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Caring places: planning for aged care and dementia 2010-2050

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Glossary

ACAP	Aged Care Assessment Program
ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Instrument
ACP	Attendant Care Program
ACPR	Aged Care Planning Region
AD	Alzheimer's disease
AE-DEM	Access Economics' demographic model
AIHW	Australian Institute of Health and Welfare
CACP	Community Aged Care Packages
CALD	culturally and linguistically diverse
CAP	Conditional Adjustment Payment
CDC	Consumer Directed Care
COAG	Council of Australian Governments
COPO	Commonwealth Own Purpose Outlay
DLB	Dementia with lewy bodies
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
FTD	fronto-temporal (lobe) dementia
GDP	gross domestic product
HACC	Home and Community Care
HASA	Health and Ageing Savings Accounts
LTCI	Long term care insurance
NHHN	National Health and Hospitals Network
NHHRC	National Health and Hospital Reform Commission
NRCP	National Respite for Carers Program
PC	Productivity Commission
SCFPA	Standing Committee on Finance and Public Administration
SDAC	Survey of Disability and Aged Care
VaD	Vascular dementia
VHC	Veterans Home Care

Executive Summary

One consequence of an ageing Australian population is the need for an aged care system that can respond to the needs of the older person, their families and carers. However, the current aged care system needs fundamental reform if the supply of community and residential care are to keep pace with the projected demand for care, while at the same time providing increased choice.

Alzheimer's Australia commissioned Access Economics to model different scenarios for the supply of aged care, to identify strategies to increase consumer choice and to promote service flexibility, and to identify funding options for a sustainable aged care system into the future.

Projected supply of aged care services

With the ageing of the Australian population an increasing number of people will require community and residential aged care services. A key driver of this increase in demand will be the increased prevalence of dementia, and the associated need for high levels of support and care. The prevalence of dementia is estimated to increase from around 257,000 people in 2010 to just over 981,000 people in 2050.[1] The growth rate is expected to peak between 2021 and 2030 as the baby boomers age. This will see a greater proportion of the total population with dementia, increasing from around 1.2% in 2010 to 2.8% in 2050.

Current policy plans for an increased supply of aged care services are based on growth in the population aged 70 years and over (DoHA, 2009c). Modelling in this study projected that between 2010 and 2050, current policy would increase the supply of:

- community aged care packages – from 54,325 to 158,276;
- operational residential aged care places – from 181,204 to 511,068; and
- home and community care (HACC) clients - from around 966,710 in 2010 to 2.7 million.

These increases may seem substantial. However, current policy will result in an undersupply of places in the future when compared to alternative aged care supply growth scenarios. These include:

- Growth in the population aged 85 years and over (as recommended by the National Health and Hospitals Reform Commission (NHHRC, 2009)). Compared to current policy, by 2050 this scenario would result in an additional:
  - 65,965 community aged care packages;
  - 213,000 operational residential aged care places; and
  - 1.2 million HACC clients.
- Projected growth in dementia prevalence. Compared to current policy, by 2050 this scenario would result in an additional:

[1] In 2009 Access Economics projected dementia prevalence to around 1.1 million Australians by 2050 (Access Economics, 2009a). Recently, the ABS made changes to population parameters, revising mortality upwards and lowering annual migration figures. This suggests dementia prevalence will be less than previously estimated in 2009. As such, dementia prevalence projections in this study are based on revised ABS population parameters and population projections undertaken using Access Economics' in-house demographic model.

- 53,759 community aged care packages;
- 173,585 operational residential care places; and
- 987,520 HACC clients.

A comparison of projected aged care supply across all three growth scenarios is presented in Table i. Dependant on the planning scenario, differences in aged care supply will result. These are summarised below.

- Planning aged care supply based on the growth rate of the population aged 85 years and over will generate similar supply as the current policy within the next decade, due to similar average growth rates between those aged 70 years and over and those aged 85 years and over.[2]
- Planning aged care supply using dementia growth will result in a greater supply between 2020 to 2030 than planning based on either the population growth of people aged 85 years and over, or the current policy. This additional growth is due to dementia prevalence being driven by the baby boomer bubble ageing.
- Aged care supply is projected to be greatest in 2050 using growth in the population aged 85 years and over.

Unmet need in current aged care supply

There is evidence to suggest a gap exists between supply and demand for aged care, in both community and residential settings. For example, the Survey of Disability Ageing and Carers (SDAC) found 678,800 people requiring assistance either had their needs partly met, or not met at all (ABS, 2004).

For modelling purposes, this level of unmet need in aged care was assumed to be 18.1%.[3] A final scenario therefore projected aged care supply based on the growth rate of dementia prevalence and assuming that current services would first be expanded to cater for the estimated unmet need. Compared to the current policy, by 2050 this scenario would result in an additional:

- 92,137 community care packages;
- 297,508 residential care places; and
- 1.7 million HACC clients.

[2] Even though the average growth rate is expected to be similar, annual growth between these two aged cohorts are projected to be different throughout the next 10 years. Growth in the population aged 70 years and over does not start to pick up until 2015, whereas growth in the population aged 85 years and over is projected to be strong in the first half of this decade but then slow down in the latter half.

[3] Part of the SDAC measured the extent to which needs are met across various activities. It found 18.1% of people requiring assistance either had their needs partly met (11.3%), or not met at all (6.8%) (ABS, 2004).

Table i: Comparison of aged care supply across three growth scenarios

	Current policy				Dementia prevalence			Population 85 years and older		
	2010	2020	2030	2050	2020	2030	2050	2020	2030	2050
	000's	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*
HACC clients	966.7	1,380.4	1,892.4	2,709.5	1,448.1	2,129.1	3,697.0	1,384.2	1,997.9	3,936.2
Community care packages	54.4	80.6	110.5	158.3	83.1	122.1	212.0	78.9	113.8	224.2
Residential care places	181.2	260.4	357.0	511.1	268.2	394.3	684.7	254.6	367.5	724.1
Total	1,202.3	1,721.4	2,359.9	3,378.9	1,799.4	2,645.5	4,593.7	1,717.7	2,479.0	4,884.5

Source: Access Economics calculations.

Cost of projected aged care services

Increased aged care supply requires increased public and private expenditure. Using estimates of average community and residential care costs per person and the share of public expenditure versus private expenditure, total expenditure on HACC services, community care packages and residential care places were estimated for 2010 and projected to 2050 for the current policy scenario (Chapter 4), dementia growth scenario (Chapter 5), and needs based scenario (Chapter 6). Results are summarised below.

- Under the current policy scenario, annual expenditure on HACC services, community care packages and residential care places is estimated to increase from $11.1 billion in 2010 to $59.6 billion in 2050 (equivalent to 436% growth). Of this, the public budget will expend $44.0 billion while the private sector will expend $15.6 billion.
- Under the dementia growth policy scenario, annual expenditure on HACC services, community care packages and residential care places is estimated to increase to $79.8 billion by 2050. This increase is equivalent to around 618% growth and $20.2 billion more than the current policy scenario. The public budget will expend $58.9 billion while the private sector will expend $20.9 billion.
- Under the unmet need scenario, annual expenditure on HACC services, community care packages and residential care places is projected to increase to $94.2 billion in 2050. This increase is equivalent to around 749% growth, $14.4 billion more than the dementia growth scenario and $34.7 billion more than the current policy scenario. The public budget will expend $69.5 billion while the private sector will expend $24.7 billion.

In addition to expenditure on HACC services, community care packages and residential care places, there will also be an increase in expenditure on other aged care services, such as community care grants, assistance with care and housing for the aged, National Respite for Carers Program (NRCP) and Department of Veterans Affairs (DVA) expenditure on community nursing or Veterans' Home Care (VHC). In total, spending by the Commonwealth Government on aged care as a proportion of gross domestic product (GDP), based on the current planning policy, is projected to grow by more than 100% in the next 40 years, with an increase from 0.8% of GDP in 2009-10 to around 1.8% in 2049-50 (The Treasury, 2010a). This rise will be driven mainly by an expected increase in demand for residential aged care.

The majority of people prefer to live in their own homes for as long as possible with the support of family and community care. The Commonwealth Government has recognised the demand for more community care services and has undertaken many trials through the Aged Care Innovative Pool. However, the relative supply of community and residential care is fixed under Commonwealth Government planning ratios. A 'one size fits all' growth strategy, as embodied in the current policy of a fixed ratio of community care and residential care packages based on the growth of the population aged 70 years and over, will not accommodate changing preferences between community care and residential care.

More than likely, the optimal mix of community and residential care will change depending on a variety of factors, such as care needs and changes in the availability of informal care from family and friends. Although some change in the balance of community care and residential care can be anticipated as community care becomes more responsive, it seems probable that residential care will continue to play an important role in dementia care, due to the reduced number of informal carers and the demanding nature of dementia care.

In the absence of more information about consumer preferences, the consequences of changes in the balance of community and residential care were modelled, based on the assumption that half the projected expenditure on low and high residential care places would be shifted to supplying community care packages under the current policy scenario. Results are presented in Table ii.

Table ii: Projected change in aged care supply due to a shift towards community care [(a)]

	2020	2030	2040	2050
CACP clients	43,638	100,010	157,332	213,478
EACH packages	19,682	44,437	69,608	94,263
EACH-D packages	18,504	41,777	65,442	88,622
Total - Community care	81,824	186,223	292,383	396,364
Low care places	-26,087	-59,786	-94,054	-127,619
High care places	-26,795	-60,494	-94,762	-128,326
Total - Residential care	-52,881	-120,280	-188,816	-255,945
Net change in aged care	28,943	65,943	103,567	140,419

Note: (a) Assumes half of residential care expenditure growth under the current policy scenario is reallocated to community care. Expenditure savings from low care residential are allocated to the CACP program while expenditure savings from high care residential are allocated equally between the EACH and EACH-D programs.
Source: Access Economics calculations.

If the Commonwealth Government were to shift half the expected expenditure from residential care to community care packages from 2011, then around 81,824 additional annual community care packages could be delivered by 2020. However, it would also result in a reduction of 52,881 residential care places, of which 26,087 would be low care and 26,795 would be high care. By changing the ratio of community and residential aged care, the Commonwealth Government could provide aged care to an additional 28,943 people.

By 2050, there would be an additional 396,364 community care packages. However there would be 255,945 fewer residential care places, resulting in a net increase of 140,419 people accessing government funded aged care services.

Increasing consumer choice

In recent years, there has been an increasing interest in consumer-directed care (CDC) to address the current lack of consumer choice and flexibility in aged care. CDC models provide a spectrum of options that extend from income support (such as cash and vouchers, known as a direct payment model) to budget holding by agencies, which enable clients and their family or carers to determine the care services they receive. Some such programs may restrict the use of benefits to approved care services.

By giving autonomy to clients and their families and carers, CDC gives people a greater say in the planning of care and in the delivery of services. The recipient of care can be involved in decisions about the range of services they perceive as most appropriate to their needs including:

- controlling when the care is delivered;
- controlling how the care is delivered such as through community care packages or residential care facilities;

- taking responsibility for the choice of care provider including hiring and firing formal carers and paying carers directly; and
- managing day to day delivery of care.

Under a CDC framework, care recipients and carers can use allocated funds or benefits to purchase services and equipment from traditional service agencies, or they can use the funds for options outside the formal care system.

