincentives face older Australians who wish to pursue this option: notably stamp duty and the age pension assets test. The Multicultural Communities Council of SA (sub. 52, p. 2) considered these were key areas needing reform.

The 2008 Senate inquiry on housing affordability recognised the disincentive effect of stamp duty, and called for state and territory governments to consider exemptions for older Australians who are downsizing their primary residence (SCHAIA 2008).

NSW recently eliminated stamp duty (from 1 July 2010 to 1 July 2012) for those over 65 years old who sell their home to move into a newly-built dwelling worth up to $600 000, in an effort to encourage them to trade down to smaller homes (Munro and Chancellor 2010). Critics of this initiative suggest that it will be of limited value and the aim of encouraging older Australians to move to more suitable housing would be better served if the newly built dwelling criterion was removed.

The Henry Review also criticised stamp duty on a number of grounds. It noted that stamp duty creates a disincentive for people to buy or sell property, which can result in people not living in the house they really want to live in or staying too long in a house that could be better used by somebody else. This disincentive is determined by the size of the tax in comparison to the non-tax costs of moving, such as real estate agent fees and removal costs (Henry 2010, p. 254). As indicated in table 10.3, stamp duty can double the total cost of moving.

Table 10.3 **Stamp duty expressed as a tax on moving in capital cities**[a]

| | *Value of median home, June 2009* | *Stamp duty payable* | *Other moving costs* | *Total cost of moving* | *Effective tax rate on moving* |
|---|---|---|---|---|---|
| | $ | $ | $ | $ | % |
| Sydney | 544 000 | 19 970 | 21 320 | 41 290 | 94 |
| Melbourne | 441 900 | 18 484 | 18 257 | 36 741 | 101 |
| Brisbane | 419 000 | 5 915 | 17 570 | 23 485 | 34 |
| Perth | 450 000 | 15 390 | 18 500 | 33 890 | 83 |
| Adelaide | 359 000 | 14 280 | 15 770 | 30 050 | 91 |
| Hobart | 336 000 | 10 990 | 15 080 | 26 070 | 73 |
| Canberra | 458 000 | 18 240 | 18 740 | 36 980 | 97 |
| Darwin | 537 100 | 26 586 | 21 113 | 47 699 | 126 |

**a** Other moving costs assume real estate agent fees of 3 per cent on the value of the home as well as a flat $5000 cost in all States. Stamp duty payable assumes that the buyer is not entitled to concessions such as first home buyer assistance. These estimates overstate the monetary non-tax costs of moving for those vendors who choose not to engage a selling agent or professional removalists.

*Source*: Henry (2010, p. 255).

The Henry review noted that stamp duty is inequitable as it falls most heavily on people with a preference for housing consumption and on those who move more often because the effective rate of tax declines as the cost of stamp duty is spread over more years of occupancy (Henry 2010, p. 256).

The review concluded that stamp duty is a highly inefficient and inequitable tax which, among other things, deters older Australians from selling their home and moving to more appropriate accommodation (Henry 2010, pp. 254–7), and recommended the removal of stamp duty (p. 263).

In principle, the Commission supports the removal of distortionary imposts such as stamp duty. Having regard to the arguments in the Senate inquiry and the Henry Review noted above, and in the context of the disincentive that stamp duty introduces to the decision of older Australians to move to more appropriate housing, the Commission endorses in principle the Henry report's conclusion that stamp duty should be removed.

The assets test for the age pension also represents a barrier to downsizing. Australian Unity (sub. 265, pp. 5–6) and Lend Lease Primelife (sub. 424, attachment, p. 4) argued the current test is a major disincentive for pensioners to release equity from their home to assist with care costs or with moving to more appropriate housing (either owner occupied or rented). If the asset test were relaxed so that people could keep their pension (or a higher percentage than present) after selling their home, they might move, releasing equity to help pay for their aged care. Further, Australian Unity argued, changing the asset test would have a limited cost to government since the default behaviour (not selling and moving) means they keep the pension anyway.

The Commission acknowledges that the current asset test has a significant deterrent effect on people's willingness to sell their home and move to more appropriate housing, particularly if that would involve renting or other forms of periodic payment for accommodation — including residential care. The asset test can also induce people to pay large sums to accommodation bonds for residential care, as such bonds are also exempt from the age pension asset test (chapter 6).

The Henry Review examined the current income and asset tests for income support payments (including the age pension). It recommended they should be replaced with a comprehensive means test which, among other things, would 'continue the means test exemption for owner-occupied housing up to a high indexed threshold' (Henry 2010, p. 540). Under the recommended changes, a surplus on the sale of one's primary residence would still be included in the means test for the age pension (Henry 2010, p. 541).

The current age pension asset test provides an incentive for older Australians to invest in their primary residence, encouraging capital into an asset that may not necessarily yield the best return for the individual or the nation. However, the issue of designing a more appropriate asset test for the age pension extends beyond the context of aged care, and is one more appropriately considered in a general economy wide context.

Given that this inquiry cannot presume that reform of the current age pension assets test will occur, chapter 6 proposes an Australian Pensioners Bond scheme which would reduce the distorting effects that the asset test has on people's choice of housing and on their choice between owning or renting that housing. Among other things, the proposed scheme should remove a constraint on the growth of rental contracts in retirement villages since the incentive to own one's primary residence (to maintain the pension) would no longer apply. Chapter 6 also proposes an aged care asset test for the purpose of determining the financial capacity to make a care co-contribution which is neutral in its treatment of the form in which older people hold their wealth.

## 10.2 Improving the age friendliness of communities

Several submissions highlighted the importance of developing age-friendly communities to complement age-friendly housing in helping older Australians to age where they live rather than move to residential care (box 10.6).

In recent years there has been a growing awareness among all levels of government in Australia of the importance of developing age-friendly communities. State, territory and local governments are particularly active in pursuing this goal.

Policies in this area have benefitted from the age-friendly city model developed by the World Health Organization (WHO) under its *Age-Friendly Cities Project* in 2006. That project identified the characteristics of the urban environment that make it more 'age-friendly' and produced a checklist of essential features of age-friendly cities (WHO 2007a) and a guide to global age-friendly cities (WHO 2007b).

At the Australian Government level, the *National Strategy for an Ageing Australia* identified the importance of age-friendly infrastructure and community support (Andrews 2001, p. 1). Government initiatives to advance this goal include the *Local Government Population Ageing Action Plan 2004-2008*, a nation-wide program of workshops with the theme '*A Community for All Ages — Building the Future*', and funding for *Healthy Spaces and Places* (box 10.7). More generally, Lui et al. (2009, p. 120) observe that the Government's commitment to social inclusion could assist the development of age-friendly communities, although they note that how this may occur is unclear.

## Box 10.6 **Participants' views on age-friendly communities**

Entry to residential care (or hospital) can be ameliorated by reducing social isolation, improved housing and age friendly neighbourhoods (ECH, Eldercare and Resthaven, sub. 100, p. 6).

The Brotherhood of St Laurence stated:

> It is important not only to consider types of housing and their design but also to consider the neighbourhood environment. Housing for the older person needs to have shops and services within walking distance or easily accessed by public transport close by. Neighbourhoods need to be age-friendly with paving, street lighting, public toilets, benches and open spaces, in order for the older person to participate in community life and to feel safe. (sub. 294, p. 7)

Denise Pendleton highlighted the cost of not providing age friendly communities:

> But what threatens my plans [for independent living in my community] more than anything else is the dereliction of responsibility by officers at both state and local levels of government who are responsible for the provision of safe and accessible infrastructure necessary for me to be able to live independently in my community as I intend. … But it appears there are also major gaps in planning and compliance processes which need to be addressed in order to maximise opportunities for our ageing population to enable them to remain active members in their communities. (sub. 116, p. 1)

Age-friendly neighbourhoods are a central plank in the National Aged Care Alliance's vision for older Australians. It noted that optimum care and support can only be achieved with government commitment to, among others:

- an integrated public and community transport system, designed to comprehensively support and accommodate the needs and aspirations of the entire community, including older people;
- urban design that ensures integrated public and living environments that are safe and accessible for all ages and promote active involvement in community life. (sub. 88, p. 6)

The South Australian government noted:

> Universal design in the public realm (ie. footpaths and public spaces) is also important to ensure that older people with limited physical mobility (and no access to a motor vehicle) can still walk or use a gopher safely to access local services. This is supported strongly by the South Australian Government through the *30 Year Plan for Greater Adelaide*. (sub. 336, p. 21)

*Sources*: Inquiry submissions.

### Box 10.7 Government initiatives to advance age-friendly communities

Between 2004 and 2008, the Department of Health and Ageing entered into a partnership with the Australian Local Government Association (ALGA), under the *Local Government Population Ageing Action Plan 2004-2008*. This included the creation of a website resource for councils which showcased news, research, data, information and innovative practices to assist local government to plan for an ageing population.

In 2006, the Department of Health and Ageing held a nation-wide program of workshops with the theme, '*A Community for All Ages — Building the Future*'. This scheme was to encourage architects, planners, builders and policy makers to rethink how they design homes and communities to sustain health and well-being.

Developing age-friendly communities was also supported by Government funding for *Healthy Spaces and Places*. This was a collaborative effort by ALGA, the National Heart Foundation of Australia and the Planning Institute of Australia to provide a national guide to support and complement planning and design initiatives of state, territory and local governments. Bridge and Elias (2010, p. 15) consider this initiative has great potential to deliver social, economic and health returns through better planning of our built environments.

*Sources*: Santoro (2006), PIA (2009, p. 2).

At the state and territory government level, all governments have introduced strategies to address the challenges of an ageing population (table 10.4) and to develop age-friendly communities. For example, the New South Wales strategy includes a focus on liveable homes and communities which (among other things) calls for a review of planning criteria to encourage a walkable and wheelable community with local public spaces that are safe and pleasant for people to use (NSW DPC 2008, p. 20). In Victoria, the focus includes factoring in the needs of older people into strategic and residential land use planning, increasing public transport and local transport options and improving the accessibility to that transport for people with mobility challenges (DPCD 2010, pp. 33–40).

Some states also have particular initiatives to advance the goal of developing age-friendly communities. In South Australia, for example, under the *Age Reform Agenda: Adding Life to Years*, the Office for the Ageing is developing guidelines for the certification of neighbourhoods, residential developments and cities as 'Age Friendly'. The guidelines, developed in accordance with the WHO criteria, will facilitate the design of environments that are safe, secure and provide services and infrastructure that are both accessible and inclusive for older people.

A feature of state level initiatives for developing age-friendly communities is the central role accorded local governments. For example, local government is a key player in implementing the *Tasmanian Plan for Positive Ageing*, with all 29 local

councils having partnership agreements with the Tasmanian government (Tasmanian. DPC 2007, p. 19).

Table 10.4 **State and territory governments' ageing strategies**

| *State/territory* | *Strategy* |
|---|---|
| New South Wales | Towards 2030: Planning for our changing population |
| Victoria | Ageing in Victoria: A plan for an age-friendly society 2010–2020 |
| Queensland | Positively Ageless — Queensland Seniors Strategy 2010–20 |
| South Australia | Improving With Age: Our Ageing Plan for South Australia |
| Western Australia | Generations together: A guide to the Western Australian active ageing strategy |
| Tasmania | Tasmanian Plan for Positive Ageing: Second five-year plan |
| Northern Territory | Building the Territory for all Generations: A Framework for Active Ageing in the Northern Territory |
| ACT | Strategic Plan for Positive Ageing 2010–2014: Towards an Age-Friendly City |

*Sources*: NSW DPC (2008); DPCD (2010); Queensland Government (2010); Government of South Australia (2006); WA Department for Communities (2006); Tas. DPC (2007); DCM (2007); DHCS (2009).

Local governments — with responsibility for matters such as physical infrastructure planning and development, traffic management, and open space planning — are uniquely positioned to influence the age-friendly nature of our communities. In 2006, the Australian Local Government Association produced a report on *Age friendly built environments: Opportunities for local government*, which included a range of strategies to achieve age-friendly communities, such as:

- promote age friendly built environments
- create safe and secure pedestrian environments
- foster age friendly community planning and design
- improve mobility options for seniors (ALGA 2006, p. 7).

Throughout Australia, local governments have been active in developing strategies and in implementing actions to achieve age-friendly communities, in their own right or in partnership with state governments and other organisations (box 10.8).

Local government plans, too, have been profoundly influenced by the WHO's checklist and guide. A report commissioned by the Municipal Association of Victoria into the use of the WHO Age-Friendly Cities Guide and Checklist found that by the end of 2009, 73 of the 79 Victorian councils had completed a positive ageing strategy, borrowing heavily on that work (MAV 2009, p. 2).

### Box 10.8 Examples of cooperative approaches to developing plans for age friendly communities

In New South Wales, COTA NSW's Age Friendly Environments Working Group has representatives from the Faculty of the Built Environment (UNSW), NRMA, Local Government and Shires Associations, Alzheimer's Australia NSW, Benevolent Society *Apartments for Life*, Independent Living Centre NSW, Housing NSW, Waverly Council, Marrickville Council, Sydney City Council, Wyong Shire Council, People with Disabilities, the Australian Domestic and Family Violence Clearinghouse and consumers.

In Victoria, the *Local Government Positive Ageing Project* (which ran from 2005 to early 2009) was a joint initiative between the Municipal Association of Victoria (MAV), COTA Victoria and the Victorian Department of Planning and Community Development. The project aimed to build the capacity of local government to plan for an ageing population and to provide leadership in promoting 'age friendly' communities that create opportunities for senior Victorians to live active and fulfilling lives.

*Sources*: COTA NSW (2009); MAV (2009).

While some coordination of efforts to advance age-friendly communities has emerged (under the ALGA umbrella for example) there appears to be no national focus or formal bringing together of best practice across Australian, state, territory and local governments. As the Brotherhood of St Laurence noted:

> Although some local governments are attempting to address these issues [providing an age-friendly built environment], there are no national guidelines to ensure that this is a requirement now and into the future. (sub. 294, p. 7)

Although the WHO guide and checklist provide a common model for informing government approaches to developing age friendly communities, there may be merit in assigning responsibility for overseeing progress and developments in this area to the Local Government and Planning Ministers Council.

## 10.3 Improving rental choices for older Australians

For those who are not home owners, the availability and affordability of rental accommodation are major influences on whether they can age in their communities or need to move into residential care (Howe 2003; AHURI 2009; AHURI 2010; Judd et al. 2010).

However, there are widespread concerns that the supply of such accommodation is insufficient to meet the future demand from an ageing population:

> Older non-home owners on a fixed low income have limited choices if they want to move to accommodation more suited to their needs. Given the decreasing affordability of rent levels in the private rental market and the increasing cost of dwellings for

purchase, particularly in major capital cities, appropriate housing options for older people on fixed low incomes are extremely restricted. (ACSA 2004, p. 7)

Older people's housing choices are limited by a shortage of suitable and affordable housing. This is particularly so for low-income older renters and people with low or modest assets. (Benevolent Society 2010, p. 29)

Housing affordability has decreased dramatically in Australia … Along with the decrease in housing affordability, there is also a lack of accessible housing suitable to the needs of persons experiencing age-related frailty or disability. … Increased options for low cost social housing also needs to be factored into planning to ensure that the most disadvantaged older people in our community are appropriately housed … (South Australian government, sub. 336, p. 20)

Without sufficient stock of appropriate and affordable housing there will be a crisis in aged support and care, as such housing is critical to both older people's welfare and quality of life has a major impact on the capacity of other support and care services to deliver effective outcomes. (COTA Australia, sub. 337, p. 36)

These concerns should be viewed against a background of the broader housing market, where underlying demand is greater than supply and has led to pressure on house prices and rent levels, and of general government housing policies aimed at improving housing supply and affordability for the community overall.

## Supply of rental accommodation for older Australians

In 2007-08, older households[4] accounted for 108 600 public rentals and 114 200 private rentals (table 10.1). Older households, though, constituted 29.6 per cent of all public rentals whereas they constituted only 5.9 per cent of all private rentals (NHSC 2010). The low private share may explain why the private rental market generally might have little incentive to invest in age-friendly accommodation (excepting niche providers of age-specific living options and shared housing) (Davey et al. 2010).

Australia has a shortage of affordable rental housing and, as a result, both public and private rental markets are pressed to meet the demands of older renters (NHSC 2010).

Governments have recognised the need to increase the supply of affordable housing, and are acting to do so. Thus, in addition to their general housing policies, Australian, state and territory governments have recently increased their commitments to providing affordable housing for all Australians, with significant changes in housing policy and initiatives in the delivery of housing assistance (AIHW 2009a). Major recent initiatives in these areas are shown in box 10.9.

4 Older households refer to those households where the reference person is 65 and over.

## Box 10.9 **Recent major affordable housing initiatives**

*The National Affordable Housing Agreement*

In 2008, the Council of Australian Governments (COAG) agreed to a National Affordable Housing Agreement (NAHA) for Australia's affordable housing strategies and included funding previously provided through the Commonwealth State Housing Agreement. The NAHA included $400 million for building new social housing to provide up to 2100 dwellings by 2010.

*The Australian Government's Social Housing Initiative*

This Initiative, announced in February 2009 as part of the Nation Building — Economic Stimulus Plan, will provide over $5.6 billion to state and territory governments. Stage 1 will see the construction of up to 19 300 social housing dwellings by 2011-12. Over 5 300 of these dwellings are targeting older Australians. In Stage 2, some 16 500 dwellings are to be constructed, with 99 per cent of these to comply with universal design principles (FaHCSIA, pers. comm., 9 August 2010). A further 10 000 dwellings that would have otherwise been lost to the social housing stock over the next two years will also receive maintenance and refurbishment.

*The Australian Government's National Rental Affordability Scheme*

Launched in July 2008, the National Rental Affordability Scheme aims to increase the supply of rental dwellings by 50 000 units by 2012 and to reduce the cost of rental housing for low and moderate income individuals and families.

The Scheme offers annual indexed incentives for 10 years. The two key incentives are a Government incentive currently of $6855 per dwelling per year as a refundable tax offset or payment and a state or territory government incentive currently of $2285 per dwelling per year in direct or in kind financial support. The incentive is provided annually on the condition that throughout the 10 year period the dwelling is rented at 20 per cent below the market rent to eligible low and moderate income households.

If the target of 50 000 homes by 2012 is reached, the scheme will be expanded to fund a further 50 000 homes.

*The National Partnership Agreement on Social Housing*

This agreement involves the Australian Government providing capital funds to the states and territories for building at least 1600 new social housing dwellings by 2009-2010. There is no particular emphasis on providing housing for older people, but one criterion is that projects 'should adhere to universal design principles that facilitate better access for persons with disability and older persons'.

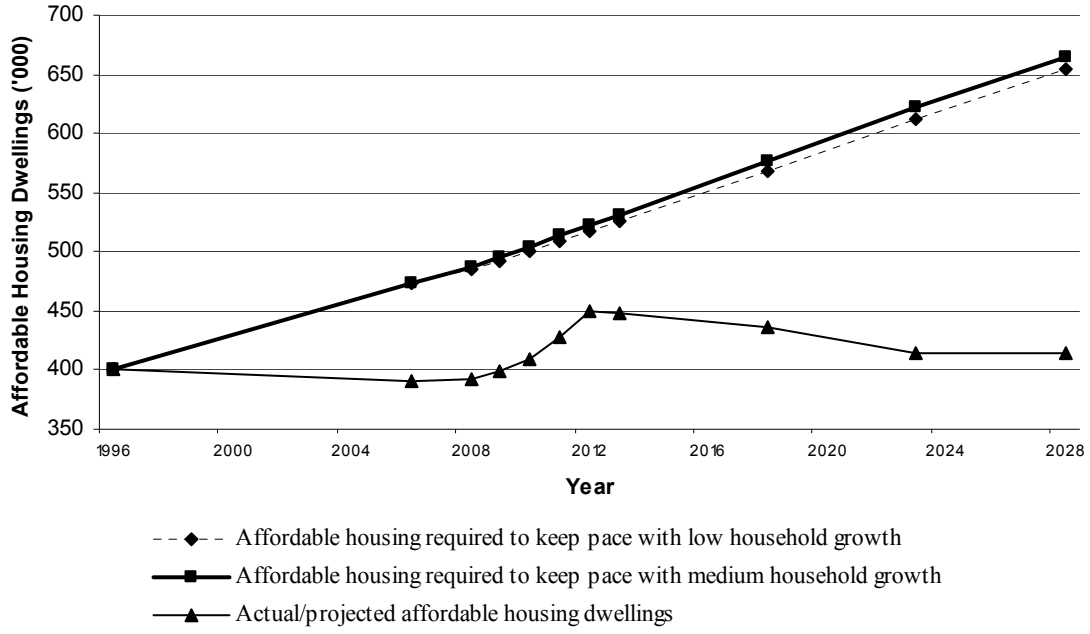
*State and territory government initiatives*

State and territory governments have set up programs to help build capacity in 'growth' organisations, for example through funding to assist larger not-for-profit bodies with business improvement strategies in order to meet registration requirements. They are also supporting public–private partnerships involving community housing providers.

*Sources*: PC (2010b, p. I.11); Housing NSW (2010, p. 5); Jones et al. (2010, p. 172), NHSC (2010, p. 147).

These initiatives will substantially increase the supply of social housing. But despite this increase, NHSC projections (figure 10.1) indicate that the gap between demand and supply for social and affordable rental housing will widen from around 2012 onwards (NHSC 2010, p. 57). These projections point to a need for these initiatives to be extended if the shortfall in supply is to be overcome (from a general population perspective, not just from that of the housing requirements of older Australian renters).

Figure 10.1 **Social and affordable rental housing demand and supply**




**Assumptions:** 70 per cent of 50 000 National Rental Affordability Scheme (NRAS) dwellings have not-for-profit/endorsed charities as tenancy managers, 35 000 NRAS dwellings included, distributed over 2009 to 2012. NRAS dwellings exit affordable housing stock as they leave the scheme. 19 300 Social Housing Initiative dwellings over years from 2009 to 2012. 600 A Place To Call Home dwellings are distributed across years 2009 to 2013. 1700 Social Housing National Partnership Agreement dwellings distributed across 2010 and 2011. Projection does not continue the trend from 1996 to 2006 in actual stock through sale and demolition.

*Data source:* NHSC (2010, p. 89).

Some participants claimed that changes to current housing policies regarding the eligibility for housing authority status (and, thus, access to government funding) would help increase the supply of social housing. Wintringham, a not-for-profit organisation (NFP), noted the benefits of qualifying for this status:

> … we have created a housing subsidiary, Wintringham Housing Ltd, which has successfully applied to the Victorian Housing Registrar at the Office of Housing to become a Housing Association and therefore eligible for growth funds. (sub. 195, p. 14)

Benetas and ACSA argued that current eligibility rules constrain new entrants from providing social housing:

> Many NFPs are not in a position to become registered housing providers, but need access for government grants and funding for housing developments for older people. Consideration needs to be given to allow NFPs with land holdings and the ability to develop this land for older persons' housing to be given access to government housing grants and funding without become registered housing authorities. (Benetas, sub. 141, p. 35)

> … aged care providers are not routinely recognised by Federal and State Governments as legitimate players in the provision of housing for people on low and medium incomes. Aged care providers should be able to compete on a level playing field with other housing providers for government funding and asset transfers. (ACSA, sub. 181, p. 29)

Similarly, the Macedon Ranges Shire Council, in discussions with the Commission, referred to this as a barrier to local governments providing social housing. The council has previously described this problem:

> … the potential for growth of the Macedon Ranges social housing program is constrained by its current structure. It appears that all future housing growth funds provided by State Government will only be provided to registered housing organizations. But … Macedon Ranges Shire Council is unable to register as a Housing Association under the regulatory system established by the State Government. (Macedon Ranges Shire Council 2007, pp. 19–20)

However, the scale of projected unmet demand shown in figure 10.1 has led to calls for housing policy to focus more on facilitating the development of age-specific housing. ACSA and COTA drew attention to the projected shortages in social and private rental markets, and stressed the need for a whole of government housing policy for older people which is focused on maintaining and enhancing the existing stock of homes, and increasing the supply of affordable and appropriate housing (sub. 181, p. 6 and sub. 337, pp. 35–6 respectively):

> These figures dramatically highlight the need for a more concerted, well-resourced and specific focus on housing supply for older Australians than has been the case for many years. COTA believes the Productivity Commission must draw this to the attention of governments … (COTA, sub. 337, pp. 35–6)

To this end, ACSA and COTA called for a national older persons' housing strategy (sub. 181, p. 4).[5] A central feature of that national strategy is action to support and upgrade over 30 000 independent living units built between the 1950s and the 1980s

[5] Major elements of that strategy are a national approach to home maintenance and modification services and adopting universal design principles in built environments and urban design. These are discussed in sections 10.1 and 10.2 respectively.

(box 10.10), reflecting concerns that they are at risk of being lost as a source of affordable housing (ACSA, sub. 181, p. 29).

### Box 10.10 **Independent living units: COTA's view**

Over 34 700 independent living units (ILUs) were developed between 1954 and 1986 with Commonwealth Government assistance.

Funding for the ILU program was transferred from the Commonwealth to the states in 1986, placing them in competition for funding with State Housing Authorities and community housing organisations. The result is that ILUs have been largely ignored by funding bodies ever since. Despite precarious funding, ILUs remain an important social housing option for older people with relatively low assets and incomes.

Despite ILUs currently providing 27 per cent of all social housing for older Australians, there is no systematic approach to funding the capital work now required. Much of the ILU housing stock is now between 40–50 years old and in urgent need of upgrading, reconfiguration and in some cases, replacement. Most of the units are small (one bedroom) and below community standards. Organisations, both large and small, are increasingly deciding that they can no longer afford to operate ILUs.

At a time when the large number of older people with unmet housing needs is increasing, this forgotten but very significant social housing sector urgently needs an injection of capital that will enable them to continue to provide secure housing for older people with low incomes and limited assets.

*Source*: COTA (sub. 337, Attach. 4, p. 3).

The Benevolent Society also highlighted the significant role that independent living units (ILUs) play in providing housing for older people. It noted the poor quality of much of that housing stock and called for greater investment in social housing for older people, including ILUs (2010, p. 31).

This particular issue is already registering at the Australian Government level. The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) is aware of the role played by ILUs in the provision of age-appropriate housing and of concerns about the state of the existing housing stock. There is, however, limited information on the ILU sector and FaHCSIA, as a first step to inform future policy in this area, has commissioned a national survey of providers of ILUs (FaHCSIA, pers. comm., 24 November 2010). The survey, which began in August 2010, is being undertaken jointly with ACSA and COTA, with input from the Department of Health and Ageing (ISR 2010).

With regard to the call for a national older persons' housing strategy, the Commission notes that the Government already has a range of housing policies aimed at improving the supply and affordability of housing for the community

overall. It has also, with state and territory governments, committed to the specific housing initiatives (NAHA, SHI, etc) listed in box 10.11. State and territory governments also have specific policies aimed at housing older people (box 10.11). Any national older persons' housing strategy would need to be integrated with these existing national, state and territory government policies.

### Box 10.11 Examples of state and territory policies aimed at housing older people

New South Wales

*New directions in social housing for older people*: a five year plan (2006–2011) focussing on providing more appropriate housing for older people and linking housing assistance programs to support services so that older people can age in their homes.

Northern Territory

*Housing the Territory*: a public housing strategy announced in March 2009 that will, among other things, create more rental housing that is affordable for low and middle income households and build more publicly funded housing, including seniors villages.

*Sources*: NSW DoH (2006); NT DoHLGRS (2009).

In the face of the growing challenge of housing an ageing population, there is merit in a national level assessment of how well the housing needs of people as they age are being met within existing general housing policies and within the recent specific initiatives listed in box 10.12. That assessment would identify what changes or additional policies (including extending the specific initiatives and means by which financially disadvantaged older Australians could better access private retirement village or ILU accommodation on a rental basis) might be required to ensure those needs are met. FaHCSIA would be best placed to lead such an assessment. The Office for an Ageing Australia could assist in that assessment to help ensure that the interfaces with other policies affecting older people (such as health and aged care support) were considered in reaching a view on the adequacy of existing housing policies to cater for our ageing population. Arising from those assessments, a national strategy to meet the growing demand for affordable housing for older Australians should be developed.

DRAFT RECOMMENDATION 10.3

***The Council of Australian Governments should develop a strategic policy framework for ensuring that sufficient housing is available that would cost effectively meet the demands of an ageing population.***

### Affordability of rental accommodation for older Australians

The Commission's previous research found that population ageing will create pressure for greater housing assistance to lower-income older people who do not own their homes and need to access the rental market (PC 2005b, pp. 223–31). More recently, the NHSC noted that there will be a considerable increase in the number and proportion of older people seeking housing assistance for private and public rental accommodation (NHSC 2010, p. 148). For many of these, affordability will be a major problem:

> Commonwealth Rent Assistance and the aged pension will not be adequate to deliver affordability outcomes for the aged in the private rental sector. (Wood et al. 2010, p. 2)

The shortfall in housing projected by the NHSC (and the upward pressure this will place on rent levels) means rental assistance will need to increase if governments are to address the affordability problem facing public and private renters (including older renters). This issue was examined by the Henry review, which concluded:

> Rent Assistance payment rates should be increased so that assistance is sufficient to support access to an adequate level of housing. Maximum assistance should be indexed to move in line with market rents. Rent Assistance should be extended to public housing tenants, with recipients generally paying rents that reflect market rates, subject to transitional arrangements.
>
> A new source of funding should be made available in respect of the tenants who have high housing needs, such as those with high costs due to disability or people likely to face discrimination in the private market. The payment would be based on the needs of recipients and where practical directed by them to providers of their choice. (Henry 2010, p. 491)

The Commission notes that changes along these lines would help address its previous concerns about the adequacy of housing assistance to lower-income older people who do not own their own homes and are required to rent on the open market. The Commission believes that options to enhance the ability of financially disadvantaged older Australians to rent privately should be explored as a matter of priority. Initiatives to deal with the increasing rental pressures on financially disadvantaged older Australians should form part of the national strategy proposed in draft recommendation 10.3.

## 10.4 Regulation of retirement living options

Retirement living options are an important form of accommodation for older Australians. Retirement villages constitute the main retirement living option (table 10.5), although residential parks (caravan and manufactured home parks) are growing in importance (table 10.6) (Consumer Affairs Victoria 2009, p. iii).

Retirement villages are increasingly catering for older people requiring care and support. This has seen a growing number of villages being built which are integrated with residential aged care or built with serviced apartments and assisted living units which can readily accommodate the delivery of aged care support in these dwellings (Jones et al. 2010, p. 7; RVA 2010, p. 4; RVA, sub. 452, p. 11).

Table 10.5 **Retirement village accommodation in Australia, 2010**

| | *NSW* | *VIC* | *QLD* | *SA* | *WA* | *TAS* | *NT* | *ACT* | *Total* |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Number of establishments | | | | |
| Retirement villages | 600 | 356 | 262 | 393 | 192 | 38 | 1 | 28 | 1 870 |
| | | | | | Number of contained dwellings | | | | |
| Serviced apartments | 2 910 | 1 672 | 1 495 | 1 071 | 282 | 53 | 0 | 22 | 7 505 |
| Independent units | 33 682 | 21 841 | 21 400 | 14 199 | 13 026 | 1 390 | 64 | 1 407 | 107 009 |
| Total dwellings | 36 592 | 23 513 | 22 895 | 15 270 | 13 308 | 1 443 | 64 | 1 429 | 114 514 |

*Source*: RVA (sub. 424, p. 16).

The Retirement Village Association (RVA) estimated that the 1870 villages identified in table 10.5 accommodated over 160 000 residents (sub. 424, p. 3). This number of residents is comparable in size to the number in residential aged care.

Nationally, retirement villages house about 5.3 per cent of the population over the age of 65, although some states have a significantly higher rate, with Western Australia at about 7 per cent and South Australia nearing 8 per cent (RVA 2010, p. 7). Significantly higher rates occur in regional growth areas such as Mandurah in Western Australia (18 per cent), Maroochy in Queensland (17.2 per cent) and Gosford in New South Wales (over 14 per cent) (JLL 2008, p. 4).

Since the 1970s, retirement villages have been the fastest growing type of housing oriented to the needs of older people in Australia (Stimson 2002, p. 6). Moreover, this form of accommodation is expected to grow in importance (Aged Care Queensland, sub. 199, appendix 7). An indication of this growth was provided by Masonic Homes Limited, citing results from a Colliers International report on retirement living:

> Considering the market penetration rate [of retirement village living] has increased from 3.5 per cent in 2001 to 5.0 per cent today we would expect this trend to at least continue over the next two decades … and equal 6.0 per cent by 2016 and 7.2 per cent by 2026. This would equate to approximately 370 000 persons choosing to reside in a retirement village by 2026. (sub. 124, pp. 16–17)

The RVA considered that the combination of an ageing population and a greater understanding of the benefits of retirement village living could result in national penetration rates in excess of 7.5–8 per cent by 2025 (RVA, sub. 424, p. 16).

A variety of tenure arrangements is used in retirement villages, for example, leases, licences, body corporate and strata titles, company titles and unit trusts. Rental models are emerging, although these mostly occur in community, social or special needs retirement village housing (RVA, sub. 424, p. 12).

As noted, residential parks are growing in importance as retirement living options, although they accommodate only about 0.9 per cent of households (13 935 households) with a reference person 65 or older (Davy et al. 2010, p. 25). Almost all long term residents of housing-oriented residential parks own their own dwelling and rent the site, although a small proportion rent both the dwelling and the site. No residents own the site, which has implications for security of tenure.

Table 10.6 **Residential park accommodation in Australia,[a] 2010**

| | | *Capacity* | | | | |
|---|---|---|---|---|---|---|
| *Period* | *Establishments* | *On-site vans* | *Other powered sites* | *Unpowered sites* | *Cabins, flats, units and villas* | *Total capacity* |
| | *no.* | *no.* | *no.* | *no.* | *no.* | *no.* |
| Short term residence [b] | 1 425 | 12 827 | 123 607 | 32 297 | 28 318 | 197 049 |
| Long term residence [c] | 213 | 3 704 | 15 230 | 1 659 | 7 494 | 28 087 |

[a] Comprising establishments with 40 or more powered sites and cabins, flats, units and villas. [b] Short term accommodation is defined as residence for less than two months. [c] Long term accommodation is defined as residence of two months or more.

*Source*: ABS (2010d).

## The regulatory framework for retirement living

Retirement villages are regulated by specific legislation in each state and territory (table 10.7). The legislation covers most aspects of retirement village ownership, operation and management. Each jurisdiction has its own definition of what is and what is not a retirement village (Minter Ellison 2010, p. 6).

Table 10.7 **Retirement village state/territory legislation**

| *Jurisdiction* | *Key legislative instruments* |
|---|---|
| New South Wales | *Retirement Villages Act 1999*<br>Retirement Villages Regulations |
| Victoria | *Retirement Villages Act 1986*<br>Retirement Villages Regulations 1 and 2 |
| Queensland | *Retirement Villages Act 1999*<br>Retirement Villages Regulations |
| South Australia | *Retirement Villages Act 1987*<br>Retirement Villages Regulations |
| Western Australia | *Retirement Villages Act 1992*<br>Retirement Villages Regulations<br>Fair Trading (Retirement Villages Code) 2009 |
| Tasmania | *Retirement Villages Act 2004*<br>Retirement Villages Regulations |
| Australian Capital Territory | Retirement Villages Industry Code of Practice |
| Northern Territory | *Retirement Villages Act 1995*<br>Retirement Villages Regulations |

*Source*: Davey et al. (2010, p. 77).

Broadly, areas regulated by the legislation include the establishment and registration of retirement village schemes, operators' disclosure obligations to prospective residents, the process of entry by residents into villages, the relationship between residents and operators during occupation, the financial operation and management of villages, and the process of departure by residents from villages (Minter Ellison 2010, p. 4).

The different approaches adopted by state and territory governments mean retirement villages legislation varies widely across jurisdictions. Some have lengthy and detailed legislation, while others have comparatively little and the ACT currently has none. Further, common areas that are regulated in many, or all, jurisdictions are often dealt with in different ways (Minter Ellison 2010, p. 5).

Residential parks are regulated by state and territory legislation. In some jurisdictions they are covered under Residential Tenancy Acts, while others have specific residential park legislation (table 10.8). In some cases, residential park living may be regulated under retirement village legislation. In Victoria, for example, a retirement village is defined by its function and not by type of operator.

Thus, if a residential park operates as a retirement village it may be regulated under Victoria's Retirement Village Act (COTA 2009, p. 2).

Table 10.8 **State/territory legislation of residential parks**

| *Jurisdiction* | *Key legislative instruments* |
|---|---|
| New South Wales | *NSW Residential Parks Act 1998*<br>*Residential Tribunal Act 1998* |
| Victoria | *Residential Tenancies Act 1997*<br>Residential Tenancies (Caravan Parks & Movable Dwellings) Regulations 1999 |
| Queensland | *Manufactured Homes (Residential Parks) Act 2003*<br>*Residential Tenancies Act 1994* |
| South Australia | *Residential Parks Act 2007*<br>*Residential Tenancies Act 1995* |
| Western Australia | *Residential Parks (Long-stay Tenants) Act 2006*<br>*Residential Tenancy Act 1987*<br>Western Australian Caravan Parks and Camping Grounds Regulations 1997 |
| Tasmania | *Residential Tenancy Act 1997* |
| Australian Capital Territory | No specific legislation |
| Northern Territory | No specific legislation |

*Source*: Davy et al. (2010, p. 81).

