Australian Government
Productivity Commission

Caring for Older Australians

Productivity Commission
Issues Paper

May 2010

The Commission has released this issues paper to assist individuals and organisations to prepare submissions to the inquiry. It contains and outlines:

- the scope of the inquiry
- the Commission's procedures
- matters about which the Commission is seeking comment and information, and
- how to make a submission.

Participants should not feel that they are restricted to comment only on matters raised in the issues paper. The Commission wishes to receive information and comment on issues which participants consider relevant to the inquiry's terms of reference.

Key inquiry dates

Receipt of terms of reference	27 April 2010
Due date for initial submissions	30 July 2010
Release of draft report	December 2010
Draft report submissions due	February 2011
Final report to Government	April 2011

Submissions can be made:

By email:	agedcare@pc.gov.au	By fax:	02 6240 3311
By post:	Caring for Older Australians Productivity Commission PO Box 1428 Canberra City ACT 2601		

Contacts

Administrative matters:	Jill Irvine	Ph: 02 6240 3223
Other matters:	Stewart Plain	Ph: 02 6240 3219
Freecall number for regional areas:	1800 020 083	

Website **www.pc.gov.au**

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

Contents

1. What has the Commission being asked to do?

Background to the inquiry

Australia's population is ageing and, on average, we are living longer. This means many more older Australians. The Australian Government's third intergenerational report projects that, over the next 40 years, the number of Australians aged 85 and over will more than quadruple — from around 400 000 in 2010 to 1.8 million by 2050 (Treasury 2010).

More older Australians will mean a significant increase in both demand for aged care services and spending on aged care. Using the current targets for the provision of aged care, the National Health and Hospitals Reform Commission (NHHRC 2009) forecasts that the number of aged care places will need to at least double by 2030 to meet projected demand. Australian Government spending on aged care is projected to increase from 0.8 per cent to 1.8 per cent of GDP by 2049-50 (Treasury 2010).

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)
- growing and substantial affluence among some older Australians
- increased diversity among older Australians in preferences and expectations (including rising preferences for independent living arrangements)
- improvements in care technologies.

As the Commission's *Trends in Aged Care Services* report said:

> A sizeable increase in the required *quantum* of services is not the only challenge in providing aged care services. Over the next few decades, older Australians are expected to become more diverse in terms of their care needs, preferences, incomes and wealth. This will have important implications for the *qualitative* aspects of aged care services (such as the range of services needed and the flexibility of service delivery) and the cost of these services. (PC 2008, p. XVII)

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

In light of the above challenges, questions have been raised about the financial sustainability of the aged care system and its ability to supply an adequately trained workforce and to respond to changing patterns of service demand.

Although the system has continued to evolve, problems with the current aged care system and the need for significant reform to meet future challenges have 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)
- the Hogan 2004 *Review of Pricing Arrangements in Residential Aged Care* (box 1).

The aged care system is also being reviewed as part of a broader reappraisal of social policy systems and funding design, including the recently announced Productivity Commission inquiry into disability care and support (PC 2010). Material related to that inquiry, including its terms of reference, can be found on the Commission website at www.pc.gov.au/projects/inquiry/disability-support.

The Commission's task

Against this backdrop, the Australian Government has asked the Commission to develop detailed options for restructuring Australia's aged care system to ensure it can meet the challenges facing it in coming decades. Specifically, the Commission has been 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 set out in attachment A.

How can you contribute to the inquiry?

This issues paper is intended to provide background material on the current aged care system and to guide contributions in the areas the Commission has been asked to examine. However, the Commission strongly encourages submissions on any other issues considered relevant. Submissions may incorporate material made available to other reviews or inquiries that are relevant to this inquiry.

Attachment B provides further information on how to make a submission. Submissions are welcome in a variety of forms, including formal documents and via less formal means, such as brief emails. The Commission is particularly interested in receiving submissions from older Australians and their families, other carers, providers, the aged care workforce and volunteers about their experiences with aged care services and their ideas on how the system could be improved.

The Commission's approach

The inquiry's reference is comprehensive in its scope and coverage. It addresses the full spectrum of care needs of older Australians and delivery of that care in community settings (including retirement villages) and residential accommodation.

Box 1 **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. (SSCFPA 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. (PC 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. (2004, p. 2)

The aged care system sits within a broader human service framework. There are important interfaces between it and other social policy areas, such as primary health, hospital 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. For example, changes in the availability and nature of care and rehabilitation in hospitals can affect demand for community and residential aged care. Accordingly, the Commission will take a system-wide perspective. It will look at the needs of older people in an holistic way, including at the interfaces of related policy areas.

In preparing its report, the Commission will conduct its own analysis, drawing heavily on input from participants through consultations, roundtables, written submissions and public hearings. The Commission will also draw on past reviews to avoid replicating research that remains current.

In keeping with its legislation, the Commission will seek to identify the set of arrangements that would give the best outcomes for the community as a whole. The interests of older people, their families and carers, and providers and workers in the aged care sector will be key considerations. However, the Commission will also take into account wider effects, including those on other social policy areas and taxpayers.

Are there findings or recommendations from previous reviews of aged care in Australia that remain relevant? If so, of those that have not been acted on, which ones are most important? The Commission also invites advice on any international reviews and policy approaches that may be relevant to this inquiry.

To facilitate soundly-based assessments and reform options, input from the various stakeholders is invited. The subsequent sections of this paper outline some specific matters on which such input would be particularly helpful. Consistent with the terms of reference, the Commission will focus on the following key areas:

- the service delivery framework
- funding and regulatory arrangements
- government roles and responsibilities
- workforce requirements
- reform options and transitional arrangements.

2. The current system

Aged care covers a range of services provided to older people who have diminished capacity to care for themselves because of physical/mental disability or frailty. They can include one or more of the following:

- assistance with everyday living activities — such as cleaning, laundry, shopping, meals and social participation
- help with personal care — such as help with dressing, eating and toileting
- health care — such as medical, nursing, physiotherapy, dietetics and dentistry
- accommodation.