While CDC may be expected to increase the flexibility of packages and increase the availability of services such as respite within the current aged care system, the potential to increase consumer choice may also be increased in two other ways.

First, separation of accommodation and care would allow people to access the right mix of community care and accommodation for their needs. This separation would enable people living in the community to remain in a familiar environment as their care needs increased, or to choose to utilise periods of residential respite care while mainly living at home. Greater choice in care and accommodation is required if growing diversity in preferences for aged care are to be met, based on the changing aged care landscape and social structure, and the associated increase in the capacity to pay for services through increased asset values such as superannuation and housing.

Another way is to ensure program structures for community care are graduated and have the capacity to meet different needs. For example, the HACC program has considerable flexibility in the delivery of services. In contrast, community care packages have limited flexibility in the services that can be accessed and there is a large gap in the amount and type of services offered between the CACP and EACH/EACH-D packages. There is an opportunity to address this inflexibility and other issues through the national approach to funding HACC, notwithstanding that Western Australia and Victoria are currently standing outside the national approach agreed by the Council of Australian Governments (COAG). For those with lower care needs, the community options approach may have the potential to achieve improved flexibility in service delivery.

To generate the greatest possible level of flexibility and choice, a review of the sustainability of residential care and those regulations that govern consumer choice should be undertaken. Future policy direction should focus on redesigning the residential care market to allow greater market signals and more incentives to innovate and differentiate. This should include addressing:

- inadequate government subsidy arrangements and the consequential financial instability;
- the lack of adequate return associated with providing aged care services;
- the lack of adequate capital funding;
- the inappropriate level of the accommodation charge and the cross-subsidisation of low care bonds to fund high care residents;
- the cross-subsidisation of capital with funds hypothecated for operational costs, such as daily Aged Care Funding Instrument (ACFI) subsidies;
- the inadequacy of the Commonwealth Own Purpose Outlays (COPOs) as an indexation formula;

- the appropriateness of Conditional Adjustment Payments (CAPs) to address rising costs;
- the inflexibility of aged care pricing to meet differentiated demand for residential accommodation and services; and
- developing an improved ACFI to promote an optimal skill mix in residential care.

Financing the supply of aged care services

Any market in aged care should operate within a framework that ensures both quality of care and equity in access. Unless the government can raise additional tax revenue or reallocate resources from other sectors, the future costs of an increased demand for aged care will place more pressure on the Commonwealth budget. As the older population increases their capacity to fund aged care through greater wealth and retirement savings, the demand for differentiated aged care will increase, thereby placing pressure on the Commonwealth Government to review the current share of aged care cost between public and private.

One option is to provide aged care as a fully funded entitlement, similar to the way health care is provided through Medicare. However, this option would be relatively costly and would require the government to find substantial additional funds to support aged care. As such, detailed treatment of an entitlement model has not been a major focus of this study. Instead, it has examined different means of increasing private funding for aged care services.

Currently, the primary sources of private funds for aged care expenditure are superannuation, accommodation bonds and reverse mortgages. [4] Alternative aged care funding mechanisms explored within the study include long term care insurance (LTCI) and Health and Ageing Savings Accounts (HASAs).

Allowing new private financing vehicles, such as LTCI and HASAs, and the promotion of current private financing vehicles such as reverse mortgages, has the potential to introduce greater private funds into the aged care system. This could relieve some of the future budget pressure faced by the Commonwealth Government.

All private funding mechanisms have their advantages and disadvantages, and there is no panacea that will increase efficiency and sustainability while maintaining equity. Ultimately there will need to be a trade-off, and a combination of aged care funding models and greater choice for people to provision for their own aged care needs, is recommended as the best option for the future.

Policy options for people with dementia

Planning and reforms to meet the needs for aged care are long overdue. Too many people are already frustrated with complex access to limited amounts of care, and there is a lack of formal services to support family and friends caring for people with dementia. Policy needs to focus on delivering an aged care system where resources are maximised, wherein the needs of

[4] A large proportion of aged care expenditure is privately funded using age pension payments, with aged care fees and charges capped to ensure people can pay for aged care using this source of income. However, as age pension payments are funded by the Commonwealth Government it can be considered an indirect public funding of aged care expenditure, and has therefore not been discussed as an alternative private financing option within this study.

carers and care recipients are the over-riding concern, and the reward for the delivery of appropriate care is fair and equitable.

The issue of dementia was not addressed in the report of the National Health and Hospital Reform Commission report (NHHRC, 2009), or in the National Health and Hospital Network (NHHN) reforms (COAG, 2010). Furthermore, although funding of the *Dementia Initiative – making dementia a National Health Priority*, was continued in the 2010-11 Commonwealth Government budget, no additional funding was provided to address gaps in dementia specific care (The Treasury, 2010). The delivery of increased funding for more doctors, nurses, hospital beds and aged care facilities is welcome, but it will not result in more appropriate care for people with dementia unless action is taken to:

- achieve a timely diagnosis of dementia;
- reduce the dangers of acute care for people with dementia;
- fund psychogeriatric services; and
- increase dementia research funding.

The prospect of increasing care choices for older people will be illusory unless either an entitlement approach is adopted for the planning of aged care services or there is a willingness to adopt a planning approach that better reflects the ageing of the population and growth in the number of people with dementia. The three pillars of a future strategy to promote increasing choice for older people are outlined below.

- Planning aged care services to take into account the projected increase in the older population and the growing prevalence of dementia. Any review of alternative growth rates for the supply of aged care services using planning ratios should also consider the need to use planning ratios, and the possibility of introducing a more market oriented approach that is coupled with regulations to ensure societal objectives are met.
- Increasing consumer choice and the flexibility of service provision by:
  - separating care and accommodation funding so that people have a choice to combine different care and accommodation options;
  - increasing consumer choice by embedding CDC in the provision of aged care services;
  - increasing flexibility in community care packages to allow individuals to respond to changing needs and preferences;
  - introducing graduated care packages to fill the gap between CACPs and EACH packages; and
  - funding 'one stop shops' to ensure consistency in the gate keeping role, adequate information to consumers, and ongoing advice to the navigation of the aged care system.
- Increasing funding for community care services to enable people to stay in the community for longer.

Early decisions need to be taken about the future funding of aged care. The favoured approach is to argue for the continuance of a tax based system supplemented by other strategies, including measures such as accommodation bonds and reverse mortgages. The introduction of alternative private financing mechanisms, such as HASAs and LTCI, would provide further opportunity to increase private aged care funding, thereby reducing pressure

on the Commonwealth budget. It could also facilitate the introduction of further incentives for providers to offer more choice and undertake more investment in the aged care system.

Reform of the aged care system, if it responds to the issues identified by stakeholders in terms of sustainability, greater flexibility and equity, will need to be significant and extensive. A transition is needed that ensures an outcome in aged care that both responds to the needs of people with dementia and the viability of aged care services.

Lastly, dementia can affect younger people. This report has also drawn attention to the lack of access to appropriate support services for people with dementia under the age of 65 years. In 2008, COAG decided that responsibility for younger people with dementia should fall within the National Disability Agreement. However, dementia services are mostly provided through the aged care system. The COAG decision has resulted in young people with dementia falling between the gap of the disability sector (which has little understanding of dementia or the resources to address the issues), and an aged care system that can only offer services to younger people with dementia as a last resort. This is despite limited access to alternative services. The Productivity Commission should address this issue as part of their review into long term disability care. One option to explore is to remove age limits for access to aged care services for younger people with dementia.

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Note: This report represents Volume 1 and presents aged care supply projections at the Australia wide level. Volume 2 contains an analysis of projections based on the growth rate of dementia prevalence by Aged Care Planning Regions (ACPRs) and Commonwealth Electoral Division (CEDs) and will be made available by Alzheimer's Australia in the near future.

1 Dementia prevalence in Australia

Australia is currently facing a dementia epidemic, primarily driven by population growth and ageing and to some extent change in modifiable risk factors. This chapter outlines the different types of dementia and their risk factors. It also provides estimated prevalence of dementia for each state and territory in 2010, and projected to 2050 using revised Australian Bureau of Statistics (ABS) population parameters. This revision has resulted in a decrease in dementia prevalence projections from 1.13 million to 981,000 by 2050.

1.1 What is dementia?

Dementia is not one condition but a term encompassing a range of conditions characterised by impairment of brain functions, including language, memory, perception, personality and cognitive skills (AIHW, 2007a). Dementia can lead to a loss of intellect, rationality, social skills, and normal emotional reactions. Conditions associated with dementia are typically progressive, degenerative and irreversible, for which there is currently no cure.

There are many types of dementia. The most common is Alzheimer's disease (AD), which accounts for around 50% of all dementia (DoHA, 2006). A person can experience more than one type of dementia at the same time. Table 1.1 lists the most common types of dementia and their characteristics.

The type and severity of symptoms will vary depending on type of dementia and the stage of the condition. For example, a person with mild dementia may only experience one or two symptoms that have a relatively minor impact on day to day living, while a person in the late stages of dementia may experience many symptoms and require 24 hour care.

The early signs of dementia are usually subtle and not always obvious to the individual or family and friends. However, there are many symptoms associated with dementia. In the early stages, the signs of dementia may not be obvious and can include:

- progressive and frequent memory loss;
- confusion;
- personality change;
- apathy and withdrawal; and
- loss of ability to perform everyday tasks (Alzheimer's Australia, 2005)

As the condition progresses from mild, to moderate, and then severe, early signs can become more severe, and people may develop other types of symptoms, including:

- disorientation to time and space, such as wandering and getting lost;
- loss of language and communication skills;
- changes in personality and behaviour, such as agitation, repetition and following;
- focal neurological signs and symptoms; and
- muscle rigidity and tremors (AIHW 2007a; Alzheimer's Association 2009).

Table 1.1: Types of dementia

Type of Dementia	Share of dementia	Description
Alzheimer's Disease (AD)	50%	AD is the most common of the dementia disorders and is associated with shrinkage/atrophy of the brain due to nerve cell loss. Abnormal brain tissue changes occur in the form of 'tangles' and 'plaques'.
Vascular Dementia (VaD)	20%	VaD occurs through a reduced blood supply to the brain, usually due to a stroke. It is the second most common dementia.
Dementia with Lewy bodies (DLB)	15%	DLB is associated with Lewy bodies which are abnormal brain cells. DLB is similar to AD but progresses much more rapidly, with earlier occurrence of frontal lobe and visuo-spatial impairments.
Fronto-temporal (lobe) dementia (FTD)	5%	FTD is associated with rounded and tangled bundles of proteins in brain nerve cells. It occurs in 1 in 5000 people, but with earlier onset (as young as 30 to 40 years of age).
Parkinson's disease	3-4%	Parkinson's disease is a progressive disorder of the central nervous system that is associated with loss of the neurotransmitter dopamine in the brain. It is characterised by tremors, stiffness in limbs and joints, speech impediments and difficulty in initiating physical movements.
Huntington's disease	<3%	Huntington's disease is a hereditary disorder of the central nervous system affecting 1 in 10,000 people. Cell death may be caused by a ball of protein that forms in the cell nucleus.
Creutzfeldt-Jakob disease	<3%	Creutzfeldt-Jakob disease is characterised by a swelling and loss of nerve cells, an increase in the size and number of brain cells (astrocytes) and abnormal prion protein deposits between nerve cells.