## Are regulatory changes warranted?

### *Alignment with Commonwealth Government aged care regulation?*

The terms of reference require the Commission to examine whether the regulation of retirement specific housing should be aligned more closely with the regulation of the aged care sector.

Some participants favoured such alignment. The Retirement Village Residents Association expressed dissatisfaction with current regulation, as it could not guarantee transition from retirement village living to residential care operated by or co-located with their residential village. It considered this concern would be solved by aligning retirement village regulation with that of aged care:

> The benefits of Retirement Village living could be maximized if the responsibility for the villages was being taken by those government bodies which are responsible for hostel and nursing home care. … even if a Retirement Village has a hostel or nursing

> home, attached to it or close by, it does not operate on the same basis as the self-care village, and village residents have no rights to a place within hostel or nursing home accommodation. If there was better alignment within the whole of this accommodation sector, the transition for a village resident, or for their spouse, to further care could be made easier and less traumatic. (sub. 30, p. 1)

However, even under current aged care regulation, residential aged care providers are unlikely to guarantee a place for a potential resident at some unspecified time in the future. This stems from the interplay of a number of factors: the current quota system, the uncertain demand for limited residential care places, and the commercial imperative on residential aged care providers to operate at close to full occupancy. Several of their concerns are being addressed through other proposed reforms contained in this report.

The Commission's proposal to remove the current quotas on residential care places (draft recommendation 6.3) would take one of these factors out of the equation. This change would give retirement villages greater scope to provide for the transition to residential aged care — an option clearly valued by retirement village residents. This outcome would not require any aligning of regulation. Further, the Commission's proposals for a single integrated system of care provision and for consumer choice of an approved provider/s and the mix of care would mean retirement village residents will be better able to access increasing levels of care in their own dwellings. This partly addresses residents' concerns about not being able to age in their village community.

Accordingly, the Commission considers that aligning retirement village regulation with that of aged care would provide no guarantee of the outcome sought by the Retirement Village Residents Association.

Sunrise Supported Living favoured aligning some aspects of retirement village regulation with that of aged care to address perceptions that the quality of care available in villages is sub-standard. It noted:

> Retirement Villages do not require formal accreditation and have no governance to ensure standards are met. The opinion of many of the general public and health professionals is that the quality of care provision is not regulated and therefore must be sub standard. In our Village that is certainly not the case, but we struggle to get that message across to aged care referral sources. (sub. 38, p. 3)

and recommended introducing:

> … a level of governance and legislation in line with the aged care sector — e.g. Quality Reporting to ensure standards are met across all community service providers. (sub. 38, p. 3)

However, the National Presbyterian Aged Care Network (sub. 110, p. 3) believed that aged care style regulation for retirement villages was overly prescriptive (and, by implication, imposed an excessive cost burden). If aligning regulation adds to the regulatory burden of developing and operating retirement villages, it would prejudice the supply of retirement village housing and their affordability.

The Retirement Village Association (RVA) argued that aligning regulation is not needed in view of the industry's rigorous self regulation and independent assessment of standards:

> Villages are not subject to the same legislative compliance that governs aged and community care, although the [Retirement Village Association] has developed a widely accepted accreditation scheme that undergoes continuous improvement. The Australian Retirement Village Accreditation (ARVA) scheme was established to ensure member villages provide the highest levels of quality to residents. (RVA, sub. 424, p. 19)

Further, it stated that its system of accreditation successfully promotes high service standards without adding a heavy compliance burden for operators. This, it claimed, contrasts with aged care, where the administrative burden imposed by the accreditation system means resources are deployed away from customer care and into office-based compliance tasks (sub. 424, p. 19).

Peak bodies (e.g. ACSA, sub. 181, p. 30) and individual providers also argued that retirement villages were just another form of housing and it was not appropriate to regulate them under aged care regulation. ECH, Eldercare and Resthaven, for example, noted that:

> Regulation of the retirement village and retirement living sector remain the province of State and Territory Governments and separate from Federal aged care regulation. (sub. 100, p. 5)

They concluded:

> We see the regulatory control of retirement housing as being outside the Federal aged care system and remaining at State level. Retirement villages are but one housing option for older people … Housing is a State Government responsibility and should not be confused with the responsibility for aged care services that might be provided to the occupant. (sub. 100, p. 16)

The South Australian Government supported the providers' position that alignment is not warranted, noting that:

> In South Australia the retirement village industry generally interacts well with the aged care system, with residents being able to access HACC and packaged care within their homes.
>
> The regulation of retirement villages should not be aligned more closely with the aged care system. (sub. 336, p. 19)

A possible reason for aligning regulation might be if the co-location and integration of retirement village living and residential aged care creates an excessive and unnecessary regulatory burden on operators. However, in its discussions with various operators, none indicated to the Commission that this was the case, and all noted that the separate regulation was not an issue for them. In this regard, Capital Cove recommended:

> Where villages choose to provide care services through dedicated and licensed facilities within the boundary of a retirement village, that those facilities continue to be governed by the requirements of the *Aged Care Act*, with no cross reference to the separately regulated retirement village component. (sub. 452, p. 15)

In view of the above, the Commission concludes that aligning retirement village regulation with that of aged care is not warranted. Accordingly, retirement village regulation should remain the province of state and territory governments.

DRAFT RECOMMENDATION 10.4

***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.***

### *Changes to state and territory retirement village regulation?*

Submissions raised other concerns with retirement village regulation which, they argued, justified changing state and territory legislation. These concerns may be categorised from the perspective of consumers/residents and of providers/operators.

#### *Consumer/resident perspective*

Submissions were critical of the regulation of retirement villages in a number of (interrelated) areas. Of particular concern were:

- complex and confusing contracts that were presented to new entrants
- inequitable financial terms and conditions (particularly for deferred management fees and the sharing of capital gains on the re-sale of village units)
- prudential oversight and security of residents' investments.

Some submissions observed that residents' contracts are often written in vague or general terms, and were complex and confusing (e.g. Retirement Village Residents Association, sub. 30, p. 2; Pam Graudenz, sub. 70, pp. 2–3). This situation raised fears that vulnerable residents were being exploited by retirement village operators and managers (Rob Harvie, sub. 104, p. 1; J. Wynne, sub. 368, p. 31; Aged Care Crisis, sub. 433, p. 23). For some participants, such as Leone Huntsman, these

concerns were sufficient to dissuade them from recommending retirement village living to others:

> … the retirement village is a wonderful model for living for people as they age. However, I would advise friends against buying into retirement villages until the lack of protection currently afforded residents is rectified. (sub. 71, p. 1)

Submissions were critical also of the financial arrangements facing residents. Pam Graudenz (sub. 70, pp. 2–3) and Neville Carnegie (sub. 89, p. 4) highlighted the signficant differences in entry costs, the deferred management fee retained by developers and capital gains distribution. As an example of the latter, Rob Harvie (sub. 104, p. 2) noted that the share of capital gains retained by the developer on re-sale could vary from 10–100 per cent. Robyn Gwynne gave an example of how onerous these exit costs can be:

> Some $50 000 will be imposed on me when I sell due to exit fees, which diminishes my future buying power considerably. (sub. 90, p. 1)

To help address the problem of complex and confusing contracts, the Retirement Village Residents Association (sub. 30, p. 2) proposed national legislation, incorporating standard contracts for each of the different types of financial arrangements (e.g. leasehold, loan-license and strata title). Similarly, Charles Adams suggested:

> Australian state legislation should be changed to ensure all future potential retirement village consumers have a choice of contracts. (sub. 33, p. 4)

As a matter of principle, such contracts should embody transparent financial terms and conditions to facilitate fully informed decision making by new entrants. This approach would be consistent with the consumer protection focus of retirement village legislation and with the thrust of the RVA's accreditation system.

Finally, Pam Graudenz, sub. 70, pp. 2–3 and Neville Carnegie, sub. 89, p. 3 also queried the adequacy of prudential regulation and monitoring of the financial structures of retirement village developers and operators. The consequences of poor regulation in this area can be serious for residents. Neil Carnegie, for example, referred to past instances in NSW when vulnerable elderly people who 'purchased' their retirement village units lost all their capital when the operator went bankrupt. These concerns have added relevance in view of Prime Retirement and Aged Care Property Trust's recent move into receivership.

With regard to this last area of concern, the Commission notes that commercial failures and their consumer consequences are economy-wide issues, and not confined to the retirement village arena. Commonwealth Government regulation and regulators (e.g. ASIC, APRA) exist to address these issues.

These (and other) concerns about current state and territory legislation should be viewed in the context of a responsive regulatory environment. Particularly important in this regard is that state and territory legislation has shifted away from the focus of protecting investors, prevalent prior to the mid-1980s, and towards protecting consumers/residents (Aged Care Queensland, sub. 199, p. 26).

Moreover, state and territory legislation inherently focuses on issues of importance in their jurisdiction, and can be reviewed on a regular basis and amended to correct deficiencies (Minter Ellison 2010, p. 6):

> A hallmark of the retirement villages legislation in Australia is the growing pace and scope of review and amendment by the governments in most jurisdictions. This is driven to a large extent by the increasingly consumer-focussed agendas being adopted by governments everywhere. (Minter Ellison 2010, p. 5)

In Western Australia, for example, ongoing monitoring of problems in the operation of retirement village legislation occurs through complaints handled by the Consumer Protection Division of the Department of Commerce. Information received through this means feeds into the legislation reform process. In addition to the current review of legislation in Western Australia, the ACT is also examining the possible introduction of retirement village legislation.

The RVA also emphasised that its members are now subject to a rigorous self regulation system via their accreditation process, which does much to address the sorts of concerns raised in submissions (sub. 424, p. 19). Although Neville Carnegie claimed the RVA accreditation system 'lacks accountability and credibility' (sub. 89, p. 4), the SA government indicated that its application to the industry more generally would benefit village residents (sub. 336, p. 19):

> … the investigation of the introduction of an accreditation system for retirement villages may be of more practical use and benefit residents. There is a voluntary accreditation system operated by the Retirement Villages Association (RVA). It is noted that there are minimal complaints regarding village practices from member villages of the RVA. (sub. 336, p. 19)

The concerns identified in submissions should also be viewed in the context of survey evidence that shows very high resident satisfaction rates. Independent research commissioned by the RVA in New South Wales found that for 98 per cent of residents, moving to a village either 'met or exceeded their expectations' (Capital Cove, sub. 452, p. 25). Capital Cove also supplied evidence of a similar result for residents in villages operated by the St Ives Group — a major retirement village and community care provider in Western Australia (sub. 452, p. 26). These findings are consistent with earlier evidence from Stimson (2002) which showed retiree satisfaction levels with villages to be very high.

*Provider/operator perspective*

Concerns from the providers' perspective centred on:

- constantly changing legislation
- legislative changes not being driven by evidence or mindful of the industry's self regulation system
- significant differences in legislation across jurisdictions.

The industry highlighted the constantly changing legislative environment which, it argued, adds to costs and dissuades investment (Capital Cove, sub. 452, p. 4). A report commissioned by the RVA described this situation thus:

> Future changes have the potential to impact financial returns and increase compliance costs. This volatile regulatory environment presents operators with risks and challenges not typically encountered in other business sectors. (Minter Ellison 2010, p. 5)

The RVA also noted these changes have a cost which is ultimately borne by retirement village residents:

> However, the constant changes and up-scaling of various aspects of regulation only serves to increase consumer uncertainty and adds cost to the industry. The net result is often the requirement to raise service charges, which impacts the resident and does not promote affordability. (sub. 424, p. 25)

A more fundamental concern for some providers was that, in their view, much of this change was ill advised (not informed by evidence) and did not deliver benefits to warrant the cost of that change. Capital Cove, for example, was critical of the growing regulatory burden despite there being no research evidence showing there is a 'problem in the industry' (sub. 452, p. 24). It claimed that the increase in regulation over the last 15 years has delivered no measurable improvement in outcomes (sub. 452, p. 4). To address the lack of evidence based legislative change, Capital Cove proposed:

> That Governments assisted by the industry commission independent research in Retirement Villages to assess the attitudes and issues of existing residents, with a view to structuring legislation to address any issues requiring attention. (sub. 452, p. 26)

Further, providers viewed much of the changing legislation as unnecessary because the industry's self regulation accreditation system was a credible alternative to deal with any problems (RVA, sub. 424, p. 19). Aged Care Queensland regarded an industry led accreditation scheme as the best regulatory option to provide consumer assurance, facilitate government oversight and drive public accountability (sub. 199, p. 26 and appendix 7).

Providers viewed the lack of consistency in retirement village legislation across jurisdictions (noted above) as a major impediment for the industry. The RVA argued this situation creates considerable confusion and administrative costs for operators managing national portfolios. Moreover, with large listed entities and developers increasing their presence in the industry, this problem is growing:

> … [the industry] is struggling under the weight of regulatory burden that exists on a state-by-state basis. Given the changing profile of the sector, in which some operators span multiple states and have to adapt to multiple legislative requirements, … Many operators are faced with the management of complicated business models that increase administrative and compliance costs. (RVA, sub. 424, p. 25)

To address this concern, the RVA sought '… more certainty and transparency in regulation, which could in turn be applied across jurisdictions' (sub. 424, p. 26). The RVA and Capital Cove suggested that this objective could be assisted by legislation incorporating a requirement for villages to be accredited under the RVA's national accreditation scheme (sub. 452, p. 6). The Retirement Village Residents Association also thought a national approach was warranted:

> All State Governments have different legislation covering Retirement Villages, and can be poorly drafted, or biased towards operators. Hence, there are no cohesive guidelines for Retirement Villages around the country. A national approach … would be a great step forward in eliminating confusing and convoluted legislation and the uncertainty and disputation which often accompanies Retirement Village living. (sub. 30, p. 2)

Some 'harmonisation' of retirement village legislation has already occurred and, it appears, more is on the way:

> … most States and Territories enacted specific retirement villages legislation in the 1980s and 1990s. Importantly, Queensland and New South Wales repealed their legislation and replaced it with more detailed and comprehensive legislation in 1999, which now serve as the benchmark for recent, current and future reforms in the other States and Territories. (Minter Ellison 2010, p. 6)

> We understand that in 2011, independently of any review of the [Retirement Village] Act itself, certain requirements in the Victorian legislation will be 'harmonised' with those in New South Wales. (Minter Ellison 2010, p. 12)

In light of the above, the Commission considers there is merit in pursuing greater consistency of legislation across jurisdictions, particularly as the growing presence of larger corporations presages the emergence of a more national market. That legislation would, however, still remain the responsibility of each state and territory government.

The Commission considers that while the development of consistent principles and regulation should proceed at the state and territory government level, COAG would be an appropriate vehicle to oversee the harmonisation process.

DRAFT RECOMMENDATION 10.5

***State and territory governments should pursue nationally consistent retirement village legislation under the aegis of the Council of Australian Governments. Changes to state and territory government legislation under this process should:***

- ***be informed by research jointly commissioned by the industry and government***
- ***have regard to the industry's accreditation process.***

### *Changes to state and territory regulation of residential parks*

The Commission's consultations with stakeholders identified concerns about security of tenure and whether the layout of residential parks and the dwellings in them were up to the task of facilitating adequate ageing in the home or the delivery of aged care (including access for emergency vehicles such as ambulances).

On the first of these, some stakeholders noted that rising real estate prices have increased the likelihood of residential parks being sold to developers and, thus, of residents being dispossessed. There is, however, no simple solution to this concern. For example, more secure or longer tenancies would see owners raise entry costs or ongoing fees to compensate for not being able to sell when the land becomes more valuable for other uses. Greater security would thus be at the expense of reduced affordability. This catch-22 situation has led some states to introduce regulation to ensure tenancy terminations are signalled longer in advance, and to improve complaint handling and arbitration procedures.

On the second, the Commission notes that residential parks are subject to regulation designed to protect the health and safety of occupiers and residents. For example, regulations mandate minimum distances between structures and minimum set backs from roads to allow emergency access in a caravan park during a fire (see PWC 2010, p. 8). Whether these regulations remain appropriate in the face of an ageing Australia and a changing age composition of residents is an issue for regulators in each state and territory.

The Commission supports the view that, as in Victoria, where residential parks function as retirement villages, they be treated as such under the retirement village legislation of the respective state or territory. Where this is the case, those residential parks would be included within the Commission's draft recommendations (above) for nationally consistent regulation for retirement villages.

## 10.5 Residential care building regulations

This section only deals with particular building regulations affecting residential aged care facilities. Other factors affecting residential care are discussed elsewhere in the report.

Some participants drew attention to the excessive burden associated with building regulations applicable to residential aged care facilities. IRT, for example, noted:

> Currently, residential aged care buildings are the sole development type in Australia to be regulated by legislative requirements additional to the BCA [Building Code of Australia]. Neither hospitals nor other highly complex buildings face such a superfluous burden. The Federal aged care certification requirements almost entirely mirror the BCA requirements, creating unnecessary red tape and inefficiencies. (sub. 356, p. 7)

Similarly, the Aged Care Industry Council (NSW & ACT) Building Committee observed that certification has run its course, and that the building requirements for residential aged care should default to the BCA (sub. 429, p. 2).

The Commission recently examined building certification for residential aged care as part of its review of regulatory burdens on business (PC 2009a). Its subsequent report included recommended changes to fire safety declarations and building certification requirements. Amaroo Care Services Inc (sub. 98, p. 5) noted that these recommendations offer scope to reduce the complexity and cost of the building accreditation. ECH, Eldercare and Resthaven (sub. 100, p. 5) also called for the Government to act on those recommendations.

The Australian Government has accepted the Commission's recommendations to introduce exceptions reporting for fire safety declarations and to incorporate residential care building requirements into the BCA. For the former, it noted:

> Ongoing monitoring of the safety and environment of a residential aged care facility, including the management of fire risks and compliance with fire safety requirements, occurs through the accreditation process and the requirement to meet the Accreditation Standards. Exceptions reporting will be introduced requiring approved providers that are assessed as not meeting the requirements of state and territory or local authority requirements to report to [the Department of Health and Ageing] to allow for ongoing monitoring.
>
> The necessary legislative amendments will be made so that exceptions reporting can commence in respect of compliance in the 2010 calendar year. (Australian Government 2009a)

The Government subsequently amended the *Quality of Care Principles 1997* to replace the annual Fire Safety Declaration process with an exception reporting

process. From 1 July 2010, approved providers of residential aged care are only required to notify the Department if they become non-compliant with any applicable state or territory laws (including local by-laws) relating to fire safety in respect of any residential care service operated by the approved provider (DoHA 2010j).

For the latter recommendation, the Government stated:

> The Government will consult with the Australian Building Codes Board (ABCB) and aged care stakeholders to develop a proposal by 30 June 2010 to consolidate building requirements for the ABCB's consideration. (Australian Government 2009a)

Since then, the Department of Health and Ageing has been consulting with aged care stakeholders and the Australian Building Codes Board. Although feedback has indicated support for incorporating privacy and space ratios into the BCA, it has also identified technical issues to be addressed and raised possible alternative approaches. The department is considering the implications of the issues raised through the consultation process and will consult further with the Australian Building Codes Board.

# 11 Delivering care to the aged — workforce issues

**Key points**

- Aged care services are delivered by informal carers, the formal paid workforce and volunteers. Medical practitioners and allied health professionals provide health care services which complement, and affect the demand for, aged care services.
- Aged care services are labour intensive, particularly direct care services. As such, access to a sufficient and appropriately trained labour supply is essential to ensure that quality and safe care can be delivered when and where required.
- Informal carers provide the bulk of care services to older Australians.
  - Carers should be better supported in their endeavours through a variety of measures including greater access to information, more education and training, better access to respite and greater workplace flexibility.
- The demand for aged care workers is expected to significantly increase as a result of the increasing number of older Australians requiring care and support and a decline in the relative availability of informal carers.
- The supply of workers is problematic. The formal aged care system currently faces difficulties in attracting and retaining workers. These difficulties are expected to intensify due to increasing competition for workers as the overall labour market tightens in response to population ageing.
  - Workforce strategies to address these difficulties include paying competitive wages, improving access to education and training, developing well articulated career paths and better management, and reducing regulatory burden.
  - More training opportunities for staff in remote locations are needed.
- The development of regionally based multi-disciplinary health teams with an aged care focus may increase access to health services through enhanced peer support, professional development and practice innovation.
- Volunteers play a relatively small but important role in the delivery of aged care services and improve the quality of life for some older people.
  - The potential pool of volunteers is expected to increase in the future but the aged care sector will need to offer meaningful volunteer experiences to attract them.
  - In addition, volunteers could be better supported to ensure they are willing to engage and continue to offer their services.

As outlined in chapter 3, the demand for aged care workers in Australia is expected to increase significantly as a result of the increasing number of older Australians requiring care and support and a decline in the relative availability of informal carers.

This chapter explores the future demand for those people providing care and support, both informally and through formal government programs (section 11.1). How informal carers can be better supported in their caring role is considered in section 11.2. Issues related to attracting and retaining aged care workers are investigated in section 11.3. Section 11.4 examines the roles of the health workforce in caring for older Australians, while ways to more effectively harness volunteers are examined in section 11.5.

## 11.1 Who delivers care services for the aged?

### Scope of workforce considerations

Older people require a variety of different care and support services. Most of these services are provided by family, friends and other informal carers. Personal and health care services represent the vast majority of services provided under the aged care system.

Services are also delivered through health and other social support systems, including disability and welfare. The capacity of the aged care system to provide timely and appropriate care can be significantly affected by access to services in other support systems, especially health services. A number of benefits can be realised where the interfaces between these systems are improved, including seamless service delivery and a reduction in service gaps for the client, enhanced efficiency in service delivery and reduced incentives to shift costs between services.

As outlined earlier in the report, personal care needs are those associated with activities of everyday living, such as showering, feeding and laundry. Delivering these services does not generally require a high level of clinical expertise compared to the delivery of health care services, but caring skills and relationship skills are very important and play a significant role in the quality of the care experience.

The Commission acknowledges that other support services are delivered to many older people. However, these services are generally provided by workers who do not require aged care specific skills (for example, tradespeople involved in home modifications, drivers involved in community transport or cooks preparing meals for residents). While it is important that there are enough of these types of support

workers that are appropriately trained, these workers should be considered in the context of their respective sectors. Accordingly, they are not directly within the scope of this inquiry.

### The importance of labour in caring for the aged

Caring for the aged is labour intensive and requires a variety of skills. The aged care sector competes for care workers with a number of other sectors, primarily the health sector and the social and community services sector. There is a shortage of qualified workers in most of these sectors and, as such, there is strong competition for workers, especially nurses. This competition is expected to intensify as the demand for aged care and health services increases and the broader Australian labour market tightens as a result of population ageing.

There may be some opportunities to reduce the labour intensity and alter the skill mix involved in delivering aged care through new models of care and the use of assistive and information technologies. However, most applications of technology adopted by aged care providers have acted to complement the workforce — for example, by improving the working environment and improving the quality of care — rather than substitute for it. It would not be prudent to assume that technological developments will significantly reduce the relative demand for labour in the future.

## 11.2 Informal carers

Most older people want to be cared for by someone they trust, who loves and has time for them, who respects their right to make their own decisions and who helps them maintain their dignity and independence. In many situations, the older person's spouse and/or children provide most of the assistance with activities of everyday living and personal care. Extended family, neighbours and friends also provide support that facilitates a level of social inclusion between older people and their community. Informal carers of older people have been labelled the 'invisible' aged care workforce as they undertake their caring role out of the public spotlight and often with limited recognition and support.

The ABS Survey of Disability, Ageing and Carers, conducted in 2003, found that 240 000 people were the primary carers (that is, those providing significant levels of assistance) of people aged 65 and over (ABS 2004). There were also a small number of older Australians who were primary carers for younger people with a severe or profound disability ('older carers'). The Commission (PC 2008) estimated that there were approximately 2.3 million people providing some level of informal

care to older Australians in 2006. The Australian Government acknowledges the role of carers and the obligations they take on through a variety of supports, including income support and respite services.

Many government statements and public inquiries have highlighted the importance of informal carers and the contributions they make. They have also identified that many carers are financially and socially disadvantaged and may have poor health, partly as a result of their caring activities. In response, changes have been recommended to the support mechanisms available to carers and those they care for. For example, the National Health and Hospitals Reform Commission (NHHRC) recommended:

> … carers be supported through educational programs, mentoring and timely advice to allow them to participate in health decisions and communications (subject, of course, to the consent of those they care for). To sustain them in this role, carers must have better access to respite care. (2009, p. 124)

A strong and sustainable community of informal carers is an important foundation for caring for older Australians. They have a positive impact on the quality of life for older people through promoting social inclusion, maintaining social networks, supporting the provision of formal aged care services (particularly in community settings) and delaying or avoiding the entry of older people into residential care. From a societal perspective, informal carers are very cost effective compared to the replacement cost of their services by formal aged care programs.

The impact of a future relative decline in the availability of informal carers can be lessened, in part, by providing better support to assist them in their caring role.

The remainder of this section examines some initiatives proposed in submissions to better support carers and evaluates the recommendations of previous inquiries, where relevant. Much of the discussion and reforms proposed in this section are relevant to all informal carers, including carers of the younger disabled.

## Encouraging and supporting informal carers

The main issues raised in consultations and submissions relate to the availability and adequacy of support mechanisms for carers including:

- information about support services for carers and those that they care for
- education and training opportunities
- access to timely and appropriate respite (including day therapy and other options to reduce the caring load), including emergency respite

- access to other supports (including transport and assistive technologies) to reduce the caring burden
- income support available to carers and its effect on the ability of carers to participate in the workforce
- workplace flexibility.

As discussed in chapter 8, the support provided by carers to older Australians should be considered in the Australian Seniors Gateway assessment of an older person's needs. The approved services should include, as appropriate, community transport and planned respite. In addition, carers should be referred to carer support services (possibly as part of the National Carer Strategy, see below) which can provide specialist services for carers themselves, including facilitating support groups, providing counselling, education and training activities, and undertaking advocacy. Such services are likely to remain the primary brokers for emergency respite as currently undertaken by the National Carer Respite Centres, although this should be further considered in the development of the national carer strategy.

### *Information about carer support services*

Timely and appropriate access to information about the aged care system, carer support, and other support services (such as health, financial and social services) is essential to ensure carers access the services they, and those they care for, need and are entitled to receive. Complex, inconsistent and unclear information about the aged care system increases the burden on carers and can reduce their willingness to continue in their caring role. This was an issue raised in a number of submissions (Carers Australia, sub. 247; Psychogeriatric Care Expert Reference Group, sub. 299; Fairfield City Council, sub. 183). Carers NSW summarised the problem:

> 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)

It is envisaged that the Australian Seniors Gateway Agency (draft recommendation 8.1) will not only assist older people to access information about services but also assist carers by reducing the time and frustration they report in navigating the system and in accessing services for those they are caring for and themselves.

### *Education and training opportunities*

Informal carers are often under-prepared for the task of caring, despite their best intentions. Organisations representing carers, community aged care providers and carers themselves strongly argue for more education and training opportunities for informal carers so they can develop the skills necessary to provide quality care and reduce premature burnout.

Various organisations that support and represent carers' interests, including the state and territory branches of Carers Australia, Alzheimer's Australia and beyondblue, offer courses, workshops and seminars to assist carers in managing their caring role and the stresses associated with caring and other aspects of their lives. These organisations make some materials available in electronic formats (for example, online or DVDs) to assist carers who may not be able to physically attend education and training sessions, such as those in rural and remote areas.

There are also a number of government programs aimed at better educating the carer population and increasing their skill base, but the majority of these programs have been developed in an *ad hoc* manner. This was recognised by the House of Representatives *Inquiry into Better Support for Carers* which recommended that the Australian Government '… develop a national strategy to address the training and skills development needs of carers' (HRSCFCHY 2009, p. 92).

While the Australian Government agreed with this recommendation, it has not yet committed to increase funding above that which it currently provides to Commonwealth Respite and Carelink Centres that purchase services from appropriate organisations that undertake carer training.

The Commission's proposal to replace these centres with an Australian Seniors Gateway Agency and the Government's commitment to a National Carer Strategy (see below) provides an opportunity for revisiting the delivery of carer education and the quantum of funding devoted to it.

### *Respite services*

Respite services enable carers to take a break from their caring role by providing appropriate care alternatives for short periods of time (currently up to 63 days in total over a financial year). Options include in-home respite (including overnight), day respite (either in community or residential settings) and residential respite (which may be for extended periods). Most respite is pre-organised but there is also limited emergency respite.

The Australian Government as well as state and territory governments fund a range of different respite services, including the National Respite for Carers Program (NCRP), Home and Community Care (HACC) funded centre-based day care, Day Therapy Centres and respite provided as part of Veterans' Home Care. While there is no reliable data for the total amount of respite provided to carers of older Australians, data is available for certain programs. For example, in 2009-10:

- there were 59 602 admissions to residential services, equating to 1.35 million days of respite
- the National Respite for Carers Program provided over 5.1 million hours of respite in a variety of settings (DoHA 2010n).

The extent of unmet need for respite services by carers of older Australians, or even for all carers in total, is unknown. However, informal carers and organisations that represent carers report that there are significant problems accessing assessments for respite care and the services themselves, for both planned and emergency respite (chapter 5).

A lack of flexibility in the delivery of respite services is also an issue for many informal carers. As Carers NSW said:

> Respite needs to be more flexible, and driven less by fixed program structures and more by the needs of the people who use it. It is the services who must meet the needs of the people, instead of the current situation where it is the carers and older people who must meet the needs of the service or go without. Better respite is fundamental to making caring, and therefore the aged care system, sustainable. (sub. 211, p. 6)

There are also restrictions (usually governed by the specific program) on what type of respite can be provided, and what other services (such as domestic assistance) can be delivered as part of a respite service. The expansion of the consumer directed care models proposed by the Commission (chapter 8) should give older Australians and their carers more flexibility to purchase services, such as respite, that are best suited to their needs. According to Carers WA, such initiatives should be promoted as:

> Supporting carers with the provision of flexible respite services can save a later, much more costly, crisis-driven response such as early entry to residential aged care or into hospital. (sub. 276, p. 13)

The Australian Government has acknowledged that respite services need to become more accessible, available, affordable and responsive (Australian Government 2010h). As such, reform of the respite system is expected to be one the key areas of change as part of the National Carer Strategy.

### *Other support services*

The availability of other support services, especially transport and assistive technologies, can contribute to the ability and willingness of carers to continue caring.

Transportation services contribute to maintaining social inclusion as they are an essential linking service between older people and their community. However, many older people do not have easy access to affordable transport, and informal carers (and volunteers) often provide such services and spend a considerable amount of time doing so.

Appointments and other activities generally occur during business hours, and this can adversely affect the capacity of the informal carer to participate in the workforce. The benefits of respite may be reduced or even negated if the carer is required to transport the older person between home and the respite location.

Community transport schemes provide valuable assistance to older people and, indirectly, to their carers. These schemes often draw on volunteers (who may be reimbursed for their 'petrol costs') and contribute to the social capital of local communities. The Commission is proposing that such schemes should continue to be block funded in recognition of the important roles that they play (draft recommendation 8.4). In areas that are not well served, local councils can often be a focus for organising a community based scheme.

Assistive technologies can increase the independence of frail older people and reduce the physical and emotional burden on carers. For example, wheelchairs, home modifications and, in some cases, lifting devices, can limit the amount of physical exertion and, as a result, the injuries that carers may sustain as part of their caring activities. Greater access to these technologies can also reduce carer burnout and avoid or defer the use of more intensive aged care services. Chapter 10 explores the potential for expanding home modification programs to support carers by increasing the safety and independence of the older people they care for.

Counselling, peer group support and advocacy services can also play a significant role in supporting carers. Henry Brodaty observed:

> Supports for families pay dividends … Counselling and education with ongoing support can reap long lasting dividends in enabling family carers to support people with dementia at home longer. (sub. 45, p. 1)

Such support mechanisms are also important in culturally and linguistically diverse communities. The Multicultural Access Projects, Metro North (Melbourne) indicated:

> Culturally sensitive and competent emotional support and counselling will help to build strengths and resilience in many families, and assist them to make the best arrangement for the older person. (sub. 379, p. 15)

Specialist carer support services are best placed to undertake these activities as they can connect carers who have similar experiences and derive economies of scale in their delivery.

### *Income support*

Some carers are not able to participate fully in the workforce as a direct result of their caring responsibilities. The Australian Government recognises this and offers income support through the Carer Payment. The Australian Government also offers those carers with significant caring responsibilities a Carer Allowance to assist in covering some of the costs incurred as part of their caring activities. Most recipients of the Carer Payment also receive the Carer Allowance. In 2008-09, there were an estimated 52 050 carers of older people receiving the Carer Payment and 127 600 carers of older people receiving the Carer Allowance which resulted in outlays of $686.9 million and $484.7 million respectively (DoHA, sub. 482).

The main issue raised in submissions regarding the conditions associated with the Carer Payment and the Carer Allowance is the reporting basis for the determination of respite days, particularly residential respite. Centrelink operates on a calendar year basis while the Department of Health and Ageing (DoHA), and residential aged care services, operate on a financial year. From the experience of a member of the Association of Independent Retirees (NSW):

> It is extremely difficult for carers to satisfy both departments given the different systems and financial periods. (sub. 303, p. 8)

### *Working arrangements for carers*

As noted earlier, there are significant benefits from carers maintaining their connection to the workforce. In this context, Carers Australia observed:

> Many carers report that their employment status can have a dramatic impact on their social inclusion as they lose social contact in their working lives if they need to disengage from the workforce. (sub. 247, p. 15)

Submissions from organisations representing carers, governments and consumers argued that carers should be better supported through greater workplace flexibility. For example, the South Australian Government acknowledged that there can be inflexibilities in working arrangements for those with caring responsibilities:

> … it becomes more difficult to access or continue in paid employment that is open and flexible enough to acknowledge and allow irregular working conditions to assist the carer in their caring role. Consequently, women with care responsibilities are often restricted to part-time or occasional work. (sub. 336, p. 10)

Alzheimer's Australia WA also said:

> Measures aimed at reconciling the conflicting pressures of paid work and care should be addressed through workplace-based policies that allow flexible work, time off and paid care leave and/or home care and other services that can substitute for informal care so that informal carers can take or retain paid employment. (sub. 345, p. 12)

Some submissions called for the *Fair Work Act 2009* to be amended to allow all carers to request flexible working hours as is available for carers of children under school age or under 18 with a disability. However, the Government has not accepted a recent recommendation to this effect by the House of Representatives *Inquiry into Better Support for Carers* on the grounds that this Act already has significant provisions for flexible working arrangements which balances:

> … the need for employees to manage their work and family responsibilities with the genuine requirements of business. (Australian Government 2009c, p. 46)

In an increasingly constrained labour environment, employers will need to consider the flexibility of their workplace conditions to ensure the attraction and retention of experienced and valued employees.

## National Carer Strategy

The House of Representatives *Inquiry into Better Support for Carers* recommended '… a national carer strategy which builds on and complements state and territory carer policies' as part of a nationally consistent carer recognition framework (HRSCFCHY 2009, p. 65). In its response, the Australian Government agreed to lead the development of such a framework and has commenced a broad community consultation process to inform a 10 year agenda to better support carers by ensuring that:

> Policy, programs and services for carers are coordinated, responsive and targeted at all stages of caring. (Australian Government 2010h, p. 8)

Consistent with the issues discussed throughout this section, the goals of the National Carer Strategy are:

- better recognition for carers
- better support to help carers work
- better information and support for carers

- better education and training for carers
- better health and wellbeing for carers (Australian Government 2010h).

Given that carer support is currently administered in an *ad hoc* way across a number of programs and jurisdictions, the Commission supports the development of a National Carer Strategy. Further, the Commission believes that Carer Support Centres should be developed from the existing National Carelink and Respite Centres and offer a broader range of supports and services delivered on a regional or localised basis. The funding for such services could, in part, come from client directed entitlements as well as direct allocations depending on the client and service mix.

DRAFT RECOMMENDATION 11.1

***The proposed Australian Seniors Gateway Agency (draft recommendation 8.1), 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 and/or assisted referral for:***

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

***Carer Support Centres should be developed from the existing National Carelink and Respite Centres to provide a broad range of carer support services.***

## 11.3 The formal aged care workforce

Aged care employees make up around 22 per cent of the total health care and social assistance industry workforce (Martin and King 2008; ABS 2009b). Aged care employees involved in direct caring activities represent around 25 per cent of all employees engaged in health and community services occupations (Martin and King 2008; AIHW 2009b).

There were an estimated 262 000 people working in the aged care sector in late 2007 (Martin and King 2008).[1] Of these, 175 000 provided services in residential aged care facilities (RACFs) and 87 000 provided aged care services in community

[1] This figure represents the bulk of aged care workers but is considered an underestimate as outlined by Martin and King (2008).

settings. The vast majority of these workers (79 per cent) provided direct care services to older Australians.