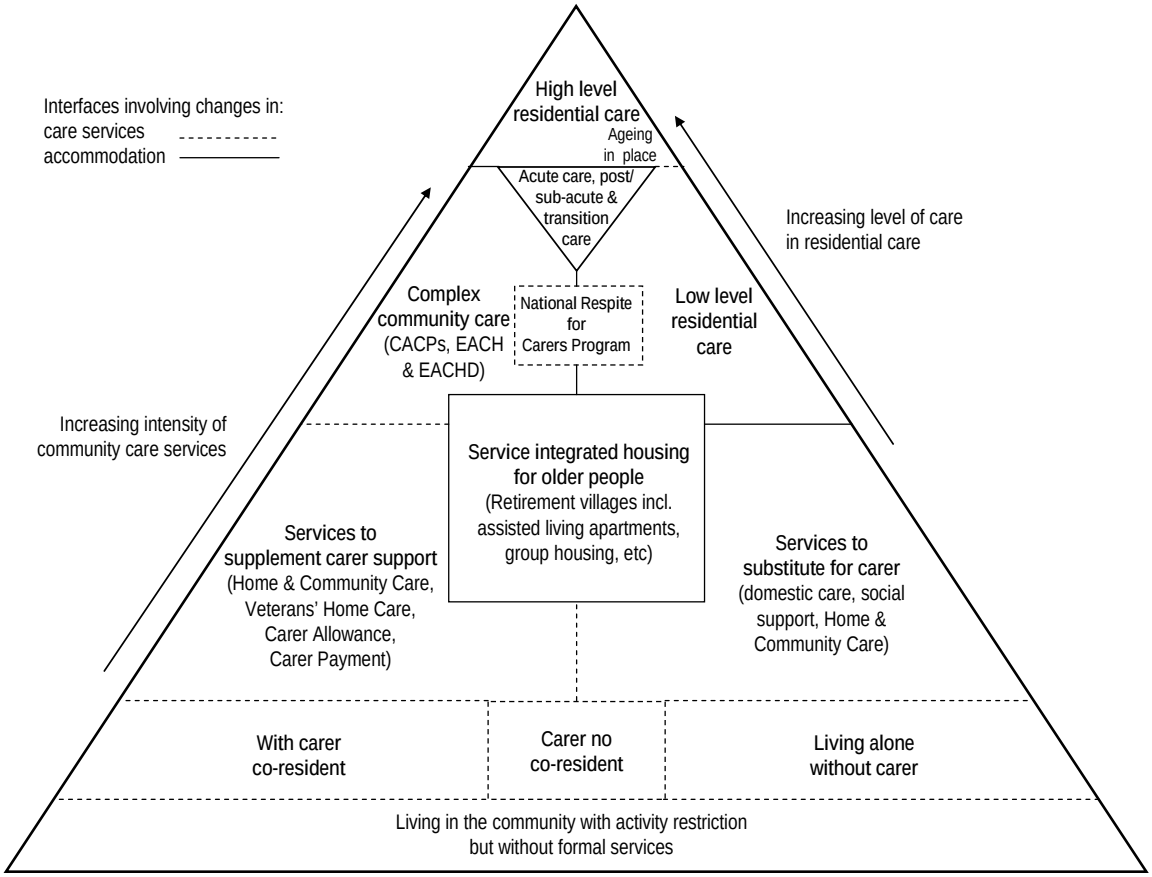
The intensity and type of aged care services required to meet the needs of older people increase with frailty and aged-related illnesses. Around 54 per cent of Australians aged 70 years and over report needing assistance with personal and everyday activities compared with 85 per cent of those aged 85 years and over (ABS 2004). The aged care service continuum is summarised in figure 1. The closer the service is to the top of the triangle, the greater the level of care required and the more resource intensive the service tends to be.

Most of the care provided to older people by partners, family, friends and neighbours is unpaid. Of those older Australians receiving assistance in community settings, 83 per cent received assistance from these informal carers in 2003. Most informal assistance is for communication, paperwork, mobility, cognitive or emotional tasks and transport (ABS 2004). Informal care also plays an important role in coordinating and facilitating care provided by formal care providers.

Around 900 000 older Australians currently receive government-subsidised aged care services (DoHA 2009). Government-subsidised aged care services are provided in the community and in purpose built residential care facilities. Care provided in the community is aimed at enabling the frail aged and those with disabilities to remain in their own homes or in assisted living arrangements. Residential care is available for those older people whose physical, medical, psychological or social care needs can no longer be practically met in the community.

The funding and regulation of aged care services are predominantly the role of the Australian Government (although all three levels of government are involved). The *Aged Care Act 1997* (the Act), together with the accompanying *Aged Care Principles*, are the main regulatory instruments establishing the aged care framework. Key provisions covered include service planning, user rights, eligibility for care, quality assurance and accountability (section 5).

Figure 1 **Modes of care in the aged care system**



Source: Howe (1996), revised with advice from Howe, A., Consultant Gerontologist, Melbourne, pers. comm., 18 May 2010.

The needs-based planning framework is a key feature of the current aged care system. It aims to ensure supply of community and residential care places by matching the number of new aged care places with growth in the aged population. The Australian Government signals its long-run intentions through a target provision ratio which provides guidance to investment by the private sector. 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 (box 2).

Aged Care Assessment Teams (ACATs), or Aged Care Assessment Services in Victoria, determine eligibility for subsidised community and residential care under the Act. ACATs generally comprise, or have access to, a range of health professionals, including geriatricians, physicians, registered nurses, social workers, physiotherapists, occupational therapists and psychologists. Their role is to assess the care needs of older people and to work closely with the client, their carer and family to identify the most suitable aged care services available.

Box 2 Needs-based planning arrangements

Each year since 1985, the Australian Government has made available new residential and community care places for allocation in each state and territory. Initially the planning arrangements sought to provide 100 aged care places for every 1000 people aged 70 years or over. Since 2004-05 provision has been expanded and is scheduled to reach 113 aged care places for every 1000 people aged 70 years or over by June 2011. In recognition of poorer health among Indigenous communities, planning also takes account of the Indigenous population aged 50–69 years.

Initially all 100 places were residential places but over the last twenty years there has been greater emphasis on community care and a re-balancing from low level residential care to high level residential care. Under the current arrangements 25 out of every 113 places are community care places (21 CACPs and 4 EACH), 44 places are for residential low care and 44 are for residential high care.