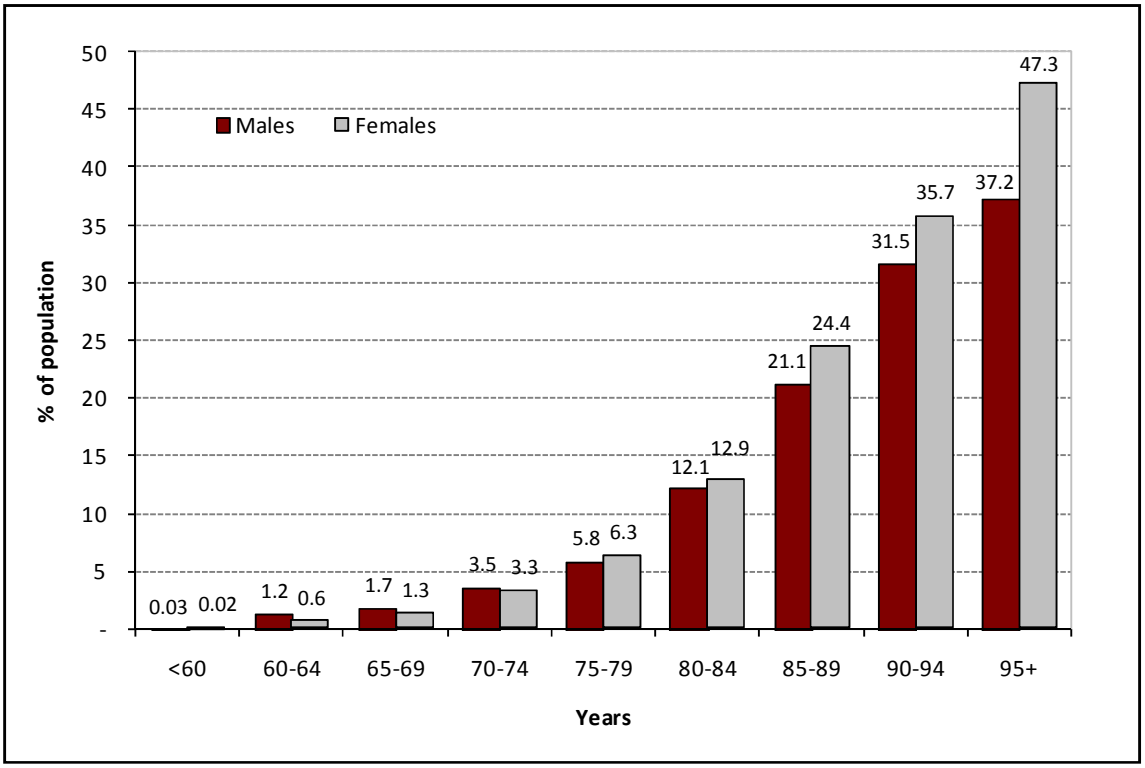
Source: Access Economics (2003), DoHA (2006).

1.2 Estimated dementia prevalence rates

Dementia prevalence rates have been taken from a previous Access Economics report that used a combination of published epidemiological studies and meta-analyses (Access Economics, 2009a). They are presented in Chart 1.1.

Dementia prevalence rates follow an exponential growth rate with age. Dementia prevalence rates are relatively low until the age of 70 years and over, where prevalence rates start to increase rapidly, indicating the increased risk of developing dementia due to age. For example, prevalence rates for males and females aged 70-74 years are around 3.5% and 3.3% respectively, which increases to 21.1% and 24.4% for those aged 85-89, and then to 37.2% and 47.3% for those aged 95 years and above.

Chart 1.1: Estimated dementia prevalence rates in Australia 2010



Source: Access Economics (2009a).

Prevalence rates used to estimate prevalence in Australia are primarily based on international studies due to a lack of Australian prevalence studies. They do not take into consideration differences in dementia rates specific to the Australian population. Indigenous or CALD populations in Australia may have different prevalence rates of dementia compared to international studies. For example, there have been a small number of studies on Indigenous Australians that suggest the prevalence and incidence of dementia in these communities is much higher than the general population (Smith et al, 2008). However, there are specific issues that limit the appropriateness of standard cognitive assessment tools to recognise dementia within Indigenous communities. These include different cultural behaviours, a higher prevalence of alcohol abuse, and limited education among the older population (Politt, 1997).

1.3 Estimated dementia prevalence

In 2005, Access Economics projected that dementia prevalence in Australia will be around 730,000 by 2050 (Access Economics, 2005). Since then, new evidence suggested prevalence rates for the older population had been underestimated. Furthermore, new data were released by the Australian Bureau of Statistics (ABS) on the size and structure of the Australian population based on the 2006 national census. Given constant prevalence rate and population ageing and growth, Access Economics projected dementia prevalence to around 1.13 million Australians by 2050 (Access Economics, 2009a).

Recently, the ABS made further changes to population parameters, revising mortality upwards and lowering annual migration figures. As such, dementia prevalence projections in this study are based on revised ABS population parameters and population projections undertaken using

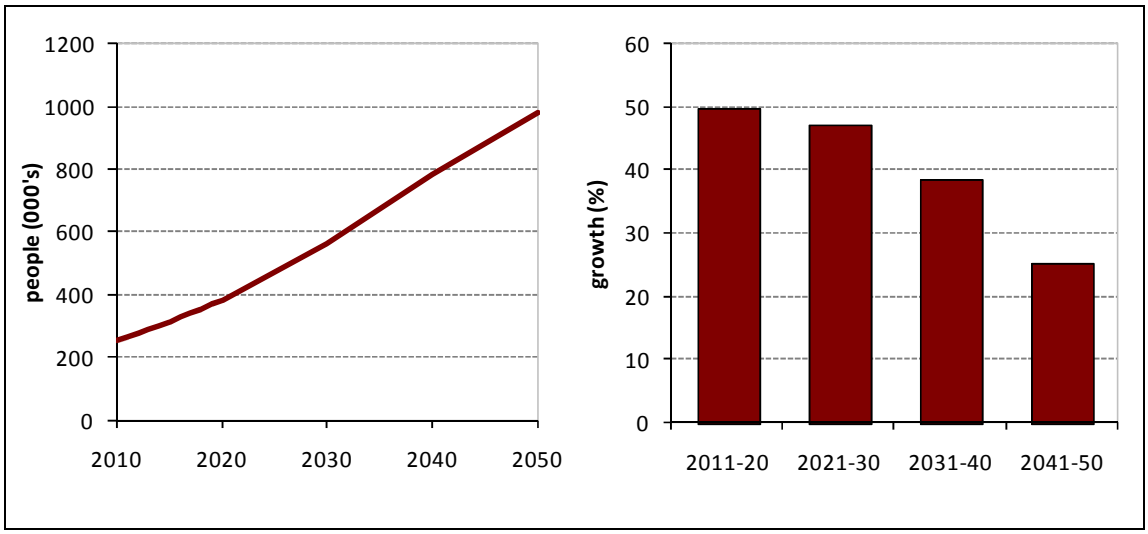
Access Economics' in-house demographic model.[5] This has seen dementia prevalence projections revised downward, with the difference increasing over time. For example, dementia prevalence projections presented in this study are 0.3% lower for 2010, but are around 13.2% lower for 2050.

Projected dementia prevalence and prevalence growth is shown in Chart 1.2 and dementia prevalence is further broken down into age brackets in Table 1.2. It is estimated there are 256,529 people with dementia in Australia in 2010. This is projected to increase to 564,987 people by 2030, and 981,044 people by 2050.

Dementia prevalence is greatest in the age bracket 85-89 years throughout the projected period, increasing from 63,120 in 2010 to 233,830 in 2050. As prevalence rates are not the highest in this age bracket, the large dementia prevalence is due to the relatively large number of people. That is, although dementia prevalence rates are higher for people 90 years and older, mortality rates are also higher and the net effect is a reduction in dementia prevalence.

Due to the relatively large growth in the older population in Australia, people with younger onset dementia (those aged less than 65 years with dementia) will make up a smaller proportion of total dementia prevalence in the future. It is projected to decline from around 6.2% in 2010 to 2.7% in 2050. The total number of people with younger onset dementia is projected to grow from 15,919 in 2010 to 26,938 in 2050.[6]

Chart 1.2: Projected dementia prevalence and growth in Australia



Source: Access Economics calculations.

The dementia prevalence growth rate will peak in the next ten years as the growth in the population aged 85 years and over will be relatively high. As the baby boomers push through the age brackets, a greater proportion of the total population will have dementia, increasing from around 1.2% in 2010 to 1.9% in 2030 and then 2.8% in 2050.

[5] AE-DEM is an in-house demographic model based on the 2006 national census undertaken by the ABS. Building up from the demographic 'first principles' of births, deaths, migration and household formation, the model projects population by age and gender for each jurisdiction.

[6] Caution should be taken when interpreting younger onset dementia prevalence due to large confidence intervals associated with dementia prevalence rates for this cohort.

Table 1.2: Projected dementia prevalence in Australia, by age bracket

Age	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050	Growth
	000's	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*%*
0-59	4.9	5.0	5.1	5.2	5.3	5.3	5.4	5.4	5.5	5.6	5.6	6.2	6.9	7.5	52.5
60-64	11.0	11.4	11.3	11.5	11.7	11.9	12.2	12.5	12.7	13.0	13.3	14.6	15.8	19.4	76.7
65-69	13.8	14.6	15.9	17.1	17.8	18.5	19.2	19.1	19.4	19.8	20.1	24.4	27.2	31.5	128.6
70-74	24.3	25.2	26.3	27.3	28.8	30.4	32.2	35.1	37.6	39.2	40.8	49.6	55.1	60.9	150.3
75-79	33.5	34.1	35.4	36.8	38.5	40.2	41.8	43.6	45.4	47.9	50.7	74.7	90.6	101.3	202.7
80-84	55.6	56.6	57.0	57.2	57.5	58.1	59.5	61.9	64.6	67.7	70.9	122.5	154.7	177.3	218.8
85-89	63.1	65.7	67.9	70.4	72.6	74.9	76.6	77.5	78.2	79.0	80.1	125.5	186.5	233.8	270.5
90-94	35.6	39.8	44.1	48.2	51.9	54.7	57.2	59.4	61.9	64.1	66.3	90.8	155.1	200.3	463.1
95+	14.7	16.1	17.4	18.6	20.0	22.7	25.7	28.7	31.3	33.8	36.4	56.7	91.2	149.1	911.2
Total	256.5	268.6	280.5	292.3	304.2	316.8	329.8	343.3	356.5	370.0	384.3	565.0	783.1	981.0	282.4
% PWD	1.15	1.18	1.21	1.24	1.27	1.31	1.34	1.38	1.42	1.45	1.49	1.94	2.42	2.76	
% YO	6.21	6.10	5.86	5.71	5.58	5.44	5.33	5.21	5.11	5.02	4.92	3.68	2.89	2.75	

Note: % PWD = Proportion of total population with dementia. % YO = Proportion of dementia population that are younger onset (classified as people aged 64 years or less).
Source: Access Economics calculations.

1.3.2 Dementia prevalence by jurisdiction

Projected dementia prevalence between 2010 and 2050 by jurisdiction is shown in Table 1.3 while growth rates are shown in Chart 1.3.