Compared to the broader health and community services industry and all industries, residential and community aged care employees are more likely to be female, work shorter hours and be older (table 11.1).

Table 11.1 **Workforce characteristics: profiles for selected sectors**
2007

| | *Residential aged care* | *Community care* | *Health and community services* | *All industries* |
|---|---|---|---|---|
| | *%* | *%* | *%* | *%* |
| Female | 93 | 91 | 79 | 45 |
| Part time | 69 | 59 | 42 | 28 |
| 45 years or older | 60 | 70 | 46 | 37 |

*Sources*: Martin and King (2008); DEEWR (2008).

There is some evidence to suggest that the direct care workforce is being under-utilised, with a significant proportion of this workforce reporting that they would like to work more hours. Martin and King (2008), found that:

- in community care over 40 per cent of the workforce would like to work at least one hour more per week
- in residential care over 27 per cent of the workforce would like to work at least one hour more per week.

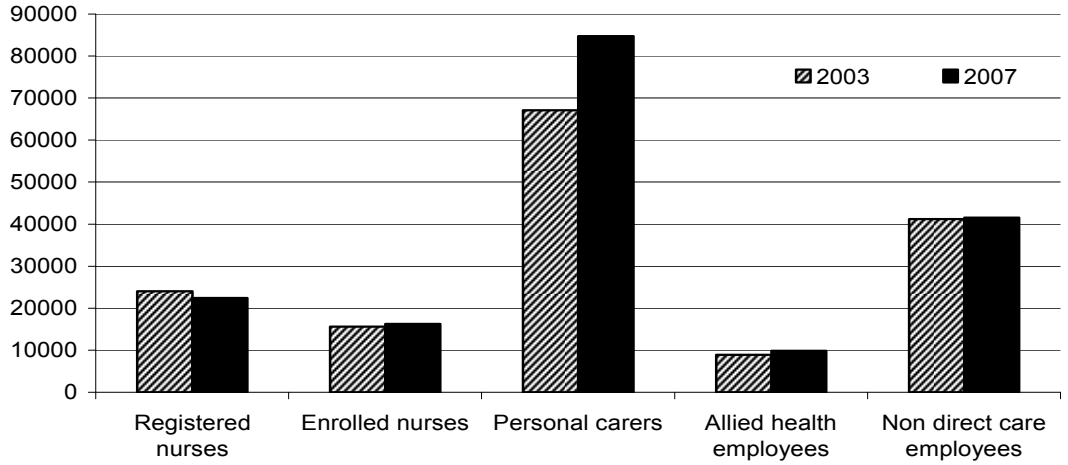
It is difficult to determine trends in the total aged care workforce over time due to limitations in the data collected and the irregularity of data collection, especially for community aged care workers. Despite these limitations, there is evidence to suggest that the workforce is growing in response to the increased supply of aged care services. For example, Martin and King (2008) reported that the residential aged care workforce grew by just over 10 per cent between 2003 and 2007. ABS industry workforce data also shows a steady increase in total residential aged care workers (ABS 2009b).

Given the increasing importance of the aged care sector, there is merit in developing more appropriate classifications for improving the collection of data on the number and skill levels of workers in the aged care sector.

*Residential aged care workforce trends*

As illustrated in figure 11.1, personal carers have accounted for almost all of the growth in the residential aged care workforce since 2003. This occurred while there was an overall rise in both the number of residents and their dependency level, as reflected in increasing proportion of high care residents in RACFs.

Figure 11.1 **Residential aged care employment**
Total employees, 2003 and 2007




*Data source:* Martin and King (2008).

There is a trend towards employing less skilled staff in residential aged care facilities. Despite an increase in the workforce overall, the number of full-time equivalent registered and enrolled nurses working in RACFs decreased from 27 210 to 23 103 between 2003 and 2007 (table 11.2). This represents a decrease from 35.8 per cent to 29.3 per cent of all full time equivalent direct care employees in only four years, with most of the reduction occurring at the registered nurse level.

While the substitution towards less skilled workers may be partly driven by financial constraints and difficulties in attracting and retaining nurses, the scopes of practice for non-nursing staff have also been widened (for example, undertaking medication management). Such initiatives have many benefits, including increasing the workplace satisfaction of personal carers and improving their skills. Importantly, as recognised by the Australia Health Ministers' Advisory Council, it meets a fundamental workforce principle that:

> … to ensure the best use of scarce workforce resources, wherever possible, services should be delivered by staff with the most cost effective training and qualification to provide safe, quality care. (2005, p. 9)

Table 11.2 **Residential aged care employees engaged in direct care**[a]
2003 and 2007

| | *2003* | | | | *2007* | | | |
|---|---|---|---|---|---|---|---|---|
| *Occupation* | *Number of employees* | *%* | *Full-time equivalent* | *%* | *Number of employees* | *%* | *Full-time equivalent* | *%* |
| Registered nurse | 24 019 | *21.0* | 16 265 | *21.4* | 22 399 | *16.8* | 13 247 | *16.8* |
| Enrolled nurse | 15 604 | *13.1* | 10 945 | *14.4* | 16 293 | *12.2* | 9 856 | *12.5* |
| Personal carer | 67 143 | *58.5* | 42 943 | *56.5* | 84 746 | *63.6* | 50 542 | *64.1* |
| Allied health employees | 8 895 | *7.4* | 5 776 | *7.6* | 9 875 | *7.4* | 5 204 | *6.6* |
| **Total number** | **115 660** | ***100*** | **76 006** | ***100*** | **133 314** | ***100*** | **78 849** | ***100*** |

**a** Full-time equivalent data is only available for employees engaged in direct care activities, not all employees.

*Source*: Martin and King (2008).

Reforms aimed at increasing competition between providers and innovations in models of care and scopes of practice, together with team-based health care, have the potential to offer further improvements in delivering safe, quality care, as well as enhancing the productivity of the workforce.

### *Community care workforce snapshot*

There were an estimated 87 000 employees delivering community aged care services in 2007 under the six community aged care programs — CACP, EACH, EACH-D, HACC, Day Therapy Centres and the National Respite for Carers Program (Martin and King 2008). This is probably an underestimate of the total number of community care workers due to limitations in data collection.

Community care workers, equivalent to personal care workers, comprised over 80 per cent of direct care employees in 2007. There is limited use of enrolled nurses and registered nurses — 2.5 and 10 per cent of the workforce respectively in 2007. This reflects the large number of low intensity care services delivered in community settings that do not require high levels of clinical skill and qualifications.

## Future aged care workforce requirements

### *Characteristics and skills*

Aged care workers will need to be adaptable, given the need to provide care to an increasingly diverse client base in a range of community and residential settings.

Workers will generally need to have a caring attitude, possess a broad range of skills and have undertaken appropriate training and experience to ensure that they can provide quality and safe care.

As summed up by the Community Services and Health Industry Skills Council (CSHISC), there is a clear focus needed for greater skills development to facilitate models of service delivery which:

> … emphasise maintaining functional independence for individuals and meeting complex demands … This continues the need to develop more advanced career paths within service provision roles and to develop management capacity. (2010, p. 7)

### *Projections of aged care workforce requirements*

The industry and governments recognise that Australia faces a significant shortfall in appropriately skilled aged care workers — that is, nurses and carers — and that this is likely to increase in the future (PC 2008). However, it is difficult to accurately estimate the future demand as there is uncertainty about the future needs of clients and the implication of any policy changes, such as modifications to funding and regulatory arrangements.

The likely trends in the supply of the main aged care workforce groups have been explored previously by the Commission. *Trends in Aged Care Services: some implications* (PC 2008) outlined the main influences on the supply of people providing care to older Australians.

A pressing issue for the formal aged care workforce is the imminent retirement of a large proportion of registered and enrolled nurses, and the projected increase in demand for high-level care services that generally require some complex clinical nursing care. DoHA, commenting on the skills required for aged care nursing, said:

> While aged care nursing is often seen as requiring less skills than in other parts of the sector the reverse is in fact true, with registered nursing requiring advanced assessment and analysis skills and the capacity to provide clinical leadership and governance. Particularly in residential care, nurses are required to exercise the full range of generalist clinical nursing assessment and analysis skills and often also develop specialised areas of expertise such as wound management, continence and dementia care. (sub. 482, p. 59)

As outlined in chapter 3, the significant increase in the number of older people, the relative decline in the availability of informal carers and regulatory restrictions on the use of volunteers in care activities demonstrates the need for a significant increase in the number of aged care workers. In its submission to this inquiry, DoHA stated:

> Assuming that the ratio of number of aged care workers to the size of the population aged 70 or over remains constant, then by 2050 a total of 827 100 will be engaged in the provision of aged care … [This] will account for about 4.9 per cent of all employees in Australia. (sub. 482, p. 38)

DoHA's estimate indicates that under current policy arrangements the aged care workforce will need to increase by between two and three times as a direct result of Australia's ageing population. The Australian Government has invested substantially in education and training through increasing the number of courses for registered and enrolled nurses and care workers, and has developed various incentive programs to encourage workers to enter or re-enter the aged care sector. Programs to increase the skills of personal care workers through vocational education and training have been acknowledged as beneficial by participants to this inquiry (see, for example, Havilah Hostel, sub. 384).

Government and industry are working in conjunction with the CSHISC to develop appropriate vocational training packages for the aged care sector and career paths for workers. This collaboration should be continued to ensure that the education and training opportunities offered match the skills required by employers and can accommodate any changes required if scopes of practice are expanded.

The Commission acknowledges that there will potentially be a significant impact on the demand for aged care workers from its proposal to lift constraints on the supply of aged care services. These reforms will also be taking place at the same time as the broader Australian labour force undergoes a period of age-induced tightening which is expected to increase competition for workers in all sectors. A more detailed examination of the workforce implications of this proposal will be conducted before the release of the final report of this inquiry.

## Direct care workforce challenges

A number of aged care providers report increasing difficulty attracting and retaining staff. Martin and King (2008) report that the number of RACFs with at least one equivalent full time vacancy for a direct care worker increased from 37 per cent to 50 per cent between 2003 and 2007. For community care service providers, 29 per cent indicated that that they had vacancies for direct care workers at the time of the survey in 2007. Residential care providers indicated that they had most difficulty attracting registered nurses in a reasonable period of time, while community care providers had relatively more difficulty finding community care workers.

Martin and King (2008) also indicated that the sector overall has a high turnover rate, with around one in four personal carers having spent less than a year with their current employer. Turnover in residential aged care is a third higher than for the health care and social assistance industry and slightly higher than for the economy in general (ABS 2008c). Baptistcare (WA) outlined its experience with high turnover in a tight labour market:

> Our staff turnover is currently running 29% per annum (and on the increase as resource projects in WA come on line). It peaked two years ago with the previous resources boom in WA at almost 38%. This is typical of the industry in WA (based on recent network benchmarking). Such a high turnover has a major impact on operating costs (recruitment and training), operational efficiency and, importantly, has implications for quality of care. (sub. 426, p. 6)

Fronditha Care provided an industry perspective about the challenges arising from the poor image of the sector:

> The issues for Fronditha are shared by the industry at a national level … concerning the image of aged care, career structures and pay discrepancies between the acute sector and aged care. (sub. 436, p. 10)

The Australian Nursing Federation (Victorian Branch) noted:

> The preliminary findings of the 2010 University of Melbourne longitudinal study reveal a worsening picture, with 44.5% of participants who had left aged care at the time of the study citing working conditions, inadequate staffing levels, poor staff resident ratios, too much paperwork or poor pay as their reason for leaving. Significantly, the study also found that poor working conditions had driven some staff to retire earlier than they otherwise would have done had working conditions been better. (sub. 341, p. 70)

The Quality Aged Care Action Group captured the concerns of many participants:

> We recognise that there is a shortage of nurses across the health system and that aged care is suffering as part of this. We also know that there are added barriers to attracting nurses to aged care: lower wages, high workloads and difficulty meeting professional responsibility, less nurses in the skill mix means less opportunity for professional collaboration and support, and the limited career paths and barriers to accessing professional development. (sub. 346, p. 10)

For some providers, recruitment and retention challenges are exacerbated not only by high turnover, but also by the relatively high use of temporary or 'agency' staff. These factors affect the capacity of providers to deliver continuity of care, put more stress on 'regular' workers, negatively affect the working environment (including for visiting health care professionals) and can unsettle older people, thus reducing the quality of their care experience.

The Commission notes, however, that during its industry visits it met with a number of providers and their staff who said they had minimal turnover and virtually no use of agency staff. When questioned, both providers and staff attributed this to good management practices. The variability of management within the aged care sector is an important determinant of the attractiveness of individual service providers as places of employment. While there have been significant investments aimed at improving the clinical care skills of aged care workers, there has been much less focus on developing management capacity and anecdotal evidence suggests that the majority of managers were formerly clinical staff with limited experience in management roles.

## Improving the attractiveness of aged care and the quality of care

Improving the attractiveness of aged care and developing a sustainable workforce to meet future demand will require an integrated approach in a number of areas, particularly remunerating staff competitively, fostering a rewarding working environment (including better management), providing further opportunities for skill development (including increasing scopes of practice) and exploring the scope to source care workers internationally.

Action in one area alone will not be enough to set the industry on a sustainable path. Most of the solutions lie with aged care providers, as they have the principle responsibility for ensuring that they provide an attractive workplace.

### *Remuneration*

The relatively low remuneration of direct care employees is consistently raised as a key issue in attracting and retaining these workers. For example, the Amaroo Care Services submission advised that:

> While aged care workers may have a passion for their work in making a difference for the elderly they care for or support, it remains a sad indictment upon our social values when an entry level zoo keeper attracts a base rate of $19.50 per hour for tending to animals while an entry level personal carer or support worker only attracts $15.90 per hour for providing care to our elderly in accordance with a new Australian industry award that came into effect during July 2010. (sub. 98, p. 14)

Similarly in the case of registered nurses, the Australian Nursing Federation submitted that:

> A national shortage of nurses and the wages gap between nurses working in the aged care sector and nurses working in the public hospital sector is exacerbating recruitment and retention difficulties in the aged care sector. The wages gap currently stands at

> 44.6% or $393.77 per week national average under an Award and 15.2% or $168.52 per week national average under an Enterprise Bargaining Agreement (EBA). (sub. 327, p. 2)

This gap has been widening over time, as outlined by the Commission previously (PC 2008).

While it is not known how many aged care nurses are paid under award agreements compared to enterprise bargaining agreements, the College of Nursing claimed that relatively low remuneration in aged care settings:

> … strongly supports the community and health professionals' belief that aged care nursing is inferior; this creates workforce issues around recruitment and retention and overarching work force planning. (sub. 86, p. 7)

This disparity in wages between the public health system and aged care can create issues within the aged care system. For example, some aged care services (such as Multi-Purpose Services in NSW) are operated by the State Government Health Departments and pay public sector wage rates. As such, these services can be more attractive to workers and can potentially exacerbate attraction and retention difficulties facing mainstream providers in the same area.

Some providers indicated in consultations that they pay the equivalent or above public sector wage rates for highly qualified staff, such as registered nurses and facility managers. Other providers also indicated that paying competitive wages is important to attracting and retaining staff, but inadequate funding and indexation mechanisms do not allow them to do so (chapter 5).

Funding restrictions may also limit the capacity of providers to attract and retain general services staff with specialist skills, such as '… maintenance staff, builders with expertise in disability modifications, gardeners, bus drivers and catering staff' (National Presbyterian Aged Care Network, sub. 110, p. 7).

The National Aged Care Alliance, in its submission supported:

> ... a dynamic and resourced workforce planning regime with adequate funding to ensure sufficient skilled, appropriately qualified and competitively remunerated staff are attracted to and retained in aged care and respected for their work. (sub. 88, p. 8)

The Commission supports the payment of competitive wages to nursing and other care staff in the sector.

There are currently two cases — the Equal Remuneration Case for Social and Community Service Workers and an Application for Low Pay Authorisation (Aged Care Award 2010) — before Fair Work Australia (FWA) which seek to substantially increase the remuneration of personal care workers and community

care workers. With hearings and deliberations ongoing, the outcome of these cases is unclear, as is the amount by which they may raise remuneration.

As the Australian Government is a significant source of funding for services employing these workers, it will incur the budgetary consequence of wage rises to the extent they are reflected in increased subsidy levels. The Australian Government, in its submission to the Equal Remuneration Case for Social and Community Service Workers, noted that:

> If any additional Government funding is provided, it would likely come at the expense of other Government funded services. (Australian Government 2010g, p. 10)

The wage disparity between nurses in different settings will not be resolved through the FWA cases, and is likely to widen in the future unless there is a concerted effort by stakeholders to move to a more competitive wage level. However, previous attempts by the Australian Government to encourage aged care providers to 'pay competitive wages' have not narrowed the wages gap for nurses. One of the reasons cited for this was that there was no specific requirement for providers to direct the extra funding towards higher wages (PC 2008).

In the long term, it is unlikely that wage for aged care workers will become or remain competitive unless there is a independent mechanism for assessing the cost of delivering care and setting scheduled care prices accordingly.

It should be noted that increases in wages to a competitive level will increase the quantum of public funding above that projected by the *Intergenerational Report 2010* (Treasury 2010). Importantly, this increase is independent of, and separate from, the fiscal impacts of the Commission's proposed aged care reforms.

### *Working environment*

There are many rewarding features of aged care work which are often overlooked in discussions around recruitment. Unlike some other health care settings, aged care offers employees the opportunity to develop relationships with many of the people for whom they care. It can also offer greater flexibility, especially for workers who only want a fixed roster as opposed to a rotating roster, or who want part-time employment. In addition, it can provide opportunities for nurses to use a wide range of their clinical skills and judgement in the delivery of quality care.

The government and the aged care sector could work together to promote these 'positive' characteristics to raise the profile of the sector to potential workers, particularly younger workers. For example, undergraduate nurse education could promote aged care positively as an industry within which to develop a career

through advanced clinical placements in 'teaching aged care facilities' (see below) and the introduction of undergraduate electives that offer students an opportunity to undertake specific gerontological nursing education and training.

However, the reality also needs to reflect the rhetoric, particularly in regard to work environments, so that workers that are attracted to delivering aged care services want to stay in the industry over the long term.

Overall, direct care staff appear under increasing pressure to provide quality care. There is some evidence to indicate that workloads for aged care workers have increased. Between 2003 and 2007, the ratio of residents to full-time equivalent direct care staff increased from 1.88 to 1.99 (Richardson and Martin 2004; Martin and King 2008; AIHW 2004b, 2008b). This occurred during a period where the acuity of residents increased (represented by the increasing proportion of high-care residents) and the number of registered nurses decreased.

This view was shared in *Who Cares for Older Australians?* which reported that:

> … many residential direct care workers feel that they do not have sufficient time or opportunity to engage in the caring tasks for which they were employed. (Martin and King 2008, p. 28)

Submissions and consultations indicate the aged care working environment is characterised by heavy workloads resulting from strenuous physical activity, excessive regulatory reporting requirements and other administrative burdens (Queensland Nurses' Union, sub. 409; Manningham Centre, sub. 325). Various proposals to improve the working environment of aged care workers include introducing minimum staffing ratios, licensing of care workers and using information and assistive technologies to increase the time available for caring activities and to reduce the physical burden associated with caring activities.

A number of submissions suggested mandatory staffing ratios be introduced to clarify what is considered an appropriate workload. Some state and territory governments have requirements on some aspects of aged care staffing. For example, Victorian public aged care facilities have minimum staffing ratios while high-care residential facilities in New South Wales are required to have a registered nurse on duty at all times. Given the variable nature of aged care clients' needs and the accreditation requirements to provide quality care, there does not seem to be a need to introduce mandatory staffing requirements. If staffing levels are considered to be inadequate, then the accreditation process (supported by the complaints process) should be the mechanism by which such inadequacies are rectified.

Other submissions called for licensing of all care workers as an indirect mechanism to increase the quality of aged care services (Queensland Nurses Union, sub. 409; Quality Aged Care Action Group, sub. 346). Currently, only registered and enrolled nurses are required to be licensed (registered) to practice in their respective occupations.

The Australian Nursing Federation (sub. 327) argued that licensing of assistants-in-nursing or their equivalent (including personal care workers and community care workers) would increase the quality of care delivered by making these workers accountable for their actions through clearly articulating their scopes of practice and ensuring that they have minimum qualifications and undertake continuing professional development. Aged and Community Care Victoria (sub. 408) considered licensing of care workers a valid alternative to the current system of police checks.

Other submissions argued that alternative measures may increase the quality of care delivered by workers without imposing the burden of licensing regime. For example, the Royal College of Nursing contended:

> … there is a need for a national practice framework and scope of practice, but is not necessarily promoting registration or further regulation of the unlicensed care worker role. Currently, the legal responsibility for hiring appropriately skilled workers rests with employers, as it does in all other employment contracts. External registration adds a further dimension to this employment arrangement that is arguably unnecessary in the case of unlicensed care workers, as it imposes a level of accountability that extends beyond their employer. (sub. 352, p. 6)

The Liquor, Hospitality and Miscellaneous Union (LHMU), one of the main unions representing personal care workers, did not support a licensing regime:

> LHMU recognises the concerns of stakeholders over the quality of care. However, we believe that investment in training and qualifications of aged care workers is a more nuanced, effective mechanism than simplistically requiring a licensing system.
>
> Licensing systems also imply that sanctions would apply or action can be taken against those licensed. There is a risk in this that individual workers carry the burden and responsibility of service provision issues beyond their control that are best placed to be the responsibility of the aged care provider. There are currently legal means by which to sanction individual behaviour that is criminal or negligent. Further sanctioning only serves to shift the responsibility from aged care providers to individual poorly renumerated overworked staff. (sub. 335, p. 14)

Some providers, particularly in rural and remote areas, indicated during consultations that a licensing system for care workers could severely affect their ability to staff their operations, as licensing also usually requires a minimum

training qualification which may be difficult to obtain. Other concerns raised include who would undertake the licensing process and be responsible for enforceable redress mechanisms when required.

On balance, the Commission considers that a licensing system for all care workers is not appropriate and could introduce a level of inflexibility within the aged care system that could exacerbate labour shortages. Ensuring the delivery of quality care is more appropriately addressed through the accreditation process, training, professional development and other mechanisms.

The excessive regulatory burdens associated with the accreditation and acquittal mechanisms for funding, and mandatory reporting requirements for missing residents and assaults, were frequently identified as reducing work satisfaction and preventing greater productivity. Submissions, such as Anglicare Sydney (sub. 272), generally indicate that the administrative and reporting burden was high, despite the introduction of the Aged Care Funding Instrument (ACFI) reducing it to some extent.

A reduction in unnecessary reporting (chapter 12) and the introduction of integrated information technology platforms for care administration could both increase worker productivity. Simplified and streamlined information technology systems have the potential to reduce the amount of time spent by aged care staff in both reporting and coordination activities (for example, medication management and electronic reporting — box 11.1). In addition, the use of information technology in the provision of care may increase the attractiveness of the sector to younger workers who are familiar with such technology and are looking to use it in their work.

The introduction of some assistive technologies (for example, in-room hoists — box 11.1) may reduce the physical burden on aged care workers from lifting clients and may also reduce time spent finding and transporting equipment to where it is needed. Such initiatives are likely to increase the amount of time that workers can spend with clients and improve occupational health and safety.

### Box 11.1 **Role of technology in improving working environments**

Information and assistive technologies can improve the aged care work environment by reducing the physical and administrative burden on employees. As such, it can enable providers to support their workforce and better meet the needs of their clients.

In the area of information technology, a number of initiatives have been proposed to streamline reporting requirements and reduce the burden on care staff. Electronic medication management, care plans and quality reporting systems all have the potential to substantially reduce the paperwork burden and, to some degree stress, for staff.

In the area of assistive technology, there appears considerable potential to reduce the level of physical exertion and increase the time staff can spend with residents by introducing in-room lifting hoists. In-room hoists can reduce workplace injuries (and compensation premiums) and resident injuries associated with lifting, repositioning and mobilising. They also reduce the time staff spend looking for and moving other lifting devices, and can be used immediately (that is, there is no need to wait for a lifting device to become available).

*Source*: Summit Care (2010).

*Skills development and career paths*

Opportunities for skills development, career paths and increased scopes of practice are important aspects of aged care that can be improved to attract and retain quality direct care staff and to develop management skills.

Consultations with providers indicate that those who report low turnover and limited use of temporary staff place a high value on supporting professional development. However, some of these providers also report they are financially constrained in their ability to develop capacity and support professional development by giving employees paid time off to undertake education and training activities. This problem is exacerbated in rural and remote areas where it can be difficult (and/or expensive) to find substitute staff and there are substantial costs associated with sending an employee to another location for training.

A major issue raised in submissions and consultations was the considerable variability in the skill level of personal carers and community care workers, even between those with comparable qualifications (generally at the certificate III or IV level). Over the last 10 years, there have been Government funded initiatives aimed at increasing the skill levels of these workers. While these initiatives are acknowledged to have increased the skill level of the care workforce, some

providers are critical of the poor quality of training provided by some registered training organisations.

Widened scopes of practice for workers can play an important role in the quality and efficiency of care delivery and in worker satisfaction. The CSHISC has worked with industry, governments and training institutions to develop a range of courses which enable workers to develop the skills they require in the delivery of aged care services and undertake courses that can widen their scopes of practice, including allied health assistant streams. These courses should be promoted within the aged care sector to allow workers to diversify their skills and take on new roles in the provision of aged care services.

The potential to increase scopes of practice is not limited to less skilled workers. In this area, the CSHISC is proposing to develop a range of advanced practice and leadership courses to promote further clinical skills development (for example, for nurse practitioners) and enhance the management skills of workers in these roles. There is significant potential for the expansion of nurse practitioners in aged care with the regulatory and funding impediments reduced by recent Government changes which facilitated access to Medical Benefits Scheme and Pharmaceutical Benefits Scheme subsidised care and medications.

Developing and implementing widened scopes of practice for health workers is one of the tasks of the recently formed Health Workforce Australia, which was created following the Commission's report into *Australia's Health Workforce* (PC 2005a). The Commission considers that widened scopes of practice will become increasingly important as broader health workforce shortages become more acute. It is also a very valuable vehicle for improving the human capital of Australia's health workforce.

In Australia, there are currently only a limited number of specialist 'teaching aged care facilities' and student experiences of placements in mainstream aged care facilities are not always positive. Research suggests that student placements in facilities which offer a variety of tailored clinical experiences can have a significant effect on the attitudes of nursing students towards older people and increase the attraction of the aged care sector as a graduate destination (Abbey et al. 2005; Robinson and See, sub. 231).

In addition to providing positive placement experiences, teaching aged care facilities can '… provide an infrastructure to support a robust and much needed program of research' (Robinson and See, sub. 231, p. 2) and support the development of management skills. These services also have the potential to provide opportunities for trainee doctors and allied health students to learn to work

with older people in aged care settings. Such initiatives may increase the willingness of health professionals to provide services to older Australians.

The Australian Government recently announced it will support the establishment of teaching nursing homes over four years (Australian Government 2010c). The Commission supports the direction of this commitment but considers the non-ongoing nature and the relatively small level of funding to be inadequate to address current and future workforce shortages in the sector.

The expansion of graduate programs for registered nurses in aged care settings can provide a platform to develop specialised clinical and management skills in a collegiate mentoring environment. Some larger providers, such as BUPA Care, recently initiated such programs as one approach to attracting more nurses into their operations.

Although these programs are only relatively new, submissions indicate that they have increased the recruitment of graduate nurses into the aged care sector and improved the variety of options available to registered nurses upon graduation. While larger aged care providers may have the economies of scale to develop such programs, it is unlikely that smaller providers will have the same capacity. To address projected workforce demand, there may be a role for the Australian Government to support the development of graduate nursing programs for organisations that do not have the capacity to take on graduates in a supernumerary capacity (that is, as an extra to normal staff rostering through the induction process).

The aged care industry also needs to further develop and promote career paths for workers to move through as their skills develop and their careers progress. Some workers will not be interested in taking on more responsibility and undertaking further study to develop their skills. However, for those that do, a number of career paths should be available to keep them satisfied in the sector.

The Australian Government and industry have been working in conjunction with the CSHISC to develop appropriate vocational training packages for the aged care sector and career paths for workers. This collaboration should be continued to ensure that the education and training opportunities on offer match the skills required by employers and are able to accommodate any changes required as scopes of practice are expanded.

However, there are even greater concerns for attracting, training and retaining staff in regional and remote areas. There is a clear need to increase the level of locally delivered training within regional settings in order to attract and retain local staff. This is particularly so for Indigenous staff who will often not travel away from their communities for extended periods. Further, the lack of provision of housing both for

staff and trainers in remote areas is a significant problem that requires attention. These issues are canvassed more extensively in chapter 9.

### *International migration*

A number of submissions argued for greater temporary or permanent migration of nurses and care workers (Alzheimer's Australia NSW, sub. 455; Catholic Health Australia, sub. 217; DutchCare, sub. 129). For example, Catholic Health Australia stated:

> Consideration also needs to be given to augmenting the local workforce by sourcing suitable staff from overseas, including staff who could receive further training in Australia. (sub. 217, p. 15)

There is some potential for Australia's aged care industry to source workers from overseas and this is being explored by Health Workforce Australia. Australia will be in competition with both the source country and other industrialised countries for these workers.

There may be issues relating to transferability and recognition of qualifications (particularly registered nursing qualifications) and English-language proficiency which currently limit the potential of sourcing aged care workers, especially higher skilled workers, from some other countries. In consultations, providers have indicated mixed experiences in attempts to use skilled workers through sponsored migration programs.

Targeted programs to increase the aged care workforce could be particularly useful in the provision of appropriate care for older Australians from non-English speaking backgrounds if the language skills of migrant workers were aligned. However, these workers will also require competent English skills (including to communicate with management and other workers, and to complete care documentation).

DRAFT RECOMMENDATION 11.2

***The proposed Australian Aged Care Regulation Commission (draft recommendation 12.1), when assessing and recommending scheduled care prices, should take into account the need to pay competitive wages to nursing and other care staff delivering aged care services.***

DRAFT RECOMMENDATION 11.3

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

- ***advanced clinical courses for nurses to become nurse practitioners***
- ***management courses for health and care workers entering management roles.***

DRAFT RECOMMENDATION 11.4

***The Australian Government, in conjunction with universities and providers, should fund the expansion of 'teaching aged care services' to promote the sector among medical, nursing and allied health students.***

## 11.4 Medical and allied health professionals

The Commission heard that some older people in both community and residential settings have difficulty in accessing timely and appropriate health services. Where this occurs, it can lead to an increase in the demand for formal aged care services and the inappropriate use of other health services, such as emergency hospital admissions.

### *Access to medical and allied health professionals*

A number of submissions referred to inadequate access to general practitioners (GPs) and allied health professionals in residential aged care facilities and in older people's homes. Catholic Health Australia cited a recent survey of its members where:

> ... common issues raised include home visits being difficult to arrange; timeliness of visits; reluctance to take on new or difficult patients; poor or inadequate documentation; inadequate after hours and emergency access; rushed consultations; and poor communication and information sharing. (sub. 217, p. 16)

The Australian Medical Association (AMA) reported a number of obstacles confronting GPs wishing to provide medical services in residential settings (box **Error! Not a valid link.**). The AMA (sub. 330) argued that 'inadequate' subsidies through the Medical Benefits Scheme for GP services contributed to the reluctance of GPs to provide services in these settings, particularly in complex cases where there is significant non face-to-face time involved in providing medical care. The AMA also noted that inadequately equipped clinical treatment areas are also a barrier to providing medical services in some aged care facilities, and that the use of agency staff who are not familiar with residents can compromise the quality and continuity of care.

## Box 11. Obstacles to providing medical services in residential settings

According to the AMA, there are a number of obstacles to providing medical services in residential settings, such as:

- a lack of access to registered nurses with whom to coordinate care
- an increasing use by residential aged care facilities of agency staff who are not familiar with residents which compromises continuity of care
- poor access to properly equipped clinical treatment rooms which limits the medical treatment that can be provided in that setting
- an absence of information technology infrastructure to facilitate access to electronic patient records and medication management, including software appropriate to the needs of GP's
- a strong financial disincentive for the doctor to leave their surgery, with all its attendant costs, to provide services in residential aged care
- a growing tendency to build residential aged care facilities in the outer growth corridors or 'urban fringe' of metropolitan areas which further adds to the time spent by doctors away from their surgeries.

*Source*: Australian Medical Association (sub. 330)

The Australian Government has attempted to increase access to GP services for older people in residential aged care settings through the GP Aged Care Access Initiative (ACAI) as part of the Practice Incentives Program (PIP). Under this initiative, GPs affiliated with a PIP practice are paid an incentive payment (up to a maximum of $3000 per annum) depending on the number of specific MBS-itemised services delivered in residential settings. Initial analysis indicates that the number of qualifying services has increased at a faster rate than comparable services (ANAO 2010). DoHA considers that this initiative has been:

> … effective in increasing GP service delivery to residents of RACFs, noting that this is an assessment relatively soon after payment implementation. (ANAO 2010, p. 163)

Reinforcing the importance of geriatric services in providing quality care, the Australian and New Zealand Society for Geriatric Medicine considered that:

> Specialist geriatrician services ideally have a role across all levels of care to guarantee quality outcomes. The rise in number of advanced trainees in geriatric medicine recently may address some … areas of need, but clearly all professionals dealing with aged persons will need education and support to develop and maintain aged care expertise across all settings, from inception of training and in continuing education programs. Thus geriatric medicine and ageing must be part of core training for all health disciplines apart from paediatrics and obstetrics as their practice will be spent increasingly providing care for our older Australians. (sub. 145, p. 3)

The AMA supported the development of teaching residential care facilities as:

> The provision of appropriate and accredited clinical training places in residential aged care would add to the overall breadth and depth of medical training and improve the quality of care of residents. It would encourage younger doctors to visit residential aged care, and educate the next generation of doctors about caring for the aged as part of routine medical practice. (sub. 330, p. 7)

The Commission acknowledges that more extensive exposure of geriatric and aged care clinical practices in the core teaching of medical, nursing and allied health students would have beneficial effects on encouraging such workers into the aged care field. It would obviously enhance the quality of care for older Australians.

Several aged care providers advised that they had formed strategic alliances with GPs and GP clinics to ensure that their services are available in a timely manner. Some GP practices are making extensive use of practice nurses to deliver health care, including to older people. There has also been the development of gerontological nurse practitioners who service a number of aged care facilities efficiently and effectively. There would seem to be opportunities for industry networking groups to play a useful role in disseminating the lessons from such initiatives to inform other providers considering forming similar alliances.

Access to allied health professionals is also constrained by government subsidy restrictions. The Australian General Practice Network (AGPN) reports:

> Access to allied health professionals for residents in RACFs is also, anecdotally, inconsistent and commonly limited and suboptimal …
>
> AGPN members have also noted significant gaps in services, particularly allied health services, to support resident rehabilitation following a major health event, which may have prompted admission to the facility or require hospitalisation. (sub. 295, p. 5)

Under Medicare, Australians with chronic diseases are only entitled to five subsidised visits to allied health practitioners each year. However, as outlined by the Dieticians Association of Australia:

> 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)

However, the Australian Government is supporting an expanded ACAI to improve access to allied health professionals for aged care residents:

> Reports from GPNs [General Practice Networks] implementing the allied health components of the ACAI model suggest this initiative is working effectively to provide better access to timely allied health services for RACF residents … Both GPNs and facilities have commented that without ACAI programs these services would not have been provided. (AGPN, sub. 295, p. 7)

The Commission strongly supports improving the means by which older Australians are able to more effectively access services by allied health practitioners.

For older people living independently in the community, especially those without informal carers, the lack of appropriate transport options limits their capacity to access medical and health services, and can constrain opportunities for social inclusion and participation. Community transport options need to be accessible and affordable to enable older people living in their own homes to access health care services.

### *Promoting team-based care*

As outlined by the Commission in *Australia's Health Workforce* (PC 2005a), there is a much greater need for multi-disciplinary team-based care to meet the demand from an ageing population for the treatment of chronic conditions.

Initiatives such as the Hospital Admission Risk Program in Victoria aim:

> … to maximise collaboration across multiple levels of the health system, including hospitals, community providers, clinical health professionals, general practices, ambulance services, consumers, carers and research bodies, in order to achieve effective and sustainable change in health service delivery. (DHS 2006, p. 2)

Palliative Care Australia also supported multi-disciplinary primary care teams to:

> … ensure that primary care services offer a team-based range of services including general practice, allied health and nursing supports, with referral pathways to and from specialist services, to … meet the needs of people at the end of life. (sub. 77, p. 14)

While the AMA considered that:

> The delivery of medical care to older people outside of the doctor's surgery, including models of care where the doctor delegates tasks to practice and/or specialised nurses, and/or other health practitioners within a team based model of care, will have an immediate impact on improving access to medical care. (sub. 330, p. 2)

Draft recommendation 8.5 supports the development of collaborative team-based health and care services as an efficient model to deliver appropriate care for older Australians. The development of regionally or locally based multi-disciplinary aged care health teams has the potential to increase the attractiveness of aged care to health professionals because of the peer support and professional development opportunities. It is likely to lead to a more holistic approach to client care and innovative practice development.