Operational aged care provision ratios differ from these planning ratios, largely because of the policy of 'ageing in place' (which allows a resident who enters a place for low care to remain in that place if and when he/she comes to need high care).

The Government has to balance the provision of services between metropolitan, regional, rural and remote areas, as well as between people needing differing levels of care. The Secretary of the Department of Health and Ageing, acting on the advice of the Aged Care Planning Advisory Committees, allocates places to each Aged Care Planning Region within each state and territory.

Following the allocations of new places to regions within each state and territory, the Government conducts an open tender to allocate these places to approved providers that demonstrate they can best meet the aged care needs within a particular planning region. Because of the time required for building approval and construction, providers have two years to make residential places operational. Community care packages tend to become operational sooner after allocation.

For each aged care planning region, the Government expects service providers to meet regional targets for supported and concessional residents, based on socio-economic indicators. The lowest regional target ratio is 16 per cent and the highest is 40 per cent. These targets aim to ensure residents who cannot afford to pay for accommodation have equal access to care.

At the same time, some aged homes may be approved to offer 'extra service' to recipients of residential care. However, approval of 'extra service' status must not be granted if it would result in an unreasonable reduction of access for supported, concessional or assisted care recipients. Not more than 15 per cent of places in each state or territory may be approved to be offered as 'extra service'.

Source: SCRGSP (2010).

Community care

Aged care in Australia is predominantly community based. Most older Australians receiving aged care services do so in their own home or in accommodation for the retired or aged (including retirement villages) and most receive low intensity levels of support in the community through the Home and Community Care (HACC) program. In 2008-09, nearly 600 000 older people (those aged 70 years or older) received HACC services — around 70 per cent of the people receiving care under the program.

HACC is jointly funded by the Australian, state and territory governments under the *Home and Community Care Act 1985*, but managed by the states and territories. Fixed budgets (specifying the types of services to be delivered) are allocated to providers that assess and prioritise people presenting for services. There were around 3300 HACC agencies at June 2009. HACC providers range from large organisations that deliver multiple services over a wide area to local community groups that might supply only one service (such as meals on wheels). Some providers contribute additional resources to the cost of providing services (that is, above government subsidies and user contributions), including funds and volunteer labour (DoHA 2008).

The Department of Veterans' Affairs (DVA) also assists a significant proportion of older people through its Veterans' Home Care (VHC) and Community Nursing programs. These programs offer a range of services similar to those available through HACC. In 2008-09, 76 500 older veterans aged 70 years or over received VHC and 31 300 received Community Nursing.

The Australian Government funds three packaged care programs — Community Aged Care Package (CACPs), Extended Aged Care at Home (EACH) and EACH Dementia (EACH-D). These packaged care programs are designed for older people who are eligible for residential care but who prefer to remain in the community and are capable of doing so (usually with the support of family or other carers, box 3).

CACPs typically provide around five to six hours of direct assistance per week to those who would otherwise be eligible to receive at least low level residential care. The EACH and EACH-D packages are individually planned and coordinated for people with complex care needs requiring higher levels of care. EACH packages typically provide around 15 to 20 hours of assistance (SCRGSP 2010).

At June 2009, around 39 300 people aged 70 years and over received packaged community care and support at home — 34 100 (CACP), 3500 (EACH) and 1700 (EACH-D).

Box 3 **Aged care services — main types and level of care**

Community care

Home and Community Care (HACC) provides services such as domestic assistance, personal care, professional allied health care and home modification, to allow people to live independently in their own homes and to reduce the potential or inappropriate need for admission to residential care.

Community Aged Care Packages (CACPs) are designed to support frail older people with significant care needs in their own homes. The care provided is roughly equivalent to low level residential care.

Extended Aged Care at Home (EACH) and *Extended Aged Care at Home Dementia* (EACH-D) packages provide higher levels of care, including nursing care, to people in their own homes. EACH-D packages are designed specifically for people who experience behaviours of concern and psychological symptoms associated with dementia.

Residential care

Low care includes personal care services — for example, assistance with the activities of daily living such as bathing, toileting, eating, dressing, mobility, managing incontinence, community rehabilitation support, assistance in obtaining health and therapy services and support for people with cognitive impairments.

High care includes personal care services *and* nursing services and equipment — for example, equipment to assist with mobility and the provision of basic pharmaceuticals, therapy services and oxygen.

Residential care also includes accommodation services (including the provision and maintenance of buildings, grounds, heating and cooling, and furnishings) and hotel-type services (such as food, cleaning and linen).

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

Flexible care

Transition Care provides 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 between the Australian Government and the states and territories.

Multi-Purpose Services (MPS) integrates health and aged care services that are individually tailored for rural and remote communities depending on their geography, population and care needs. Each MPS is financed by a flexible funding pool, with contributions from the Australian Government and the states and territories.

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.

Source: DoHA (2009).

In recognition of the demands placed on informal carers, governments also provide support through respite services (both in home and through residential care), as well as through carer specific payments and allowances. In 2008-09, almost 42 000 people received short-term respite care in aged care homes, equivalent to around 1.27 million respite days. The National Respite for Carers Program, which complements support provided to carers through residential respite care, provided assistance to around 127 500 carers, or approximately 4.7 million hours of respite in 2008-09 (DoHA 2009).

Residential care

There are two main classes of residential care — low level care and high level care (box 3). Low level care covers the provision of accommodation and related everyday living services, as well as some personal care services. High level care covers additional services including nursing care, palliative care and other complex care arrangements. The Aged Care Funding Instrument (ACFI) is used to allocate funding in residential care according to a person's assessed level of personal and health care needs.