Dementia prevalence growth generally follows the size of the population for each jurisdiction, with NSW expected to have the greatest prevalence in 2010 and throughout the projection period, while the Northern Territory is projected to have the least. It is estimated that:

- NSW has 87,975 people with dementia in 2010, projected to increase to 302,510 people by 2050;
- Victoria has 65,669 people with dementia in 2010, projected to increase to 246,389 people by 2050;
- Queensland has 46,842 people with dementia in 2010, projected to increase to 221,748 people by 2050;
- Western Australia has 22,945 people with dementia in 2010, projected to increase to 108,802 people by 2050;
- South Australia has 22,751 people with dementia in 2010, projected to increase to 62,398 people by 2050;
- Tasmania has 6,462 people with dementia in 2010, projected to increase to 19,646 people by 2050;
- Australian Capital Territory has 3,090 people with dementia in 2010, projected to increase to 14,659 people by 2050; and
- Northern Territory has 795 people with dementia in 2010, projected to increase to 4,892 people by 2050.[7]

There is significant variation in the growth of dementia prevalence across jurisdictions, which is a reflection of the age structure and growth of the population. Across Australia, dementia prevalence is expected to grow by around 282% between 2010 and 2050.

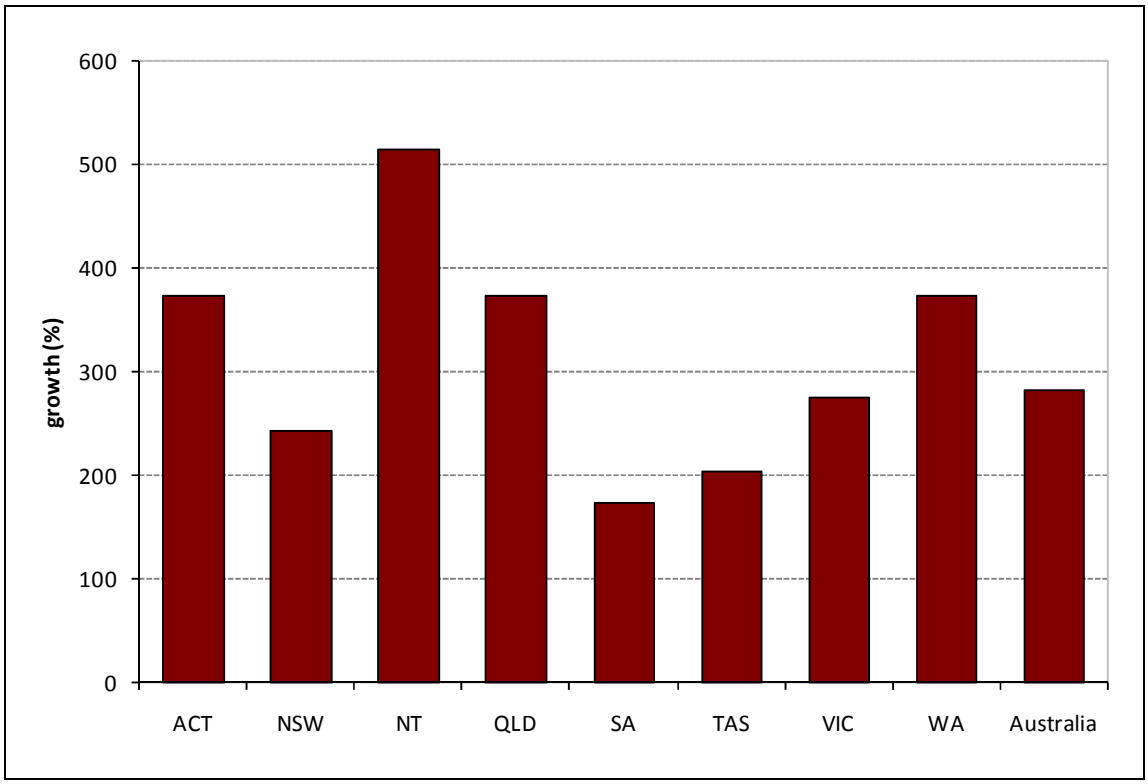
[7] Dementia prevalence rates used in this study do not specifically account for differences in dementia rates found in Indigenous Australians. There have been a small number of studies on Indigenous Australians that suggest the prevalence and incidence of dementia in specific communities is much higher than the general population (Smith et al, 2008). Consequently, confidence intervals surrounding estimated dementia prevalence for the Northern Territory are likely to be large, so dementia prevalence estimates should be interpreted with care.

Table 1.3: Projected dementia prevalence in Australia, by jurisdiction

Age	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
	000's	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*
ACT	3.1	3.3	3.5	3.7	3.9	4.1	4.3	4.5	4.8	5.0	5.3	8.4	12.1	14.7
NSW	88.0	91.9	95.8	99.6	103.4	107.4	111.6	115.8	119.9	124.0	128.4	182.5	247.8	302.5
NT	0.8	0.8	0.9	0.9	1.0	1.1	1.2	1.2	1.3	1.4	1.5	2.8	4.0	4.9
QLD	46.8	49.3	51.7	54.1	56.6	59.4	62.2	65.2	68.2	71.2	74.5	117.2	170.3	221.7
SA	22.8	23.5	24.3	25.0	25.7	26.5	27.2	28.0	28.7	29.5	30.3	41.8	52.3	62.4
TAS	6.5	6.7	6.9	7.1	7.3	7.6	7.8	8.1	8.3	8.6	8.9	12.7	16.2	19.6
VIC	65.7	68.9	72.0	75.0	78.2	81.4	84.7	88.1	91.4	94.8	98.3	141.8	196.3	246.4
WA	22.9	24.2	25.5	26.7	28.0	29.4	30.8	32.4	33.9	35.4	37.0	57.8	84.2	108.8
Australia	256.5	268.6	280.5	292.3	304.2	316.8	329.8	343.3	356.5	370.0	384.3	565.0	783.1	981.0

Note: % pwd = Percent of total population with dementia.
Source: Access Economics calculations.

Chart 1.3: Growth rate of dementia prevalence, by jurisdiction



Source: Access Economics calculations.

2 Supply of aged care in Australia

This chapter estimates the current supply of care in Australia for 2010. It provides an estimate of the amount of informal care, the number of HACC clients receiving community care services, and the number of operational formal community care packages offered by Department of Health and Ageing (DoHA) under the *Australian Aged Care Act 1997*. The chapter also presents estimates of operational low and high care residential places.

2.1 Informal care

Informal care is unpaid assistance or support provided to people whose health restricts their ability to undertake daily activities. Most informal carers are family or friends of the person receiving care. Several surveys have been undertaken to determine the number of informal carers in Australia. Most recently, the National Census conducted by the Australian Bureau of Statistics in 2006 (ABS, 2007) found there were 1.6 million people who, in the two weeks prior to the Census night, spent time providing unpaid care, help or assistance to family members or others because of a disability, long term illness or a condition related to old age.

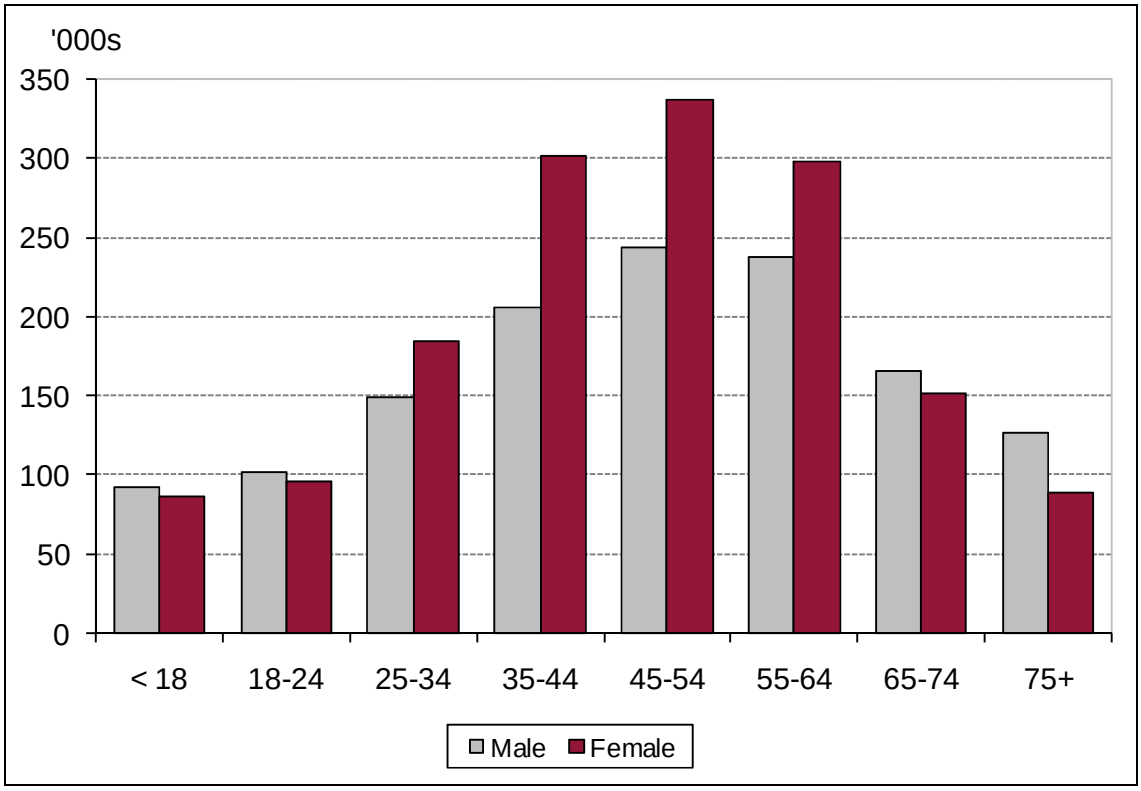
In comparison, the Survey of Disability, Ageing and Care (SDAC) (ABS, 2004) specifically investigated the number of carers in Australia, and found there were around 2.6 million people providing informal care, of whom 475,000 were primary carers and 2.1 million were non-primary carers. Of all informal carers, females aged 35-64 accounted for around 32.3% of all carers (primary and non-primary) and around 47.2% of all primary carers (Chart 2.1). Based on the age-gender profile of carers and non-carers from ABS (2004), and extrapolated using series B population estimates from ABS (2008), it is estimated that around 2.9 million Australians will provided 1.3 billion hours of informal care in 2010.[8] A breakdown of the estimated number of informal carers, by age and gender, is shown in Chart 2.1.

The ageing population and changing social construct will profoundly affect the supply of informal care. For example, increasing female workforce participation, increasing divorce rates, and smaller family size will reduce the pool of informal carers. Table 2.1 shows a breakdown of family carers by age. In 2003, 39% of working age carers cared for a parent, friend or other relative, while 83% of carers over 65 and 28% of working age carers provided care to a spouse. Furthermore, on continuation of current trends there will be a 90% rise in 65+ single person households from 1996 to 2021 (ABS, 2001).

Informal carers are more likely to be unemployed or not participating in the paid workforce than those who are not carers. In 2003, only 19.2% of primary carers were in full-time employment compared with an Australian average of 42.0% (ABS, 2004). The ageing of the population will result in a tighter labour market. Higher demand for labour will increase the opportunity cost of providing unpaid care rather than participating in the paid workforce. Consequently the supply of informal carers may decrease in the future.

8

Chart 2.1: Estimated number of informal carers in Australia, 2010



Source: Access Economics calculations and ABS (2004).