On the specific issue of care coordination, the Commission is proposing that this function be undertaken as part of the proposed Australian Seniors Gateway Agency

(draft recommendation 8.1), and that case management be an approved service entitlement, when required.

## 11.5 Volunteers

### The role of volunteers

Volunteers contribute substantially to the delivery of some aged care services and their roles vary depending on the setting in which they are engaged. In residential settings, their role is primarily to complement care delivery through improving the quality of life of residents by providing entertainment and companionship. In community settings, their roles can be more diverse from providing 'quality of life' services to more fundamental roles, such as preparing and delivering meals and providing home maintenance services and community transport.

Volunteering activities benefit the recipients, volunteers and the social capital of the broader community. Interactions between volunteers and older people can promote social inclusion and improve health and welfare outcomes. In turn, this can reduce the need for formal community aged care services and/or reduce the likelihood of premature entry into residential care.

Data currently collected sheds little light on trends for volunteering in community care activities specifically targeted towards older Australians. However, there have been a number of government initiatives designed to increase the level of volunteering in residential aged care, particularly through the Community Visitors Scheme. These initiatives have had some success, with the number of volunteers in RACFs increasing by 55 per cent between 2000 and 2009 (ABS 2001, 2010a).

Previous research indicated that the potential pool of volunteers in the community is expected to be larger in the future, primarily as a result of the retirement of the 'baby boomers' (PC 2005b). However, this does not necessarily translate into more volunteering in the aged care sector. Baptcare relating their experience said:

> The ageing of the population is changing the profile of volunteers willing to support the aged care sector. The hours volunteers are willing to donate seem to be decreasing. Early retirees, who tend to have been well represented among volunteers, now have different pressures and choices to previous generations. Their family obligations may well be different; this can include aged parents who are still alive and grandchildren with both parents working. Coupled with this, early retirees have broader life style choices including travel and a wide range of volunteer opportunities. (sub. 212, pp. 45-46)

Looking forward, the South Australian Government considers:

> It is critical that an aged care system for the future supports small volunteer based organisations as they are most likely to be responsive to the needs of their community and deliver a cost effective service. Support includes ensuring that the regulatory administrative and reporting burden is sustainable and that governance and training support is provided to assist in both the delivery of quality care services and their sustainability. (sub. 336, p. 18)

## Options to encourage more volunteers into aged care

Submissions to this inquiry and previous research, such as the Commission's study into the *Contribution of the Not-for-Profit Sector* (PC 2010b), indicate that there are a number of barriers to people undertaking volunteering activities, including the increasing costs of engaging volunteers, regulations surrounding volunteer involvement (such as liability and negligence) and personal costs associated with volunteering. For example, the Multicultural Communities Council of Illawarra stated that the:

> Volunteering supported model is currently experiencing significant barriers and challenges. Costs to petrol prices, low remuneration returns, lack of bilingual volunteers, and a drop in volunteering rates is creating significant challenges in the sector, particularly in regional areas. (sub. 286, p. 12)

One of the major barriers is the significant cost associated with organising, training and managing volunteers. These costs are predominantly incurred by organisations for which they are often not funded or relatively underfunded when the full costs of engaging volunteers are considered. Many organisations need to employ full time volunteer coordinators or combine this role with another position, such as an activities officer or diversional therapist (Diversional Therapy Australia, sub. 175).

Older people are considered vulnerable citizens and those working or volunteering with them are required to have a background check to ensure that older people are not put at risk of exploitation or abuse. Most organisations incur the costs of background checks, which may cost up to $52 per volunteer depending on where the check is undertaken. Some jurisdictions have taken steps to reduce these costs. For example, the South Australian Government offers free background checks for volunteers in organisations working with vulnerable groups (Volunteering Australia 2009). The ACT Government has introduced legislation that also proposes to offer this service to volunteers free of charge (Stanhope 2010).

In addition, the ACT legislation proposes a 3-year portable registration system to allow volunteers (and employees) to move between organisations within the ACT without the need to be rechecked (Stanhope 2010). Portable background checks

may reduce the regulatory burden on volunteer organisations and formal care providers, and should be considered by other jurisdictions. Ideally, work should be undertaken on the development of a national system for background checks to remove the need for volunteers to be rechecked in each jurisdiction.

Other regulation, particularly related to occupational health and safety and food safety regulations, can also affect the capacity of organisations to use volunteers, especially periodic volunteers, and impose costs that reduce the number or quality of services provided (PC 2010b).

As outlined in previous research, the application of regulations designed to protect workers, volunteers and consumers should be proportionate to the risks posed. Funding arrangements should take into account the costs associated with regulations and training where these activities significantly increase the costs of engaging volunteers.

Some volunteering activities may impose substantial costs on the volunteers themselves, and this can act as a disincentive. The aged care sector is at risk of losing volunteers in areas where substantial costs may be incurred, such as transport services and delivery of meals (DutchCare, sub. 128). Some organisations reimburse volunteers for these out-of-pocket expenses, but others cannot afford to do so. As such, the potential pool of volunteers available to provide aged and community services could be reduced, especially among those with low incomes (such as pensioners).

Through its *Volunteer Grants 2010* initiative, the Australian Government has supported over 253 000 volunteers in more than 6000 organisations to assist with:

> … the costs of training courses for volunteers, and to undertake background screening checks for their volunteers. Funding is also available to purchase small equipment items to help volunteers, and to contribute towards fuel reimbursement for their volunteers, including those who use their cars to transport others to activities, deliver food and assist people in need. (FaHCSIA 2010c, p. 1)

In addition to reducing barriers to volunteering, consideration could be given to improving the image of providing volunteering services to older people. Such initiatives could be targeted at 'baby boomers' and younger people for maximum effect. For example, Charles Stuart University called for the:

> Development of programs aimed at school-aged children (primary and secondary) that highlight the need for volunteering and the benefits of volunteering ... (sub. 121, p. 9)

DRAFT RECOMMENDATION 11.5

***The proposed Australian Aged Care Regulation Commission (draft recommendation 12.1), in assessing and recommending scheduled care prices, should take into account the costs associated with:***

- ***volunteer administration and regulatory costs***
- ***appropriate training and support for volunteers***
- ***reimbursement of out-of-pocket expenses for those volunteers who are at risk of not participating because of these expenses.***

# 12 Regulation — the future direction

## Key points

- The aged care system needs to be regulated to manage risks to the wellbeing of older Australians and the fiscal risk to taxpayers. However, the current regulatory framework is unsatisfactory and there is scope to improve its efficiency and effectiveness while ensuring an acceptable approved standard of care.
- A variety of regulatory problems have been identified throughout previous chapters, including: excessive and ineffective quantity and price restrictions; excessive regulation of accommodation payments; and over-reaction to risk. In addition, problematic governance arrangements inhibit best practice regulation.
- There is an overly adversarial approach to enforcing regulation which reduces the supervisory resources available to monitor those providers that deserve greater scrutiny.
- Duplicate and overlapping regulation of quality leads to higher costs while jurisdictional variations increase complexity for both providers and consumers.
- Going forward, the focus of regulatory reform should be on:
  - reducing the extent of regulation on quantity, quality and price of aged care
  - concentrating DoHA's responsibilities for aged care primarily on policy development, price setting and subsidies, and funding independent consumer advocacy services and special programs
  - consolidating regulatory functions in an independent Commission, including the approval of providers, the quality of residential and community care and prudential regulation, as well as the provision of advice to the Government on prices and costs in aged care. It would also handle complaints and undertake reviews. Arm's length appeals to its decisions would be heard by the Administrative Appeals Tribunal.
  - creating an Australian Seniors Gateway Agency which provides information, assessment and care coordination
  - widening the range of available enforcement tools, adopting a risk-based approach to handling complaints and enforcement, streamlining reporting and embracing technology in receiving and transmitting information between government and providers
  - continuing to simplify jurisdictional responsibilities and harmonising regulation.

Currently, aged care services are primarily funded and extensively regulated by the Australian Government. These regulations cover price, quantity and quality. However, all levels of government are involved to some extent, with some state and local governments also directly providing aged care services.

This chapter outlines a framework for regulation that puts into practice the policy and funding reforms outlined earlier in this report and the features of best practice regulation.

To establish what regulatory changes are needed it is useful to: understand why regulation is needed; have in mind some 'best practice' yardsticks against which to assess the current regulatory arrangements; and understand the current regulations. Further elaboration on these is provided in appendix E.

Section 12.1 provides a brief summary of the current regulatory arrangements. The proposed regulatory reforms are outlined in the following four sections (sections 12.2–12.5). These include:

- improving Australian Government governance arrangements
- implementing 'responsive regulation' with appropriate standards and streamlined reporting
- reducing the extent of regulation
- clarifying and simplifying jurisdictional responsibilities and harmonising regulation.

Chapter 14 sets out the transition path to implementing the Commission's proposed reforms for aged care, including regulation.

## 12.1 What are the current regulations?

### Australian Government

Two Government acts, the *Aged Care Act 1997* (the Act) and the *Home and Community Care (HACC) Act 1985* (the HACC Act) govern aged care. (Further details are set out in appendix E). The key points are:

- residential aged care is primarily regulated under the Act and the associated 22 Aged Care Principles as well as Determinations
  - quality standards are assessed on the basis of 44 Accreditation Standards which are set out in the Quality of Care Principles 1997 under the Act. In addition, there are also 35 Residential Care Standards and Specified Care and

Services for Residential Care Services set out in the Quality of Care Principles, with the latter to be provided in a way that meets the Accreditation and Residential Care standards (as the case requires)

  - the Act contains prudential regulations and providers who accept bonds or entry contributions are subject to these regulations, including the Liquidity, Records and Disclosure Standards within the User Rights Principles 1997. These prudential requirements are supplemented by others in the *Aged Care (Bond Security) Act 2006*

- packaged community care (Community Aged Care Package (CACP), Extended Aged Care at Home (EACH), Extended Aged Care at Home Dementia (EACH-D)), Multi-Purpose Services (MPS), innovative care and transition care are regulated under the Act
  - Community Care Standards are set out in the Quality of Care Principles 1997 under the Act
- basic community care (HACC) is regulated under both the Act and the HACC Act
  - quality standards are set out in the HACC National Standards which establish outcomes for consumers in seven areas and 27 national standards, each of which is stated as an expected consumer outcome
- a division within the Department of Health and Ageing (DoHA) — the Office of Aged Care Quality and Compliance (OACQC) — is responsible for aged care regulation policy advice. In addition it has overarching responsibility for accreditation, compliance and enforcement of a range of aged care regulations (the Act, the HACC Act and the Community Care Common Standards (DoHA 2010d)).
  - generally speaking OACQC makes all enforcement decisions but whether or not it also accredits or checks compliance depends on the type of aged care.
    - for residential aged care, day-to-day administration of accreditation and compliance checking is delegated to the Aged Care Standards and Accreditation Agency (ACSAA). DoHA monitors compliance of approved providers with all their other responsibilities under the Act.
    - for packaged community aged care and the National Respite for Carers Program (NRCP), the day-to-day administration of compliance is undertaken by OACQC through the process of Quality Reporting
    - for basic community aged care (HACC), day-to-day responsibility for administering all aspects of the regulation (including enforcement sanctions) is delegated to the states and territories

  - the OACQC also has overarching responsibility for complaints handling in relation to all community and residential aged care services funded under the Act. This is administered on a day-to-day basis through the Complaints Investigation Scheme (CIS)
- from 1 March 2011, Community Care Common Standards (DoHA 2010d) will apply to basic and packaged community care as well as the NRCP. All Ministers have endorsed the standards and all, with the exception of Queensland, have agreed on an implementation date of 1 March 2011 (DoHA, pers. comm., 11 November 2011)
- the Office of the Aged Care Commissioner (OACC) provides a review mechanism for all community and residential aged care services funded under the Act
- the Administrative Appeals Tribunal (AAT) is the main avenue for appeals to administrative decisions.

Figure 12.1 provides an overview of the current organisational and governance structures for Government regulation policy and enforcement (DoHA), accreditation and compliance of residential aged care (ACSAA), and complaints handling (CIS).

### State, territory and local government

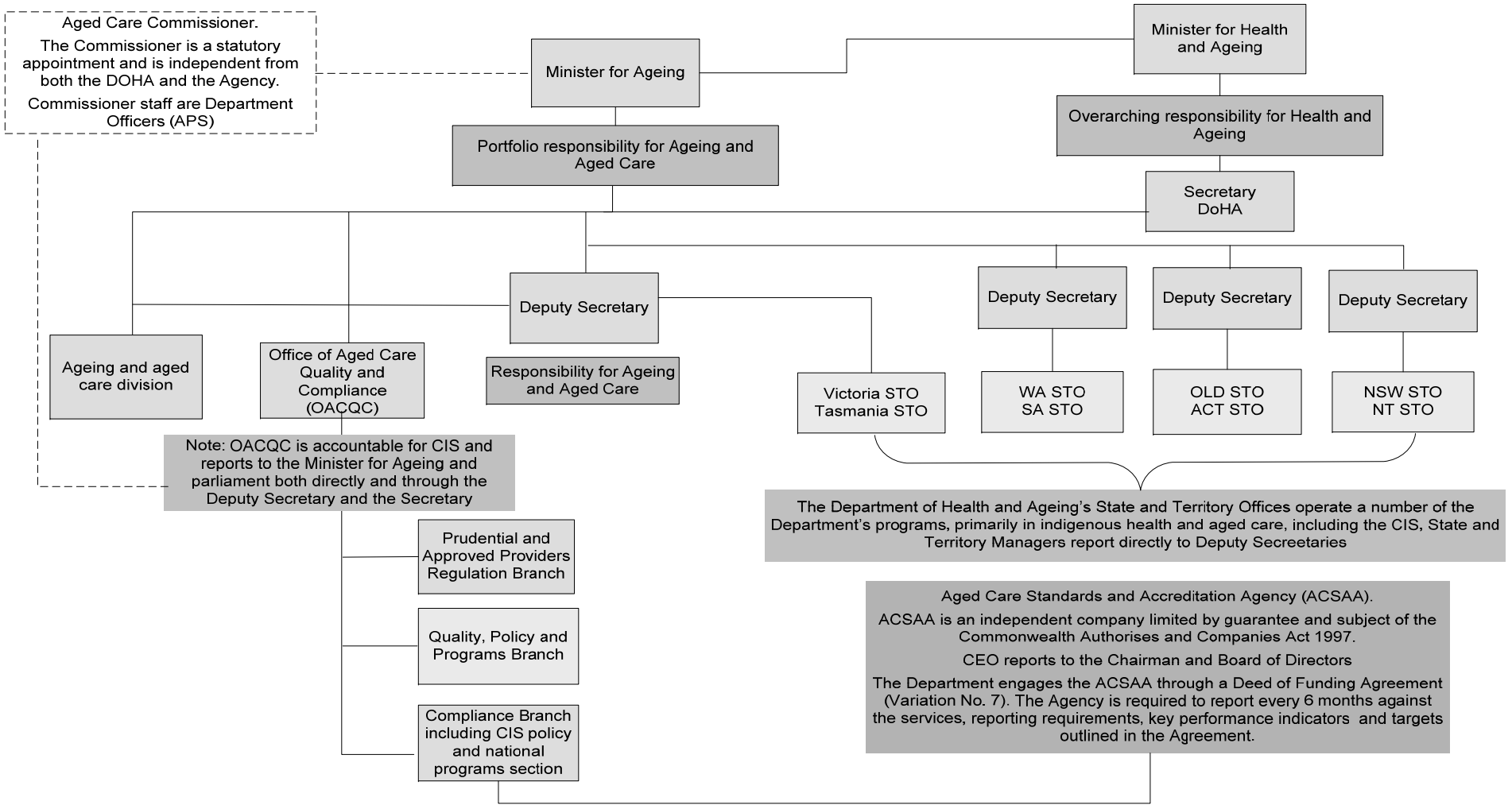
Currently, states and territories have regulatory responsibility for basic community care funded through the HACC program. In addition, state, territory and local government regulation in a range of other areas also affects the provision of aged care, for example building codes, planning approvals, and health services (chapter 2).

### Regulatory arrangements from 2012

In April 2010 as part of the National Health and Hospitals Network (NHHR) reforms (chapter 2; COAG 2010a) it was announced that from 1 July 2012 the Australian Government will be responsible for regulating:

- packaged community (CACP, EACH and EACH-D) and residential aged care delivered under Government aged care programs, as currently
- basic community care services (HACC) for people aged over 65.

Figure 12.1 **Current Australian Government governance structure for aged care regulation**[a]




**a** This diagram is a modified version of the diagram on p. 26 of the Walton Review.

*Source*: Walton Review (2009).

However, because Victoria and Western Australia are not party to these reforms, these jurisdictions will remain responsible for the day-to-day regulation of all HACC services, irrespective of the age of the recipient. The Commission has recommended that all jurisdictions agree to the national aged care arrangements (draft recommendation 12.5).

A variety of regulatory problems have been identified and documented in the preceding chapters. Having regard to these problems, the features of best practice regulation — including establishing good governance arrangements, choosing appropriate standards, implementing a 'responsive' regulatory model which encourages and enforces compliance, and developing streamlined reporting arrangements (appendix E) — and the reforms proposed in this inquiry, the following sections outline the proposed future direction of Australian aged care regulation.

## 12.2 Improving Australian Government governance arrangements for aged care

One of the key lessons from the broad sweep of regulatory experience is to separate regulatory responsibility from policy responsibility in governance arrangements. Good practice governance arrangements also involve 'arm's length' separation of appeals about the actions of the regulator from the regulatory body itself. Comparing the current Australian Governance arrangements in aged care (which do not clearly separate policy, regulation and appeals) with contemporary governance practice suggests there is a significant opportunity to reform these arrangements to achieve a more effective structure.

The Council of the Ageing Australia Ltd (COTA) agreed with the need for reform:

> The relationship and divisions of responsibility between [DoHA] on the one hand and the [ACSAA], the Aged Care Complaints Investigation Scheme and the National Aged Care Advocacy Program on the other, need to be redesigned to clarify boundaries, strengthen roles and ensure greater independence of quality agencies from the funder and the regulator. COTA believes that all compliance, complaints and advocacy programs should be and be seen to be independent of the funder, i.e. the federal department. (sub. 337, p. 39)

Aged Care Crisis (ACC) has expressed concern about the conflict of interest inherent within the system of aged care:

> ACC has analysed the interdependencies of the CIS, [ACSAA] and the [OACC] and DoHA. Although all three bodies have distinct roles, final decision regarding regulation and compliance ultimately rest with DoHA. (sub. 433, p. 1)

ACC is also concerned that:

- approved residential aged care providers are able to overturn independent Aged Care Assessment Team (ACAT) assessments of a person as high care to one of low care, with implicit acquiescence from DoHA
- the OACC can only review (and not overturn) decisions made by CIS and in some instances DoHA has ignored the concerns of the OACC. Accordingly, ACC says that the OACC's 'power and authority is illusory' (sub. 433, p. 10).

A recent Australian National Audit Office (ANAO) audit also noted that the involvement of DoHA (as the regulator) in assisting some providers to negotiate ownership transfer from a troubled provider to an alternative provider while also possibly having to institute future compliance action against the alternative provider 'poses some risk to the perceived objectivity and impartiality of the regulator' (ANAO 2009, p. 20).

Previous reviews have canvassed these types of governance issues (for example, the Walton Review (2009)) as have submissions to this inquiry. Submissions have mainly focussed on accreditation arrangements (including the overlapping responsibilities between ACSAA and DoHA) and complaints handling. For example:

> [DoHA] is responsible for managing the funding provided by government for the system. It has a responsibility to manage those funds in a prudent manner. It also has responsibility for maintaining and ensuring quality care is provided within the system, a position not necessarily compatible with its funds management role. In addition, it controls entry to the system through its assessment processes and as well as being the regulator of the system, investigates complaints about the system, and penalises providers for infringements of the system. These roles are not all compatible and create conflicts of interest within the department, ignore the principles of natural justice, and fail to adequately serve the interests of any of the stakeholders within the system. While the Department will point to the existence of the Aged Care Standards Agency and the Complaints Investigation Service as agencies which address some of these conflicting priorities, neither is truly independent, nor operates at a truly arms length fashion. (Baptistcare, sub. 213, p. 5)

The Commission considers that these governance issues must be addressed by establishing a national independent regulatory regime which brings together a number of functions currently undertaken by multiple jurisdictions, agencies and departments. As detailed below, the Commission is proposing the establishment of the Australian Aged Care Regulation Commission (AACRC).

## Regulating the quality of residential aged care

The regulation of quality in a service industry typically occurs via the process of accrediting both providers and their staff.

> Accreditation is an internationally recognised evaluation process that is used in many countries to assess the quality of care and services … (ACSAA, sub. 354, p. 2)

Although ACSAA does not regard itself as a regulatory body (it regards DoHA as the regulator (sub. 354)), it does have some regulatory responsibilities — accrediting residential aged care facilities and assessing the performance of these facilities against the 44 Accreditation Standards. While ACSAA has the capacity to vary or revoke a facility's period of accreditation, it has no other enforcement powers.

In 2009 DoHA initiated a review of the accreditation processes and standards. Submissions to the DoHA review closed on 17 July 2009. The review received 147 submissions from a range of stakeholders. Subsequently, DoHA split this review into two separate reviews: one on accreditation standards, the other on accreditation processes. It also chose not to publish submissions to these reviews. At the time of writing, DoHA is still conducting consultations in relation to these reviews and has indicated that, when these consultations are finalised, it will advise the Australian Government on the proposed amendments to the Accreditation Grant Principles and the draft set of standards (DoHA, pers. comm., 11 November 2010). Nonetheless, a number of submissions to this inquiry attached a copy of their submission to these accreditation reviews and others have made their submissions to these reviews available on their websites. Many of the issues canvassed in the submissions apply to considerations of the over-arching regulatory framework and associated governance issues. Issues raised in those submissions are summarised in box 12.1.

### *Competition in accreditation arrangements*

Competition in accreditation arrangements was an approach previously recommended in the Banks Review (2006). However, there are divergent views on this matter. On the one hand, the Australian Government (2006) and Senate Community Affairs References Committee (SCARC) (2005) argued for one accreditation agency, to ensure consistency in assessment and to limit providers from forum shopping for a 'soft' auditor. On the other hand, COTA (sub. 337) argued for greater competition in the accreditation market as a way of facilitating the separation of ACSAA's accreditation and education function from its 'policing' role. While the Productivity Commission acknowledged these different views in its

## Box 12.1 **Reforms sought in submissions to DoHA's review of the accreditation processes and standards**

- a simpler, more consumer-oriented and outcomes-focussed regulatory framework (National Seniors Australian (NSA) 2009; UCA NSW, sub. 369; Michael J. Wynne, sub. 368)
- greater independence in accreditation, derived from improved governance arrangements (COTA sub. 337, Attachment 6; Victorian Health Services Commissioner, sub. 349)
- increased engagement with consumers (NSA 2009; COTA, sub. 337 Attachment 6; Commonwealth Ombudsman, sub. 290)
- enhanced gathering of statistical information — focussed on measuring resident outcomes — from an appropriately sized sample of residents (UCA NSW, sub. 369 Attachment D), preferably augmented with social engagement measures to enable a better insight into quality of life (NSA 2009)
- more open, transparent and comprehensive information to consumers, including performance information and best practice information, to drive quality and inform consumer choice (NSA 2009; UCA NSW, sub. 369; ACC, sub. 433; OPRG, sub. 25). Such measures could be centred around a set of national outcome measures accessed on a My Aged Care website (UCA NSW, sub. 369) similar to the UK's Care Quality Commission (School of Management UTS, sub. 8). The ACA (sub. 433) has drawn attention to the use of privacy concerns as a barrier to transparency or accountability
- an appropriate mix of skills in accreditation assessment teams (NSA 2009; UCA NSW, sub. 369; ACA, sub. 433; Maree Bernoth, sub. 253) together with a focus on training as assessor skills are critical to the identification of deficiencies and consistency of findings (UCA NSW, sub. 369, Attachment D)
- reducing the ability of providers to nominate assessors (NSA 2009; ACC, sub. 433)
- a simpler self-assessment process for providers (UCA NSW, sub. 369, Attachment D) backed by a rolling program of accreditation audits (NSA 2009) with a preference towards targeting residential care homes considered at risk for more regular review audits (UCA NSW, sub. 369, Attachment D)
- a greater emphasis on unannounced visits (relative to announced visits) to create incentives for continuous improvement in the quality of care together with accreditation periods no longer than three years (NSA 2009; ACC, sub. 433). In this context, the ACC (sub. 433) notes the Community Visitor Program managed by the Office of the Public Advocate in Victoria through which trained, volunteer members of the community make regular unannounced visits to residential care homes in that state which are documented in the Community Visitor's Annual reports
- greater competition in accreditation arrangements (COTA, sub. 337, Attachment 6).

*Sources:* NSA (2009); inquiry submissions.

annual review of regulatory burdens, it recommended the introduction of competition into accreditation arrangements (PC 2009a). The Australian Government in its response to that report (Australian Government 2009a) maintained its earlier view (Australian Government 2006) and did not accept the Commission's recommendation.

ACSAA (sub. 354) noted that in many other countries, an accreditation agency for long term care which is related to, but at arm's length from, government is not unusual. ACSAA also drew attention to the risks associated with introducing multiple Designated Auditing Agencies which were outlined in the Auditor General of New Zealand's (2009) review of arrangements for checking standards in residential care homes. ACSAA paraphrased the risks in the following terms:

- conflict of interest that could compromise the integrity of audits. The risk that homes might select the cheapest or most lenient audit organisation
- commercial pressures might compromise the auditor's independence
- multiple auditing organisations might interpret the standards differently
- auditors might have inadequate skills and expertise. (sub. 354, p. 10)

ACSAA (sub. 354), while acknowledging the importance of consumer engagement in the accreditation process, also recognised that it was limited in the current process. ACSAA indicated that it had recently commenced dialogue with consumer groups to discuss how gathering information on resident experiences could form an ongoing part of assessment as well as to consider the concept of incorporating consumers as members of assessment teams. Considerable research on the capacity of aged care residents to provide feedback on quality can inform this process (Braithwaite et al. 2007 and Braithwaite 2001). National Seniors Australia (NSA 2009) has also pointed to the example of the Netherlands and its approach to consumer engagement for both accrediting and assessing standards in residential and community care.

### *Investigations into non-compliance*

Under the Act, both DoHA and the ACSAA have responsibilities for monitoring compliance of residential aged care facilities. While ACSAA is focussed on assessing providers' compliance with Accreditation Standards under the Act's Accreditation Principles, DoHA's role is wider, covering providers' responsibilities in matters such as certification, fees and charges, and specified care and services.

As noted by the Commission, this can be confusing for providers:

> While [ACSAA] and [DOHA] have a protocol regarding actions each organisation takes when non-compliance is identified or suspected, the protocol allows both

> organisations to make independent decisions — which increases the potential risk of duplication. (PC 2009a, p. 65)

For example, alongside audit reports which are not helpful to providers because they are 'generally bland and inappropriately similar', UnitingCare Ageing NSW.ACT (UCA NSW) notes that:

> The current practice of publishing both the audit report of the assessment team and the [ACSAA]'s decision is confusing when the [ACSAA]'s decision differs from that of the assessment team's recommendations. (sub. 369, Attachment D, p. 52)

To add to this confusion for providers regarding monitoring of compliance, the CIS can refer accreditation issues to ACSAA that have arisen from complaints to DoHA.

To address this potential confusion, the Productivity Commission (2009) recommended the respective agencies clarify their roles (regarding the monitoring of provider compliance with accreditation standards) and communicate the agreed protocol (explaining actions each organisation takes when non-compliance is identified or suspected). The Australian Government's (2009a) response accepted the recommendation and agreed to undertake further consultation with the Ageing Consultative Committee on the issue. DoHA has subsequently indicated that this issue will be considered in the context of implementing outcomes from the reviews of CIS and accreditation processes and standards (DoHA, pers. comm., 11 November 2010).

Notwithstanding attempts to address this issue through consultation and reviews, on balance the Commission considers that it is better to limit potential confusion and increase the efficiency of regulation through establishing a single entity responsible for investigations of non-compliance.

### *Summing up …*

Bearing in mind that a principal function of ACSAA is a regulatory one — that is, the assessment of the residential care facilities that it has accredited — and the confusion which currently arises from the doubling up of investigations into non-compliance, further changes to governance arrangements surrounding regulation are warranted. In particular, while acknowledging the respect that ACSAA has gained from many providers in the industry:

> … [when] seen against the backdrop of the need at the time of its introduction, for urgent and effective action to raise standards … we believe the system has serviced consumers and providers well. (UCA NSW, sub. 369, p. 34)

it is also apparent that the current structure it currently operates within is problematic for a number of reasons.

First, under the Australian Government's policy, *Governance Arrangements for Australian Government Bodies* (Department of Finance and Administration 2005), regulatory agencies are more appropriately governed under the *Financial Management and Accountability Act 1997* (FMA Act). ACSAA is a company limited by guarantee that is wholly-owned by the Commonwealth, and subject to the *Corporations Act 2001* and the *Commonwealth Authorities and Companies Act 1997* (CAC Act). The policy notes that company structures are more appropriate for commercial and entrepreneurial functions.

Further, ACSAA's sole shareholder is the Minister for Ageing. At the same time, ACSAA also operates under contract to DoHA. This situation creates a potential conflict of interest for the Minister for Ageing as both the sole shareholder and the only contractor of this company's services.

There has been a trend over several years for regulatory agencies to be established under (or transferred to) the FMA Act, rather than the CAC Act. For example, on 1 July 2007, the Australian Securities and Investments Commission (ASIC) and the Australian Prudential Regulation Authority (APRA) moved from governance under the CAC Act to the FMA Act, and the Australian Fisheries Management Authority (AFMA) moved on 1 July 2008. In 2009, Fair Work Australia and Safe Work Australia were both established under the FMA Act.

Second, the current governance arrangements for accreditation need to be reconsidered within the context of an enhanced consumer-oriented and outcomes-focussed approach to assessing the quality of care. Moreover, many features of best practice 'responsive regulation' (appendix E) are difficult to achieve when one aspect of regulatory responsibility (that is, accreditation and compliance checking) is structurally separated from enforcement decisions surrounding quality. Regulatory behaviour would be enhanced by locating quality assessment within the same organisation that receives consumer complaints and makes the enforcement decisions. As UCA NSW notes:

> Such a reconsideration is all the more merited given just how onerous the current quality system is for providers. (sub. 369, p. 35)

Finally, if quality assessment were to be expanded to cover both residential and community care (discussed below), a different approach would be required:

> Looking to the future, an increased emphasis on community care would sit more naturally with a different approach to quality regulation. (UCA NSW, sub. 369, p. 27)

The Commission notes the ACC's (sub. 433) views that ACSAA's two main roles (regulation and education) are conflicting and some arrangements are subject to potential bias. However, these two functions can be complementary — especially within the context of moving towards a 'responsive regulation' model (appendix E). The creation of an independent regulator under the FMA Act would also be a significant step toward reducing the potential for perceived bias.

The Commission is proposing that ACSAA be administered under the FMA Act as a statutory office within the proposed Australian Aged Care Regulation Commission. The office (ACSSA) would be headed by a statutorily appointed Commissioner for Standards and Accreditation. The Commission envisages that the current Board of Directors of ACSAA would become an advisory committee to that Commissioner.

## Regulating the quality of community aged care

In relation to packaged community aged care (defined in section 12.1), the Australian Government (through DoHA) entirely funds and regulates this type of aged care under the Act and, from 1 March 2011, will do so in accordance with Community Care Common Standards (DoHA 2010d).

By contrast, the funding and regulation of basic community aged care (defined in section 12.1) is subject to a division of responsibilities between federal and state and territory governments. For example, Anglicare Sydney noted:

> … there is no single set of standards to report against but rather a plethora of standards and frameworks that creates significant overlap at a time when community care programs are increasing, in number and service type. (sub. 272, p. 14)

Historically, according to Weiner et al., this arrangement:

> … has resulted in protracted negotiations on many aspects of the program, including standards. (Weiner et al. 2007, Appendix B, p. B-4).

Since 2001, state and territory governments have implemented the HACC Standards Instrument using one of two methods (box E.5, appendix E). While there is a HACC minimum data set (DoHA 2010k) and all jurisdictions have provided annual business reports since 2003, no agreement has been reached on the release of these findings and no publicly available information is available on the extent to which HACC services meet the national standards (Weiner et al. 2007).

From 1 July 2012, these complex jurisdictional responsibilities will be simplified, with the Australian Government (through DoHA) taking responsibility for funding and regulating basic community aged care on a day-to-day basis. Nevertheless,

some complexities remain because, at the time of writing, the Victorian and Western Australian Governments are not parties to these reforms.

In addition, a number of submissions have suggested that a single regulator be responsible for both residential and community aged care. For example:

> If the funding model for aged care is to change to one covering both residential and community care, then it would be appropriate to implement a regulatory system that encompasses both areas. (Mercy Health, sub. 215, p. 10)

To limit the potential for confusion and overlapping regulation, to increase the efficiency of regulation and to facilitate best practice regulation, a single organisation should undertake the regulation of quality, andinvestigations of non-compliance, across **all** aged care regulations for which the Australian Government has responsibility.

The Commission also notes that approval of care providers for Australian Government funding of both residential and community aged care is currently undertaken by DoHA, while accreditation of residential aged care is undertaken by ACSAA. Both approval and accreditation are required for a provider to obtain Government funding but they are managed through separate processes. With the proposed move to a single independent regulator (the AACRC) and the proposed operation of ACSAA as a statutory office within that body, the Commission envisages these two processes would be streamlined.

In particular, the Commission proposes that AACRC have responsibility for approving both community and residential aged care providers for Government subsidised services and the right to limit, suspend or terminate such approvals where there is non-compliance. On-going approvals of residential and community care providers would be dependent on maintaining appropriate accreditation (as necessary) together with compliance with other aged care regulations. As proposed below, appeals against the decisions of AACRC would be to the Administrative Appeals Tribunal.

These reforms should greatly strengthen the decision making processes and remove the potential for and perception of political influence, inherent in the current process.

In addition, in consideration of the efficiency requirements and the consumer and industry obligations of AACRC, the resulting governance arrangements should be subject to review following a suitable period after the creation of that Commission.

## Regulating prices

As recommended earlier in this report (draft recommendation 6.11), the Commission is proposing that AACRC's regulatory responsibilities would include the monitoring of prices charged to consumers and the costs of care. The AACRC would also be responsible for transparently advising the Government on a scheduled set of care prices and subsidies across the various elements of the aged care system and a rate of indexation.

## Prudential regulation

The Commission is proposing that AACRC be responsible for prudentially regulating accommodation bonds paid to residential aged care providers. This arrangement appropriately separates policy development from the administration of prudential regulation.

In this context, the recommendations and guidance from the ANAO (2009) audit on the *Protection of Residential Aged Care Accommodation Bonds* are relevant to the operations of the proposed AACRC. That report made seven recommendations, all of which have been agreed to by the Government (table F.4, appendix F).

DoHA has advised the Commission that it is progressively implementing the ANAO's recommendations. Among other things, the Government is developing an enhanced prudential framework around accommodation bonds as part of a 2010-11 budget measure ($21.8 million over four years) to strengthen protections for accommodation bonds held by aged care providers. The arrangements include:

- applying more stringent requirements on how accommodation bonds can be invested
- criminal penalties for the misuse of accommodation bonds
- stronger reporting requirements in relation to how bonds are used (Australian Government 2010c).

DoHA has released an issues paper (DoHA 2010g) as part of a consultation process in anticipation of putting the new arrangements in place by 1 July 2011 (DoHA, pers. comm. 11 November 2010 and Australian Government 2010d). Commenting on DoHA's issues paper, the Australian Guardianship and Administration Council stated:

> The proposed initiatives if implemented, will significantly address the concerns that we have raised in our earlier submission. This would be a most positive development although the actual separation of the management and investment of such significant

> accommodation funds … from the 'arms' of the 'approved providers', is still something that the Commission may care to consider. (sub. 478, p. 4)

Chapter 6 addresses a number of options which could reduce the risk around accommodation bonds. The Commission notes that even if the Government were to create a separate trust fund to hold all future accommodation bonds, prudential regulations would continue to apply to the current stock of accommodation bonds held by approved providers. Prudential arrangements would also be required to manage the trust fund balance in these circumstances.

Discussion surrounding the consumer disclosure requirements under existing prudential regulation is in section 12.4.

## Regulating quotas for supported residents

The Commission has recommended (draft recommendation 6.5) the maintenance of quotas for supported residents in most residential aged care facilities and, further, that the trading of these quotas will be allowed within a region. These quotas will be set by the Australian Government from time to time but the Commission envisages that AACRC's responsibilities would be to oversight any related regulations and compliance with these quotas.

## Communicating with stakeholders

In the context of adopting best practice regulation, AACRC will need to undertake regular communication with all stakeholders in relation to its regulatory responsibilities and activities, including information on the appeals processes. In doing so, it will need to liaise with the Australian Seniors Gateway Agency (chapter 8) and the AAT to ensure consistency of approach. Its information products should also be available to consumers in a variety of readily accessible and digestible formats, including different languages (chapters 9 and 11).