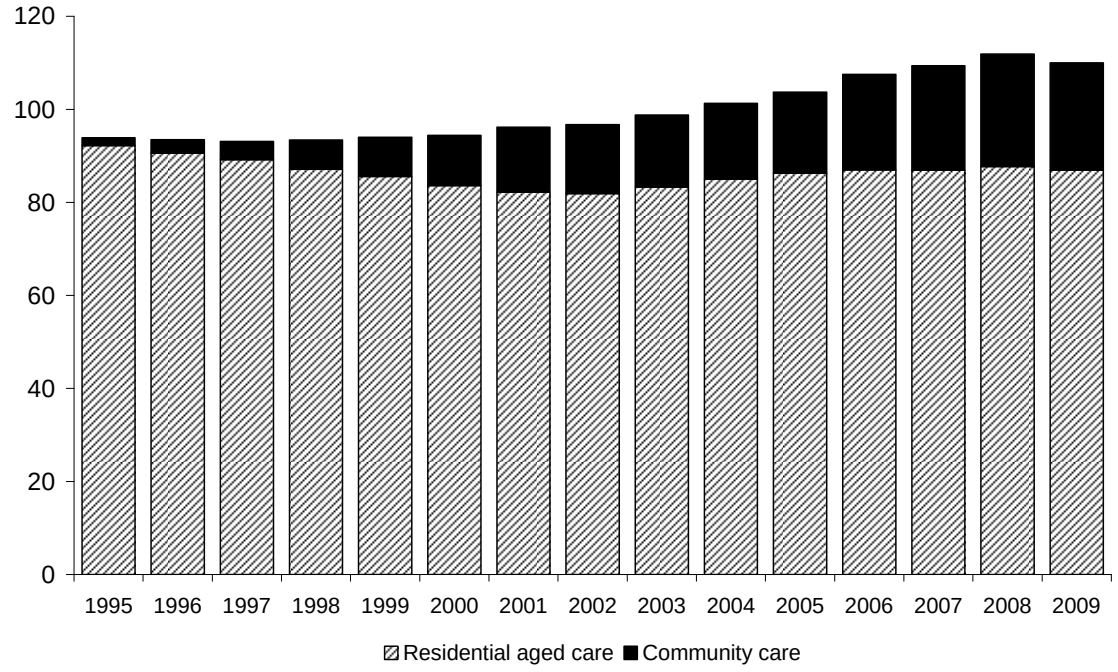
At June 2009, permanent residential aged care was provided to around 147 000 people aged 70 years or over (DoHA 2009). Of these, the majority received high level care (76 per cent under ACFI), were aged 85 years or over (59 per cent) and were women (73 per cent). The share of permanent residents receiving high level care has increased significantly over the last decade — it was around 58 per cent in 1998 (AIHW 2008).

There were 2783 aged care homes across Australia providing residential care at June 2009. The not-for-profit group (comprising religious, charitable and community-based providers) accounted for almost 60 per cent of residential places and the commercial providers around 34 per cent. The balance (6 per cent) were government operated facilities. Around 65 per cent of all residential facilities offer fewer than 60 places while around 10 per cent offer more than 100 places. Over the last decade or so, the number of smaller residential facilities has declined — the share of facilities with 40 or fewer beds has decreased from 53 per cent to 34 per cent between 1998 and 2007 (AIHW 2008).

The desire of most aged people is to receive assistance in their own home when possible (be it the family home or in a retirement village). Because of this, and shifts in government policy (box 2), there has been a trend away from residential care towards community care. In 1995, community care places (CACPs, EACH, EACH-D and transitional care places) made up less than 2 per cent of all aged care

places. By June 2009, this had increased to around 22 per cent. An important part of this growth was the expansion of funding to support flexible care places (figure 2).

Figure 2 **Operational aged care places and packages**
Places and packages per 1000 people aged 70 year or older[a]



[a] Community care includes CACP, EACH and EACH Dementia packages and transition care places. Excludes HACC.

Data sources: AIHW (2008); DoHA (2009).

Flexible care and care for people with special needs

Flexible care is aimed at addressing the needs of care recipients in ways other than the care provided through mainstream residential and community care (box 3). In addition to the EACH programs, flexible care includes transition care places (care for older people after a hospital stay), Multi-Purpose Services (a program that supports the integration of health and aged care services in regional, rural and remote communities) and innovative care (a platform for testing new approaches to providing care).

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

The Australian Government also seeks to balance the provision of services between metropolitan, regional, rural and remote areas, as well as between people needing differing levels of care (box 2). Additional funding and assistance (including through the provision of zero real 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, 1418 residential and 1488 community aged care places were allocated to regional, rural and remote areas. A further 851 residential aged care places and 1425 community care places were allocated to providers directing care to special needs groups including — people from Indigenous communities, people from non-English speaking (culturally and linguistically diverse) backgrounds, people who live in rural or remote areas, people who are financially or socially disadvantaged and veterans (DoHA 2009).

The Commission invites comment and evidence on the main strengths and weaknesses of aged care services — community, residential, flexible and respite care — as they are currently configured.

Are the aged care services that older Australians require available and accessible? Are there gaps that result in a loss of continuity of care? Is there sufficient emphasis within the current system on maintaining a person's independence and on health promotion and rehabilitation? How might any inadequacies in the system be addressed?

How well does the aged care system interface with the wider health and social services sectors? To what extent should the aged care system be treated as a separate arm of government policy to other social policies?

Is the current system equipped, or can it adapt, to meet future challenges?

Should there be greater emphasis on consumer-directed care in the delivery of services, and would this enable more older Australians to exercise their preference to live independently in their own homes for longer with appropriate care and support?

Comments are also invited on the current system (and possible alternative arrangements) for providing services to people with special needs, including those living in rural and remote locations, those with culturally and linguistically diverse backgrounds, Indigenous Australians, veterans, the older homeless, older people with a mental illness, those with a disability, and other special needs groups, such as gays and lesbians.

Retirement villages

Retirement villages are playing an increasingly important role in accommodating older Australians. The Retirement Village Association estimates that there are now around:

- 1850 retirement villages in Australia
- 115 000 dwellings in the villages
- 160 000 residents.

The term 'retirement villages' covers a wide spectrum of independent living options, including various forms of independent living units, assisted living units and some rental accommodation. The quality of the accommodation (and choice of in-houses services) ranges from basic to luxury resort living.

Over the past eight years, the market penetration in the retirement living sector has more than doubled from 2.3 per cent to 5.5 per cent of people aged 65 or over. For those aged 75 or more, the market penetration rate is even higher — around 10 per cent. There is also some evidence that the age of entry to retirement villages is increasing, indicating that people are staying in the family home longer.