Table 2.1: Relationship between informal carer and care recipient, 2003

Person cared for	Carer aged 15-64	Carer aged 65+
	%	%
Spouse/partner	28.4	82.8
Parent	29.0	5.7
Son/daughter	32.7	3.7
Other	9.9	8.0

Source: ABS (2004).

This effect may be amplified by a change in social attitudes towards caring for the elderly. Access Economics (2009d) found that generation X and generation Y were nearly 10% less prepared to provide primary care than the baby boomers. There are many factors that might contribute to this. The weakening of family and community ties, the more individualistic attitude of generations X and Y, and the negative effects of informal care on health and wellbeing for example. However, more research is need in this area to determine the cause and effect of changing social attitude on provision of informal care.

2.1.2 Informal care recipients with dementia

There are limited data on the number of informal carers of people with dementia. Access Economics (2009) estimated that around 60% of people with dementia were living in the community in 2008. Data from the Pathways in Aged Care (PIAC) study suggests that 73% of

these people have an informal carer (AIHW, 2010). Based on data from the 2003 Survey of Disability and Aged Care (SDAC), the average hours of care provided by a primary carer for a person with dementia is estimated indicatively to be around 38 to 42 hours of care per week (ABS, 2004). In 2010 people with dementia are estimated to receive around 210 million hours of informal care (Access Economics, 2009d).

Providing informal care to a person with dementia is particularly time intensive and can result in negative health and well-being outcomes for the carer. Consequently the effect of an aging population, workforce constraints and willingness to provide informal care is likely to have a greater impact on the supply of care for older people with dementia than for older people more generally.

2.2 Community care

Community aged care refers to formal services usually provided in the care recipient's home. In many cases, people living in the community and receiving community aged care also rely on an informal carer. There are a number of government programs that provide formal care for people living in the community.

- The Home and Community Care (HACC) program is the largest program. Services provided include transport, nursing, home maintenance, counselling and personal care (DoHA, 2009c). The HACC program delivers services to people with a range of disabilities, regardless of whether that disability is related to an acquired condition or injury.
- The Community Aged Care Package (CACP) targets older people living in the community with care needs equivalent to a low level residential care. A range of support services are provided, such as personal care, domestic assistance and social support, transport to appointments, food services and gardening. Approval from an Aged Care Assessment Team (ACAT) is required before services can be obtained (DoHA, 2009c).
- Extended Aged Care at Home (EACH) packages target older people living at home with care needs equivalent to high level residential care. ACAT approval is required to receive services. In addition to the services offered by CACP, an EACH client may be able to receive nursing care, allied health care and rehabilitation services (DoHA, 2009c).
- EACH-D extends the EACH package with service approaches and strategies to meet the specific needs of care recipients with dementia (DoHA, 2009c).

The HACC program is jointly funded by the Commonwealth and jurisdictional governments under the *Home and Community Care Act 1985*. Access to HACC services is at the discretion of providers and funding is allocated largely based on demand.

Data on the number of HACC clients are collected from providers and are available in the HACC Minimum Dataset (MDS). The number of clients and the proportion of HACC service agencies who responded with information about clients are shown in Table 2.2. The estimated number of clients has been adjusted for non-responding providers assuming that these providers service an average number of clients.

In summary, it is estimated there will be around 966,710 people accessing HACC services throughout 2009-10. Victoria is expected to have the largest number of HACC clients with around 302,328 people. Despite having the largest population, NSW is expected to have only

the second highest number of clients with around 272,165. South Australia and Tasmania are estimated to have the greatest proportion of clients at around 5.6%, while the Northern Territory is estimated to have the lowest at 2.2%. Table 2.3 shows the proportion of the population receiving HACC services by age for all jurisdictions.

The distribution of HACC services across remoteness categories is variable across jurisdictions, which reflects population dispersion within each jurisdiction. For example, Table 2.4 shows that 99.2% of HACC services in the ACT will be delivered in a major city setting (Canberra), whereas no HACC services in the Northern Territory are delivered in either a major city setting or inner regional setting (as classified by the Australian Bureau of Statistics). Instead, HACC services in the Northern Territory are delivered to outer regional, remote, or very remote areas. Of the jurisdictions with the larger populations, the majority of HACC services are delivered within a major city, inner regional or outer regional settings.

The type of assistance delivered through the HACC program for each client varies considerably across jurisdictions, reflecting variation in perceived needs of clients and the organisation of disability service delivery. For example, Table 2.5 shows there are large variations in centre-based day care, client care coordination, formal linen services, the quantity of medical care aids, the amount of money spent on home modification aids, personal care, and respite care to name just a few (DoHA, 2009a).

Recent policy changes outlined in the National Health and Hospitals Network (NHHN) reforms indicate the Commonwealth Government will take full policy and funding responsibility for aged care services. This means current resourcing made by jurisdictions for the HACC program will be transferred to the Commonwealth (except in Victoria and Western Australia), in the hope of generating greater consistency for low care to high care needs across aged care services (COAG, 2010).

Currently CACPs, EACH and EACH-D packages are funded by the Commonwealth Government under the *Aged Care Act 1997*. The number of packages made available each year is determined using planning ratios. The current target ratio for community care is 25 packages per 1,000 people over the age of 70 by 2011, four of which are to be split between EACH and EACH-D packages (DoHA, 2009c). However, the number of community care packages is yet to reach these targets, with the Australian average being 23.1 packages per 1,000 people aged 70 years and over in 2009.

Table 2.2 Estimated number of HACC clients, 2009-10

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Aust
Number of clients	11,604	239,505	3,707	168,050	95,747	27,342	272,095	68,256	886,307
Provider response rate (%)	100	88	98	94	95	99	90	98	91
Estimated number of clients	11,604	272,165	3,782	178,777	100,786	27,618	302,328	69,649	966,710

Note: Estimated number of clients has been adjusted for non-response by some agencies using agency participation rates for 2007-08 and assuming each non-responding agency has an average number of clients.
Source: DoHA (2008; 2009a) and Access Economics calculations.

Table 2.3: Estimated proportion of the population receiving HACC services, 2009-10

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Aust
	%	%	%	%	%	%	%	%	%
0-49	0.7	0.4	0.6	0.6	1.1	0.8	0.9	0.5	0.6
50-54	1.5	1.2	2.0	1.6	2.5	2.3	2.1	1.5	1.7
55-59	2.1	1.7	2.9	2.6	3.6	3.9	3.1	2.1	2.5
60-64	3.3	2.8	5.8	4.0	5.6	5.8	5.1	3.3	4.0
65-69	6.5	5.5	11.5	7.5	10.5	10.0	9.6	6.4	7.6
70-74	12.5	10.2	21.4	14.1	17.9	17.6	17.1	12.5	13.9
75-79	26.5	18.8	35.2	26.6	28.7	32.7	27.8	23.5	24.4
80-84	38.2	29.4	43.1	40.1	41.3	46.0	39.1	36.2	36.2
85+	49.6	41.8	48.4	57.1	54.1	63.7	50.7	47.7	49.4
Total	3.0	3.1	2.2	3.8	5.6	5.6	4.6	3.2	3.8

Source: DoHA (2009a) and Access Economics calculations.

Table 2.4: Distribution of HACC clients by remoteness, 2008-09

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Aust
	%	%	%	%	%	%	%	%	%
Major city	99.2	60.7	-	57.8	67.5	-	65.4	68.3	61.3
Inner regional	0.4	26.1	-	25.4	13.6	65.4	25.6	15.4	24.4
Outer regional	-	10.3	51.1	13.2	14.3	32.2	8.5	10.9	11.5
Remote	-	1.0	21.9	2.0	3.6	1.7	0.3	3.2	1.5
Very remote	-	0.2	26.9	1.3	0.9	0.6	-	1.8	0.6
Not stated	-	1.7	0.1	0.2	0.1	0.1	-	0.4	0.6

Source: DoHA (2009a).

Table 2.5: Average HACC services received per client, by selected assistance type, 2008-09

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Centre-based day care (hours)	114.2	144.5	55.6	163.1	107.5	131.3	110.8	147.2
Client care coordination (hours)	4.9	4.4	5.8	5.7	3.6	4.6	25.3	3.3
Formal linen services (deliveries)	43.1	29.9	39.2	5.7	14.5	6.4	-	28.7
Medical care aids (quantity)	50.0	15.6	-	2.2	1.1	-	-	1.0
Home modification ($)	3,319.0	782.1	-	387.0	180.8	391.3	-	714.5
Personal care (hours)	58.8	108.4	41.4	22.3	67.6	51.1	40.9	52.6
Respite care (hours)	123.0	98.2	106.2	65.2	110.5	106.8	78.4	77.7

Source: DoHA (2009a).

Table 2.6 shows the number of operational community care packages by jurisdiction and level of care. The estimated number of operational packages under the CACP, EACH and EACH-D programs in 2010 are shown in Table 2.7, Table 2.8, and Table 2.9 respectively. These were calculated using the number of operational packages as at 30 June 2009 and population growth. Supply was also adjusted to reflect the Commonwealth Government's commitment to reach their stated planning targets by 2011.[9]

Table 2.6: Ratio of operational community care packages, 2009 [(a)]

	CACP	EACH / EACH-D	Total
ACT	21.2	6.4	27.6
NSW	19.5	3.0	22.5
NT	104.0	17.8	121.8
QLD	18.9	2.8	21.7
SA	19.6	2.9	22.5
TAS	20.3	3.6	23.9
VIC	19.4	3.1	22.5
WA	22.1	4.1	26.1
Australia	19.9	3.2	23.1

Note: (a) Ratio represents the number of packages per 1,000 people aged 70 years and over as at 30 June 2009.
Source: DoHA (2009c).

The CACP program provides the greatest number of operational packages, estimated at around 45,654 in 2010. The number of operational EACH packages is estimated at around 5,770 while EACH-D offers around 2,901 operational packages.

The number of operational packages provides an estimate of the number of people receiving community care packages. However, some community care packages have been allocated to

[9] In 2009 the planning ratios were 19.9, 2.2 and 1.1 packages per 1,000 people aged 70 years and over for CACP, EACH, and EACH-D programs respectively. It was assumed there will be linear growth in packages between 2009 and 2011 to meet stated planning ratio target of 25 packages per 1,000 people aged 70 years.

specific areas but are not yet operational. For example, as at 30 June 2009 around 2,646 community care packages were not filled, which represents around 5.2% of the total number of community care packages. Of these, 81% were CACPs, 12% were EACH packages and 6% were EACH-D packages.

There are a number of reasons why some community care packages may not be filled. Some of these include:

- delays in assessments by ACATs;
- a mismatch between supply and demand in particular regions; and
- not enough qualified staff or infrastructure to make allocated places operational.[10]

The government also allows two years for providers to make allocated aged care places operational, noting this is to provide time for building approval and construction. However, this generally relates to residential care facilities as CACPs and EACH packages typically become operational soon after being allocated.

[10] There may also be some community care packages that are empty due to transition between one person and another at the time of the survey.