It will be vital for AACRC to demonstrate impartiality and balance in its decision making through appropriate transparency of its processes and decisions (section 12.3). As part of its communication role, the Commission will also be responsible for the collection and dissemination of data and research (chapter 13).

## Complaint handling and appeals

Complaints can come from several sources. They can be the result of consumer complaints (usually about a particular provider) or the result of providers'

complaints about the enforcement decision(s) of a regulator. The latter is more appropriately described as an appeal.

Well structured complaint handling with rights to independent appeals processes is an important feature of good governance arrangements (appendix E).

*Improving the structures for complaint handling …*

As figure 12.1 shows, while the Government's aged care CIS reports directly to the OACQC within DoHA, it also has reporting arrangements in practice which are spread across DoHA.

In 2009 the Walton Review (2009) (the Review) examined the CIS. The Review largely focussed on complaint handling in relation to residential aged care facilities. It also received a small number of submissions relating to community care.

The Review documented a number of difficulties experienced by consumers, providers, staff working in the CIS and the OACQC. A summary of the key issues identified by the Review is contained in box 12.2.

Box 12.2 **Summary of key issues identified in the *Review of the Aged Care Complaints Investigation Scheme* (CIS)**

- The need for the CIS to improve its communication processes with both consumers and providers.
- The importance of encouraging a range of options for managing complaints — from resolution at the local provider level, to mediation and investigation by the CIS.
- The perception that as the funder and regulator of aged care services, [DoHA] is not the appropriate body to manage the complaints investigation process.
- The need to revise the complex management and accountability structure within the CIS and the Office of Aged Care Quality and Compliance to ensure more effective complaints management.
- The impact of the workload and competing priorities of CIS staff on the ability to achieve quality outcomes.
- The need for more specific and ongoing training for CIS staff.
- The necessity to amend current CIS processes and practices to achieve a more efficient and effective system which achieves satisfactory outcomes for all parties.

*Source*: Walton Review (2009, p. 5).

According to the Review, these difficulties largely emanated from the design and inadequate structure and location of the CIS:

> In comparison with other complaint bodies the CIS … is in a rudimentary complaint management phase and does not yet have the attributes of best practice complaint management. … The lack of time frames, lack of focus on early resolution and often poorly executed investigations are a consequence of bad design and not the fault of the managers of CIS or the investigation staff.
>
> Further, the consequence of a complaint system that is not housed in the one body impacts on the way staff see their roles and responsibilities. Staff I spoke with saw themselves primarily as employees of [DoHA]. This impacts on how they respond to departmental challenges, which may or may not be in conflict with good complaint management. (Walton Review 2009, p. 72)

Accordingly, the Review's key recommendations largely centred on governance arrangements.

To deal with the inadequate design and structure, the Review recommended the CIS be restructured into three separate divisions: Assessment and Early Resolution; Investigations; and Communications and Stakeholder Management (recommendations 3.2–3.4).

The Review also recommended the establishment of an independent Aged Care Complaints Commission and the creation of the position of Aged Care Complaints Commissioner who would report directly to the Minister for Ageing (recommendation 3.6).

The Review outlined a raft of additional recommendations for immediate implementation within the existing structural framework of the CIS (recommendation 3.7). These recommendations covered: recruitment and training; clinical advice; risk assessment framework; information collection and investigation; natural justice; provisions to review decisions; relationship between the CIS, the Commissioner, the ACSAA and other relevant bodies; processes, practices and timeliness of responses to complaints; and other issues.

Finally, in relation to risk assessment, the Review suggested that the structure of CIS has resulted in an overly risk averse approach to the handling of complaints:

> CIS have adopted a very low threshold of risk in their assessment of complaints for investigation … There is also the perception that if they make a mistake in the assessment, harm may befall the resident (and possibly reflect badly on the CIS). Fear of mistake becomes a significant factor in complaint management when a risk assessment framework is not used, or inconsistently applied. (Walton Review 2009, p. 52)

Accordingly, the Review suggested that the CIS adapt the New South Wales Department of Health Risk Severity Assessment Matrix in the context of aged care complaints, after review and appropriate modification.

In response to the Walton Review recommendations, the Government (in its 2010-11 Budget) committed $50.6 million over four years to improve CIS' procedures to manage complaints and reduce its caseload. These included: more timely responses to complaints through early risk assessment and resolution; greater access to clinical expertise; improved processes, procedures and training for the scheme; a broader range of options for resolution of complaints; an enhanced communications strategy for the scheme; and better access to seek an independent review of the scheme's decisions and processes (DoHA, pers. comm., 11 November 2010). This budget measure also provided additional funding for ACSAA to meet the likely rise in referrals from the expanded Aged Care Complaints Investigation Scheme (Australian Government 2010c).

The Victorian Health Services Commissioner, in her submission to this inquiry, expressed concerns around the inherent conflict arising from an organisation being the funder, regulator and investigator, and concerns around the provision of natural justice to the parties of CIS. The submission also supports the Review's recommendation to establish an Aged Care Complaints Commission independent from DoHA. In addition, the submission argued:

> Recommendations made by the [OACC] are not always accepted but it is not so much the relationship between the CIS and the [OACC], [ACSAA] and other relevant bodies which is the issue, it is the structure that is the problem.
>
> … consideration should be given to the establishment of a discrete conciliation arm within the independent Commission, similar to the conciliation functions in my office (sub. 349, pp. 1–2)

The OACC also supported the Review's recommended approach to creating an independent complaints body, but with the additional caveat:

> Such a body would determine complaints and be subject to review of its administrative decision-making processes by the Commonwealth Ombudsman. (sub. 444, p. 12)

The OACC (sub. 444) also:

- suggested that a complaints body should have the capacity to refer matters directly to: relevant Health Service Commissioners (HSC) in relation to hospital complaints; the Australian Health Practitioner Regulation Agency (AHPRA) in relation to complaints about health care professionals; and relevant police authorities and/or coroners

- argued that the complaints body should also deal with complaints about all Commonwealth funded aged care organisations and/or programs (for example, ACATs, HACC), provide education and information to a range of industry and consumer organisations (to maximise its quality improvement commitment) and — aligned with Victorian Health Services Commissioner's submission — consider establishing a discrete conciliation arm. In addition, it suggested that the complaints body establish an internal review mechanism prior to access to an appeals mechanism for dissatisfied parties and that it be funded from a separate parliamentary appropriation with concomitant accountabilities and reporting
- argued for a complaints management process that is 'clearly independent and transparent, meets natural justice requirements, attempts to resolve complaints simply and inexpensively at the local level within an entity that provides a nationally consistent policy and administrative framework' (sub. 444, p. 12).

The importance of separating complaints handling from the funding department was also echoed in submissions from COTA (sub. 337), the Commonwealth Ombudsman (sub. 290) and Blake Dawson (sub. 465). In addition, Blake Dawson noted that this separation may result in:

> … less pressure on [DoHA] to respond to concerns raised by the media or other political pressures in relation to the investigation of complaints. (sub. 465, p. 42)

The Commonwealth Ombudsman (sub. 290) noted that complaints it receives often perceive that the current system of regulation is not sufficiently independent of DoHA or the aged care industry. In this vein, the Commonwealth Ombudsman's submission reiterated the need for an independent assessment of care needs and that the results of this assessment be amenable to merits review:

> For example, a person can appeal to the Administrative Appeals Tribunal (AAT) about an ACAT assessment that results in a limitation on their approval as a care recipient, but if a provider successfully argues to DoHA that the person requires a different level of care, despite there being no limitation on the ACAT assessment, the person does not have recourse to the AAT. (sub. 290, p. 10)

The Commonwealth Ombudsman is also of the view that while the current complaints process meets regulatory needs it often places parties in an adversarial position rather than helping parties resolve complaints:

> Many of the aged care complaints to the Ombudsman's office evidence dissatisfaction with the outcome of the investigation of complaints taken to the CIS or the [O]ACC. In our view this is principally because the CIS and [O]ACC investigate complaints from a regulatory perspective. They consider whether or not there has been a breach of the aged care standards (some of which are very broadly worded), and whether any breach warrants the issuing of a *notice of required action*. Complainants, on the other hand,

> seek acknowledgement of or redress for past events, or the resolution of an issue which is personal to them.
>
> … The current complaints scheme has not provided the type of resolution mechanism required in circumstances where there will be an ongoing relationship between the facility and the care recipient. (sub. 290, pp. 19–20)

Blake Dawson's submission reiterated the point that the adversarial culture is a function of the way the CIS operates under its legislation:

> In our opinion, replacing the previous complaints scheme under the Aged Care Act, which permitted mediation or conciliation of issues, with the current investigation scheme in 2006, has resulted in an unsatisfactory and skewed system. The only possible responses to a complaint are an investigation or the exercise of the Secretary's discretion not to investigate the complaint (which we understand rarely occurs). (sub. 465, p. 42)

To resolve this problem, Blake Dawson's submission argued for a broader framework so that 'while it remains possible to conduct an investigation of serious issues, other means of dispute resolution are also available where appropriate' (sub. 465, p. 43). Options would include: informal resolution, including giving an apology; mediation; conciliation; formal investigation; and referral to relevant registration bodies (where the complaint concerns registered professional staff) for action following an investigation.

A number of submissions (for example, TLC Aged Care, sub. 392) raised the issue of potential conflicts arising in providers' handling of some psycho-geriatric patients in relation to the 'security of tenure' and 'duty of care' statutory obligations. Blake Dawson have suggested one remedy for dealing with the circumstances under which individuals can and should relocate which involves complaint handling processes being 'empowered to consider whether a determination should be made enabling a resident to be relocated in specific circumstances' (sub. 465, p. 44).

Finally, the Commonwealth Ombudsman noted that there is currently no requirement to provide a complaint and redress mechanism under the Flexible Program which covers Indigenous aged care. Its submission notes that over 1000 complaints have been received through outreach since the creation of the Ombudsman's Indigenous Unit in 2007 (very few Indigenous Australians complained to the Commonwealth Ombudsman prior to the formation of this unit). Accordingly, the Commonwealth Ombudsman recommends regular outreach of complaints services to ensure accessibility for all, including Indigenous Australians.

The Commission accepts the need to create a complaints handling process which is separate from the funding and policy department. At the same time, however, best

practice regulation (appendix E) suggests that complaint handling should form part of an independent regulator's functions. Such an arrangement facilitates appropriate feedback loops (including in a risk assessment framework) to the regulator's management of compliance and, where necessary, enforcement.

Accordingly, the Commission supports the approach in the Walton Review's (2009) recommendations (3.2 to 3.4) to restructure complaints handling into three functional groupings: Assessment and Early Resolution; Investigations; and Communications and Stakeholder Management. A discrete Conciliation component, within the Early Resolution function, is also supported. In addition, an outreach component should also form part of AACRC's Communications and Stakeholder Management function. Complaints should be able to be referred to other regulatory agencies as appropriate. Empowering the complaint handling process to make determinations which balance conflicting regulations (for example, security of tenure and duty of care) should also be considered.

To accommodate the key elements of the Walton Review, and to ensure structural separation from the Department of Health and Ageing, the Commission is proposing a statutory office be established within the new regulatory body, the AACRC, and be headed by a Commissioner for Complaints and Reviews. This office would have a broad range of complaint handling and review functions, but would not be an appeals body. The current Aged Care Commissioner's position and role would be replaced by this position and function.

### *… and independent appeal*

While complaints and reviews are best handled by a statutory office within the regulator, appeals are best dealt with at arm's length from the regulator and decision maker. Existing aged care appeal arrangements currently occur through the OACC and the AAT.

Wesley Mission Victoria noted there is merit in instituting an intermediate appeal body between the independent regulator and the AAT:

> … It is expensive and time consuming to go to the Administrative Appeals Tribunal (AAT). An alternative would be a middle agency, between the accreditation body and the AAT that can be contacted and is not such an expense. Perhaps a formal review process that is independent of the accreditation Agency that can be undertaken before going to the AAT, for example, an Aged Care Ombudsman. (sub. 311, p. 13)

The Commonwealth Ombudsman (sub. 290) also considered that the time frame of:

- 14 days for a person to appeal to the OACC is too short

- 28 days for the right to appeal to the AAT in relation to a determination by Centrelink or the Department of Veterans' Affairs on the persons assets should be aligned to the usual time frame for appeals for decisions for these organisations, which is 13 weeks.

Finally, the ACC has requested that careful consideration be given to the appointment of the head of an appeal body:

> Not only should there be no conflict of interest in the appointment of those charged with ensuring our aged-care system is fair and equitable, but that there should also be the *perception that no conflict of interest occurs*. (sub. 433, p. 9)

The Commission supports the need for a separate mechanism to determine appeals at arm's length to both the proposed independent regulator (AACRC) and the proposed consumer gateway, the Australian Seniors Gateway Agency (ASGA) (chapter 8). Moreover, this independent appeals process should be available to both providers and consumers in relation to the determinations of AACRC and ASGA. This avenue should be used when complaint handling and review within these two agencies has been exhausted. However, the Commission is also mindful of Government policy not to unnecessarily duplicate existing administrative appeal arrangements (primarily the AAT) where practical (Department of Finance and Administration 2005).

The Commission is confident that the establishment of a statutory office within the AACRC, headed by a Commissioner for Complaints and Reviews, will enable complaints to be handled in a manner which is aligned with 'responsive regulation'. As such the Commission does not believe that the establishment of an intermediate appeal agency is necessary, and supports reliance on the AAT to provide the separate appeals mechanism. Nonetheless, the creation of an Aged Care Division within the AAT may be appropriate, and the Commission seeks feedback from participants as to the merits of establishing such a Division.

DRAFT RECOMMENDATION 12.1

***The Australian Government should establish a new regulatory agency — the Australian Aged Care Regulation Commission (AACRC) — under the Financial Management and Accountability Act 1997. This would involve:***

- ***the Department of Health and Ageing ceasing its regulatory activities (except for regulation policy development — including quality standards — and advice)***
- ***establishing the Aged Care Standards and Accreditation Agency as a statutory office within the AACRC***

- ***establishing a statutory office for complaints handling and reviews within the AACRC.***

***The AACRC would have three full time, statutorily appointed Commissioners:***

- ***a Chairperson***
- ***a Commissioner for Standards and Accreditation***
- ***a Commissioner for Complaints and Reviews.***

***The Chairperson would have responsibility for pricing and all other regulatory matters.***

***Key functions of AACRC would include:***

- ***responsibility for compliance checking and the enforcement of regulations covering the quality of community and residential aged care***
- ***approving community and residential aged care providers for the provision of government subsidised aged care services***
- ***administering prudential regulation and all other aged care regulation, such as quotas for supported residential care***
- ***monitoring and assessing costs and transparently recommending a scheduled set of prices, subsidies and a rate of indexation for subsidised aged care services***
- ***assisting and educating providers with compliance and continuous improvement***
- ***handling consumer and provider complaints and reviews***
- ***providing information to stakeholders, including disseminating and collecting data and information.***

DRAFT RECOMMENDATION 12.2

***The Australian Aged Care Regulation Commission's (AACRC) Commissioner for Complaints and Review should determine complaints by consumers and providers in the first instance. Complaints handling and reviews should be structured into the three areas: assessment, early resolution and conciliation; investigations and referral; and communication, stakeholder management and outreach. The Australian Government should abolish the Office of the Aged Care Commissioner.***

***All appeals in respect of decisions of the AACRC and the Australian Seniors Gateway Agency (draft recommendation 8.1) should be heard by the Administrative Appeals Tribunal (AAT). Consideration should be given to the establishment of an Aged Care Division within the AAT.***

## Access to independent consumer advocacy services

According to Queensland Ageing and Disability Advocacy Inc, consumer advocacy:

> … plays a valuable role in the provision of aged care services. It is an effective means of early resolution of issues; often preventing issues going through formal complaints processes such as the [CIS], and promotes an environment of continuous quality improvement. (sub. 207, pp. 3-4)

The Aged Rights Advocacy Service (ARAS) also noted that advocacy services provide:

> … a non-conflicted, independent voice for vulnerable older people, which supports them to resolve issues to their satisfaction (sub. 137, p. 4)

In addition, appropriately staffed advocacy services are also important for special needs groups (Jo Harrison, sub. 190, Multicultural Disability Advocacy Association of NSW, sub. 144).

Freedom of advocacy is one of features of good governance arrangements (appendix E), covering both personal advocacy and policy advocacy.

The Australian Government funds aged care consumer advocacy services in each state and territory under the National Aged Care Advocacy Program (NACAP). NACAP has its legislative basis in the Act, and the Advocacy Grant Principles 1997 (appendix E). In addition to providing independent advocacy and information to recipients or potential recipients (or their representatives) of aged care, the services also perform an educative role for aged care recipients and approved providers on the rights and responsibilities of care recipients.

In 2009-10, services under NACAP undertook over 4100 advocacy cases, handled 5300 general enquiries and provided over 1600 face-to-face education sessions (DoHA 2010n). However, as ACC (sub. 433) notes, due to the existence of other state-based consumer advocacy services, it is likely that these are under-estimates of the actual number of advocacy cases involving aged care.

ARAS drew attention to the Walton Review's recognition of the relatively high case load for consumer advocacy services. ARAS also pointed to the instability that is created by NCAP's annual funding arrangements and that growth funding would also be required if advocacy was to be formally included in an early resolution stage within the complaint handling process (as recommended by the Walton Review):

> The current year by year funding of the NACAP is detrimental to keeping our experienced staff however, and we would advocate that the NACAP would benefit from tri-annual funding which applies to most other programs, and an increase in

> funding if the CIS is to refer more cases. The other three programs operated by ARAS receive three year recurrent funding from the HACC Program which enables some stability.
>
> … there is a need to establish appropriate growth funding to enable increased access to advocacy as outlined in the CIS [Walton] Review recommendations. (sub. 137, p. 5)

The Australian Government's Community Visitors Scheme program could also be a conduit to enable those who are socially or culturally isolated to gain access to personal advocacy services if needed.

While some of the demands on advocacy services are likely to be relieved through improved information provision to consumers via the development of the ASGA (chapter 8), a continuing role for independent personal advocacy is also envisaged. But because not everyone will require a personal advocate in the first instance, in practice there will need to be some eligibility rules developed around access to subsidised consumer advocacy services.

Because of the importance of independence in, and freedom of access to, consumer advocacy in aged care, advocacy services should be subsidised and governed in a way that allows these services to be independent of both DoHA, ASGA and AACRC. That is, while these services are funded directly by DoHA, consistent with the usual practice, they are funded and governed in a way that allows them to be independent.

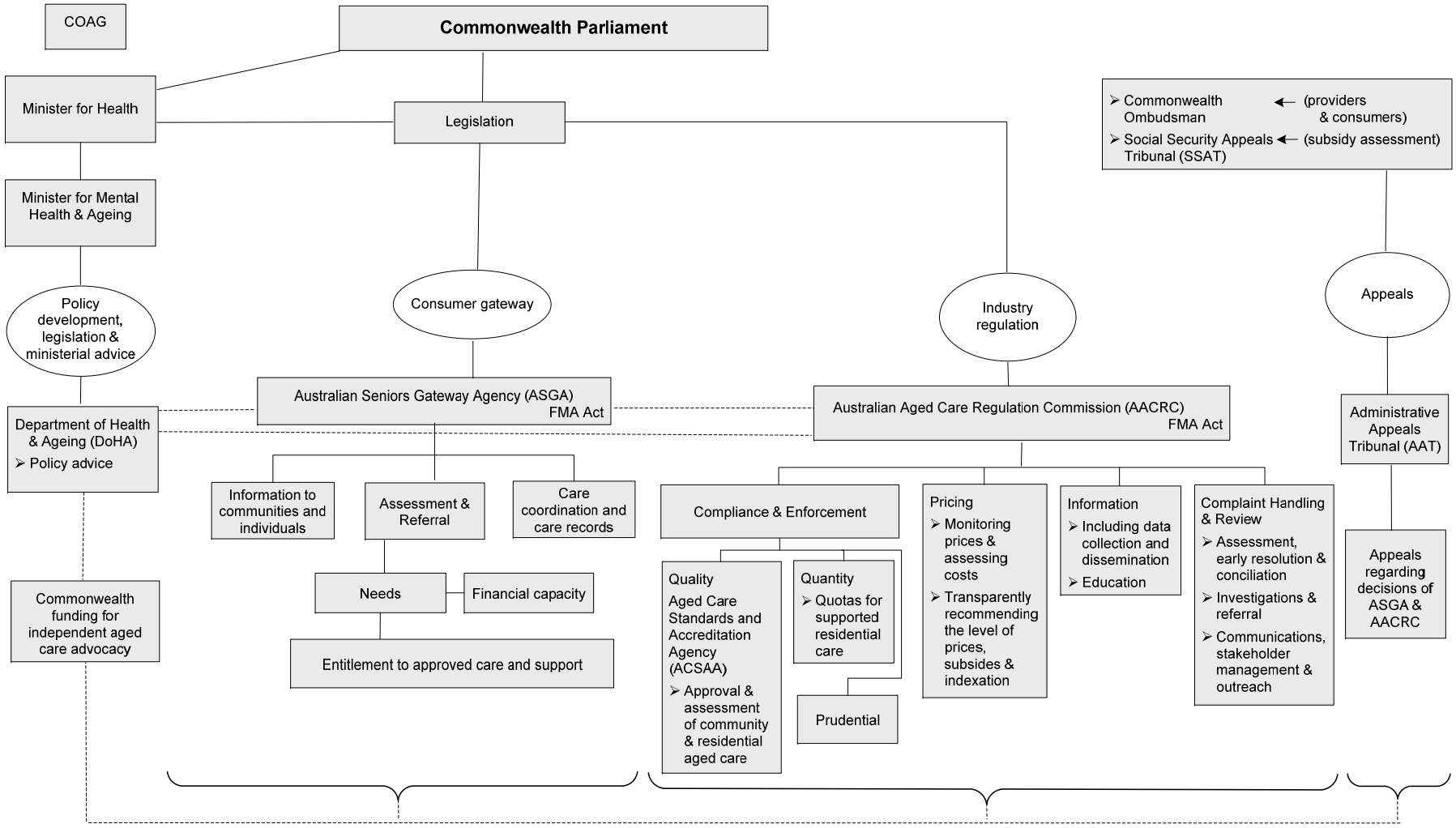
The Commission supports all governments continuing to fund independent personal advocacy services that can be accessed by all recipients of Government funded community and residential aged care.

## Putting all this together …

Drawing on best practice governance arrangements (appendix E), the Commission's recommended governance arrangements for policy development and advice, consumer advocacy, regulation and appeals are represented in figure 12.2.

This governance diagram also includes the recommended approach for consumer directed care (chapter 8) which involves establishing a gateway for older people seeking information about, and access to, aged care services — the ASGA — that is separate from DoHA and AACRC. The backbone of the system would be an expanded system of electronic care records, which would include information on assessment, eligibility, services used, payments made to recipients and referrals.

Figure 12.2 **Suggested Australian Government governance arrangements for aged care**



These governance arrangements should be subject to review after five years of operation.

## 12.3 Implementing 'responsive regulation' with appropriate standards and streamlined reporting

Best practice regulation involves not only establishing appropriate governance arrangements (section 12.2) but also: determining an appropriate set of standards; implementing approaches to encourage and enforce compliance; and streamlining reporting arrangements (appendix E).

### Developing appropriate standards for quality care and prudential regulation

The choice of regulatory standard is a matter of judgement by governments based on assessments by policy makers using the Principles of Best Practice Regulation (box E.2, appendix E). In the context of aged care, the main consideration is to balance any systemic risks of poor outcomes for recipients against the effects of onerous duplicate and inconsistent regulation. The Commission's proposals regarding the disclosure requirements for accommodation bonds and mandatory reporting requirements for missing residents (section 12.4) are examples of the tensions which need to be balanced in establishing regulatory standards.

Under the proposed arrangements, AACRC will be required to administer regulations covering standards in two key areas: quality of care and prudential regulation.

#### *Quality of care — residential aged care*

Currently the Act has a two-part quality assurance process that covers certification of buildings and environment, and certification and accreditation of care standards for residential care. Having adopted a number of Commission recommendations regarding regulatory burdens in aged care, the Government is currently working to remove the certification of buildings and environment from the Act and to modify the Building Code of Australia, as appropriate (chapter 10). These changes will leave the Act with its primary focus on quality of care standards and prudential regulation.

Weiner et al. described the current Australian quality standards for residential aged care as:

> … very broad and non-specific to allow providers considerable latitude in demonstrating how they achieve quality goals. (Weiner et al. 2007, p. vi)

While praising the flexibility implicit in the Australian accreditation standards and the way that it encourages assessors to communicate with providers and users to establish whether and how the expected outcomes have been achieved, Weiner et al. (2007) also outlined a number of concerns with these standards. These include whether:

- the common quality system across a heterogeneous range of dependencies is appropriate
- the general nature of standards leaves too much flexibility for providers and assessors (with the latter subject to 'regulatory capture' by the former)
- it might be possible to develop a middle ground between broad standards and specific standards which allow the development of more systematic, quantifiable measures of the quality of care that could be used over time to compare facilities or to benchmark the whole system to track changes over time
- the standards provide enough incentive for providers to improve quality above the lowest common denominator.

While a national framework to streamline and standardise documentation was issued in 2005, complaints by providers remain (box 12.3 and chapter 5). Moreover, while ACSAA makes its decisions publicly available along with a copy of the assessors' full report, these reports are often not user-friendly for lay readers.

The Queensland Nurses Union (QNU) pointed to a need to ensure the development of appropriate performance measures (and associated data collection) before moving to fully adopt and implement performance-based standards. It noted the Steering Committee for the Review of Government Service Provision's (2010) report which:

> … commented that for several aspects of aged care services, indicators are not fully developed and there is little performance reporting available. We concur with the Commission's priorities for the future which include:
>
> - continued improvement of efficiency indicators, including for HACC services and assessment services;
> - improved reporting of waiting times for residential aged care;
> - improved reporting of long term aged care in public hospitals;
> - further development of outcome indicators. (QNU, sub. 409, p. 18).

### Box 12.3 **Common criticisms of the accreditation process**

Too much focus on documentation in accreditation …

> A common criticism is that assessors focus too much on documentation to demonstrate that systems are in place, rather than looking directly at actual care practices and the outcomes that result … Providers argue that the amount of time taken to complete desk work is time that could have been better spent attending to residents. (Weiner et al 2007, Appendix B, p. B-7).

… and in investigations of non-compliance.

> … once again direct care staff are left feeling that the paperwork is more important than the service and care provided to our elderly. (Fronditha Care, sub. 436 , p. 9)

There are different regulatory approaches in aged care and acute care:

> The present aged care standards are focused more on the achievement of minimum standards than on the idea of continuous quality improvement. In contrast to the EQuIP program in Hospitals, aged care standards compliance is enforced via a range of sanctions available to the Commonwealth Government under the Aged Care Act. Best practice accreditation systems focus on quality improvement to find the underlying causes of errors or system failures so that their future incidence can be reduced. (Mercy Health, sub. 215, p. 9)

*Sources*: Weiner et al. (2007); inquiry submissions.

As discussed, DoHA is currently undertaking reviews of accreditation standards and accreditation processes. At the time of writing, a range of options, including new draft standards, had been circulated for comment to stakeholders through the Ageing Consultative Committee. This Committee has suggested changes to the range of options and the Australian Government is currently considering these prior to drafting amended Accreditation Grants Principles (DoHA, pers. comm., 11 November 2010).

In the absence of information on the proposed changes to the existing quality of care standards and the ensuing comments on them, the Commission is not in a position to make detailed comments in its draft report. Nonetheless, the Commission urges DoHA to ensure the development of accreditation standards is consistent with the *Best Practice Regulation Handbook* (Australian Government 2010e) and be subject to periodic review.

#### *Quality of care — community aged care*

Quality of care regulations in community aged care differ with those in residential aged care. First, because community care is delivered into people's homes it is often much more difficult to strictly regulate in practice. But, second, community care typically involves a choice by the individual to trade-off a potential increase in risk

against maintaining their own perceptions about the quality of life in community versus residential care. This perspective on the difference between residential and community care in developing appropriate standards has been put forward by Dianne Beatty:

> Given community care is only one of usually many contributors to older people's lives in their homes and that older people living in their homes are effectively choosing quality of life and risk over the comparative safety of residential aged care, we recommend that:
>
> - community care be not subject to the accountability and responsibility documentation levels and systems applied to residential aged care. (sub. 413, p. 4)

Notwithstanding this fundamental distinction, the quality of HACC and community aged care packages is currently subject to a range of different quality standards across jurisdictions. The development of these quality standards have been praised while the actual standards themselves have been criticised. For example:

> Notwithstanding the progress made in implementing Quality Reporting across the community care programs, the process remains focused on service outputs. The process does not measure the quality of the respite experience, and hence its value, for the person with dementia and their carer. A shift in focus to the outcomes of service use, not just service outputs, is essential to supporting quality service provision, and suitable outcome measures need to be developed and adopted in quality assurance systems. (Bruen and Howe 2009, p. 53, attachment to Alzheimer's Australia, sub. 468)

The Commission has previously called for outstanding issues to be resolved so that jurisdictions can agree to a common set of community care quality standards and reporting arrangements consistent with the methodology and principles supporting Standard Business Reporting (SBR) (PC 2009a, p. 86). The majority of these remaining problems now appear to have been remedied, with the Community Care Common Standards (appendix E) to be implemented by most jurisdictions from 1 March 2011 (with Queensland starting later) (DoHA, pers. comm., 11 November 2010).

In relation to reporting arrangements which are consistent with the SBR, DoHA has indicated that it is currently trialling an automatic financial reporting arrangement for community care providers under the NRCP. It has also indicated that once SBR has been tested, opportunities for expanding its application will be considered, subject to a compelling business case (DoHA, pers. comm., 11 November 2010).

Gauging the extent to which HACC, packaged community care, and NRCP services meet these new national Community Care Common Standards is also important. However, it is unclear from the guidelines whether the results and the performance measures will be made publicly available (DoHA 2010d).

Consistent with best practice, a review of these Community Care Common Standards should be conducted at an appropriate point in the future.

DRAFT RECOMMENDATION 12.3

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

### *Prudential regulation*

Strong prudential regulation along with transparent reporting requirements are important to ensure accountability in the aged care industry (Financial Planning Association of Australia, sub. 376).

As noted previously, and in view of the rapid growth in the quantum of accommodation bonds which the Government guarantees, in April 2010 the Australian Government announced some changes to strengthen the prudential regulation of accommodation bonds. At the time of writing, the Government was consulting on the proposed changes — submissions were due by 19 November 2010. While the Commission recommends significant changes to aged care financing that should affect the relative attractiveness, and individual value, of accommodation bonds, there will be a need to prudentially regulate accommodation bonds for the foreseeable future.

The Commission is strongly of the view that any proposed revisions to aged care standards (including quality care and prudential regulation) be developed in a way that is consistent the Principles of Best Practice Regulation. Further, proposed changes to prudential standards applying in aged care should also be consistent with broad prudential standards.

## Taking steps towards encouraging and enforcing compliance

Putting into practice ‘responsive’ regulation involves adhering to the principles of consistency, proportionality and transparency (appendix E). Other best practice arrangements include implementing a risk-based approach to ensure compliance.

### *Consistency*

The principle of consistency ensures that similar workplace circumstances lead to similar enforcement outcomes. However, current governance arrangements which duplicate investigations into non-compliance potentially give rise to some inconsistent enforcement outcomes.

Robert Wilson has noted that the inconsistent approach to collecting consumer information between basic (that is, HACC) and packaged community care, in turn, could lead to inconsistent enforcement decisions:

> Unfortunately in [packaged community care] there is no engagement of consumers in evaluation or review of services (for example through the Quality Review process). (sub. 185, p. 5)

There are also perceived inconsistencies in the gathering of information for accreditation reviews. For example:

> There have been reports by care staff of inconsistent evidence requirements, leading to delays and rework. (Blue Care, sub. 254, p. 58)

Such inconsistency in information gathering could arise for two different reasons. One is the result of adopting a risk-based approach to investigating potential problems. The other reason could be associated with inconsistencies between ACSAA and the CIS investigations processes, which in turn could lead to inconsistent enforcement outcomes.

The Australian Nursing Federation (Victorian Branch) is concerned that inconsistent enforcement outcomes arise because only those providers that get 'caught' are the ones who receive sanctions, while other similar (non-compliant) providers that manage not to get caught are treated differently:

> On this point, ANF (Vic Branch) is regularly advised by our members of reports that an RAC facility can be deemed to be compliant with accreditation standards at the time of a scheduled visit from the Agency, yet the same home may become non compliant very shortly thereafter, or when the Agency undertakes an unannounced visit to the same home. (sub. 341, p. 24)

The OACC also pointed towards material in the Walton Review which provide evidence of inconsistency:

> … There was some discussion from providers about the miscommunication of outcomes. Some providers said that the investigator may relay one view of the outcome of a site visit but the finalisation letter advises a different outcome. (sub. 444, p. 8)

However, to the extent that the regulation of basic community aged care continues to be the subject of a number of jurisdictional responsibilities (even within the

context of Community Care Common Standards), there is a possibility of some inconsistency in enforcement outcomes. That said, the Commission's general regulatory recommendations should reduce the likelihood of such inconsistencies.

### *Proportionality*

The proportionality principle focuses on the need for enforcement responses to be proportional to the seriousness of non-compliance. This is a key feature of the 'responsive regulation' model, where a regulator's compliance and enforcement policy is based on a pyramid-shaped escalation of sanctions. The less severe (more often used) 'advice and persuade' options are reflected in the lower half of the pyramid while the more severe (but less often used) punitive strategies are represented at the peak of the enforcement pyramid (figure E.1, appendix E).

Currently, there is a range of enforcement tools that can be imposed on approved residential care providers for non-compliance with the Act (box 12.4). The imposition of these on approved providers is also dealt with in the Sanctions Principles 1997.

Many of the suspensions outlined in box 12.4 involve a loss of income for the facility while the revoking of a residential aged care facility's approved provider status amounts to its closure. If a provider's approval is revoked, the provider can agree to certain arrangements to ensure that the revocation does not take effect. If the sanction notice specifies that this is an option, the provider can agree to:

- provide, at its expense, training for officers, employees and agents
- provide security for a debt owed to the Australian Government
- appoint an adviser or an administrator, approved by the Australian Government
- transfer some or all of its allocated places to another approved provider.

DoHA has also established adviser and administrator panels and the Sanctions Principles sets out the timetable for nominating and appointing people from those panels for enforcement purposes.

Sanctions on residential aged care facilities can be imposed in two ways. Either:

- immediately (if there is an immediate and severe risk to the safety, health or wellbeing of residents as a result of the provider's noncompliance) or
- after issuing a series of notices (if there is no immediate or severe risk).

### Box 12.4 **Enforcement tools able to be imposed under the Act**

The Secretary of DoHA can impose one or more of the following sanctions, by notice, in writing:

- revoking or suspending approval as a provider of aged care services
- restricting approval to existing services or places
- restricting funding to existing residents
- revoking or suspending the existing allocation of places
- varying the conditions of approval for allocated places
- prohibiting the further allocation of places
- revoking or suspending extra service status
- prohibiting granting of approval for extra service status
- revoking or suspending certification
- prohibiting the charging of accommodation charges or accommodation bonds
- requiring repayment of grants
- other sanctions as specified in the Sanctions Principles.

*Source*: DoHA (2009f, p. 237).

The notices include: a notice of non-compliance; a notice of either intention to impose sanctions, remedy the non-compliance or impose sanctions to a specific part of the non-compliance; and a notice of a decision on whether to impose sanctions.

In relation to non-compliance with accreditation, DoHA (2009f) indicates that ACSAA can organise a review audit and DoHA can impose one of three types of sanctions: vary the period of accreditation, revoke accreditation, or not revoke accreditation, in which case DoHA may agree on a timetable for improvement.

The OACC pointed towards evidence from the Walton Review which showed that some consumer participants:

> … considered that the actions required through an NRA [Notice of Required Action] were merely a slap on the wrist and not in proportion to the issue complained about or the breach found. (sub. 444, p. 9)

Weiner et al. (2007) noted that, unlike enforcement systems in a number of other countries, the imposition of fines are not featured and have not generally been raised as an option in the Australian context. However, significant fines can create unintended consequences, especially for small providers.

The Commission notes that as the aged care system transitions away from its heavy reliance on quantity restrictions in residential aged care (for example, through removing bed licences and extra service places) the range of enforcement tools available to the regulator should be expanded. In addition, as AACRC (and its statutory office, ACSAA) take over the day-to-day administration of the quality of community care (via Community Care Common Standards), there will also be a need to develop a wide range of enforcement tools for community aged care.

Other types of enforcement options to assist the regulator to manage risk in the light of a serious and high risk complaint (for example, elder abuse) alongside usual processes for complaints, compliance visits and independent consumer advocacy could include:

- criminal liability — for example, in New South Wales, under changes to the *Crimes Act 1900* (NSW), people who seriously neglect elderly citizens in their care could face up to five years' jail (Hatzistergos 2010)
- appointing an appropriately qualified external team (rather than immediate evacuation and close down) to take over the administration of a residential aged care facility.