In addition, the distinction between retirement villages and residential aged care facilities is, in some respects, becoming less marked. Following the successful piloting of CACP and EACH packages in retirement villages in 2003-04, operators are increasingly competing in aged care approval rounds for new community care places.

The Commission seeks comment on the regulatory and financial issues facing retirement villages. How do retirement specific living options interact within the broader aged care system and what changes are expected in both the number and structure of villages over coming years? Should the regulation of retirement specific living options be aligned more closely with the rest of the aged care system?

Are there any factors that act as a barrier to older Australians entering retirement specific living options (such as opportunities to age in place and departure fees)? And, more generally, is the way the retirement village sector operates compatible with an ageing population, including in regards to quality, clients' expectations and as a platform in which to receive aged care services?

Are there particular models of retirement specific accommodation that are suited to the provision of social housing to meet the needs of low income or disadvantaged older Australians?

3. Objectives of the aged care system

A key starting point in developing options for a restructured aged care system is to specify the objectives for government involvement in the provision of care and support to frail older Australians. 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 … through a safe and secure aged care system. (DoHA 2009, p. xi)

Key themes running through the *Aged Care Act 1997*, the accompanying *Aged Care Principles*, and the *Home and Community Care Act 1985* are the need to:

- guarantee an acceptable standard of care
- provide accountability and transparency
- facilitate access to care regardless of economic and other circumstances
- target services and funding to those with the greatest need
- encourage diverse, flexible, efficient and responsive services that facilitate independence and choice.

A further long-term objective of government is to realise greater integration in the provision of care for older Australians. The National Healthcare Agreement states that:

> Older Australians [should] receive high quality, affordable health and aged care services that are appropriate to their needs and enable choice and seamless, timely transitions within and across sectors. (COAG 2009)

How effective has the aged care system been in addressing these objectives? What changes, if any, should be made to the objectives? What are the implications of such objectives for any redesign of the current system?

Should the objectives have equal weighting or should some have higher weighting, and if so why? Where conflicts might arise, which objectives should be given priority?

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?

4. Who should pay and what should they pay for?

Formal aged care services in Australia are predominately financed by taxpayers with some user co-payments (including contributions from government-funded income support pensions).

In 2008-09, total direct government expenditure on aged care services was around $10.1 billion. Around two-thirds of government expenditure on aged care services was for residential care, with the balance for community care and assessment and information services (table 1). The Australian Government shares the funding responsibility for community care with the states and territories and has primary responsibility for funding residential aged care.

Table 1 **Government expenditure on aged care services, 2008-09**

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

[a] Assessment and information services include only Australian Government expenditure. [b] Residential care services include DoHA and DVA (including payroll tax supplement) and state and territory governments expenditure. [c] Community care services include HACC, CACP, EACH and EACH-D, NRCP, Community care grants, VHC, DVA Community Nursing, Assistance with Care and Housing for the Aged. [d] Services provided in mixed delivery settings 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 (2010).

The HACC program receives the bulk of public subsidies for the provision of community care — around $1.8 billion in 2008-09 (the Australian Government provides 60 per cent of funding and the states and territories 40 per cent, DoHA 2009).[1] State and territory governments develop their own HACC service fee policies and scales. User contributions to HACC services are estimated to be around 5 per cent of the cost of the services (DoHA 2008).

Australian Government spending on CACPs was $480 million and $256 million on EACH and EACH-D packages in 2008-09 (DoHA 2009). On average, user

[1] Recent changes to funding arrangements (COAG 2010) will make the Commonwealth (with the exception of Victoria and Western Australia) the sole funder of HACC services for older people.

contributions account for around 16 per cent of the costs of CACPs and about 5 per cent of the cost of EACH programs (DoHA 2008).

Australian Government funding for residential care, paid to aged care providers for providing care, was $6.5 billion in 2008-09. Around 70 per cent of residential care is provided by the Australian Government subsidy. The annual subsidy per residential place averaged $40 100 in 2008-09 — $48 550 for high care residents and $17 750 for low care residents (DoHA 2009).

Aged care residents who can afford to, contribute to the cost of their care and accommodation. Residents contribute to the cost of residential care via basic daily fees, income tested fees, asset tested accommodation payments, extra service fees and additional services fees (box 4).

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. Providers can deduct monthly amounts, called retention amounts, from the bond for up to five years and derive income from the investment of the bond. The income from accommodation bonds and retention amounts is intended to be used to meet capital costs or retire debt related to residential care, or to improve the quality and range of aged care services. In 2008-09:

- the average accommodation charge for new residents was $19.35 per day
- the average bond agreed with a new resident was $212 958 (DoHA 2009).

Funding trends

Growing demand for aged care services over the last decade has seen a significant increase in funding for the sector. Total aged care funding by governments increased from $4.7 billion in 1995-96 (2008-09 dollars) to the current amount of just over $10.1 billion, an average annual real increase of 6.4 per cent.

The past decade or so has also seen a shift towards greater private funding of aged care services arising from structural reforms of the residential aged care sector in 1997. At this time, accommodation payments and income testing of daily care fees, (which previously only applied to low level care) were introduced for all residential care and residential care providers were permitted to request an accommodation bond from clients entering low care (or making use of extra service high care facilities). Around 71 per cent of aged care homes received income from accommodation charges in 2008-09 and 82 per cent of facilities held accommodation bonds (at June 2009).

Box 4 Residential aged care fees and charges

Residents in Australian Government subsidised residential aged care can be asked to pay fees as a contribution towards accommodation costs, living expenses and the cost of their care. A resident may be charged:

Basic daily fee — all residents in aged care, 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 $37 500 who require high level care may be asked to pay an accommodation charge. The charge increases to a maximum of $26.88 per day for residents with assets of $93 410.40 or greater.

Accommodation bonds — residents with sufficient assets who require low level care 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 $37 500 in assets. The aged care provider can deduct monthly amounts, called retention amounts, 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 $299.00 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 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, the former home and the rental income are exempt for as long as a periodic payment is 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 (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) (ANAO 2009). In real terms, the average bond value increased around 9.5 per cent annually between 1998 and 2008-09.