Table 2.7: Estimated number of operational CACPs, 2010 [(a)]

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Aust
Males									
<65	20	348	54	272	77	-	268	134	1,172
65-69	13	241	45	182	61	18	299	101	959
70-74	12	364	45	233	94	27	440	148	1,363
75-79	27	578	45	359	145	60	582	229	2,025
80-84	39	1,085	41	574	263	79	829	283	3,192
85+	66	1,608	23	934	400	93	1,264	448	4,835
Total	176	4,224	253	2,554	1,039	276	3,682	1,342	13,546
Females									
<65	19	344	100	267	76	25	265	127	1,224
65-69	17	397	53	275	117	43	458	126	1,487
70-74	34	888	87	484	183	69	720	206	2,672
75-79	53	1,618	67	851	394	128	1,252	456	4,819
80-84	115	2,753	69	1,388	711	212	1,988	750	7,985
85+	231	4,964	56	2,666	1,293	425	2,950	1,336	13,920
Total	470	10,965	432	5,931	2,774	901	7,634	3,001	32,108
Persons									
<65	39	692	154	539	153	25	533	261	2,397
65-69	30	638	99	458	178	61	757	227	2,446
70-74	47	1,252	132	717	277	95	1,161	354	4,035
75-79	80	2,197	111	1,211	539	188	1,834	685	6,844
80-84	154	3,838	109	1,962	973	291	2,817	1,033	11,177
85+	297	6,572	79	3,599	1,692	518	4,215	1,784	18,756
Total	646	15,189	685	8,485	3,812	1,177	11,316	4,344	45,654

Note: (a) For 30 June 2010.
Source: Productivity Commission (2010).

Table 2.8: Estimated number of operational EACH packages, 2010 [a]

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Aust
Males									
<65[b]	-	-	-	-	-	-	-	-	-
65-69	8	38	11	32	12	8	73	33	215
70-74	7	104	17	72	10	4	115	37	366
75-79	7	127	9	79	29	7	109	50	417
80-84	13	135	9	86	43	11	126	44	468
85+	15	193	3	129	44	15	128	55	583
Total	50	597	49	398	138	45	551	220	2,048
Females									
<65[b]	-	-	-	-	-	30	-	-	30
65-69	12	78	6	64	9	5	76	40	290
70-74	9	145	9	61	22	9	126	65	446
75-79	12	176	11	107	35	21	160	88	609
80-84	10	264	6	145	74	22	197	99	817
85+	60	518	24	243	139	28	308	209	1,530
Total	102	1,181	56	620	279	114	868	501	3,722
Persons									
<65[b]	-	-	-	-	-	30	-	-	30
65-69	19	116	16	96	21	13	150	73	505
70-74	16	249	26	133	32	13	242	102	812
75-79	19	303	20	186	64	27	269	138	1,026
80-84	24	399	15	230	117	33	323	143	1,285
85+	75	711	27	373	183	43	436	264	2,113
Total	153	1,779	105	1,018	417	159	1,419	721	5,770

Note: (a) As at 30 June 2010 (b) The actual number of EACH packages delivered to those aged under 65 years may not be zero in some jurisdictions as the calculations are subject to ratios rounded to one decimal point by the Productivity Commission.
Source: Productivity Commission (2010).

Table 2.9: Estimated number of operational EACH-D packages, 2010 [(a)]

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Aust
Males									
<65[(b)]	-	-	-	-	-	-	-	-	-
65-69	-	20	4	19	-	-	30	10	82
70-74	4	31	9	14	-	2	47	7	114
75-79	3	49	2	51	24	3	64	32	228
80-84	5	80	2	50	24	9	74	26	269
85+	6	108	2	78	22	12	58	53	338
Total	17	287	20	211	70	26	272	127	1,031
Females									
<65[(b)]	-	-	-	-	-	-	-	-	-
65-69	2	41	2	19	5	6	15	9	100
70-74	5	34	2	28	17	3	26	15	131
75-79	6	85	7	79	25	15	65	42	324
80-84	11	169	2	93	36	22	100	43	476
85+	15	272	9	160	66	25	165	126	839
Total	39	601	22	380	150	71	371	235	1,870
Persons									
<65[(b)]	-	-	-	-	-	-	-	-	-
65-69	2	61	6	37	5	6	45	19	182
70-74	9	65	11	42	17	5	72	22	244
75-79	8	134	9	130	50	18	129	74	552
80-84	16	249	5	143	59	31	173	69	745
85+	21	380	11	238	88	37	223	179	1,177
Total	56	889	43	591	219	97	643	363	2,901

Note: (a) As at 30 June 2010. (b) The actual number of EACH-D packages delivered to those aged under 65 years may not be zero in some jurisdictions as the calculations are subject to ratios rounded to one decimal point by the Productivity Commission.
Source: Productivity Commission (2010).

2.2.2 Community care recipients with dementia

There are no recent data on the proportion of community care package recipients who have dementia. AIHW (2007) used data from the CACP census, EACH census and a report by Silver Chain WA to estimate the proportion of clients with dementia. The findings of this report are shown in Table 2.10 and the age-gender breakdown for the CACP program and EACH program is shown in Table 2.11. By definition all EACH-D clients have dementia.

Information on HACC services delivered to people with dementia is not available in the HACC minimum data set. Assessment teams record physical and mental functioning but do not specifically record data on dementia status. Instead a HACC dependency pilot survey of around 1,000 clients conducted in Victoria in 2002 was used, which found 5.2% of these clients were people with dementia (VGDHS, 2004).[11] The proportion of people under 65 years of age was less than 1%, but rose from 4% for those aged 65-74 years to 10% for those aged 85 and over.

Table 2.10: Proportion of community care recipients with dementia, 2002

Community care program	Proportion of recipients
	%
HACC	5.2
CACP	18.4
EACH	31.7
EACH-D	100.0

Source: VGDHS (2004), AIHW (2007).

Table 2.11: Proportion of community care recipients with dementia by age and gender, 2002

Age	Male	Female
CACP program	*%*	*%*
<65	9.4	7.5
65-74	14.0	14.0
75-84	20.3	20.3
85+	19.2	20.3
EACH program		
<65	42.9	20.8
65-74	13.8	16.1
75-84	25.7	33.9
85+	44.0	45.6

Note: By definition all EACH-D packages are allocated to people with dementia.
Source: AIHW (2007).

The estimated number of HACC clients with dementia and the number of community care packages delivered to people with dementia in 2010 are presented in Table 2.12. It is estimated there will be around 50,269 people with dementia that receive HACC services in

[11] This data may under represent the number of people with dementia accessing HACC program services due to improvements in diagnosis since 2002.

2010. In addition, around 17,419 operational community care packages will be allocated to people with dementia at any one time, comprising 12,658 CACPs, 1,861 EACH packages and 2,901 EACH-D packages.

Table 2.12: Estimated community care delivered to people with dementia, 2010

		Community care packages			
Age	HACC	CACP	EACH	EACH-D	Total
<65	n.a.	202	6	-	208
65-74	n.a.	907	199	426	1,533
75-84	n.a.	3,658	711	1,297	5,666
85+	n.a.	7,890	945	1,177	10,012
Total	50,269	12,658	1,861	2,901	17,419

Note: A breakdown of HACC recipients with dementia by age is not available.
Source: VGDHS (2004), AIHW (2007) and Access Economics calculations.

2.3 Residential care

Residential care is provided at an aged care facility by paid formal carers. It is for people for whom community care is not desirable or feasible, often because health care requirements are high or access to informal care is limited. Residential care provides accommodation, living services (e.g. cleaning, laundry, meals) and assistance with personal tasks (dressing, eating, and bathing). Residents usually have access to allied health and nursing care as required. Eligibility for residential care is determined by an ACAT. There are two classes of residential care.

- Low level care, which focuses on personal care services such as help with daily activities, accommodation, support services such as cleaning, laundry and meals, and some allied health services such as physiotherapy and occupational therapy. There is limited access to nursing staff.
- High level care, for those who require full-time supervised health care under the supervision of registered nurses. People also receive the same services as those under low care.

The number of residential aged care places in Australia is determined using a planning ratio. The ratio Australia wide in 2009 was 86.9 operational places per 1,000 people over the age of 70 years, although this varies considerably by jurisdiction and care type (DoHA, 2009c). Table 2.13 shows operational residential care places in 2009 by jurisdiction and level of care. The target set by the Commonwealth Government is to ensure 88 operational residential care places per 1,000 of the population aged over 70 by 2011, split equally between low and high care. Each year the government allocates new residential aged care places to providers and they have two years to make them operational. Around 2% of residential aged care places are used to provide respite care to people living in the community (DoHA, 2009c).

The supply of operational residential aged care places in 2010 was estimated using the number of operational residential care places per 1,000 people aged 70 years and over in 2009 (Table

2.13) and population growth. Supply was also adjusted to reflect the Commonwealth Government's commitment to reach their stated planning targets by 2011. [12]

Table 2.13: Operational residential care places per 1,000 people 70 years and over, 2009

	Low care	High care	Total
ACT	39.7	33.2	72.9
NSW	42.3	45.0	87.3
NT	43.3	54.3	97.6
QLD	45.1	39.5	84.6
SA	44.3	49.4	93.7
TAS	41.1	45.2	86.3
VIC	46.8	41.2	88.0
WA	44.0	37.3	81.3
Australia	44.2	42.6	86.9

Note: As at 30 June 2009.
Source: DoHA (2009c).

The ratio of operational residential places varies across jurisdictions. In low care, Victoria has the greatest ratio at 46.8 places per 1,000 people aged 70 years and over, while the ACT has the lowest at 39.7 places. In high care, the Northern Territory has the greatest ratio at 54.3 places per 1,000 people aged 70 years and over, while the ACT once again has the lowest at 33.2 places.

Differences in the ratio of operational places across jurisdictions may result from several factors on the demand and supply sides. The demand for residential care places is driven by need, which is determined by the prevalence of disability and the availability of substitute care, such as community care, respite care and informal care. The supply of operational residential care places will be driven by the perceived demand, the incentive to invest, and decisions made by the Commonwealth Government on how residential care places are to be distributed across regions.

The incentive to invest within a specific region is determined by the factors that affect the estimated rate of return. Revenue is generated through government subsidies (around 70% of the cost of each residential place is funded by the Commonwealth Government) and through residents from fees and accommodation bonds. The costs of providing care, such as wages, capital and land, also affects the estimated rate of return. Jurisdictional and local planning regulations may restrict the supply of residential care facilities, and delays in bringing allocated residential care places into operation are often due to planning difficulties (DoHA, 2009c).

Decisions to allocate residential care places are based on applications demonstrating that aged care needs can be met within a specific planning region. DoHA considers the suitability and experience of key personnel, previous experience in providing aged care services, record of financial management, the capacity to meet aged care standards, and the number of places

[12] In 2009 the planning ratios were 44.2 and 42.6 places per 1,000 people age 70 years and over for low and high residential care respectively. It was assumed there would be linear growth in packages between 2009 and 2011 to meet stated planning ratio targets of 44 places per 1,000 people aged 70 years and over for low and high residential care.

already allocated within the region (DoHA, 2009c). The tender process is highly competitive and not all applications are allocated requested places.

Estimated numbers of operational low and high care residential places in 2010 by jurisdiction are presented in Table 2.14 and Table 2.15 respectively. In total, it is estimated that there are 181,204 operational residential care places in 2010, with 89,772 high care places and 91,431 low care places. The number of places is generally representative of jurisdictional population, with NSW the highest and Northern Territory the lowest.

There is a current mismatch of low and high care residential places with the needs of residents. Under the *Aged Care Act 1997* residential care providers are allowed to allocate a low level care place to be used for high care, enabling residents to stay in the same place of care as their needs grow. However, this has led to a significant number of residents allocated to a low care place with classified high care needs, and in 2009 around 43% of low care places were utilised for high care (DoHA, 2009c). This equates to around 29,400 permanent residents.