DRAFT RECOMMENDATION 12.4

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

Given the continued involvement of a number of states and territories in the regulation of basic community care, harmonisation of enforcement tools to ensure the proportionality principle is adhered to will involve negotiation and agreement — between the Australian, Victorian and Western Australian Governments in particular. The Commission can find little evidence of benefits arising from a split system given the desirability of developing a seamless care and support system across Australia.

DRAFT RECOMMENDATION 12.5

***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 that allows for 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.***

### *Transparency*

The principle of transparency enables regulators to demonstrate impartiality and balance in the decisions they make. Aside from the lack of transparency in reporting the results of national standards assessments for basic community care, there are a number of other areas where transparency could improve.

In particular, the OACC (sub. 444) noted the problems arising from the lack of transparency in the complaints process outlined in the Walton Review. In addition, Blue Care noted that the procedures around complaints lacks transparency:

> The [CIS] investigates all complaints made to them by visiting the facility usually for a whole day and asking for a large range of seemingly irrelevant material including interviews with people unrelated to the incident in question. In some cases the matter will be referred to [ACSAA], but it is unclear when this is meant to occur. (sub. 254, p. 62)

The Victorian Health Services Commissioner also pointed to, among other things, the lack of transparency in the regulatory processes around complaint handling:

> … Communication is inadequate, investigators do not have complaints specific training, the CIS's processes are not accessible to the complainant and there is a lack of clinical expertise. There is insufficient referral for expert advice. (sub. 349, pp. 1–2)

The Lesbian and Gay Solidarity (Melbourne) also suggested:

> That CIS provide more public information about the majority of the complaints: where have they come from e.g. residents of facilities, their families, suppliers of services to a facility etc; the kind of complaint e.g. treatment, food, discrimination, the quality of care, unqualified staff, intimidation of residents so that they are afraid to use formal methods to complain, financial abuse of the elderly etc. (sub. 115, p. 24)

With the establishment of AACRC, it will be important for its work practices to embed transparency in decision making.

### *Risk-based approach*

As noted, the emphasis in the 'responsive regulation' model is on using a risk-based approach to compliance and enforcement where those undertaking the compliance checking are also able to carry out compliance and enforcement actions.

In this context, it is important that AACRC have available to it a range of tools to manage risk in the light of a serious and high risk complaint. Situations of elder abuse and life threatening risks to the health of the frail elderly are examples of two such risks.

As the ANAO (2003, p. 19) notes, to '… be effective, the risk management process needs to be rigorous, structured and systematic'. However, by itself risk management is not enough, otherwise it may become a procedure-based exercise. Tacy (2004) explains that employees need to be engaged in and have ownership of all the various elements of good public sector governance (Barrett 2003; ANAO 2003; McPhee 2007) to make a risk-based approach work. In turn, this is a function of the behaviours and values of the organisation's leaders and of the overall culture of the organisation.

Accordingly, it is imperative that AACRC adopt good public sector governance arrangements (ANAO 2003 and Department of Finance and Administration 2005) that facilitates an appropriate risk-based approach to its compliance and enforcement activities.

## Putting into place streamlined reporting arrangements

The Commission's *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services*, noted as a key point that:

> Many industries complained of overly burdensome, duplicative and redundant reporting requirements. Extending the SBR principles and methodology to many of the sectors covered in this review could substantially reduce the reporting burden. (PC 2009a, p. XIX)

As highlighted in submissions to this inquiry, the reporting requirements often take up management and staff time which could be better directed towards other activities, primarily the care of residents.

While the current scope of SBR is to reduce the burden of business-to-government financial reporting, there is broad potential for SBR methodologies to ease regulatory burdens in other sectors, including aged care (box E.3, appendix E).

In implementing the National Quality Reporting Framework (NQRF) (now known as Common Care Community Standards) for community aged care, the Australian Government (2009) indicated that the NQRF will be implemented broadly in line with the objectives of Standard Business Reporting. A process is currently being trialled through the NRCP and the outcomes of this trial will be used to inform any possible wider rollout to other community care programs (DoHA, pers. comm., 11 November 2010).

No such process currently appears to exist for streamlining reporting in residential aged care.

As illustrated by the introduction of the Government's e-health initiative, there is significant scope for information technology to reduce the burden of reporting.

DRAFT RECOMMENDATION 12.6

***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 (SBR).***

***The Australian Aged Care Regulation Commission (AACRC) should explore the case for embracing technological advances in receiving and transmitting information from and to providers in line with SBR. This could be facilitated by imposing a requirement that all providers submit key reports electronically to AACRC.***

## 12.4 Reducing the extent of regulation

There appear to be two main areas in which regulation has extended beyond what might be considered reasonable. First, are quantity and price restrictions. Second, are a number of other areas associated with service delivery where regulations have inexorably grown in response to incidents involving aged care residents — following such an incident, the Government is pressured to 'act', leading to ever more regulation, often without examining the efficacy and efficiency of the additional regulation.

### Reducing existing quantity and price restrictions

Historically, the Australian Government (as the predominant funder of aged care) has sought to limit its fiscal exposure by limiting supply.

In residential care, this has mainly occurred through capping the number of bed licences. Consequently, to manage fiscal risk and in order to ensure that providers do not abuse local market power created by this supply restriction, price controls — covering fees (determined by ACFI), basic daily living fees and high care accommodation charges — have also been established (chapter 5).

In community care, chapters 5 and 8 document a number of quantity restrictions and restrictive pricing arrangements. The consequences of these restrictions are: long waiting times for assessment of needs; the limited number, nature and funding of 'packages'; reduced competition; and the inability of providers to respond to demand.

Draft recommendations in previous chapters to address these problems include the progressive removal of quantity constraints, improved price setting processes and the partial liberalisation of prices.

### *Appropriate prudential regulation of accommodation bonds remains necessary*

As the draft recommendations from this inquiry include the retention of (limited) accommodation bonds as one form of funding of residential aged care, a variety of related prudential regulations will continue to apply.

As noted above, enhanced prudential arrangements for accommodation bonds (DoHA 2010g) have been announced and the Commission has suggested (section 12.3) that any revisions be subject to consideration of broad prudential regulation and the Principles of Best Practice Regulation.

While the Australian Government (2009) accepted in principle a number of recommendations to change prudential regulations in the Commission's 2009 *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services* report, it did not accept the Commission's recommendation in relation to consumer disclosure requirements. In particular, the prudential regulations include mandatory requirements which require providers to disclose the following information to residents and potential residents:

- a statement about whether the provider complied with the prudential standards in the financial year
- an audit opinion on whether the provider has complied with the prudential standards in the relevant financial year
- the most recent statement of the aged care service's audited accounts.

As indicated in its response to the Commission's (PC 2009a) recommendation on this issue, the Government had planned to evaluate these consumer Disclosure Standards (Australian Government 2009a) but this did not proceed (DoHA, pers. comm., 11 November 2010). Previously, Aged and Community Services Australia has been critical of the reporting requirements associated with prudential regulation (PC 2009a). By contrast, Aged Care Crisis (sub. 433) support full transparency and disclosure to consumers of all aspects of residential aged care.

While the ANAO's (2009) audit on the *Protection of Residential Aged Care Accommodation Bonds* did not make any recommendations which were specific to these current consumer disclosure requirements, it did recommend that DoHA develop a client service charter and regulatory code of conduct in relation to the prudential regulation of the bonds and that DoHA report annually on performance

against this charter. This client service charter has almost been finalised (DoHA, pers. comm., 11 November 2010).

The Government also operates an Accommodation Bond Guarantee Scheme — which guarantees the refund of accommodation bonds to residents in the event that a provider becomes insolvent.

In the light of the recently announced strengthening of prudential regulations of accommodation bonds and given that all seven ANAO (2009) recommendations in relation to the prudential regulation of accommodation bonds have been accepted, there is not a strong case for continuing the mandatory disclosure requirements to consumers. Removal of their 'mandatory' status, while making them available on request, would reduce the (not insignificant) disclosure burden associated with servicing incumbent and prospective care recipients. Often the volume of disclosure confuses users of aged care services and defeats its purpose.

DRAFT RECOMMENDATION 12.7

***The Australian Government should amend the residential aged care prudential standards to allow residential aged care providers to disclose (to care recipients or prospective care recipients) on request, rather than automatically:***

- ***a statement about whether the provider complied with the prudential standards in the financial year***
- ***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.***

## Removing other restrictions

Chapter 5 documented a number of areas where regulation has grown in response to incidents involving residential aged care residents, and which, in turn, has created burdens and limited choice and flexibility.

### *Regulation relating to residents' safety is at times burdensome*

In relation to a number of regulatory burdens relating to residents' safety, the Productivity Commission (2009) made a number of recommendations and the Australian Government (2009) responded by establishing the previously mentioned review of the accreditation standards and processes and by seeking opportunities to harmonise the arrangements for police checks, including learning from developments through COAG's Exchange of Criminal History Information about

People Working with Children Project, being progressed under the *National Framework for Protecting Australia's Children 2009-2020* when this information becomes available (DoHA, pers. comm., 11 November 2010). By contrast, the Australian Government did not accept the Commission's (2009) recommendation in relation to missing residents.

In this inquiry, several participants — namely the Aged and Community Services Association of NSW and ACT (ACSA NSW) (sub. 140) and Baptistcare (sub. 426) — raised the examples of the reporting of missing residents, police checks and the mandatory reporting of assaults as added regulatory burdens on approved providers. Some of these were regarded as 'additional regulations other than the normal checks and balances afforded to the acute sector' (Baptistcare, sub. 426, p. 6).

*Missing residents*

The regulations on reporting missing residents require providers to report to DoHA those missing residents who have been reported missing to the police within 24 hours of the report to police. These requirements are set out in the Act's Accountability Principles 1998.

While some submissions (ACSA NSW, sub. 140) have argued that these regulations be repealed, others such as the Aged Care Association of Australia (ACAA) (sub. 291), Blue Care (sub. 254) and the National Presbyterian Aged Care Network (sub. 110) have argued for modifications to them because of the increase in the compliance costs and regulatory burden associated with these and other reporting requirements. Benetas (sub. 141) is currently trialling a tracking device that triggers an alarm when the resident moves outside specified coordinates. The device also enables the person to be easily found. Extending such technology across the industry may make redundant these regulatory requirements.

Nonetheless, as noted in the Commission's regulatory burdens report (PC 2009a), the short reporting time frame (currently 24 hours) takes resources away from the priority at hand (reporting to the police and finding the missing resident). While the reporting requirement does allow DoHA to offer prompt support to the family of the missing resident and to ensure a quick assessment of whether or not the facility concerned had the appropriate systems in place, a longer reporting time frame would still allow any systemic problems to be dealt with once the initial emergency has passed.

***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 Department of Health and Ageing, while continuing to promptly report missing residents to police services.***

*Mandatory reporting of assaults*

In relation to the compulsory reporting of assaults, the OACC (sub. 444) pointed to the difficulties and complexities faced by providers in relation to compulsory reporting of assaults. For example:

> While providers fulfil their obligations under the Act by making reports of prescribed matters, the CIS has, at times, used the report to find the provider in breach of their responsibilities. The providers felt this was contrary to the legislative intent.
>
> … Providers also explained that it was damaging to the team environment, in that it could set staff members against each other. (sub. 444, p. 8)

Drawing on the results of an on-line survey on compulsory reporting of assaults and the outcomes of an industry 'think tank', ACSA NSW (sub. 140) argued that a comprehensive review of the compulsory reporting of assaults be undertaken.

The regulations on compulsory reporting of assaults require all approved providers of residential aged care to report to DoHA and the police all allegations or suspicions of resident physical abuse within 24 hours of the allegation being made or the suspicion being raised. The reporting requirements apply to all except in very specific and sensitive circumstances. (These regulations are in sections 63–1AA and 96-8 in the Act.)

The Commission acknowledges that sensitive and ethical concerns are raised when considering these issues. The Commission also notes that its 2009 report did not make a recommendation in relation to this issue and that having a conciliation function within the complaints area of the regulation Commission is also likely to assist in promptly remedying these types of issues (draft recommendation 12.2). Moreover, as the regulations are relatively new, rather than immediately reviewing them it may be more appropriate to address this issue within the context of the proposed broader review of the new reforms (chapter 14).

*The Commission seeks views on whether a review of mandatory reporting is warranted at this time and, if so, the specific areas of the current policies that may require review or modification.*

## 12.5 Clarifying and simplifying jurisdictional responsibilities and harmonising regulation

In future, both the harmonisation of community care standards (for most jurisdictions from 1 March 2011 under the Community Care Common Standards) and the reforms to funding and regulatory arrangements for HACC (from 1 July 2012 under the National Health and Hospitals Network Agreement) represent significant steps towards simplified jurisdictional responsibilities. However, as discussed earlier, until Western Australia and Victoria agree to the reformed HACC arrangements, the regulation and funding of community aged care will continue to be subject to different jurisdictional arrangements across Australia. Accordingly, the Commission supports the Council of Australian Governments continuing to work towards achieving simplified jurisdictional responsibilities in relation to Home and Community Care until such time as it is incorporated into the new integrated model of care (draft recommendation 12.5).

A number of previous reports (Banks Review 2006; PC 2008 and 2009a), as well as submissions to this inquiry, have pointed to areas where duplication or regulatory overlap are causing problems. The main issues fall within four areas: the building code; retirement village legislation; infectious disease outbreaks, occupational health and safety, food safety and nursing scope of practice; and enduring guardianship, enduring power of attorney and advanced care directives.

### Building code

In relation to the issue of duplicate accreditation arrangements covering aged care buildings, chapter 10 notes that the Australian Government has amended the Quality of Care Principles to replace the annual Fire Safety Declaration process with an exception reporting process.

In relation to incorporating residential care building requirements into the Building Code of Australia (BCA), the consultation process conducted by DoHA has highlighted technical issues that need to be addressed and has raised possible alternative approaches. DoHA is considering the implications of the issues raised through the consultation process and will further consult with the Australian Building Codes Board (chapter 10).

### Retirement village legislation

Some submissions called for state and territory government retirement village regulation to be aligned with the Australian Government's regulation of aged care,

arguing that this would facilitate the transition of village residents to residential care within their community. The Commission found (chapter 10) no compelling case for such alignment. However, changes proposed by the Commission (to remove restrictions on the number of residential care places, to provide a single integrated system of care provision and consumer choice of care providers) will substantially address residents' concerns about not being able to age in their village community.

A number of submissions also raised problems with existing state and territory retirement village legislation from the perspective of consumers and providers. Chapter 10 recommends that while retirement village legislation should remain the responsibility of state and territory governments, those governments should pursue nationally consistent legislation through the standard COAG arrangements.

### Infectious disease outbreaks, occupational health and safety, food safety and nursing scope of practice

The Productivity Commission, in relation to the issue of duplicate regulations, noted that:

- regulations in residential care homes for infectious disease outbreaks like gastroenteritis are more onerous than in health (private and public hospitals) or human services (child care centres)
- because the fourth aged care Accreditation Standard covers physical environment and safe systems, there is a tendency for ACSAA reviewers to make judgements and recommendations about occupational health and safety (OHS) matters
- ACSAA officers (who do not have the relevant expertise) attempt to comment on or make recommendations in relation to food safety
- some state and territory legislation on nursing scope of practice are more prescriptive than the *Aged Care Act 1997*, with such restrictions on nursing practice reducing the efficient management of aged care facilities (and nurses' job satisfaction) without any noticeable benefit to residents. (PC 2009a, pp. 68-69)

Accordingly the Commission recommended that DoHA use the reviews of accreditation processes and accreditation standards to identify and remove onerous duplicate and inconsistent regulations. As indicated above, the Australian Government accepted this recommendation but, at the time of writing, DoHA's reviews have yet to be finalised (DoHA, pers. comm., 11 November 2010).

## Enduring guardianship, power of attorney and advanced care planning

The topic of individual choice and the quality of life at the end of life is one that is often unsettling for many people (Gillick 2006). These issues have also been touched on in chapter 5. Moreover, independent consumer advocacy arrangements also play a role in this context (section 12.2 and chapter 8) and relevant regulatory arrangements cover a variety of legal arrangements, including advanced care plans, enduring guardianship and power of attorney.

A number of submissions encouraged the promotion of advanced care planning to facilitate improved choice by individuals (box 12.5).

### Box 12.5 **Advanced care planning and individual choice**

Roger Hunt suggests that the Respecting Patient Choices Program (RPCP) — jointly funded by the Australian and Victorian Governments — offers an established model for advanced care planning that could be rolled out systematically into residential care homes:

> Satisfaction with care is improved when residents are given the opportunity to express their wishes about their management, and clinicians show a willingness to respect their wishes. (sub. 12, p. 2)

Palliative Care Australia (PCA) have also pointed to the importance of advanced care plans, considering them to be:

> … an important social investment to help ensure quality care at the end of life that accords with the individual's needs and preferences. Advance care planning should be consumer driven and controlled, providing a reliable and flexible mechanism to anticipate and express care choices, in partnership with and supported by the health system. Broader application and coordination of advance care planning provides a mechanism to plan and thus better meet patients' needs, while limiting unnecessary hospitalisations. (sub. 77, pp. 14–15)

In addition, General Practice Victoria suggested that:

> … The shared electronic health record should also serve as a point of storage for advance care planning documents (i.e. Medical Enduring Power of Attorney, Refusal of Treatment certificates, statements of wishes) as this will enable them to be accessed at any time, from any place including hospital Emergency Departments. (sub. 235, p. 4)

The Centre for Health Communication has called for the further evaluation of existing tools and models of care in the Australian context:

> For example The Gold Standards Framework developed by Dr Keri Thomas and her colleagues in the UK for use in the community and now adapted for implementation in Acute Care Settings and Aged Care Facilities and The Respecting Patient Choices Programme, an initiative originally piloted in Melbourne, and now being implemented inconsistently across several other states, including at John Hunter Hospital, Newcastle, NSW. Such initiatives need to involve consultation with all stakeholders involved including GPs, Ambulance Services, Aged Care providers and Acute Facilities. (sub. 280, p. 3)

In 2009 Australia's Health Ministers endorsed the development of nationally consistent best practice guidelines for the use and application of advance care directives. A draft National Framework for Advance Care Directives (ACD) has now been produced by a Working Group of the Clinical, Technical and Ethical Principle Committee of the Australian Health Ministers Advisory Council. The Working Group is currently seeking comments from stakeholders.

Other submissions have pointed to the confusion and difficulties which arise from jurisdictional differences in legislation relating to ACDs, power of attorney and enduring guardianship legislation (box 12.6). In addition, a number of submissions indicated that power of attorney and enduring guardianship arrangements were also vehicles for elder abuse by family members and hence required appropriate safeguards (box 12.6).

To support the current COAG initiative to develop a National Framework for Advance Care Directives, there is a case for harmonising state and territory based legislation for enduring power of attorney and enduring guardianship. Protocols for protecting individuals from potential abuse from attorneys and family members — including the ability of advocates and providers to refer matters to relevant boards or authorities — should be included in this harmonisation process.

DRAFT RECOMMENDATION 12.9

***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 scope of practice, power of attorney, guardianship and advanced care plans.***

## Box 12.6 Views in submissions on advanced care directives, power of attorney and enduring guardianship

*There is confusion between them …*

Pam Webster said:

> … To ensure that an Advanced Health Care Directive is carried out, it is also important that people appoint a Power of Attorney and have an Enduring Guardianship in place. There needs to be some work done to promote these concepts so that the majority of people have these in place. Even more importantly, there needs to be a change in the legislation in all states and territories across Australia to remove current differences. One way may be to have Federal Government legislation that overrides any differences in the state and territory legislation. (sub. 178, p. 5)

Similarly, The Aged-care Rights Service (TARS) noted:

> … the confusion created by the different definitions of Power of Attorney and Guardianship documents adopted by different state legislation. Clarity as to the role of a Guardian and the role of an Attorney across Australia could be achieved through the introduction of Commonwealth legislation. (sub. 322, p. 8)

Taking a step further, TARS (sub. 322) argued for civil and criminal remedies against attorneys who abuse their position under an enduring power of attorney appointment and offered an approach to how this could be achieved.

*… and they can potentially lead to elder abuse*

The South Eastern Region Migrant Resource Centre said:

> … There have been instances of carers and family members taking advantage of enduring power of attorney, abusing the privilege for profit. There needs to be a regime of strict safeguards and monitoring if the doctrine of consumer-directed care becomes widespread. (sub. 126, p. 2)

Blake Dawson suggested that from the perspective of a provider it is often unclear whether and how to bring proceedings before a guardianship tribunal or board. They argue that consideration should be given to:

> … legislating or facilitating recourse to or access to such bodies by approved providers (without fear, for example, of reprisal from family members) or in establishing a national body that can deal with these issues in the context of providing aged care services. (sub. 465, p. 44)

In addition, Blake Dawson argued for a gateway approach to consumer services. These are described in this submission as 'Senior Living Centres', which provide locally focussed case management and community service centres. In the context of guardianship issues, Blake Dawson suggests that:

> Senior living centres could also perform a role in this regard, either through being conferred powers to refer matters to existing guardianship mechanisms or by playing a greater role in direct advocacy and intervention. (sub. 465, p. 44)

# 13 Aged care policy research and evaluation

**Key Points**

- An evidence-based policy approach is about providing the best possible evidence to inform the development and implementation of sound public policies. Reliable and accessible data and quality research are essential components.
- In the current framework, detailed data about the aged care sector is regularly collected, but there is limited reporting and publically available analysis of the data. There are grounds to:
  - increase the availability, accessibility, and coordination of data currently collected by establishing a national data clearinghouse
  - increase the usefulness of data by establishing consistency across datasets, improving linkages of databases and developing more outcomes based data
  - increase public accountability through greater transparency and independence of research reviews and evaluations.
- Improved and more timely access to aged care data allows greater scrutiny of published findings and results, and better informs public debate and assessment of the sector.
- A more consumer-directed aged care system will require accessible and reliable data and information to assist various decision-makers, including older people and their carers, governments and providers.
- Consistent, timely, and accessible data will provide the basis for valuable research into aged care and help build a better evidence base to support ongoing policy evaluation and development.

Reliable and accessible data and quality research are essential for good policy. However, as noted throughout this report, there is a significant lack of publicly available data and policy relevant evidence in the area of aged care. This limits the scope for comprehensive and independent assessment of the system. It also means that care recipients, their families, and service providers may not be as well informed as they might be in making decisions about care and support needs.

This chapter looks at the scope for improvement in: data collection and its access by older people and their carers, providers and researchers (section 13.1); building a better evidence base (section 13.2); and research capacity (section 13.3).

## 13.1 Improving data collection and access

Many participants to this inquiry argued that more could be done with the data that is currently collected on aged care. They also argued that there is scope for significant improvements in the collection and dissemination of good evidence to assist the development of aged care policy. Over the last decade or so, the aged care industry has struggled to achieve major reform, despite a number of inquiries and reports. Evidence is increasingly seen as an essential building block to establishing a more convincing case for reform and enhancing the prospect of reform being adopted.

### Coordination of data sets

While data on aged care services is collected regularly, participants argued that the usefulness of the data is limited because of a lack of coordination of some data sets. The New South Wales Government, for example, argued the need for consistent data definitions:

> The current maintenance of separate data bases, for example, for the Aged Care Assessment Program Minimum Data Set (MDS) and the HACC MDS, limits the usefulness of routine performance and activity reporting for the purposes of accountability and transparency. Combining these data bases and using consistent data definitions will facilitate future monitoring of access to and use of services by older people and help identify any gaps in service delivery. (sub. 329, p. 11)

Anglicare Sydney saw the need for better coordination of data across both programs and jurisdictions:

> Currently a significant amount of data is being captured by Government in various databases for various programs across the country. However there appears to be no intention to consolidate and analyse this data for high level reporting back to the sector on performance and outcomes. (sub. 272, p. 14)

The Aged Care Association of Australia suggested that there was a unique opportunity to better coordinate data collected on aged care services with that held by Centrelink and Medicare:

> … between Centrelink and Medicare there is a very substantial database on each person's history, domestic status and financial circumstances. There is a unique opportunity to establish systems which integrate this information and share it among

> the various funding or service provider agencies to try and avoid both the excessive red tape that follows and the constant intrusion into the individual's affairs. A sufficiently robust system should be deployable to safeguard privacy while permitting the sharing of information among the various entities. (sub. 291, pp. 30–31)

The value of data is enhanced when it is collected and disseminated in a consistent and regular way over time.

Central to enhancing the usefulness of data sets and the ability to combine information across data sets and agencies is the alignment of data definitions, processes, protocols and systems. Transitioning to standardised collection processes will take time and incur costs in the short term, due to changes in practice. But for providers, standardised collection could significantly reduce their administrative burden over the longer term. In the Commission's view, greater compatibility of data sets would ultimately build a more effective evidence base in aged care and allow for a more robust comparison of service delivery across Australia.

The Australian Institute of Health and Welfare (AIHW) has made significant progress in promoting consistent databases, including the development of the National Community Services Information Model Version 1.0 and National Community Services Data Dictionaries. Based on the international standard for defining data elements issued by the International Organisation for Standardisation, these models provide a framework for more consistent data definitions and collections for the aged care sector.

The Commission is proposing that its recommended regulatory body, the Australian Aged Care Regulation Commission (AACRC), should play a central role in coordinating the collection of national data sets on aged care and facilitating the linking to data contained within Medicare and Centrelink (chapter 12).

## Access to data

Several participants — including service providers, consumers and research groups — argued that the usefulness of collected data is limited because of the lack of public access to the data sets and data analysis in the current framework. The Benevolent Society, for example, described the current situation for service providers as a 'black hole' phenomenon:

> … data is submitted to government and then is never seen again in a format that is useful to the service provider. (sub. 252, p. 9)

Other participants also indicated that this lack of feedback limited the scope for improving practices and service planning (box 13.1).

### Box 13.1 **Where does the data go?**

The Victorian National Respite for Carers Program argued that there was no 'feedback loop' of data provided to the Department of Health and Ageing (DoHA):

> All providers contribute data to the DoHA about level of service provision and issues encountered. There is currently no feedback loop. Services would benefit from regional and state-wide information to assist with gap analysis and service planning. (sub. 334, pp. 4-5)

The National Ageing Research Institute:

> Data collected via existing auditing and quality assurance processes should be analysed and fed back to the services concerned. This would provide direct evidence to service providers to enable practice improvement. The data currently collected via these processes should also be aggregated and analysed to determine trends and service/quality issues on a population level. This data would provide a wealth of rich information to inform policy. (sub. 260, p. 3)

Dutchcare:

> … after 12 years of ACARs, there is no cumulative or definitive information in the States or Territories on which mainstream providers have received aged care places for NESB consumers, how many there are, what type or category they are, where they are, or who uses them… This lack of data makes it difficult to ascertain whether culturally and linguistically diverse communities have been accorded equitable, or proportional, access to residential and community aged care places through funding round mechanisms. (sub. 128, p. 2)

Publicly available data and information on the sector would also provide consumers and their families with greater information and knowledge in order to make more informed decisions about the care options available to them — particularly in terms of quality assurance. Under a more consumer-directed and provider-responsive aged care system, improved access to data and information will become increasingly important.

Currently, the Australian Government provides information on the system and data for consumers through the Aged Care Australia website (www.agedcareaustralia.gov.au), including a list of, and search option for, residential aged care facilities around Australia. But a number of participants considered that this was an area where more information could assist care recipients and their families. National Seniors Australia, for example, said:

> … more can be done to help consumers and their families make informed choices. Currently, the government's Aged Care Australia website does not give information about the quality of care provided by a residential age care facility. This makes it difficult for residents and their families to compare providers. (sub. 411, pp. 18–19)

Quality of care information relating to residential aged care facilities can only be found via the latest accreditation reports. These reports, however, are in formal and

technical language (not overly user-friendly), which makes it difficult to compare aged care facilities (Weiner et al. 2007). This contrasts with the system operating in the United States, which has a 'Nursing home compare' website (www.medicare.gov/NHCompare/) that includes a user-friendly star-rating system — based on health, staffing and quality benchmarks — of registered nursing homes.

There are a number of regular publications containing aged care data. Each year the Minister for Ageing presents a report to Parliament on the operation of the *Aged Care Act 1997*. The report includes extensive information on aged care programs and policies, funding, and compliance with accreditation standards. The AIHW also publishes detailed reports in a number of areas including community care packages, Home and Community Care services, residential care, aged care pathways and dementia. These reports largely present data at national and/or state and territory levels of aggregation.

However, there is also a significant amount of data that is collected but is not readily publicly available. Currently, the main repository and disseminator of detailed data on the aged care system is the Department of Health and Ageing (DoHA). While DoHA indicated that no one who had requested data has been denied access, and DoHA responded to numerous data requests made by the Commission as part of this inquiry, participants raised concerns about the timely release of data. For example, Gill Lewin, who was seeking to undertake a randomised controlled trial of a restorative home care program, said:

> While the data collection part of the study has been complete for over 18 months, there has been a delay in being provided with the requested data from Commonwealth aged care data sets, and to date only WA held data have been made available. As a consequence it is not yet possible to answer the research questions as completely as was initially hoped. The availability of data for this type of research is an issue that needs to be addressed. (sub. 114, p. 1)

Delays in receiving data from DoHA were also experienced by the Commission during the course of this inquiry.

Poor access to, and delays in accessing, data can prevent research being undertaken or, as noted above, can prevent more detailed and complex analysis of data. Poor data access can also prevent scrutiny of research findings, which in turn limits informed public debate. Better and more timely access to data on aged care would:

- allow researchers to replicate and verify any published results
- encourage more aged care research, including more detailed and complex analysis

- facilitate the linking of data sets for a more informed assessment of the impact of arrangements across jurisdictions and other policy areas.

Access to data clearly needs to preserve the privacy and confidentiality of individuals and providers. There are, however, ways in which information is, and can be, de-identified for wider use (PC 2009b).

- The Australian Code for the Responsible Conduct of Research and the National Statement on Ethical Conduct in Human Research set out principles and guidelines on how to manage research data and protect the privacy and confidentiality of participants (Australian Government 2007a, 2007b).
- The Commonwealth Scientific and Industrial Research Organisation (CSIRO) has developed a tool that integrates health data repositories while retaining privacy and security of individual patient records. Health Data Integration links individual patient records from different data repositories while maintaining privacy by encrypting the demographic data. This enables identifying information, such as the patient's name and date of birth, to be protected (CSIRO 2008).

While privacy and confidentiality safeguards need to be in place, privacy concerns do not have to be a significant barrier to achieving improved accessibility and transparency in the aged care system. In the Commission's view, given that the Government already collects and maintains detailed data sets relating to aged care, the provision of better public access to this data is likely to generate sizeable net benefits.

## Establishing a data clearinghouse for aged care

Data quality and data access, as well as the subsequent quality of research and evaluations about aged care, can be improved through changes to the collection and reporting requirements that exist in the current framework.

### *Who should collect the data?*

While the Commission's proposed independent regulator will play a central role in collecting and co-ordinating aged care data (see figure 12.2 in chapter 12 for an overview), it would still be practical and appropriate for different data collection points and agencies to operate for various areas of the aged care system. For example:

- to determine the level of need of older people and their eligibility for subsidies, DoHA would continue to collect relevant data to inform its policy development

- the Commission's proposed National Seniors Gateway would collect data through its role in aged care assessments and care coordination
- the Commission's proposed AACRC would collect data through its role of ensuring compliance with accreditation standards by service providers.

In the Commission's view, having more than one collector of data is not a problem in itself. More important is the level of consistency in definitions and data sets, the ability to match and co-ordinate different sources, and the ease of access to data sets for analysis and research.

### *Who should store the data?*

To improve access to data sets and facilitate informed research and evaluations, an approved data clearinghouse or central agency to co-ordinate, store and distribute data would provide the necessary contact point for data and information for policymakers, researchers, industry and the wider community (box 13.2).

#### Box 13.2 **Participants call for a stronger evidence base**

The Royal District Nursing Service:

> Quality practice must be underpinned by research and evidence. Currently there is a poor evidence base for many of the practices within aged care. A greater proportion of the total available funding for research must be allocated to aged care if we are to improve the quality, efficiency and effectiveness of aged care services in the future. (sub. 198, p. 5)

The National Ageing Research Institute:

> With the structural and numerical ageing of the Australian population, there is a clear need to review current policies, programs and services and plan for an increased demand on the aged care service system in the future. To do this, a sound evidence base is required.
>
> To build a sound evidence base upon which to develop policy in this area, funding dedicated to ageing research is needed. (sub. 260, p. 2)

The Australian Association of Gerontology:

> … building a robust evidence-base is an essential foundation upon which to develop ageing and aged care policies and reforms to best meet the challenges and opportunities of an ageing Australian population. (sub. 83, p. 2)

Benetas:

> Service delivery improvements and development of new services must be based on strong evidence provided by rigorous research projects and evaluation. While research into the care of older people is already underway, much of it is focuses on physical health and clinical care … there should be a greater emphasis on research which examines a more holistic view of the wellbeing of older people and their quality of life. (sub. 141, p.4)

Aged care data that is collected by various agencies and departments should be directed to the data clearinghouse in a timely manner, and then be made publicly available — subject to confidentiality and misuse conditions — through the clearinghouse.

Given its intended role and function in the aged care system, the Commission's proposed AACRC would be well placed to take on the role as the data clearinghouse for aged care.

## 13.2 Building a better evidence base

Beyond the collection of data sets, there is also a need for rigorous analysis of the data to test and evaluate policies, programs and proposed reforms. Many participants argued the need for a stronger research or evidence base to inform policy (box 13.2). For example, the Futures Alliance said there was an 'urgent need for ongoing research to provide a solid evidence base for planning, policy development and service provision' (sub. 44, p. 8). Hal Kendig also said:

> Research and evaluation are critical to identifying the support and care needs of frail older people and their carers, and for informing ways of increasing the appropriateness, effectiveness and efficiency of services and other actions on their behalf. (sub. 431, p. 9)

### Research is needed to assess effectiveness

Throughout this inquiry it became apparent that a better evidence base is needed to answer basic questions about many aspects of aged care, including the effectiveness of preventative and early intervention measures, home maintenance and modifications and assistive technologies. Several submissions also indicated a need for an improved evidence base to answer various other research 'gaps' (box 13.3).

The AIHW's submission to the Senate Inquiry into residential and community aged care in Australia identified a number of information gaps. The list included the lack of:

- a currently accepted approach to the measurement of potential or actual demand for formal aged care services
- national level information about the care preferences of potential and current aged care program consumers and their carers and families
- on-going information about the care needs of people who receive Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) and

Extended Aged Care at Home Dementia (EACH-D) packages and the amount and type of assistance provided through these programs

- cross-program information which could be used, among other things, to develop more robust estimates about the number of people using all aged care services and to build better evidence about utilisation patterns and pathways through the system of aged care services as a whole. (2008c, p. 4)

### Box 13.3 **Some unanswered questions and research 'gaps'**

The National Ageing Research Institute:

> … we don't know what models of community care are most acceptable, effective, cost efficient and feasible in an Australian context.
>
> We know that healthy lifestyle choices, such as adequate physical activity and a healthy diet can prevent or delay the onset of a range of chronic diseases, such as diabetes, depression and cognitive decline. Primary health interventions (including education, early intervention) that are supported by government funding incentives should also be trialled and evaluated. (sub. 260, p. 2)

The Australian Association of Gerontology:

> … there has been very limited study or quantification of the burden on carers, who are vulnerable to stress, depression, poor health as well as considerable social and economic loss. (sub. 83, p. 5)

Day Therapy Centres (Victoria):

> Coping with frailty is a poorly understood area. There is a need for more research into this area and the sort of services that lead to the best outcomes. We also need to promote greater acceptance of this part of the human condition. (sub. 448, p. 7)

Villa Maria (Victoria):

> More research into coping with frailty should be supported to identify and develop the services that lead to the best outcomes. (sub. 395, p. 4)

Better monitoring and evaluation would ensure that government funded services are accountable and that funds are appropriately allocated between the various service types, as well as providing a basis for future policy development. Evidence on effectiveness would also aid service providers in improving their practices (box 13.4).

### Box 13.4 **Research on effectiveness: providers' perspectives**

From a provider's perspective, a stronger evidence base on effective aged care and support practices will assist them in better meeting the needs of their clients and help to inform their business and care model into the future.

Benetas:

> In caring for older people, services must take into account the needs of the whole person — physical, emotional, psychological and spiritual. To assist service providers in this work, research has to be undertaken to provide evidence for what is best practice in enhancing the quality of life of older people under their care. (sub. 141, p. 12)

Medibank:

> There is a need to research and build an understanding of 'what works' in age care supports so that these learnings may be applied more broadly to benefit people as they age and improve the quality of services provided. (sub. 250, p. 9)

Providers also have an important role to play in informing the evidence base through their day-to-day practices and practical 'know-how'.