Key issues

Beyond the adequacy of the current schedule of fees and subsidies, there has been much debate about the efficiency, equity and sustainability of aged care funding arrangements. Particular concerns include:

- the extent to which some elements of residential care (notably accommodation and everyday living expenses) are more heavily subsidised than equivalent care received in the home
- the regulatory restrictions on accommodation bonds for high care residents (providers claim the restrictions have resulted in significant shortages of capital which, in turn, has meant a reluctance to take on new licenses)
- the method for indexing care subsidies within the aged care sector and the extent to which this results in funding falling behind rises in input costs
- the absence of a well-defined benchmark of care against which costs and funding levels can be assessed
- the way in which payments are determined and collected in community care
- the adequacy of funding for care provided in rural and remote settings
- the effectiveness of the provision of 'extra service' and the incentives facing providers and consumers.

More generally, commentators have questioned the appropriateness of requiring current taxpayers to subsidise the costs of caring for older Australians under a 'pay-as-you-go' system, particularly given the projected increase in aged care needs over the next 40 years.

The Commission has been asked to develop funding options that ensure access to services at an appropriate standard of care, deliver diverse and fiscally sustainable care modes and allow smooth transitions between different types and levels of care. There is a wide range of possible reforms in this area, from minor refinements of the current arrangements to large scale departures from them. Many have argued that fundamental changes are needed to address some of the problems with the current funding system and to effectively manage emerging challenges.

Who should pay for aged care services? Are the current government subsidies and user charges for aged care appropriate? Are there components of aged care costs — accommodation, living expenses, personal and health care — that warrant government subsidies and/or should they be the personal responsibility of older Australians? To what extent should means testing be applied?

Under the current system, have differences in user charges for aged care services led to problems or distortions in the demand for services? How appropriate are the current accommodation user charges in residential care (including the regulatory restrictions on accommodation bonds for high care residents)? Do accommodation bonds act as a disincentive to access appropriate care? What has been the effect of allowing payment for extra service? What changes, if any, should be made to user contributions to the cost of accommodation for residential care?

How might the public and private exposure to the financial risks associated with aged care costs be best managed? Should it be a mixed model with a dominant taxpayer funded component (as currently applies), or a system that relies more heavily on consumer contributions underpinned by a financial safety net? This could involve additional or alternative mechanisms such as greater reliance on private savings (including reverse mortgages) or the introduction of private long-term care insurance or a social insurance scheme. If an additional funding mechanism is considered appropriate, should it be for all aged care costs or for particular components of aged care costs?

How important is the provision of choice for older people requiring care? Are there components of aged care which older people value choice more highly than others? Is there any evidence which suggests that the provision of greater choice may have resource implications? Should subsidies that 'follow' approved clients be paid to providers directly or should care consumers be given the choice of receiving such payments first to promote a greater capacity to exercise choice?

What are the critical funding implications and concerns arising at the interface of the aged care system with the disability and hospitals systems?

Are current subsidies sufficient to provide adequate levels of care? What are the minimum benchmark levels of care in each of the service areas and how should they be adjusted over time to meet changing expectations?

What are the most appropriate methods for adjusting public funding, or insurance arrangements, to keep pace with cost increases and changes in any care benchmark, while providing incentives to increase efficiency and productivity?

5. What role for regulation?

Aged care is heavily regulated in Australia. Under the *Aged Care Act 1997*, key areas of regulation include:

- service planning through the allocation of new aged care places
- assessing client eligibility
- funding of services
- setting of prices
- specifying quality of care.

Regulation of residential and community care packages is supplemented by a range of quality assurance and consumer protection measures. These include accreditation of aged care homes by the Aged Care Standards and Accreditation Agency; building certification requirements; a Complaints Investigation Scheme; an Aged Care Commissioner; and prudential regulation in relation to accommodation bonds.

A range of state, territory and local government regulations also affect the delivery of aged care services including regulation of building and planning design, occupational health and safety, fire safety, food and drug preparation and storage, and consumer protection.

Regulation and funding are intertwined within the current system. For example, in order to receive Australian Government subsidised care, four key conditions must be met:

- the recipient must be assessed as eligible by an Aged Care Assessment Team
- the care must be provided by a government approved provider
- care must be provided through a government allocated place
- care must be of a specified quality determined by the accreditation process.

The charges on users and the level of public subsidy are then set according to a complex set of rules.

A number of recent reviews have identified significant shortcomings in the current regulatory regime. The main areas of concern include:

- dual gate keeping mechanisms, restricting both eligibility and supply of funded places
- limited scope for effective competition and innovation by service providers as a result of quantity and price restrictions

- limited opportunities for choice and flexibility for consumers and insufficient information on the quality, location and price of available places
- restrictions on the use of bonds (and other forms of user charges) as a source of funding
- excessive compliance costs associated with some regulations designed to ensure residents' safety
- high compliance costs in relation to financial reporting requirements
- duplication of regulations within and across governments
- excessive regulation of aspects of building certification (PC 2008, 2009; NHHRC 2009).

Importantly, these reviews indicated that, in many areas, there is limited scope for gains from minor changes to the regulatory system, highlighting the need for fundamental changes to secure significant and lasting improvements.

As in many other areas of health and social policy, proposed reforms will need to balance increased flexibility with effective protections for care recipients and fiscal sustainability. The terms of reference for this inquiry specifically require the Commission to examine regulatory options that provide appropriate financial protections and quality assurance for consumers.

Is the current level and scope of regulation and its enforcement appropriate? What impact does the regulation and its enforcement have on older people, their carers (including access to, and quality of, care) and providers (including their business models and size of their operations)?

Are the rights of aged care consumers adequately protected and understood? Are complaint and redress mechanisms accessible, sufficient and appropriate for all parties?

Do current regulatory arrangements act as a disincentive to older Australians wishing to move to more suitable accommodation (such as eligibility for the age pension and the imposition of stamp duty on the sale of property)?

What specific regulatory reforms could address the concerns listed above? How would the reforms improve outcomes for users and providers of aged care services while maintaining appropriate control of quality and safety?