There is also a mismatch in supply and demand within some regions of Australia, with the number of operational residential care places higher than the number of people receiving residential care at any one time. In 2009 there were 175,225 operational residential care places in Australia but only 158,863 permanent residents (DoHA, 2009c). Assuming around 2% of places are used for respite at any one time (DoHA, 2009c), this suggests there were 12,858 (or 7.3%) operational residential care places not filled.[13]

Conversely, some regions have a greater demand than supply of residential care places. According to DoHA, this is due to varying quality and quantity of applications received for new residential care places (DoHA, 2009c).

The number of people accessing residential care services throughout a year is higher than the number of operational places due to turnover. For example, the proportion of turnover in 2008 was 0.32, meaning that around one third of permanent places were newly occupied during the year. The reason for the high rate of turnover is mostly due to mortality, and 89% of separations were attributable to this. Of those who were reported to have died, 36% had been at the facility for less than a year (AIHW, 2009c).

[13] Some residential care places may be empty due to transition between one person and another at the time of the survey.

Table 2.14: Estimated number of people in high care residential places, 2010 [(a)]

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Aust
Males									
<65	23	741	19	432	153	55	545	148	2,116
65-69	21	571	13	277	133	50	364	145	1,574
70-74	20	911	13	470	186	58	584	207	2,449
75-79	35	1462	13	679	362	113	1,034	316	4,013
80-84	60	2115	19	1,012	579	167	1,459	439	5,850
85+	123	3801	21	1,865	1,088	288	2,627	742	10,555
Total	282	9601	98	4,736	2,502	730	6,612	1,997	26,558
Females									
<65	12	733	27	424	151	55	539	140	2,082
65-69	21	541	18	260	141	54	403	142	1,581
70-74	30	1,000	16	470	276	99	704	235	2,829
75-79	50	2,185	20	1,030	641	192	1,519	474	6,112
80-84	124	4,568	35	2,144	1,310	330	3,226	966	12,704
85+	322	13,886	65	6,229	4,002	1,021	9,425	2,956	37,907
Total	559	22,914	181	10,557	6,522	1,751	15,818	4,914	63,215
Persons									
<65	35	1,474	46	857	304	109	1,084	289	4,198
65-69	42	1,112	31	537	275	105	767	287	3,156
70-74	50	1,910	29	940	462	157	1,288	442	5,278
75-79	84	3,648	33	1,709	1,003	304	2,553	790	10,125
80-84	184	6,683	54	3,156	1,889	497	4,685	1,405	18,554
85+	445	17,687	86	8,094	5,090	1,309	12,053	3,698	48,462
Total	841	32,514	279	15,293	9,024	2,481	22,430	6,911	89,772

Note: (a) As at 30 June 2010.
Source: PC (2010) and Access Economics calculations.

Table 2.15: Estimated number of people in low care residential places, 2010 [(a)]

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Aust
Males									
<65	-	605	23	403	-	37	449	203	1,720
65-69	7	448	10	323	88	33	360	110	1,379
70-74	12	722	19	424	127	35	502	192	2,033
75-79	29	1,177	27	648	227	68	889	253	3,319
80-84	37	1,963	33	1,020	476	125	1,524	501	5,679
85+	136	4,179	8	2,310	1,136	312	3,565	1,112	12,758
Total	221	9,094	121	5,128	2,053	610	7,290	2,372	26,888
Females									
<65	27	-	-	395	-	37	445	-	904
65-69	8	375	-	213	76	18	270	100	1,060
70-74	21	832	6	433	171	53	569	213	2,298
75-79	67	1,918	25	1,110	429	125	1,544	468	5,686
80-84	174	4,571	23	2,438	1,289	338	3,599	1,196	13,628
85+	468	13,184	42	7,408	3,917	1,032	11,271	3,646	40,967
Total	765	20,880	97	11,995	5,882	1,603	17,697	5,623	64,543
Persons									
<65	27	605	23	798	-	74	894	203	2,624
65-69	15	822	10	536	164	51	630	210	2,439
70-74	33	1,554	25	857	298	88	1,071	405	4,331
75-79	96	3,095	53	1,758	656	193	2,433	721	9,005
80-84	212	6,534	56	3,457	1,766	462	5,123	1,697	19,307
85+	604	17,364	51	9,718	5,052	1,343	14,836	4,758	53,726
Total	986	29,974	218	17,124	7,936	2,213	24,987	7,995	91,431

Note: (a) As at 30 June 2010.
Source: PC (2010) and Access Economics calculations.

2.3.2 Residential care recipients with dementia

There is limited information regarding the specific conditions of people in residential care facilities. Using data from the 2003 SDAC (ABS, 2004), the AIHW estimated that the proportion of permanent residents in low residential care with dementia was 23%, increasing to 63% in high residential care (AIHW, 2007). These figures were used to estimate the number of permanent residents with dementia in 2010, which are presented in Table 2.16.

It is estimated there are approximately 82,815 permanent residents in residential care in 2010 who have dementia. These people account for around 49% of all residents. Of these, there are 69,047 people with dementia who are classified as high care residents and 13,768 people with dementia who are classified as low care residents.

However, data from SDAC are relatively old and improvements in diagnosis of dementia since 2003 suggests data may underestimate the number of people with dementia in residential care places, especially those with mild forms of dementia (AIHW, 2008).[14] Although not as detailed (in terms of age and gender splits), data collected as part of the Aged Care Funding Instrument (ACFI) appraisal process in 2007-08 suggest the proportion of residents with dementia in residential care is around 63% (AIHW, 2009c). This equates to around 114,158 residents with dementia in 2010.

Table 2.16: Estimated permanent residential care residents with dementia using SDAC, 2010

Age bracket	Low care	High care	Total
<65	289	954	1,243
65-69	435	1,146	1,581
70-74	891	2,497	3,388
75-79	1,808	6,229	8,037
80-84	3,049	15,715	18,764
85+	7,296	42,506	49,802
Total	13,768	69,047	82,815

Note: As at 30 June 2010.
Source: AIHW (2004; 2007) and Access Economics calculations.

2.4 Care for people with younger onset dementia

Younger onset dementia (YOD) is the term used to describe any form of dementia diagnosed in people under the age of 65. It is estimated that younger onset dementia affects approximately 16,000 people in Australia today, which is approximately 6.2% of the total population with dementia (see Section 1.3).

In 2009 Alzheimer's Australia held a national consumer summit on younger onset dementia (Alzheimer's Australia, 2009). The summit recognised several issues associated with caring for someone with younger onset dementia.

[14] The most recent SDAC was completed between April and December 2009. There are several significant additions to the survey compared to the 2003 SDAC. New content includes questions on unmet demand for disability services and services for the elderly; additional questions relating to carers; social inclusion; and labour force participation. Results are due to be released in the second half of 2010.

First, timely and accurate diagnosis is particularly problematic for younger people because there is low awareness of younger onset dementia among health professionals, limited access to specialist diagnostic service, and a lack of awareness of the availability of genetic testing. In many instances, accurate diagnosis can take several years because symptoms are often attributed to other conditions (such as stress or depression).

Given the delay in diagnosis, there can also be delays in accessing appropriate care for people with younger onset dementia. Community and residential care services for people with younger onset dementia, their carers and their families are mostly provided under the *Aged Care Act 1997,* although some services are provided through the HACC program. There is no specific restriction of community care and residential care to younger people, the only criterion being that the person is assessed as having complex care needs.[15]

The type of support services needed for people with younger onset dementia are not the same as for those who are older, and care in a residential facility may not be appropriate, given that a different mix of skills may be required to meet specific needs. For example, people with younger onset dementia are likely to be physically able, which is particularly problematic for residential care and respite services because facilities are often designed for the physically frail or disabled. Entering high level aged care at a young age is also demoralising for both the person with dementia and their family.

Greater support is required in the community care setting to enable younger people with dementia to continue to combine work and family responsibilities. For example, children of people with younger onset dementia may be at greater risk as the family tries to cope with the condition and relationships come under stress. Support services therefore need to be available for children and teenagers to help them cope with the effect of dementia on their parent (Alzheimer's Australia, 2007).

While many of the needs of younger people with dementia are similar to those of older people, there are significant differences primarily because of the life stage at the onset of dementia. For example, younger onset dementia is likely to impose greater financial stress because the person is often in employment, and the onset of dementia may result in a demotion, early (unplanned) retirement, or sale or failure of a business. This can generate a large emotional and financial burden from needing to leave employment unexpectedly (especially if that person is still supporting a family), or the need for a spouse to leave employment in order to provide care. These are issues that are less common for older people with dementia. Furthermore, people with younger onset dementia require access to dementia specific legal advice and specialist financial advice for future planning that is in line with their future health and personal care instructions.

In order to address these issues (and others), participants in the national consumer summit on younger onset dementia developed 39 recommendations that were grouped into six broad priority areas. They include:

- increase awareness of younger onset dementia to reduce stigma and social isolation through a national awareness and social marketing program, and greater recognition of younger people with dementia in social inclusion policies and initiatives;

[15] Specific mention is made within the *Approval of Care Recipients Principles 1997* that for a person who is not aged, access to residential care will only be granted if there are no other care facilities or care services more appropriate to meet the person's needs.

- implement timely and accurate assessment and diagnosis through specialist diagnostic clinics, dementia awareness initiatives for health professionals, and improving the range of clinical diagnostic tools including the introduction of a national framework for genetic testing;
- provide access to appropriate services through a review of accommodation services, developing a targeted strategy to improve the range and quality of in-home and out of home care services to younger people with dementia, their families and carers, and additional training for staff on specific issues related to younger onset dementia;
- ensure employment and financial needs are met, through programs that allow people with younger onset dementia to participate in full time or part time work, volunteer or recreational activities, and to remove the inequities in accessing superannuation and income security entitlements;
- improve legal and bureaucratic systems to reduce complexity and improve flexibility through harmonisation for power of attorney and advanced care directives, and to improve the recognition of younger people with dementia in government legislation and private insurance; and
- increase investment in research into younger onset dementia to accurately measure the number of younger people with dementia in Australia, and to improve the knowledge base on the cause and treatment of younger onset dementia, including the issue of appropriate care (Alzheimer's Australia, 2009).

The lack of recognition of younger onset dementia has meant that the needs of this group have been met through an ongoing reliance on the aged care sector. In 2008, COAG agreed that responsibility for this group should be included under a new National Disability Agreement. Alzheimer's Australia has raised questions with the Minister for Ageing and the Parliamentary Secretary for Disabilities and Children's Services that need to be addressed, including:

- How is the disability sector going to gain an understanding of the care and support needs of people living with dementia?
- What resources are available to develop services appropriate for people with younger onset dementia?
- What requirement is there on jurisdictions to include younger people with dementia within the current initiatives? (Alzheimer's Australia, 2010).

There is a significant risk of younger people with dementia being shifted between disability and aged care services. When disability services are no longer able to meet a younger person's needs due to the progression of dementia, the person and their family carers are required to navigate a second unfamiliar system. The progression of dementia in younger people can be quite rapid. The challenge is to develop a smooth and seamless service. One option might be to remove age limits for access to aged care services for those with dementia, and to ensure the services received are appropriate.