Anglicare Australia:

> In research on older people, service providers need to be involved so that they can impart their knowledge to inform the research and in turn improve their services as a result of the research. (sub. 461, p. 14)

The thin evidence base available on the cost-effectiveness of preventative and early intervention measures is partly because evaluating such strategies is not easy. For example, it can take years for the benefits of social marketing campaigns to become evident and many of the benefits are manifested as a 'non-event' (for example, enhancing protective factors or reversing or reducing risk factors). As noted in an Organisation for Economic Co-operation and Development paper on health promotion and prevention:

> Medical or public health-driven preventive interventions struggle to fit into a broad health care resource allocation framework alongside curative, diagnostic and palliative interventions, because of the somewhat uncertain and distant nature of their outcomes. This places them in a league of their own and often makes governments (and, indeed, health insurance organisations) uncomfortable about diverting resources away from uses that have a more immediate and certain return, particularly in a tightly resource-constrained health care system in which it is not even possible to fund all potentially available curative interventions. (Sassi and Hurst 2008, p. 47)

Despite these difficulties, some participants argued that there are potentially large gains to be made from investing in research into preventative health measures for older people. Alzheimer's Australia, for example, said that if the onset of Alzheimer's disease could be delayed by five years, it would reduce the number of those with the disease by half between 2000 and 2040 (sub. 79, p. 6).

Given the claims about the potential cost-effectiveness of prevention and early intervention measures, there is a need to know more about the effectiveness of different interventions in preventing or reducing the likelihood of particular outcomes (such as the need for residential aged care, reduced risk of falls, dementia, etc.) and their overall cost effectiveness. As the National Health and Hospitals Reform Commission (NHHRC) said:

> Like any spending, our investment in prevention should be both clinically effective and cost effective. (2009, p. 97)

The NHHRC recommended the establishment of a National Health Promotion and Prevention Agency (also recommended by the National Preventative Health Taskforce in 2009). Research with a focus on prevention and early intervention for older people could be placed within such an agency.

The broader questions of whether the level of home and community-based care is adequate to support those wishing to age in their homes and the appropriate balance between resources devoted to residential care and to home and community-based care are also in need of a stronger evidence base, if they are to be addressed.

A widely held view is that providing care in the home is generally more cost effective than doing so in residential aged care. However, because of deficiencies in the cost-benefit research on this issue, the true extent of any savings is not known (AHURI 2006). As this view appears to underpin the allocation of progressively greater levels of budget expenditure on home and community-based care, the Australian Government should encourage more rigorous research to better inform policy and program delivery in order to achieve the most appropriate aged care and housing interventions.

A further area where little light has been shed is how efficiently and effectively aged care services are supplied in concert with other health and welfare services. A number of initiatives have been put in place in recent years to improve service interfaces, but there is only limited evidence on how older people receiving aged care interact with other services and how well their needs are being met. As the Commission previously said:

> … further research and analysis is required. This needs to be underpinned by better data than is currently available, if we are to move away from a largely static 'stock' view of aged care and develop a much better understanding of 'flows'. For example, to investigate how the care needs of older people change over time; how these changes trigger interactions between different parts of the aged care system (and between the aged care system and the broader health and community welfare system); and how efficiently and effectively the care needs of older people are being met. (PC 2008, p. 90)

## Assessing outcomes

A number of participants called for greater use of outcome measures — essential for assessing the effectiveness of policy and programs (see box 13.5 for an international example). The Benevolent Society considered an outcomes based approach to be more conducive to improvements in service quality:

> Developing an outcomes approach, combined with a better use of mandatory data reporting, is a practical strategy for quality improvement. It could bring a better understanding of the needs of clients, of gaps in funding or services, and of the impact on wellbeing of clients with different socio-economic characteristics or service dosage/type. (sub. 252, p. 9)

### Box 13.5 **Outcomes based data: the United States**

The United States Administration on Aging provides comprehensive information on consumer-reported outcomes through its *Aging Integrated Database*.

Public access files of annual national surveys of aged care service recipients (through the Older Americans Act program) are provided online (www.agidnet.org/DataFiles/NPS/) and are categorised by services, including case management, home delivered meals and caregiver services. The survey on case management, for example, includes questions such as:

- Does your case manager return your phone calls in a timely manner?
- Do you and your case manager work together to decide what services you need?
- How would you rate the case management services that you have received?
- As a result of the services you receive, are you better able to care for yourself?

These comprehensive surveys (which also provide information on the health status of the individual) allow Americans and others to easily access a vast amount of data and information about service quality, effectiveness and consumer outcomes.

*Source*: AoA (2010).

The Centre for Health Service Development also said:

> Measuring outcomes as a means of improving the effectiveness of services encourages innovation as it demands that service users, their informal carers and providers think about the different ways they can meet their desired goals. By comparing the outcomes for clients who are of a particular type … then the practical experiences of service users are able to be built in to a quality improvement system. (sub. 343, p. 3)

As mentioned, assessing the effectiveness of aged care services and initiatives is not easy to do. There are limits to which outcomes based data can be collected and the ability to ascertain the outcome of a particular service or program with certainty. That is, establishing the appropriate timeline to evaluate a program, relating

program outputs to wellbeing outcomes, and defining what constitutes a 'good' outcome is not always clear (particularly for older people who are becoming more frail with age). The Centre for Health Service Development acknowledged these challenges:

> Finding answers about what actually makes a measurable difference for carers and consumers is a complex undertaking, the timelines involved in building sustainable benchmarking systems are long, and workable systems have to be built up from assessment through to care planning and case closure, using rigorous and practical methods that can collect the right data. (sub. 343, p. 3)

## Using trials and pilot programs to build evidence

Where evidence about the effectiveness of a proposed policy option or program reform is uncertain, it can be good practice to conduct trials or pilot programs before full implementation. Relatively small investments in trialling policy reforms, the sequential rolling out of policies to facilitate progressive improvement, and the collection of baseline and other data can, assist policy design and implementation.

A variety of trials and pilot programs have been used to facilitate experimentation in the design and delivery of aged care services under DoHA's Aged Care Innovation Pool. Currently, trials of consumer directed care models are being funded through this program (chapter 8). There was support from participants for such trials to build evidence on the effectiveness of policies and programs. KinCare, for example, said:

> Some providers have begun piloting consumer directed care models and the Australian government recently tendered funds for a consumer-directed care pilot. These steps towards increased consumer-directed care are welcome and should be evaluated to begin to establish the foundation of a consumer-centred aged care system. (sub. 324, p. 9)

Internationally, trials and pilot programs have been used, sometimes extensively (as is the case with the United States' long term care system), as a means to ascertain the effectiveness of certain programs and initiatives (appendix C).

### *Evaluation and follow-through*

The value in trials and pilot programs, however, lies in their potential for follow-through action upon evaluation and review. According to some participants, this is a factor that is missing in the experimental aged care initiatives and programs. Some noted that trials can continue to be trials for extended periods or that successful pilot projects can fail to result in programs and continued funding. The Australian Association of Gerontology said:

> Unfortunately, clearly demonstrating a successful model of remote community care does not guarantee ongoing funding. To date, the Lungurra Ngoora service has not secured recurrent funding and cannot make the transition from successful pilot to sustainable service. (sub. 83, attachment, p. 2)

Southern Cross Care (Tasmania) Inc also said:

> The use of pilot programs to trial services and service delivery models is a sound approach but firm decisions are needed around the continuation or otherwise of the programs following evaluation of pilot programs. An example is the Dementia Behaviour Management Assessment Service (DBMAS). This program is funded on a short term basis from Department of Health & Ageing to, in Tasmania, the state Mental Health Service. The predecessor to DBMAS the Psychogeriatric Unit or Dementia Support Unit, had an identical delivery model and was a 'pilot' for nearly 10 years. The DBMAS is still a 'pilot' with no guarantees of ongoing funding. (sub. 267, p. 22)

Trials and pilot programs need to be evaluated and the findings made publicly available so that policy decisions about the continuation (or otherwise) of programs and initiatives can be scrutinised.

A phased approach to the implementation of programs, accompanied by timely post-implementation evaluations before broad scale rollout, is also a sensible way to manage the risks of uncertain evidence, particularly if the costs of implementation and program reversal are low. In this report, the Commission has recommended adopting a phased implementation approach to some of its draft recommendations (chapter 14).

## The need for greater transparency and independence in research

Participants to this inquiry expressed concern about the lack of transparency of Government research relating to aged care. Hal Kendig, for example, said:

> Consultancy reports are seldom released into the public domain where they could inform service improvements.
>
> … The Commonwealth Department of Health and Ageing has conducted commissioned studies or evaluations over recent years but few have been released into the public arena where they could be of wider use. The extensive data collected through the aged care assessment teams has been progressively less available for informing aged care research and development. (sub. 431 , p. 10)

Anna Howe also said:

> … the Department of Health and Ageing should be required to release reports on all research and evaluations that it commissions within a set timeframe and actively disseminate these reports. In the event that the Commonwealth and/or other parties involved in advisory committees overseeing joint projects have any reservations about the findings reported, these matters should be set out in a formal response and released

with the report. The failure to release these reports raises questions of accountability for the funding involved and of responsiveness to the many agencies and individuals who contribute to such projects.

Without access to these reports, discussion is less well informed than it should be. (sub. 355, pp. 20-21)

There would be value in evaluations being made publicly available to allow for greater scrutiny of findings and provide, where necessary, momentum for further implementation or redesign. As the Commission's Chairman has argued, public scrutiny of analysis is in itself is a 'useful form of evidence':

Transparency ideally means 'opening the books' in terms of data, assumptions and methodologies, such that the analysis could be replicated. The wider the impacts of a policy proposal, the wider the consultation should be. Not just with experts, but also with the people who are likely to be affected by the policy, whose reactions and feedback provides insights into the likely impacts and help avoid unintended consequences. Such feedback in itself constitutes a useful form of evidence. (Banks 2009, p. 14)

On 1 November 2010, the Office of the Australian Information Commissioner (OAIC) was officially launched by the Hon. Brendan O'Connor MP, Minister for Privacy and Freedom of Information. Speaking about the reforms to the freedom of information laws, Australian Information Commissioner, Professor John McMillan said:

These changes reflect a broader policy change that acknowledges that information held by the Government is a national resource to be managed for public purposes. We look forward to ensuring that this policy shift becomes a reality for all Australians when they deal with Australian Government agencies. (OAIC media release 2010)

Independence in the evaluation of aged care policy is also important to reduce potential conflicts of interest that may influence the types of projects undertaken and the publishing of findings. As Banks contended:

Good research is not just about skilled people, it is also about whether they face incentives to deliver a robust product in the public interest. (2009, p. 17)

The Australian Nursing Federation maintained that:

… the Australian Government should facilitate continuous, robust independent research into how the aged care system is meeting its obligations outlined under regulatory frameworks. (sub. 341, p. 24)

DoHA currently plays the role of policy-maker, data collector and program and policy evaluator. An independent body to coordinate data collection and allow for greater access to users would help reduce the potential for conflicts of interests to influence the research undertaken and findings. Such an initiative could further enhance public confidence that research findings are reliable.

Key requirements for making research arrangements more effective include:

- increased independence from government and industry, though with close consultation
- improved transparency, including through increased access to data from government and industry, and wider dissemination of research findings to inform public debate
- greater provision for multi-disciplinary input and collaboration.

With significant public money being invested in research, there is a strong public interest in its timely and public dissemination.

## 13.3 Research capacity

The Australian Government has demonstrated its commitment to ageing research through a range of initiatives over the years and there are various research institutes and centres focused on ageing (see examples in box 13.6). In 2002, ageing research was recognised in the National Research Priorities as a means to promote and maintain good health and since then, nationally-focused research programs and networks on ageing research have been established.

In 2003, the AIHW established the *Framework for an Australian Ageing Research Agenda*, which included an Australian Ageing Research Online website initiative to strengthen networks and sharing of research and information between researchers.

In 2005, the *Australian Research Council (ARC)/National Health and Medical Research Council (NHMRC) Research Network in Ageing Well* was created with the goal of increasing 'the scale, focus, and capacity of Australian research to inform national efforts to respond constructively to an ageing society' (Centre for Education on Research on Ageing 2009). The NHMRC/ARC *Ageing Well, Ageing Productively* research funding program was also established to provide the impetus for quality research and analysis. Both initiatives concluded in 2010.

## Box 13.6 **Research centres with a focus on ageing and aged care**

**The Australian Institute of Health and Welfare (AIHW)**

The AIHW is a national agency that provides information on Australia's health and welfare through statistics and data development, as well as producing research on a range of issues including ageing and aged care.

**The Centre for Ageing Studies — Flinders University**

The Centre for Ageing Studies (CAS) promotes the need for and undertakes multidisciplinary research, education and policy development to achieve better outcomes for older people. It is multidisciplinary in nature with a focus on the integration of health and social sciences.

**The Monash Research for an Ageing Society (MonRAS) — Monash University**

MonRAS is facilitating a cross-faculty multidisciplinary approach to the study of ageing, that will consolidate and focus the research activities and resources of the entire university to the development of devices, therapies, policies and programs that address significant issues and improve quality of life of older people.

**The Research Centre for Gender, Health and Ageing (RCGHA) — Newcastle University**

RCGHA aims to facilitate collaboration across existing organisations and individuals working in the fields of research, education, products and services required of an ageing population. The Centre brings together businesses and researchers in a dynamic relationship that creates synergies and new alliances.

**Dementia Collaborative Research Centres**

An Australian Government initiative that includes three centres for dementia research focus: assessment and better care (University of New South Wales), early diagnosis and prevention (Australian National University) and carers and consumers (Queensland University of Technology).

**The National Ageing Research Institute (NARI)**

NARI conducts research in ageing and improving the quality of life of older Australians through its focus on care in the community, hospital and residential care settings.

In the same year, it was announced that an ARC Centre of Excellence for Population Ageing Research would be established in 2011 with the aim of developing world class research on population ageing:

> The Centre for Population Ageing Research brings together researchers, government and industry to address one of the major social challenges of the 21st century. It will establish Australia as a world leader in the field of population ageing research through a unique combination of high level, cross-disciplinary expertise drawn from Economics, Psychology, Sociology, Epidemiology, Actuarial Science, and Demography. (ARC 2010)

While analysis should be undertaken by those with knowledge and experience in the field, there should also be scope to broaden the knowledge base by allowing verification and analysis by other parties as well — including those who specialise in certain methodologies, academics, and those in industry (PC 2009c).

Head (2009) posits that a good knowledge base for evidence-based policy comprises many participants:

> The knowledge base for EBP [evidence-based policy] is diverse. Systematic research (scientific knowledge) provides an important contribution to policy making, and is undertaken in external institutions as well as in the public service. But science is only one of the inputs for EBP. The larger world of policy and program debate comprises several other types of knowledge and expertise that have legitimate voices in a democratic society. (p. 18)

With Government commitment to ageing research and the large number of institutes and centres around the country, Australia appears well placed to undertake high quality and evidence-based research.

However, a number of participants said there was still insufficient institutional capacity and inadequate funding to undertake quality aged care research in Australia. For example, Anna Howe argued for an expanded role (and additional funding) for the AIHW to undertake research into critical issues in aged care (sub. 355, p. 21).

The National Ageing Research Institute said:

> The Australian Government's *Ageing Well, Ageing Productively* Research Program has been of benefit in promoting collaboration between ageing researchers and the development of an ageing research agenda. However, this initiative has now concluded and there is still a need for a national ageing research program that promotes collaborative, cross-disciplinary research and supports skill development and career opportunities for emerging researchers. (sub. 260, p. 3)

Hal Kendig supported the establishment of an Aged Care and Support Research Program modelled on the Australian Housing and Urban Research Institute — a national research organisation (sub. 431, pp. 10-11). He also highlighted the need for more support for research and evaluations:

> … Commonwealth support for research and evaluations has fallen to levels far below those that proved to be very valuable in developing and implementing the community and residential care reforms of the 1980s and 1990s. (sub. 431, p. 10)

In the Commission's research report on the contribution of the not-for-profit sector, one of the recommendations included the establishment of a Centre for Community Service Effectiveness:

> Among its roles, the Centre should provide: a publicly available portal for lodging and accessing evaluations and related information provided by not-for-profit organisations and government agencies; guidance for undertaking impact evaluations; support for 'meta' analyses of evaluation results to be undertaken and made publicly available. (PC 2010a, p. XLII)

The importance of establishing programs to ensure ongoing evaluation and costing of government programs was also highlighted:

> Australian government agencies providing extensive grants to, or using external agencies for, service delivery should establish evaluation programs to assess the effectiveness and actual cost of their programs. Where related to community services, these evaluations should be posted with the Centre for Community Service Effectiveness. (2010, p. XLVII)

Australia is not unique in encountering difficulties in the area of ageing research. Other countries and regions have faced similar concerns in recent times (box 13.7).

DRAFT RECOMMENDATION 13.1

***To encourage transparency and independence in aged care policy research and evaluation, the proposed Australian Aged Care Regulation Commission (draft recommendation 12.1) should perform the role of a national 'clearinghouse' for aged care data. This will involve:***

- ***being the central repository for aged care data and coordinating its 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 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.***

## Box 13.7 **International experience: ageing research**

Similar to Australia's experience, there seems to be growing concerns in some OECD countries about a lack of focus on or funding for ageing research.

The United Kingdom has recognised the need for more coordinated research efforts in its recent blueprint, *A strategy for collaborative ageing research in the UK*, launched by research councils and health departments.

The strategy identifies mental wellbeing and enhancing independence of older people as areas of research focus, with the broad recommendation of enhancing collaboration between various research groups:

> … we have the potential to make a significant impact by joining forces across disciplines and sectors to bring innovative approaches to tackling complex ageing-related research challenges. (Medical Research Council 2010, p. 13)

In the European Union, there has also been recognition of the lack of sufficient linkages between research institutes on ageing and the need for a more holistic approach. FUTURAGE, a two year collaborative project was launched in 2009 to 'produce the definitive Road Map for ageing research in Europe for the next 10-15 years'.

In the United States, claims of underfunding of research on ageing and consequent constraints on innovation and attracting researchers into the field has been a recent concern. In response to these concerns, Richard Hodes, the National Institute of Aging Director, posted an open letter stating:

> We at NIA recognize and empathize with the struggle that our constrained funding creates for the research community, and feel that it is vital that we do everything we can to sustain the momentum of investigator-generated research in this successful and vibrant field, as we continue to make a difference in health and well-being in later life. (2010)

*Sources*: AGE Platform Europe (2010); Hodes (2010); Medical Research Council (2010).

# 14 Reform implementation

**Key points**

- Australia's aged care system is characterised by extensive, complex and interacting government involvement in both the funding of services and the regulation of their delivery. Fundamental reform of the system, as proposed in this report, raises challenging implementation issues.
- Some of the Commission's draft recommendations can be implemented quickly. Others will need more time, in part, to allow older Australians, their carers, providers of care services and government agencies to adjust to the changes.
- The proposed implementation framework is indicative. The Commission will develop a more detailed proposal in its final report, drawing on feedback to this draft report.
- The Government should establish an implementation framework, comprising:
  - a publicly released timetable for changes and their expected effects on older people, carers, providers and governments
  - provision for extensive consultation with all stakeholders, including the community more generally
  - feedback processes that enable policies to be refined in the light of new evidence
  - appropriate grandfathering and sequencing arrangements.
- The Commission envisages a three-stage implementation plan:
  - the first stage would cover measures that can be expedited within two years
  - the second would comprise the bulk of the Commission's draft recommendations and should be pursued within two to five years
  - the final stage would involve the full removal of supply restrictions followed by a public review of the operation of the new aged care system.
- Among other things, the proposed public review would analyse and recommend:
  - whether the consumer directed system had developed sufficiently so that care and supported accommodation prices could be liberalised in certain markets
  - whether the quota arrangements for supported residents be continued or replaced by a tendering mechanism
  - any changes to aged care accreditation standards
  - any changes that may be needed to maintain fiscal sustainability
  - any changes that may be needed to ensure access for special needs groups.
- An Aged Care Implementation Taskforce should be established to oversee the implementation of the reforms and to liaise with stakeholders.

This concluding chapter outlines an indicative transition path for the implementation of the Commission's draft recommendations.

The chapter first outlines an indicative implementation framework and principles to guide the process for moving to the proposed system (section 14.1). It then discusses grandfathering arrangements (section 14.2), outlines an indicative three-stage implementation plan (section 14.3) and finally discusses the major implications of the proposed reforms for older Australians and their carers and providers (section 14.4).

## 14.1 An indicative implementation framework

In its terms of reference, the Commission has been asked to:

> … 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.

This section sets out the Commission's framework for progressively implementing the proposed new model of care in a timely manner. The proposed reforms are cognisant of the importance of the Government meeting its medium term fiscal strategy (box 14.1).

### Box 14.1 The Government's medium term fiscal strategy

The Government's medium-term fiscal strategy is designed to ensure fiscal sustainability. The strategy has remained unchanged since the Government's first budget in 2008-09 and is designed to provide a clear and stable basis for the conduct of fiscal policy. The key elements of the strategy are:

- achieve budget surpluses, on average, over the medium term
- keep taxation as a share of GDP below the level for 2007-08, on average
- improve the Government's net financial worth over the medium term.

*Source*: Australian Government (2010d).

The current policy framework applying to aged care is characterised by extensive, complex and interacting government involvement in the funding and regulation of aged care services. Given the need for wide ranging reform, the Commission's proposals raise challenging transitional issues in several areas:

- the consolidation and enhancement of disparate activities into a single information, assessment and care coordination agency which will also establish entitlements to approved services
- the establishment of a fully integrated approach to the provision of care and support services which is tailored to the needs of individual older Australians, together with the removal of supply constraints on the provision of care and accommodation
- the overcoming of inequities and inefficiencies in the pricing of different forms of care, through a funding regime which empowers consumers to purchase services from competing providers, places greater responsibility on older people who have the financial capacity to contribute to the cost of their care and requires people to be responsible for the cost of their accommodation
- the improvement of governance arrangements through the transfer of regulatory functions such as quality assurance and complaints handling to an independent commission, together with regulatory reform that is less burdensome on consumers and providers and better manages risks.

The Commission's proposals, if implemented, will substantially change the aged care system. As with any major reform, changes will need to be introduced in a coherent and predictable way. Crucial to the success of the implementation process will be a clear statement by the Government that commits it to a credible package of reforms and a firm timetable. Older people and their carers, providers and government agencies will need certainty and time to plan for, implement and adjust to changes.

Overall, the Commission considers that most of its draft recommendations could be implemented within five years of announcement.

In view of the complexity of the transition and the need for a smooth implementation, the Commission considers that the Government should establish an Aged Care Implementation Taskforce. This should comprise, at a minimum, senior officials from the Department of the Prime Minister and Cabinet, the Department of the Treasury, the Department of Finance and Deregulation, the Attorney-General's Department and the Department of Health and Ageing. This Taskforce would thoroughly and carefully manage the transition, consult extensively and take responsibility for the development of the new aged care system.

## 14.2 Grandfathering arrangements

The protection of existing aged care consumers and providers from disruptive change arising from policy reform can be achieved, where appropriate, through the continued application of the *status quo* (grandfathering).

There is already a legacy of grandfathering, particularly in relation to fee schedules, which adds to the complexity of the sector. However, the Commission is mindful that existing residents of aged care facilities and existing recipients of community care entered their care on the basis of the existing funding arrangements and would be particularly vulnerable during a transitional period to the proposed new system. Accordingly, the Commission proposes that:

- existing residents of aged care facilities and those who enter prior to the implementation of the regulatory changes, should be subject to current funding arrangements while they remain in residence
- existing users of community care should be subject to current funding arrangements for all community care services. However, should they need to move to residential care when the new arrangements are in place, they should be subject to the new funding rules.

The Commission proposes that all new residential aged care facilities be required to meet the supported resident quota, with the opportunity to trade that quota among providers within a region. However, residential places which currently have extra service status and are not required to meet the supported resident requirements, will continue to be exempt.

## 14.3 Sequencing of reform

Differences in the scale and complexity of the reform proposals, together with a need to introduce some reforms upfront to provide a foundation to secure the benefits of subsequent reforms, suggest that a staged transition is required.

While some reform proposals can be introduced quickly, others will require:

- extensive consultation among older people and their carers, providers, governments, community organisations, the aged care workforce and the community more generally
- grandfathering of provisions to protect existing recipients and, to an extent, some of the financial arrangements of providers of care services

- preparatory work by the Australian Government, including standards development, legislative and regulatory changes, trials and research and development
- packaging and sequencing of measures to reduce the costs of implementation for providers and governments
- monitoring and review of outcomes to ensure that the new arrangements are working effectively and to manage any emerging unintended consequences.

An important issue is the timing of initiatives to free up quantity and price restrictions. In the Commission's view, there are strong reasons to liberalise quantity restrictions before moving away from regulated prices (box 14.2).

That said, the immediate removal of quantity restrictions could adversely affect providers who have planned and invested on the basis of the current regulations. This suggests the need for a gradual easing of these restrictions followed by price liberalisation, while retaining provisions for price monitoring and setting.

The Commission envisages a three-stage implementation process, as outlined below. The discussion is not a comprehensive detailing of each of the Commission's draft recommendations. Rather, it provides guidance on the sequencing of reform, drawing on examples of key reform measures and when they should be implemented. An indicative implementation plan is outlined in box 14.3 at the conclusion of this section.

## First stage reforms (within two years)

Several of the Commission's proposals could be implemented relatively quickly to address some important deficiencies with the current arrangements.

The removal of the distinctions between residential high and low care and between ordinary and extra service status is a necessary first step in the rationalisation of residential care regulation and in the promotion continuity of care.

Presently the accommodation component of residential high care is funded via an accommodation charge, which the Commission has found to be too low. Residential low care and extra service high care is principally funded via accommodation bonds, many of which exceed the underlying cost of supply.

## Box 14.2 **Which should be liberalised first: quantity or price?**

The optimal order for the liberalisation of a highly regulated sector has been the subject of much scholarly debate. McKinnon, in writing about economic liberalisation, stated:

> In securing this noninflationary financial equilibrium, however, there are definite limits on the relative speeds of liberalization in commodity and capital markets and on how fast interventionist policies or planning controls over domestic and foreign trade can be withdrawn. How fiscal, monetary, and foreign exchange policies are sequenced is of critical importance. ... there is an 'optimal' order of economic liberalization. (1993, p. 4)

McKinnon concluded that, in general, prices which are less elastic should be liberalised before those which are more elastic.

Australia's aged care system is regulated in three dimensions: by price, quantity and quality. In general, the control which is least responsive should be liberalised first; that which is most responsive last, although the entire policy direction should be carefully enunciated by the Government to provide a credible and transparent reform path. So, for example, were price to be deregulated first, the quantity controls would lead to price spikes in regions of relatively short supply: price being most flexible would become volatile.

By contrast, if quantity is deregulated first, it is relatively slow in responding to change: new supply, or the withdrawal of supply, rarely occurs swiftly. By relaxing quantity controls first, then, the industry would adjust to the new regime by planning the quantity of aged care services (and residential facilities) based on its expectation of the future direction of prices — volatile shocks in price could be avoided through continuing price controls. However, any pre-existing distortions in regulated prices — such as underfunding or the absence of a direct link to the cost of service provision — would need to be removed to encourage appropriate quantity related adjustments. Subsequently, these modifying price controls could be lifted, particularly if the market was likely to be contestable.

Ergas supported this approach to regulatory reform, stating:

> As those changes [quantity controls and the removal of distortions caused by government assistance between forms of care provision] come into effect, and competition became a real factor shaping market outcomes, controls over prices could be eased and eventually eliminated, ensuring efficient providers of aged care could fully recover their costs. (2009, p. 36)

As noted, in liberalising quantity first, though, prices need to be at sufficient levels to provide reasonable returns to service providers.

*Sources*: McKinnon (1993); Ergas (2009).

Under the Commission's proposals, residential facilities would be required to set an accommodation charge that is consistent with the cost of providing the accommodation (rather than a resident's ability to pay) and to publish the charge, as well as set and publish an equivalent accommodation bond (if offered). The Commission's proposed removal of accommodation bond retention amounts would occur at the same time.

With the continuation of the supported resident quota, it is also necessary to increase the accommodation charge paid by the Government for supported residents. However, the Commission considers that the charge should be increased gradually to a level that is sufficient to reflect the cost of the approved basic standard of accommodation. Ultimately this charge, along with subsidies for care services discussed below, will be set by the Government based on the transparent advice and recommendations of the proposed Australian Aged Care Regulation Commission (AACRC).

To improve the scope for providers to tailor services to different client groups, facilities should be able to trade supported resident quota obligations with others in the same region so that some facilities could operate below their target and others could provide a more specialised service to needy groups. At the same time, the current quotas of supported residents should be reviewed on a regional basis to better reflect the real level of local need.

These reforms, including the setting of a charge for standard accommodation, will lead to a reduction in the average value of accommodation bonds. As a consequence, there will be a need for an alternative means for age pensioners to deposit any excess funds from the sale of their home in a form that is exempt from the age pension assets test so that these individuals can remain eligible for the age pension. The proposed Australian Pensioners Bond would therefore need to be established in parallel with the accommodation payment reforms.

A number of participants argued that the present indexation of government payments to the industry is insufficient, causing financial pressure on some operators. Unfortunately, there has been insufficient information available to test this claim. Accordingly, the Commission proposes that the AACRC collect and analyse costing data and recommend to the Government a scheduled set of care prices and a rate of indexation for subsidised aged care services. However, this will not be feasible in the immediate future — instead the Commission considers that DoHA (in consultation with the industry and other stakeholder groups) should conduct a public benchmarking study of aged care costs to initially set the required

scheduled prices, thus providing some funding certainty for the next couple of years.

The Commission has also argued that there is a strong case for greater transparency in the provision of data and information generally, to generate opportunities for more effective research and evaluation. The Commission proposes that the AACRC be given a mandate and responsibility for the collection and dissemination of data and information (including, for example, future demand trends and ways for providers to improve to quality of their services in line with best practice). It would also be appropriate for the Government to release a larger amount of data. This will greatly assist in building up a body of knowledge to aid the proposed five year review. The release of such data would assist existing and potential providers to respond to the changing market environment.

The Government should also harness the existing research organisations to conduct an examination of the public and private costs and benefits of residential and community based care.

## Second stage reforms (within two to five years)

Most of the Commission's proposals will require legislative changes, which could take at least two years to effect. That said, the early announcement of the Government's intentions would enable existing and potential providers to commence their planning. The Commission considers that the following proposals would comprise the second stage of the reform process and that they could be implemented within two to five years of announcement.

### *The aged care gateway*

The Australian Seniors Gateway Agency, would be established under the *Financial Management and Accountability Act 1997* (FMA Act) at the start of this second stage. The agency would set up a national information platform, and redundant services would be terminated. It would develop the new needs assessment service and tools, building on the current ACATs, establish protocols with Centrelink for assessments of financial capacity and establish a care coordination function.

The agency would be responsible for implementing a significant education campaign to inform older Australians and their families of the new system and how it affects them, including the revised care co-contribution scheme.

### *An independent regulator*

An independent regulatory body — AACRC — would be established under the *Financial Management and Accountability Act 1997* (FMA Act) to separate the policy arm of Government (DoHA) from the regulation and supervision of aged care. Concurrently, the Aged Care Standards and Accreditation Agency would become a statutory office within the AACRC.

While the transfer of regulatory powers from DoHA to the AACRC would occur on a specified day, it will be necessary for the AACRC to be established prior to the formal transfer. Close cooperation and coordination with DoHA during this period (and beyond) will be crucial.

An important role of the AACRC will be to inform the industry of the revised aged care regulatory system, including, for example, the greater range of enforcement options and how it will affect them. It will also function as the national data clearinghouse for aged care and promote greater dissemination of data and research. This should commence as soon as practicable after its creation.

### *Care services and subsidies*

A central reform is the provision of a continuous range of care services, using a fully-integrated building block approach across both community and residential care. This new regime would replace the current discrete home and community care programs and packages, and also give the gateway assessors responsibility for specifying (initially) the care entitlements for those entering residential facilities.

In addition, the Commission's proposed new care co-contribution regime should be implemented (with protection for those with limited means) and the stop-loss limit should also be introduced at this stage. The proposed equity release scheme would be set up at this time to enable older people, whose financial capacity largely consists of equity in their homes, to contribute to their aged care costs.

As discussed above, prices for the approved services provided under the aged care system should continue to be set by the Government until the new AACRC has been established. The proposed AACRC would benchmark the costs of care in both community and residential settings as soon as practicable and make transparent recommendations to the Government on a set of scheduled prices, indexation rates and the price to be paid for the basic standard of accommodation.

Older people with entitlements to care would pay their care co-contributions directly to their chosen provider and would, for administrative efficiency, sign over their subsidy.

*Supply restrictions — bed licenses and community care places*

It would be disruptive to remove the supply restrictions (in both community and residential settings) immediately, with some regions having excess supply and others excess demand at current price levels. The Commission has been advised that the value of residential care bed licenses varies significantly by region. In some areas, licenses have been handed back to DoHA, implying a zero valuation (or a very low valuation reflecting timing considerations if waiting for a new Aged Care Approval Round (ACAR) allocation).

In order to ensure a smooth adjustment, it would be preferable to liberalise supply gradually, allowing time for providers to assess emerging market opportunities and to build their capacity to provide additional services. During this time, prices for care and standard accommodation should remain regulated, to minimise the fiscal risk to the taxpayer and care co-contributions by users.

Options to achieve a smooth adjustment of supply include:

- abolishing all licenses and packages immediately on implementation of the new aged care system. This option could particularly affect some providers who rely on the asset value of their licenses.
- continuing with the ACAR to set the number of licenses and community care packages for a fixed period via its existing methodology, but with an additional percentage (perhaps 10–20 per cent) of licenses provided progressively above that baseline. This would gradually increase supply until it is effectively fully liberalised in both residential and community settings. Entitlements to subsidised care would still be dependent on an assessment of need by the gateway agency.

The Commission favours the latter, with a period of five years from the announcement of the Government's policy being sufficient to allow a smooth adjustment by the industry, with the removal of all quantity restrictions at the commencement of stage three. Consistent with increasing the continuity of care services, the removal of quantity restrictions would also apply to basic support services, such as those currently provided under HACC.

The Commission's proposed reforms could affect some providers who rely on the asset value of bed licenses as collateral for borrowings. Participants suggested that a three to five year phase out of bed licenses would address the most significant of these concerns. The Commission also notes that new licences are issued without charge and that there will be new opportunities for providers.

*Supported and concessional residents*

In response to concerns about the adequacy of current pricing incentives to ensure that providers are supplying a sufficient number of beds for supported residents, the Commission proposes that the present arrangements be retained until they have been reviewed as part of the third stage reforms. However, the different supported and concessional resident supplements should be harmonised and increased to a level that reflects the cost of providing the basic standard of accommodation.

The five year review should advise on whether the supported resident scheme be continued or replaced by a tendering mechanism where there is a competitive market of service providers.

## Third stage reforms (five years and beyond)

Over the first five years of its implementation plan, the Commission has proposed a gradual increase in the number of places in both community and residential settings. At the commencement of the third stage of the reform process, the remaining supply restrictions should be removed. That is, accredited providers in both community and residential settings would be free to supply the number of care services and residential places that they saw fit. Demand would continue to be limited by the number of older people who had entitlements to approved care.

Following the removal of these restrictions, the Government should commission an extensive public study into the implementation of its reforms and the state of the aged care system. Such a review would be informed by the increased availability of data and information under the mandate provided to the new regulator. Among other things, the review should analyse and recommend:

- whether the consumer directed system had developed sufficiently so that care and supported accommodation prices could be liberalised in certain markets
- whether the quota arrangements for supported residents be continued or replaced by a tendering mechanism
- any changes to aged care accreditation standards
- any changes that may be needed to maintain fiscal sustainability
- any changes that may be needed to ensure access for special needs groups.

The Commission further considers that additional public reviews of the aged care system should be conducted at least every five years.

## Box 14.3 **Draft Implementation Plan**

**Stage 1: expedited measures within two years**

- remove the distinctions between low and high care, and between ordinary and extra-service status
- require residential aged care facilities to set accommodation charges consistent with the cost of supply, to disclose the charges and an equivalent accommodation bond (if offered) and remove accommodation bond retention amounts
- introduce the Australian Pensioners Bond
- conduct a public benchmarking study of aged care costs to initially set the scheduled prices, progressively increase the accommodation charge paid by the Government for supported residents, set regional quotas for supported residents and allow providers to trade those quota obligations.

**Stage 2: within two to five years**

- establish the Australian Seniors Gateway Agency, terminate redundant services and introduce the new model of care assessments and services entitlements
- establish the Australian Aged Care Regulation Commission (AACRC) and transfer regulatory responsibility to it from the Department of Health and Ageing
- transfer the Aged Care Standards and Accreditation Agency to a statutory office in the AACRC
- introduce the new co-contribution and stop-loss funding arrangements and equity release scheme, and set care prices and the accommodation charge for supported residents based on transparent recommendations from the AACRC
- implement the Commission's draft recommendations relating to age friendly housing and communities, workforce and catering for diversity reforms
- gradually increase the quantity of residential and community places by 10 to 20 per cent above the baseline established by the Aged Care Approvals Round
- continue to set the regional supported resident ratio which would apply to all new and existing residential aged care facilities (except those subject to explicit grandfathering arrangements).