Where multiple regulatory instruments are seen as requiring joint reform, which reforms should take priority? What scope is there to reduce duplicative regulations

(for example, the dual gatekeeping mechanisms imposed by the ACAT assessment and the allocation/planning system)?

Comments are sought on the lessons that can be learnt from aged care reforms and systems internationally and the extent to which that experience is relevant to Australia.

6. Roles of different levels of government

Responsibility for the funding and delivery of aged care services is spread across all three levels of government. This can result in gaps in service, breakdowns in continuity of care across the care spectrum, and disagreements about funding. Specifically, this fragmentation can create incentives for cost shifting and affect the quality of care.

Participants of recent reviews have voiced concerns regarding system shortcomings consequent on shared service delivery responsibilities, including that the system is overly complex, difficult to navigate and fails to offer continuity of care for those with complex needs.

The Commission will take into account the changes in government responsibilities which were announced at COAG in April 2010. However, it also invites comments on further reform options in this area, such as:

- improving coordination (or competition) between the Australian, state and territory governments
- developing a more integrated planning and funding framework at a regional level involving performance contracting and funds pooling
- reallocating responsibilities across the Commonwealth and states and territories in relation to policy development, funding, administration and other aspects of aged care.

There are clear interdependencies between any changes in administrative arrangements and the possible regulatory and funding reforms discussed above.

Will the announced changes in government roles and responsibilities benefit aged care users and improve the administration of the aged care system? Will the changes facilitate greater integration in the delivery of support and care services? In particular, what will be the implications for the administration and delivery of HACC and community care packages? Should common system entry points and assessment be developed, and if so, what are the opportunities and risks?

What issues remain to be addressed? Should there be further reforms to the way in which the system is administered? What are the net benefits that such reforms might deliver?

What are the possible medium and long-term fiscal impacts of such administrative reforms?

Examples and evidence are sought of administrative reforms that have delivered improvements to related areas such as health and disability services in Australia or internationally. Views on the extent to which such reforms may be transferable to the aged care system are welcome.

Comment is sought on issues and potential solutions at the interface of the aged care system with other regulated services systems, including the hospital and disability care systems.

7. A workforce to care for the elderly

Aged care services are delivered by formal paid workers, informal carers and volunteers. Services are also supported by, and are dependent on, doctors, nurses and allied health professionals such as physiotherapists, podiatrists and pharmacists. The formal paid workforce is part of the broader health and community sector workforce.

In 2007, around 175 000 people were employed in residential care, and of these around 133 000 were direct care employees (Martin and King 2008). The direct care workforce is a mix of:

- 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 balance of the residential care workforce is non-direct care staff (such as cooks, cleaners and administrators).

In community care, around 87 500 people were employed in 2007, of whom about 85 per cent were direct care workers (Martin and King 2008). By occupation, the community 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).

Family members and other informal carers are the most significant providers of care to older people. They provide a wide variety of care and everyday living support services and play a fundamental role in the coordination and facilitation of formal community care services. The Commission estimated that there were approximately 2.3 million people providing informal care to the aged in 2006 (PC 2008).

Volunteers provide companionship and entertainment in residential aged care facilities and are integral to the delivery of certain community care programs, such as meals-on-wheels. The number of volunteers, both informal and formal, involved in the provision of support services to the aged is not known, but it is thought to be significant.

Key future workforce challenges include:

- ensuring a sufficiently large, skilled workforce in a market situation where labour intensive activities will face growing pressures, given the anticipated slowdown in workforce growth across the whole economy and increasing labour demand from other service sectors, in particular health
- responding to the increasing demand for formal care services as Australia's population ages and accommodating an expected relative decline in the availability of informal family carers and growing competition for voluntary workers
- upgrading the skills base and training opportunities available to workers to ensure the improved delivery of safe, quality care services to older Australians
- adapting the aged care sector and its workforce to changes in consumer needs and preferences, which seem likely to increase the demand for community based care relative to residential care (PC 2008).

For informal carers and volunteers, the key reform challenges include:

- providing adequate access to information about the support services available to older people and their carers
- improving access to respite and other care services to support informal carers to continue caring
- enabling informal carers to participate in the broader workforce through appropriately structured financial support and workplace flexibility
- providing training and education to ensure that informal carers are able to undertake their caring role in a sustainable and safe manner
- encouraging volunteers to participate in supporting the aged and reducing the regulatory barriers to participation.

In considering workforce reform, productivity and efficiency gains in the sector are also important. There are diverse views on this issue, in particular about the most appropriate output and productivity measures to use and on the size and attainability of possible gains.

What are the key issues concerning the current formal aged care workforce, including remuneration and retention, and the attractiveness of the aged care environment relative to the broader health and community care sector?

Views are sought on reform options to secure a larger, appropriately trained and more flexible formal aged care workforce into the future. In particular, views are sought on the need for and nature of reforms to models of care, scopes of practice, occupational mix, service delivery, remuneration, education, training, workforce planning and regulation.

Are reforms required to more appropriately support informal carers and volunteers?

Are there unexploited productivity and efficiency gains in the aged care sector? Where such unexploited gains are seen to exist, what policy changes are needed to support their realisation? How might technology be used to enhance the care of older Australians? Are there any impediments to technological developments that could ease workforce demand or enable higher levels of support?

8. Transition issues

The terms of reference specifically ask the Commission to identify paths for moving to a new system. The need to maintain continuity of care and to allow adequate time for the sector to adjust are mentioned explicitly, as is the need to account for the Australian Government's medium-term fiscal strategy.

The identification and development of transition paths should take into account:

- the magnitude of proposed reforms and the extent to which they require adjustment in the sector
- the desirability of including arrangements to facilitate adjustment, such as 'grandfathering', phasing and risk mitigating mechanisms as part of any transition path
- the sequencing and timing of changes to existing regulatory and funding settings
- the extent to which a reform cuts across jurisdictions and/or programs, and therefore requires 'buy in' from a range of key players

- the implications of the Australian Government's medium term fiscal strategy for any reform package
- the consistency of reforms with related developments in other sectors, such as health care, disability and housing.

What lessons should the Commission draw from previous reforms of aged care systems (in Australia and overseas) to minimise adjustment costs faced by older Australian and their carers, providers, aged care workers and governments of moving to a new system?

Views are sought on desirable timing and sequencing of transitional arrangements, including any changes to existing regulatory and funding settings, and on alternative or additional mechanisms that may be required to facilitate a smooth adoption of a new aged care system.

References

ABS (Australian Bureau of Statistics) 2004, *Disability, Ageing and Carers: Summary of Findings*, Cat. no. 4430.0, Canberra.

—— 2008, *Australian Historical Population Statistics*, Cat. no. 3105.0.65.001, Canberra.

—— 2009, *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0, Canberra.

AFTS Secretariat 2010, *Australia's future tax system: Report to the Treasurer*, Canberra.

Aged Care Price Review Taskforce 2004, *Review of Pricing Arrangements in Residential Aged Care*, Final Report (Prof. W.P. Hogan, Reviewer), Canberra.

AIHW (Australian Institute of Health and Welfare) 2008, *Residential Aged Care Services in Australia 2006-07: A Statistical Overview*, Cat. no. AGE56, Aged Care Statistics Series no. 26, Canberra.

—— 2009a, *Residential aged care in Australia 2007-08: a statistical overview*. Aged care statistic series 28. Cat. no. AGE 58. Canberra: AIHW.

—— 2009b, *Australia's Welfare 2009*, Australia's welfare series no. 9. Cat. no. AUS 117. Canberra: AIHW.

—— 2009c, *Aged Care Packages in the Community 2007-08*, Aged care statistics series 29, Cat. no. AGE60, Canberra.

ANAO (Australian National Audit Office) 2009, *Protection of Residential Aged Care Accommodation Bonds*, Audit Report No.5 2009–10 Performance Audit.

COAG (Council of Australian Governments) 2009, National Healthcare Agreement, http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/IGA_FFR_ScheduleF_National_Healthcare_Agreement.pdf (accessed 19 May 2010).

—— 2010, *Communiqué*, 20 April.

DoHA (Department of Health and Ageing) 2008, *Submission to the Senate Standing Committee on Finance and Public Administration*, Submission 114.

—— 2009, *Report on the Operation of the Aged Care Act 1997: 1 July 2008 to 30 June 2009*, Canberra.

—— 2010, *Fees and Charges for Residential Aged Care - An Overview*, http://www.health.gov.au/internet/main/publishing.nsf/Content/38A97C5DDFEB223ACA25744000810E58/$File/Info09.pdf (accessed 19 May 2010).

Henry Review. *See* AFTS Secretariat 2010.

Hogan Review. *See* Aged Care Price Review Taskforce 2004.

Howe, A. 1996, 'Changing the balance of care: Australian and New Zealand', p. 231 in OECD 1996, *Caring for Frail Elderly People: Policies in evolution*, Social Policy Studies no. 19.

Martin, W. and King, D. 2008, *Who Cares for Older Australians? A Picture of the Residential and Community Based Aged Care Workforce 2007*, National Institute of Labour Studies for the Department of Health and Ageing, Flinders University, Adelaide.

NHHRC (National Health and Hospitals Reform Commission) 2009, *A Healthier Future for All Australians*, Final Report, June.

PC (Productivity Commission) 2008, *Trends in Aged Care Services: some implications*, Productivity Commission Research Paper, Canberra.

—— 2009, *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services*, Research Report, Canberra.

—— 2010, *Inquiry into Disability Care and Support: Productivity Commission Circular*, 14 April. www.pc.gov.au/__data/assets/pdf_file/0011 /96518/circular-1.pdf (accessed 21 April 2010).

SCRGSP (Steering Committee for the Review of Government Service Provision) 2010, *Report on Government Services 2010*, Productivity Commission, Canberra.

SSCFPA (Senate Standing Committee on Finance and Public Administration) 2009, *Residential and Community Aged Care in Australia*, April.

Treasury 2010, *Intergenerational Report 2010*, Canberra.

Attachment A — Terms of reference

INQUIRY INTO AGED CARE

Productivity Commission Act 1998

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.

Attachment B

HOW TO MAKE A SUBMISSION

This is a public inquiry and the Commission invites interested people and organisations to make a written submission.

Each submission, except for any information supplied in confidence (see below), will be published on the Commission's website shortly after receipt, and will remain there indefinitely as a public document. Copyright in submissions sent to the Commission resides with the author(s), not with the Commission.

How to prepare a submission

Submissions may range from a short letter outlining your views on a particular topic to a much more substantial document covering a range of issues. Where possible, you should provide evidence, such as relevant data and documentation, to support your views.

This is a public review and all submissions should be provided as public documents that can be placed on the Commission's website for others to read and comment on. However, under certain circumstances the Commission can accept sensitive material in confidence, for example, if it was of a personal or commercial nature, and publishing the material would be potentially damaging. You are encouraged to contact the Commission for further information and advice before submitting such material. Material supplied in confidence on personal or commercial grounds should be provided under separate cover and clearly marked 'PERSONAL IN CONFIDENCE' or 'COMMERCIAL IN CONFIDENCE' accordingly.

How to submit a submission

Each submission should be accompanied by a submission cover sheet. The submission cover sheet is available on the inquiry webpage. For submissions received from individuals, all personal details (for example, home and email address, phone and fax number) will be removed before it is published on the website for privacy reasons.

The Commission prefers to receive submissions as a Word (.doc) file attachment to an email (see address below). PDF files are acceptable. To ensure your PDF is as electronically readable as possible, the Commission recommends that it is derived

from word processing software (eg Microsoft Word or Lotus notes) and not from a scanner, fax or photocopying machine.

Track changes, editing marks, hidden text and internal links should be removed from submissions before sending to the Commission. To ensure hyperlinks work in your submission, the Commission recommends that you type the full web address (for example, www.referred-website.com/folder/file-name.html).

Submissions can also be accepted by fax or post (see address below).

By email*: agedcare@pc.gov.au

By fax: 02 6240 3311
By post: Caring for Older Australians
Productivity Commission
PO Box 1428
Canberra City ACT 2601

* If you do not receive notification of receipt of an email message you have sent to the Commission within two working days of sending, please contact the Administrative Officer.

Due date for submissions

Please send submissions to the Commission by 30 July 2010.