**Stage 3: five years and beyond**

- after five years, remove supply restrictions in both residential and community care
- commission a public review which would analyse and recommend:
  - whether the consumer directed system had developed sufficiently so that care and supported accommodation prices could be liberalised in certain markets
  - whether the quota arrangements for supported residents be continued or replaced by a tendering mechanism
  - any changes to aged care accreditation standards
  - any changes that may be needed to maintain fiscal sustainability
  - any changes that may be needed to ensure access for special needs groups.

***In implementing reform, the Australian Government should:***

- ***announce a timetable for changes and how they are expected to affect the sector***
- ***consult with providers, consumers, carers and government agencies on issues expected to arise from the implementation of the new system***
- ***embed feedback processes and enable fine-tuning of the new system***
- ***grandfather current users of care services, including those in residential aged care facilities, and relevant financial arrangements of some of the providers of aged care services***
- ***sequence reforms carefully to facilitate adjustment to the new system***
- ***establish an Aged Care Implementation Taskforce to oversee the implementation of the reforms and to liaise with stakeholders.***

## 14.4 What do the reforms mean for older Australians and service providers

The draft recommendations in this report will introduce significant changes to the aged care sector. This section discusses the major implications for older Australians, their carers and for aged care providers.

### Older Australians and their carers

While protecting existing users of aged care services through appropriate grandfathering arrangements, the Commission's draft recommendation will result in a significant change in the way in which older Australians, their carers and family engage with the aged care system in the future. They would:

- obtain general advice on ageing issues and regionally-specific information regarding aged care services from a range of sources that all draw from a national information platform run by an aged care gateway agency
- be assessed for their care and support needs by the gateway agency, with a simple phone call or form (from their GP, health clinic, on the net etc.) for basic support and a more detailed assessment for personal care, specialised services and associated carer support

- receive an entitlement to a set of services that match their needs and be advised of the price of those services and approved providers that they can choose from, to provide the services
- be offered a care coordination service run by the gateway and a case management service when needed
- be given every opportunity to maintain or regain functional independence
- have a single, updated, aged care electronic record that means that they do not have to keep repeating their history and personal circumstances
- be subject to a simple or comprehensive financial means test — based on income and assets, and the value of approved care services — 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
- have access to an equity release scheme to meet their care and accommodation costs if their wealth is held mostly in the form of their house
- choose their preferred provider (quantity limits on providers having been lifted), having regard to the quality of service 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
- 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 (retirement village, serviced apartment, residential care facility etc.) and pay a lower capital sum or daily charge, by investing the excess proceeds from the sale in a pensioner bond
- 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 proposed AACRC is monitoring the quality of the providers and is an independent avenue for examining consumer complaints.

## Aged care providers

The Commission's reforms will involve significant changes for both community and residential aged care providers, overcome current financial pressure points and create scope for expansion within an emerging competitive market. Good managers who meet the needs of empowered older people will have significant 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 approved care and support services as determined through the assessment process by the gateway agency (comprising a care co-contribution from the client and a subsidy from the Government)
- while meeting the minimum 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 agency 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 proposed AACRC on matters of quality standards and assessments, complaints handling and costs of service delivery
- be able to access information from the proposed AACRC regarding projections of future demand trends and ways to improve the quality of services.

In addition, providers of residential care would:

- 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
- 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)

- charge a daily accommodation charge for all new residents that reflects the cost of supply or, if desired, offer accommodation bond up to the equivalent amount, and publish those charges and bonds (with current bonds being grandfathered)
- be provided with a set daily accommodation fee from the Government for supported residents, based on the cost of a two-bed room and shared bathroom
- be required to provide for a minimum quota of supported residents (with current exemptions being grandfathered), with that quota being tradeable within each region and liaise with the proposed AACRC on quota issues
- be able to offer a range of other services in their facilities, such as respite care, transition care, 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.

# A Conduct of the inquiry

The Commission received the Terms of Reference for this inquiry on 27 April 2010. In line with its normal inquiry procedures, the Commission has actively encouraged public participation

Soon after receipt of the Terms of Reference, the Commission advertised the inquiry in national and metropolitan newspapers and sent a circular to people and organisations thought likely to have an interest in the inquiry.

In May 2010, the Commission released an issues paper to assist those wishing to make written submissions. Prior to the release of this draft report the Commission received 487 submissions (table A.1). The public part of these submissions are available on the Commission's website (www.pc.gov.au/projects).

The Commission also met with more than 150 domestic stakeholders/groups and government agencies (table A.2).

Five workshops were held covering finance and funding, workforce, care needs and the provision of care, accommodation and technology (table A.3).

In November 2010, the Commission requested, and the Government granted, an extension to the inquiry's reporting date. The final report will now be submitted to the Government at the end of June 2011.

The Commission would like to thank all those who have contributed to the inquiry so far. With the release of this Draft Report, the Commission now invites comments on the analysis and draft recommendations. Further comments can be made through written submissions and/or participation in the public hearings, commencing in March 2011. Times, dates and venues for these hearings are set out at the front of this report.

Table A.1 **Submissions received**

| *Participants* | *Submission no.* |
|---|---|
| Ability Options Limited | 222 |
| Able Community Care | 14 |
| ACH Group Inc | 111 |
| ACT Chinese Aged Care Info Service | 171 |
| Adams, Charles | 33 |
| Aegis Aged Care Group | 206 |
| Aged & Community Care Victoria | 408 |
| Aged & Community Services Australia (ACSA) | 181 |
| Aged & Community Services of NSW and ACT | 140 |
| Aged & Community Services Western Australia | 271 |
| Aged & Disability Services, Mosman Municipal Council | 282 |
| Aged Care Assessment Service Victoria | 214 |
| Aged Care Assessment Service Victoria | 262 |
| Aged Care Association Australia — SA Inc | 309 |
| Aged Care Association of Australia | 291 |
| Aged Care Association of Australia and Deloitte Touche Tohmatsu | 285 |
| Aged Care Crisis | 433 |
| Aged Care Industry Council (NSW & ACT) Building Committee | 429 |
| Aged Care IT Vendor Association | 264 |
| Aged Care Queensland Inc | 199 |
| Aged Care Standards and Accreditation Agency Ltd | 354 |
| Aged Rights Advocacy Service Inc | 137 |
| Aggar, Christina RN, Ronaldson, Susan (Dr) RN PhD FCNA, Cameron, Ian D (Prof) MB BS PhD FAFRM (RACP) | 42 |
| Alliance for Forgotten Australians — Families Australia | 486 |
| Alzheimer's Australia | 79, 446, 468 |
| Alzheimer's Australia NSW | 455 |
| Alzheimer's Australia WA | 345 |
| Amana Living | 236 |
| Amaroo Care Services Inc | 98 |
| AMP Capital Investors | 342 |
| Anderson, Shirley | 60 |
| Anglican Care | 49 |
| Anglicare Australia | 461 |
| Anglicare Sydney | 272 |
| Annecto | 402 |
| Antioch, Kathryn (Dr) | 417 |
| Ansell, Cam and Toohey, Jim | 464 |
| Arcare Pty Ltd | 434 |
| Archibald, Mary T PSM | 359 |
| Association of Independent Retirees — Morton Bay Region Branch | 11 |
| Association of Independent Retirees Limited — New South Wales Division | 303 |
| Attendant Care Industry Association of NSW Inc | 157 |

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Table A.1 **(continued)**

| *Participants* | *Submission no.* |
|---|---|
| Atkinson, Sallyanne AO | 339 |
| Australian & New Zealand Society for Geriatric Medicine | 145 |
| Australian Academy of Technological Sciences and Engineering | 120 |
| Australian Asian Association of WA Inc | 188 |
| Australian Blindness Forum | 244 |
| Australian Capital Territory Government | 365 |
| Australian Council of Trade Unions | 228 |
| Australian Dental Association Inc | 288 |
| Australian Federation of Aids Organisations Inc and National Association of People Living with HIV/Aids | 378 |
| Australian General Practice Network | 295 |
| Australian Greek Welfare Society | 225 |
| Australian Health Insurance Association Ltd | 65 |
| Australian Lawyers Alliance | 353 |
| Australian Meals on Wheels Association | 209 |
| Australian Medical Association | 330 |
| Australian Nursing Federation | 327, 469 |
| Australian Nursing Federation (Victorian Branch) | 341 |
| Australian Osteopathic Association | 80 |
| Australian Physiotherapy Association | 227 |
| Australian Polish Community Services | 160 |
| Australian Psychological Society | 158 |
| Australian Unity | 265, 459 |
| Ballarat District Nursing and Healthcare | 130 |
| Banksia Villages | 467 |
| Banksia Villages Ltd Residents' Committee | 481 |
| Baptcare | 212 |
| Baptist Village Baxter Ltd | 170 |
| Baptistcare (WA Baptist Hospitals and Homes Trust Inc) | 426 |
| Beatty, Dianne | 413 |
| Bega Valley Meals on Wheels Plus | 51 |
| Bell, Pamela | 43 |
| Benetas | 141 |
| Bernoth, Maree (Dr) | 253 |
| beyondblue | 216 |
| Bithell, Barbara | 59 |
| Blackall Range Care Group Inc | 62 |
| Blackwell, Peter | 375 |
| Blake Dawson | 465 |
| Blue Care | 254 |
| Blue Cross Community & Residential Services | 441 |
| Boandik Lodge Incorporated | 99 |
| Bourne and Associates Pty Ltd | 374 |
| Brennan, Ngaire | 226 |

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Table A.1 **(continued)**

| *Participants* | *Submission no.* |
|---|---|
| Brodaty, Henry (Prof) | 45 |
| Bromilow Home Support Services Pty Ltd | 471 |
| Brooke, Libby (Assoc Prof) | 331 |
| Brotherhood of St Laurence | 294 |
| Brucker, B | 418 |
| Bryant, Joanne | 101 |
| Burrows, Christine RNM MN CNC | 35 |
| Business Council of Australia | 274 |
| Cameron, Anne | 361 |
| Canberra Multicultural Community Forum Incorporated | 202 |
| Capital Cove Pty Ltd | 452 |
| Care Connect Ltd | 229 |
| Care Net Community Nursing Pty Ltd | 150 |
| Carers Australia | 247 |
| Carers NSW | 211 |
| Carers Queensland | 28 |
| Carers Victoria | 292 |
| Carers WA | 276 |
| Carnegie, Neville | 89 |
| Catholic Community Services | 256 |
| Catholic Health Australia | 1, 217 |
| Catholic Homes | 381 |
| Catholic Social Services Victoria | 358 |
| Centre for Cultural Diversity in Ageing | 224 |
| Centre for Health Communications, University of Technology Sydney | 280 |
| Centre for Health Service Development, University of Wollongong | 343 |
| Chandraratne, Donald (Dr) | 425 |
| Chinese Community Social Services Centre Inc | 240 |
| Chua, Ben (Dr) | 17 |
| City of Port Adelaide Enfield | 32 |
| City of Port Phillip's Older Persons Consultative Committee | 245 |
| City of Salisbury | 263 |
| Clare Dewan and Associates | 119 |
| Clubs Australia, the RSL and Services Clubs Association and Richmond Club Ltd | 197 |
| Coad, Jan | 54 |
| Colonial First State | 332 |
| Combined Pensioners & Superannuants Association of New South Wales Inc | 380 |
| Commonwealth Ombudsman | 290 |
| Community Based Support South Inc | 275 |
| Community Care (Northern Beaches) Ltd | 142 |
| Community Transport NSW Future Directions Working Group | 208 |
| Consumers Health Forum of Australia | 287 |

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Table A.1 **(continued)**

| *Participants* | *Submission no.* |
|---|---|
| Cook Care Group | 10, 442, 443 |
| Council on the Ageing (COTA) Australia Ltd | 337 |
| Curnow, Venessa | 191 |
| Cussen, Karen | 317 |
| Dalby and District Aged Persons Homes Association | 82 |
| Day Therapy Centres Network in Victoria | 382 |
| de Bellis, Anita (Dr) | 248 |
| dela Rama, Maria, Edwards, Melissa (Dr) and Dalton, Bronwen (Dr) | 8 |
| Department of Health and Ageing | 482 |
| Dieticians Association of Australia | 371 |
| Diversional Therapy Australia | 93, 175 |
| Dutch Care Ltd | 128, 129 |
| East Wimmera Health Service — Donald Campus | 315 |
| ECH Inc, Eldercare Inc and Resthaven Inc | 100, 453 |
| Echuca Community for the Aged | 438 |
| economic Security4Women (eS4W) | 485 |
| School of Nursing, Midwifery and Postgraduate Medicine — Edith Cowan University | 230 |
| Eliza Purton Ltd | 223 |
| Embracia | 439 |
| Ethnic Communities' Council of NSW Inc | 193 |
| Ethnic Communities' Council of Victoria | 169 |
| Evans, K A G | 4 |
| Fairfield City Council | 183 |
| Federation of Ethnic Communities' Councils of Australia | 210 |
| Federation of Jewish Aged Care and Community Service Organisations | 383 |
| Ferrie, Margaret | 9 |
| Financial Planning Association of Australia Limited | 376 |
| Findlay, Therese | 20 |
| FORTUS | 463 |
| Fronditha Care | 436 |
| Frontier Services | 323 |
| Gavan, Joan RN RM and Fitzgerald, Hilda RN | 78 |
| Gay and Lesbian Health Victoria | 68 |
| Gay Lesbian, Bisexual, Trans and Intersex Retirement Association Incorporated | 57 |
| General Practice NSW | 85 |
| General Practice South, Tasmania | 278 |
| General Practice Victoria | 235 |
| Gillespie, Cathy | 24 |
| Glenorchy Linkages Group, Glenorchy City Council | 87 |
| Graudenz, Pam | 70 |
| Gray, Margaret | 26 |
| Great Community Transport Inc | 75 |

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| *Participants* | *Submission no.* |
|---|---|
| Greek Welfare Centre NSW | 238 |
| Gross, Eva | 435 |
| Gwynne, Robyn | 90 |
| Gymea Home and Community Care (HACC) Projects | 319 |
| HammondCare Group | 168 |
| Harrison, Jo (Dr) | 190 |
| Harvie, Rob | 104 |
| Havilah Hostel Inc | 384 |
| Health and Community Services Union Tasmania | 372 |
| Health Care Consumers Association of the ACT Inc | 326 |
| HealthCube Management Pty Ltd | 103 |
| Hellenic Community Aged Care | 186 |
| Helping Hand Aged Care Inc | 196 |
| Herdy, Wayne (Dr) | 18 |
| Hicks, Ronald (Dr) PhD | 457 |
| Hills Positive Ageing Project | 163 |
| Hixon, Laurel L | 328 |
| Hobsons Bay City Council | 97 |
| Hoffman, Rob (Dr) | 184 |
| Home Instead Senior Care | 134 |
| Homeshare Australia & New Zealand Alliance | 347 |
| Howe, Anna L (Dr) | 355 |
| Hunt, Roger (Dr) | 12 |
| Huntsman, Leone | 71 |
| Hurst, Carmel | 284 |
| Illawarra Forum Inc | 428 |
| Illawarra Retirement Trust (IRT) | 356, 462 |
| Independent Living Centre WA's Multicultural Aged Care Service | 139 |
| Innovative Care Ltd | 234 |
| Institute for Social Participation, La Trobe University | 367 |
| Institute of Policy Studies, Victoria University New Zealand | 47 |
| Italian Benevolent Foundation SA Inc | 233 |
| J R Cumpston Pty Ltd | 255 |
| Jacobs, Nancy | 182 |
| James Underwood and Associates Pty Ltd | 293 |
| Jannali Neighbourhood Aid | 318 |
| Jewish Care Victoria Inc | 385 |
| Julia Farr Association | 201 |
| Just Better Care | 131 |
| Just Better Care Brisbane South | 281 |
| Kellock Lodge Alexandra Inc | 386 |
| Kendig, Hal (Prof) | 431 |
| KinCare | 324 |
| Kobold, Marjory | 450 |

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| *Participants* | *Submission no.* |
|---|---|
| Koppel, Pauline BMM, MIT | 107 |
| Latrobe Community Health Service | 220 |
| Law Society of New South Wales | 350 |
| Legacy Australia Council | 373 |
| Leichhardt Community Transport Group Inc | 257 |
| Lend Lease Primelife | 76 |
| Lend Lease Primelife — Retirement Living | 305 |
| Lesbian & Gay Solidarity (Melbourne) | 115 |
| Lewin, Gill (Prof) | 114 |
| Linburn Nursing Home | 314 |
| Liquor, Hospitality and Miscellaneous Union (LHMU) | 335 |
| Little Company of Mary Health Care Ltd | 289 |
| Little, Valerie (Mrs) | 239 |
| Living Care | 460 |
| Local Government Association of NSW and Shires Association of NSW | 427 |
| Local Government Association of South Australia | 259 |
| Londregan, Peter | 22 |
| Long, Marilyn | 34 |
| Lower Mountains Neighbourhood Centre | 270 |
| Lower North Shore Community Transport Inc | 357 |
| Macarthur Aged & Disability Forum | 416 |
| Macarthur/Wingecarribee HACC Forum | 108 |
| MacDonald, David | 106 |
| MacKinlay, Elizabeth (Rev Prof) AM PhD FRCNA | 132 |
| Macular Degeneration Foundation | 437 |
| Management Consultants and Technology Services Pty Ltd | 125 |
| Manly Warringah Pittwater Community Aid Service Inc | 320 |
| Manningham Centre Association Inc | 325 |
| Manor Court Werribee Aged Care Ltd | 387 |
| Martindale Nursing Home, Valleyview Aged Care Facility and The Kensington Aged Care Facility | 304 |
| Mary MacKillop Care SA Ltd | 364 |
| Maskell, Lucynda | 56 |
| Masonic Homes Limited | 124 |
| Masso, Janine | 249 |
| Matrix Guild (Vic) Inc and Coalition of Activist Lesbians — Australia | 397 |
| Maxwell, Juliette (Mrs) | 118 |
| McAuley, John P | 480 |
| McCall Gardens Community Ltd | 162 |
| McClatchie, Gordon | 31 |
| Medibank Private | 250 |
| Medical Technology Association of Australia | 187, 484 |
| Melbourne City Mission | 173 |
| Melbourne Medical Deputising Service | 405 |

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| *Participants* | *Submission no.* |
|---|---|
| Mental Health Council of Australia | 69 |
| Menzies Centre for Health Policy, The University of Sydney and the Australian National University | 400 |
| Mercy Aged Care Services Brisbane | 221 |
| Mercy Health | 215 |
| Migrant Information Centre (Eastern Melbourne) | 154 |
| Mission Australia | 117 |
| Monash University Gippsland and the University of Tasmania's Department of Rural Health | 302 |
| Morrison, Lena | 451 |
| Motor Neurone Disease Australia Inc | 147 |
| Multicultural Access Projects in Cumberland/Prospect, Nepean, and Northern Sydney | 379 |
| Multicultural Aged Care Inc | 243 |
| Multicultural Communities Council of Illawarra | 286 |
| Multicultural Communities Council of SA | 52 |
| Multicultural Disability Advocacy Association of NSW | 144 |
| Municipal Association of Victoria | 333 |
| Murphey, Shannon | 316 |
| My Longevity Pty Limited | 189 |
| Name withheld | 36 |
| Name withheld | 58 |
| Name withheld | 61 |
| Name withheld | 91 |
| Name withheld | 312 |
| Name withheld | 415 |
| National Aged Care Advocacy Program (NACAP) Members | 167 |
| National Aged Care Alliance | 88 |
| National Ageing Research Institute Inc | 260 |
| National Council of Women of Australia Inc Ltd | 67 |
| National Disability Services | 102 |
| National Foundation for Australian Women | 95 |
| National Health, Aged and Community Care Forum | 241 |
| National LGBT Health Alliance | 138 |
| National Presbyterian Aged Care Network | 110 |
| National Rural Health Alliance Inc | 277 |
| National Seniors Australia | 411 |
| New England HACC Development | 232 |
| Niemotko, Waldemar | 21 |
| Nixon Hostel, Kingston City Council | 53 |
| North and West Region CACP / EACH/D / ACAS Forum | 133 |
| Northside Community Forum Inc | 143 |
| NSW Aged Care Alliance | 430 |
| NSW Council for Intellectual Disability | 155 |

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Table A.1 **(continued)**

| *Participants* | *Submission no.* |
|---|---|
| NSW Government | 329 |
| NSW HACC Development Officers Network | 113 |
| NSW Home Modification and Maintenance Services State Council | 268 |
| NSW Ombudsman | 313 |
| NSW Transcultural Aged Care Service | 360 |
| NSW Trustee & Guardian | 297 |
| Occupational Therapy Australia | 203 |
| O'Donnell, Carol | 39 |
| Office of the Aged Care Commissioner | 444 |
| Office of the Health Services Commissioner | 349 |
| Older People's Reference Group | 25 |
| Ottrey Homes, Cobram District Retirement Village Inc | 388 |
| Ozcare | 218 |
| Pakary Pty Ltd, Yalding Pty Ltd and Hahndorf Holdings Pty Ltd | 308 |
| Palliative Care Australia | 77 |
| Palliative Care NSW and Palliative Care Advisory Group NSW | 445 |
| Palliative Care Victoria | 340 |
| Parkinson's Australia | 122 |
| Parry, Yvonne | 16 |
| Pearce, Janet K | 153 |
| Peden, Maureen | 40 |
| Pendleton, Denise | 116 |
| Peninsula Advisory Committee for Elders, Mornington Peninsular Shire | 219 |
| Peninsula Care Planning Group | 344 |
| Penrith City Council | 351 |
| Perth Home Care Services Inc | 398 |
| Phillips, Joy (Ms) | 151 |
| Physical Disability Australia Ltd | 96 |
| Physical Disability Council of NSW | 261 |
| Pieters-Hawke, Sue | 159 |
| Pinkas, Georgina | 179 |
| Polish Welfare Office | 362 |
| Probets, Jennifer | 66 |
| Proprietors Networking Group | 449 |
| Psychogeriatric Care Expert Reference Group | 299 |
| Public Interest Advocacy Centre Ltd | 321 |
| Puttman, Margaret | 29 |
| Quality Aged Care Action Group Inc | 346 |
| Quality Aged Care Action Group Inc, Blue Mountain Branch | 81 |
| Queensland Aged and Disability Advocacy Inc | 207 |
| Queensland Law Society | 204 |
| Queensland Nurses' Union | 409 |
| Queensland Smart Home Initiative | 172 |
| Quirk, Lisa | 7 |

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Table A.1 **(continued)**

| *Participants* | *Submission no.* |
|---|---|
| R M Begg Kyneton Aged Care | 389 |
| Redfern & Inner City Home Support Service Inc | 348 |
| Redleaf Training and Consultancy | 177 |
| Regional Coordination Office of Community Transport, Northern Sydney | 165 |
| Regis Group | 237 |
| Retired Teachers Association, NSW | 84 |
| Retirement & Aged Care Services, Manchester Unity Aust Ltd | 205 |
| Retirement Village Association Ltd | 424 |
| Retirement Village Residents Association Inc | 30 |
| Returned & Services League of Australia | 148 |
| Robinson, Andrew (Prof) and See, Catherine (Dr) | 231 |
| Robinson, Susanne | 13 |
| Penhall, R K (Dr) | 112 |
| Royal College of Nursing, Australia | 352 |
| Royal District Nursing Service | 198 |
| Rudolph, Peter J (Dr) MBBS DipGerMed | 174 |
| Rural Doctors Association of Australia | 307 |
| Ryder, Susan | 55 |
| Salisbury Private Nursing Home | 310 |
| Salvation Army (Vic) Community Aged Care Program | 447 |
| Samarinda Aged Services Inc | 390 |
| Seasons Living Australia | 136 |
| Shaw, Rhonda (Dr), Sappey, Jennifer (Dr) and Gullifer, Judith (Ms) | 121 |
| Shepparton Villages | 391 |
| Sherwood Respite Services Inc | 399 |
| Short, Leonie M (Ms) | 2 |
| Silver Chain Nursing Association Incorporated | 246 |
| Smith, Christine MP — Member for Burleigh | 135 |
| South Asian Muslim Association of Aust Inc | 123 |
| South Australian Government | 336 |
| South Eastern Region Migrant Resource Centre | 126 |
| South Sydney Community Transport | 200 |
| Southern Cross Care (Vic) | 266 |
| Southern Cross Care (Tas) Inc | 267 |
| Southern Cross Care (WA) Inc | 432 |
| Spakia Pty Ltd | 306 |
| Sridharan, Swarupa M (Ms) | 48 |
| St George Migrant Resource Centre | 300 |
| St Johns Village Inc | 404 |
| St Laurence Community Services Inc | 156 |
| Stewart Brown Business Solutions Pty Ltd | 192 |
| Sukkar, Khalil RN DBA | 421 |
| Sundale Garden Village, Nambour | 269 |
| Sunrise Supported Living (SSL Management) | 38 |

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Table A.1 **(continued)**

| *Participants* | *Submission no.* |
|---|---|
| Sunshine Coast and Wide Bay Health Service District | 419 |
| Sutton, Gillian | 46 |
| Swan Hill Rural City Council | 180 |
| Tablelands Futures Corporation | 194 |
| Tabulam and Templer Homes for the Aged Inc | 338 |
| Tandara Lodge Community Care Inc | 105 |
| Tanunda Lutheran Home Inc | 161 |
| Tasmanian Council of Social Service | 466 |
| Tasmanian Government | 458 |
| Taylor, Jan | 283 |
| Tech4Life | 273 |
| Tender Living Care Australia Pty Ltd | 487 |
| Tender Loving Cuisine | 23 |
| Thacker, Wendy | 483 |
| The Aged-care Rights Service | 322 |
| The Australian Association of Gerontology Inc | 83 |
| The Benevolent Society | 252 |
| The Bethanie Group Inc | 407 |
| The College of Nursing | 86 |
| The Country Women's Association of New South Wales | 149 |
| The Futures Alliance | 44 |
| The Home Nursing Group | 6 |
| The Pharmacy Guild of Australia | 296 |
| The Repatriation Commission | 366 |
| The Royal Australasian College of Physicians | 403 |
| The Royal Australian & New Zealand College of Psychiatrists | 73 |
| The Rural City of Murray Bridge | 242 |
| The Salvation Army Aged Care Plus | 363 |
| The Salvation Army (Vic) Property Trust Adult Services | 401 |
| Tickled Pink Aged Care Pty Ltd | 301 |
| TLC Aged Care | 392 |
| Toohey, Jim | 410 |
| Totts Inc | 3 |
| Trieu, Luan Ho | 19 |
| Tunney, Joy | 440 |
| Tunstall Healthcare Asia Pacific | 176 |
| Twitchin, Joe | 72 |
| U3A Online | 37 |
| Ukrainian Elderly People's Home | 166 |
| Uniting Care Ageing NSW.ACT | 369 |
| Uniting Care Australia | 406 |
| Uniting Care Community Options | 152 |
| van Dam, Tom | 92 |
| Van Deventer, S | 109 |

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Table A.1 **(continued)**

| *Participants* | *Submission no.* |
|---|---|
| Vasey RSL Care Ltd | 393 |
| Victoria Manor Aged Care Facility | 394 |
| Victorian Council for Civil Liberties | 164 |
| Victorian Day Therapy Centres Network | 448 |
| Victorian Deaf Society | 127 |
| Victorian Government | 420 |
| Victorian National Respite for Carers Programs Services Network | 334 |
| Vignolo, Alba | 146 |
| Villa Maria Society | 395 |
| Village Baxter | 422 |
| VincentCare Victoria | 258 |
| Volunteer Home Visitors | 423 |
| Walker, Robyn (Mrs) | 64 |
| Warrigal Care | 279, 454 |
| Watts, Geoffrey | 63 |
| Webster, Pam | 178 |
| Wesley Homeshare Advisory Committee | 251 |
| Wesley Mission Melbourne | 311 |
| West, Julie | 15 |
| West, Rosemary (Mrs) | 94 |
| Western Australian Government | 412 |
| Western District Health Service | 396 |
| Williams, G, James, M, Buckby, B and Simpkins, W | 5, 27 |
| Willoughby City Council | 50 |
| Wilson, Jill (Prof), Wright, Olivia (Dr), Ward, Liz (Prof), Capra Sandra (Prof) and Petersen, Maree (Dr) | 370 |
| Wilson, Robert | 185 |
| Winterton, Peter (Dr) | 41 |
| Wintringham | 195 |
| Woodville Nursing Home Pty Ltd | 298 |
| Wortley, Jean | 470 |
| Wyanga Aboriginal Aged Care Program Inc | 456 |
| Wynne, J Michael MB. ChB, FRCS, FRACS, Grad Cert Ed (UQ) | 368 |
| Yates, Mark (Assoc Prof ) FRACP | 74 |

Table A.2 **Consultations**

| *Interested parties* |
|---|
| ***Australian Capital Territory*** |
| Aged and Community Services Australia |
| Aged Care and Rehabilitation Service, ACT Health |
| Aged Care Standards and Accreditation Agency |
| Alzheimer's Australia |

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## Table A.2 **Consultations**

*Interested parties*

Ambassador for Ageing (Noeleen Brown)
ANZ Bank
Australian Medical Association (AMA)
Australian National Audit Office
Australia's Chief Commonwealth Nurse (Rosemary Bryant)
AVEO Live Well
BCS Community Aged Care Services
Board of the Aged Care Association of Australia
Carers Australia
Catholic Health Australia
Council on the Ageing (COTA)
Department of Families, Housing, Community Services and Indigenous Affairs
Department of Finance and Deregulation
Department of Health and Ageing
Department of Prime Minister and Cabinet
Department of the Treasury
Department of Veterans' Affairs
Ginninderra Gardens
Goodwin
Grant Thornton
Health Workforce Australia
Illawarra Retirement Trust
L.E.K. Consulting
Medibank Private
Morshead Home
National Aged Care Alliance
National Australia Bank
National Rural Health Alliance
Nelson Partners
Office of the Aged Care Commissioner
Realise Performance
Retirement Village Association Australia
Royal College of Nursing Australia
St George Bank
Uniting Care Aged Care Victoria
Uniting Care Australia

***New South Wales***

Aged Care Action Group
Alkira Gunnedah
Anglicare Retirement Villages
Armidale Home Nursing Group
Aspley Reiv
Aspley Riverview Walcha (PAC)

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## Table A.2 **Consultations**

*Interested parties*

Australian Social Policy Association – Benevolent Society
Autumn Lodge Armidale
Caravan and Camping Industry Association
Charles Chambers Court, Surry Hills
College of Nursing
Frontier Services (National Office)
Guild Accountants
Hunter New England and Area Health Service
Illawarra Retirement Trust
Liquor, Hospitality and Miscellaneous Union (LHMU)
Magnolia Manor Aged Care, Kanwal
Maroba Aged Care, Newcastle
McLean Village, Inverell
McMaugh Gardens, Uralla
Merton Court, Denman
Mission Australia
NSW Health
Nurses in Management – Aged Care, New England
Quality Aged Care Action Group
Quirindi Retirement Homes Ltd, Quirindi
Realise Performance
Residential Gardens for the Spanish Speaking Frail Aged, Rooty Hill
Richardson House, Barraba
Sir Moses Montefiore Jewish Home, Randwick
St Andrews, Ballina
Stewart Brown Business Solutions
Stockland Group
Summit Care
The Aged-care Rights Service (TARS)
The Benevolent Society
Thompson Health Care
Touriandi Lodge, Bingara
Uniting Care Ageing
Waverley Aged Care Assessment Team

***Northern Territory***

Aboriginal Health Registration Board
Department of Health and Families
Frontier Services (The Juninga Centre/Rocky Ridge/Kalano/Katherine Hostel)

***Queensland***

Aged Care Queensland
Blue Care, Toowong
Carers Queensland
Hillview House, Merrimac
Queensland Nurses Union

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## Table A.2 **Consultations**

*Interested parties*

***South Australia***

ACH Group
Aged Care Association of South Australia
Anglicare
Department of Premier and Cabinet
Department of Health
Office for the Ageing, Department for Families and Communities
Padman Health Care, Norwood

***Tasmania***

Aged and Community Services Tasmania
Department of Health and Human Services
Huon Eldercare, Franklin
The Gardens, Claremont

***Victoria***

Aged and Community Care Victoria (ACCV)
Aged Care Association of Australia and Deloitte
AlfredHealth
Anna Howe (Consulting Gerentologist)
Australian Nursing Federation
Bayview Waters Supported Residential Service, Frankston
Benetas
Bendigo Health
Brotherhood of St Laurence
Caulfield General Medical Centre
- Sub-acute Ambulatory Care Services
- Hospital Admission Risk Program
- Aged Persons Mental Health Service
- Caulfield Community Health Service
- Residential Care Services
- Aged Care Assessment Services

City of Greater Dandenong
Clark Phillips Consultants
Council of the Ageing (COTA)
Department of Health
Department of Health, Loddon Mallee Region
Fermont Lodge Supported Residential Service, Noble Park
Healthscope
Maryborough District Health Service
National Aged Care Alliance
Public Sector Residential Aged Care Leadership Committee
Regis Group
Regis Waverley Gardens, Dandenong North

(Continued on next page)

## Table A.2 **Consultations**

| *Interested parties* |
|---|
| Retirement Village Association and Deloittes' Senior Living Group |
| Rural Health Workforce Australia |
| Tender Loving Aged Care, Heidelburg |
| The Bethanie Group |
| Village Baxter, Frankston |
| West Wimmera Health Services |
| Wintringham |
| ***Western Australia*** |
| Aegis Aged Care Group |
| Aged and Community Services of Western Australia |
| Aged Care Association Australia (WA) |
| Alzheimers Australia WA Ltd |
| Department of Health |
| Department of Premier and Cabinet |
| GLBTI Retirement Association Inc. (GRAI) |
| Perth Home Care Services |
| Silver Chain |
| The Bethanie Group |
| Western Australian Centre for Health and Ageing (WACHA) |
| ***Overseas*** |
| Organisation for Economic Cooperation and Development (OECD), Paris |

## Table A.3 **Attendees at workshops**

| *Participant* |
|---|
| ***Financing and Funding — Canberra (31 August)*** |
| Access Economics |
| Aged & Community Services Australia (ACSA) |
| Aged Care Association Australia (ACAA) |
| Andrew Podger, Centre for Policy Development |
| Anna Howe, Consultant Gerontologist |
| Bruce Chapman, Crawford School of Economics & Government, Australian National University |
| Cam Ansell, Grant Thorton Australia |
| Henry Ergas, Consultant |
| Jim Toohey, Consultant |
| Laurel Hixon, Centre for Health Services Management, University of Technology, Sydney |
| Michael Porter, Committee for Economic Development (CEDA) |
| Simon Kelly, KELLYresearch |
| ***Workforce — Sydney (3 September)*** |
| Aged & Community Services Australia |
| Aged Care Association Australia |

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Table A.3 **(continued)**

| *Participant* |
|---|
| Australian Nursing Federation |
| Bupa Australia |
| College of Nursing |
| DutchCare Ltd |
| Frontier Services |
| Hammond Care |
| Liquor, Hospitality & Miscellaneous Union |
| National Rural Health Alliance |
| Palliative Care Australia |
| Royal College of Nursing Association |
| ***Care needs and the provision of care — Canberra (15 September)*** |
| ACH Group |
| Alzheimer's Australia |
| Anglican Retirement Villages |
| Anna Howe, Consultant Gerontologist |
| Catholic Health Australia |
| Council on the Ageing (COTA) Australia |
| Federation of Ethnic Communities' Councils of Australia |
| Gill Lewin, Centre for Research on Ageing, Curtin University of Technology |
| Hal Kendig, Ageing, Work, and Health Research Unit, University of Sydney |
| Henry Brodaty, Professor of Age Care Mental Health, University of New South Wales |
| National Seniors Australia |
| Palliative Care Australia |
| Rhonda Nay, Australian Centre for Evidence Based Aged Care, LaTrobe University |
| St Ives Group |
| The Benevolent Society |
| The Whiddon Group |
| ***Accommodation — Canberra (29 September)*** |
| Andrew Jones, Queensland Housing and Urban Research Institute (AHURI), University of Queensland |
| Australian Unity Retirement Living |
| Caravan and Camping Industry Association |
| Catherine Bridge, CityFutures Research Centre, University of New South Wales |
| Community Housing Federation of Australia |
| Council on the Ageing |
| ECH Inc |
| Hal Kendig, Ageing, Work, and Health Research Unit, University of Sydney |
| National Seniors Australia |
| Office of Housing, Department of Families, Housing, Community Services and Indigenous Affairs |
| Robert Stimson, Institute for Social Science Research, University of Queensland |
| Retirement Village Association |
| The Benevolent Society |

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Table A.3 **(continued)**

| *Participant* |
| --- |
| ***Technology — Melbourne (13 October)*** |
| Aged Care Association Australia |
| Aged & Community Services Australia |
| Australian Academy of Technological Sciences and Engineering |
| Department of Broadband, Communications and Digital Economy |
| iCare |
| Independent Living Centre |
| LeeCare |
| Medical Technology Association of Australia |
| Royal District Nursing Society (South Australia) |
| Samarinda |
| Silverchain |
| Simavita |
| Tunstall Healthcare |

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