Issues surrounding the appropriate treatment of young people with dementia are relevant for the Productivity Commission's review into the long term disability care and support scheme (PC, 2010a). Under this inquiry, the Productivity Commission will examine specific design issues for a national disability insurance scheme to reduce the level of unmet demand for disability services, and accommodate pressures from demographic change and the anticipated

decline in the availability of informal care. Part of the inquiry is to determine eligibility criteria for the scheme, including appropriate age limits, assessment and review processes.

It should be recognised within the inquiry that dementia is not age related. Rather, dementia is a condition related to disease, and a condition that can impose significant disability, requiring a high level of complex care from a relatively early age. Consequently, applying age limits to eligibility under a national disability scheme may generate unequal access to care for a proportion of people with dementia, and should therefore be avoided.

2.5 Psychogeriatric care

While acknowledging that dementia results from neurological disease that can affect people from an early age, the majority of those with dementia are aged 65 years and over. Furthermore, dementia is often associated with a range of behavioural and psychological symptoms, and for this reason, people with dementia often come under psychogeriatric care.

Effectively managing behaviours associated with dementia (e.g. wandering, sundowning and forgetting to eat) requires training as well as specialist support. In Australia most residential care received by people with dementia is not dementia specific (Hogan, 2004). This is despite the fact that dementia specific care has been shown to be beneficial for the person with dementia, the staff providing care and other residents living in the residential care facility.

Providing dementia specific training to staff equips them with the skills and knowledge to manage the challenging behaviours and psychological symptoms associated with dementia. For example, an important aspect of dementia care is stability in daily routine and interaction with the same staff. Awareness of factors that upset particular patients, and then minimising these factors, can have a positive effect on the emotional state of the person being cared for.

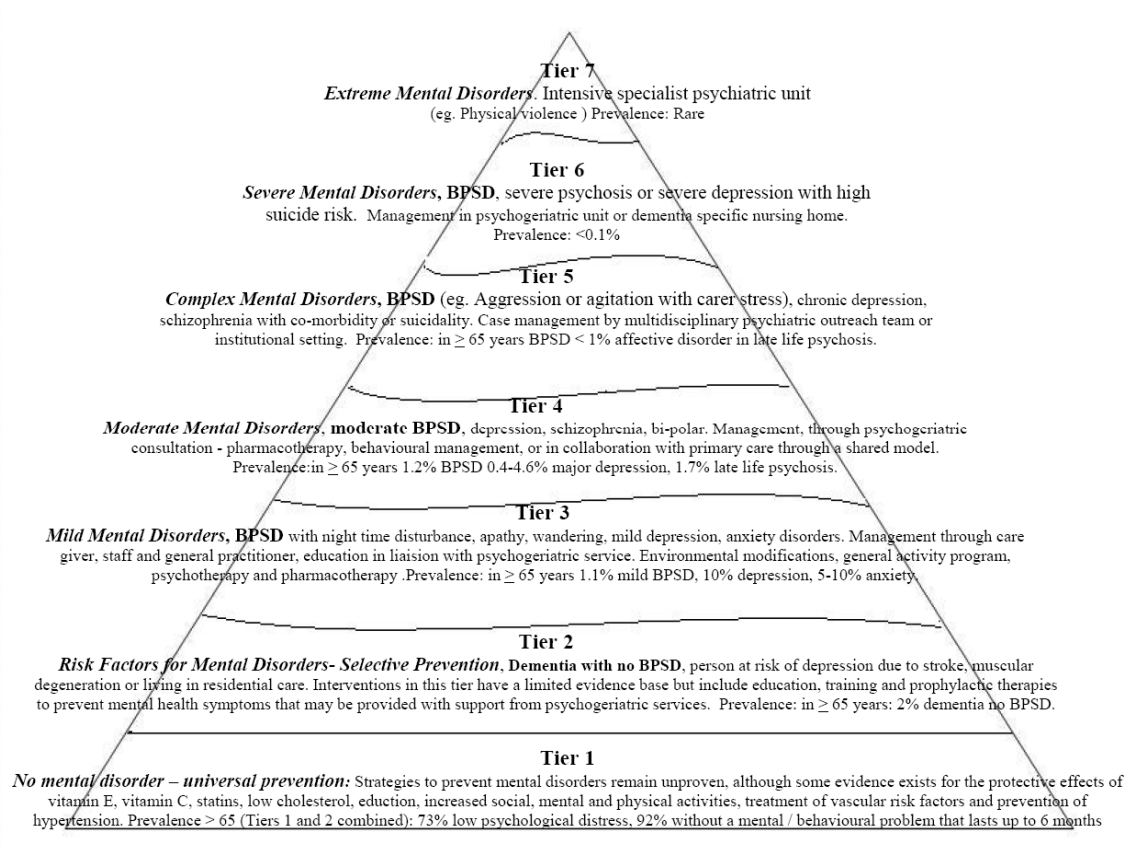
Dementia care is time intensive compared to the care requirements associated with many other conditions common in older people. In a residential care setting that provides services to people with a range of illnesses there is a risk that staff will not be able to provide the necessary attention to people with dementia. This can serve to exacerbate some of the behaviours often exhibited by people with dementia, which can be disruptive and upsetting to other residents.

One of the greatest concerns for families and friends of people with dementia is that staff in residential care facilities often lack dementia specific training. A recent survey by Access Economics found that family and friends of those with dementia were concerned about the lack of dementia specific training among care assistants within residential care facilities (Access Economics, 2009d). Respondents highly valued staff who could provide patience and compassion to a person with dementia and were able to communicate with that person on their level. Respondents were willing to trade-off other desirable residential care attributes such as reduced travel time and private facilities to receive specialised dementia care.

However, residential care facilities may not be the best setting for providing dementia care to some people with dementia. People with extreme behavioural and psychological symptoms may require specialist mental health services because the person can place themselves, and others, at risk of harm, thereby imposing significant burden on the health care system in general. These are generally people who fit into tier six and tier seven of the Brodaty-Draper

triangle (see Figure 2.1), although others who fit into tier four and five may also need specialist services to develop tailored behavioural management strategies (DoHA, 2008a).

Figure 2.1: Seven tiered model of service delivery for mental health disorders in old age



Source: DoHA (2008a).

The Dementia Behaviour Management Advisory Service (DBMAS) was established by the Commonwealth Government in 2004 to coordinate care for people with dementia who require specialised psychogeriatric care due to complex and challenging behaviours. Services are provided to improve the capacity of the residential care sector in preventing and dealing with escalating behaviours, and include case management, clinical support, mentoring, and behaviour management advice.

Some jurisdictions (NSW, Victoria, Western Australia and Tasmania) have responded to the need for specialist psychogeriatric care by providing specialised intensive treatment in sympathetically designed facilities that offer greater and more appropriate care than dementia specific residential aged care (DoHA, 2008a). The aim is to help people transition to residential aged care where mainstream services are delivered. Yet there is some variation in psychogeriatric care across jurisdictions, and no jurisdiction has the optimal system of care.

A model of an optimal system of care and options for improving care has been presented in a report to the Minister for Ageing on residential care and people with psychogeriatric disorders (DoHA, 2008a). The optimal system allows people who are mobile and have dementia related moderate to severe behavioural and psychological symptoms to be treated in a high dependency unit on a temporary basis. These high dependency units would be designed to

help reduce the need for psychogeriatric care and shift people to long term residential care facilities using a case management approach to ensure continuity in care. Where people in residential care start to exhibit moderate to complex mental disorders, close relationships with psychogeriatric care units would enable a seamless transition to higher care so behaviour could be stabilised.

The report to the Minister for Ageing on residential care and people with psychogeriatric disorders (DoHA, 2008a) also presented several factors that are necessary to delivering optimal care. In summary these include:

- mainstream residential care facilities should prevent escalation of behavioural problems by incorporating dementia specific design and staff specifically trained in dementia care;
- access to medical and psychiatric diagnosis and cure needs to be assured, including on-going support from old age psychiatrists and mental health teams;
- admission criteria within a residential care facility needs to consider the appropriate fit of potential residents, for example, to ensure frail residents are not at risk from potential aggression from other residents; and
- residential care facilities must employ staff capable of recognising early signs of moderate to complex behavioural and psychological symptoms, and the means of preventing escalation and the need for psychogeriatric care.

The report outlined several strategies that could be undertaken to strengthen the current aged care system in relation to people with complex behavioural and psychological symptoms. These include:

- maintain support for people with psychogeriatric disorders as high profile 'front of mind' issue for senior level aged care administrators and planners;
- develop protocols for effective collaboration across the residential aged care and jurisdictional mental health systems;
- establish evidence based practice guidelines to promote consistent best practice in residential care facilities;
- develop strong collaborative networks between primary, acute, mental health and aged care service systems;
- encourage best practice residential care facilities to take a proactive role in developing referral mechanisms within their facilities and the region that they operate in;
- incorporate planning provisions for high dependency transitional services within the aged care planning ratios under the Aged Care Act 1997;
- provide a greater level of training for aged care nurses and personal care staff in managing complex behavioural and psychological symptoms, especially aggressive and sexually inappropriate behaviours;
- provide greater training for General Practitioners (GPs) in recognising and treating dementia related behavioural problems; and
- facilitate progression models of care to enable people to seamlessly move into, and out of, psychogeriatric care units (DoHA, 2008a).

No systemic changes have resulted from the report. The National health and Hospital Network (NHHN) or the Productivity Commission's Inquiry into Aged Care, may provide the opportunity to fill these gaps.

3 Supply of aged care using current planning policy

This chapter presents forecasts of community care programs and residential care programs based on current planning policies. Results are broken down by jurisdiction, and Aged Care Planning Regions (ACPRs). The analysis was also undertaken by Commonwealth Electoral Divisions (CEDs) but has been published in a separate report that is available upon request.

3.1 Current planning policy

Under the *Aged Care Act 1997,* the Department of Health and Ageing (DoHA) uses planning ratios to manage the supply of residential care places and the number of packages offered under the Community Aged Care Packages (CACP) program, Extended Aged Care at Home (EACH) program and Extended Aged Care at Home Dementia (EACH-D) program.

The current planning ratio is for 113 places per 1,000 people aged 70 years and over to be achieved by 2011 (DoHA, 2009c). These are allocated as follows.

- 44 high care places.
- 44 low care places.
- 25 community care places, which comprise:
  - 21 CACPs; and
  - 4 EACH or EACH-D packages.

These ratios are used in an attempt to ensure the supply of aged care services keeps up with growth in the aged population, and therefore growth in the demand for services. Planning ratios are built on the assumption that a good predictor of demand is the population aged 70 years and over. New places are made available by DoHA each year for competitive allocation in each state and territory. Allocation of places to regions and groups most in need is based on the advice of Aged Care Planning Advisory Committees in each jurisdiction. In the Aged Care Approvals Round (ACAR) for 2009-10 there were 12,218 new places made available, comprising 8,140 residential care places and 4,078 community care packages (DoHA, 2010).

The Home and Community Care (HACC) program is jointly funded by jurisdictional governments and the Commonwealth Government, with the latter accounting for around 60% of the funding. However, HACC is administered by jurisdictional governments with the Commonwealth maintaining a broad strategic policy role.[16] Consequently, HACC planning is undertaken by each jurisdictional government using individual planning methods by taking into consideration disability rates within the community and population growth. For example, the NSW government applies the sum of moderate, severe and profound disability rates derived from the most recent Survey of Disability, Ageing and Carers (SDAC) to the relevant population projection (DADHC, 2007).

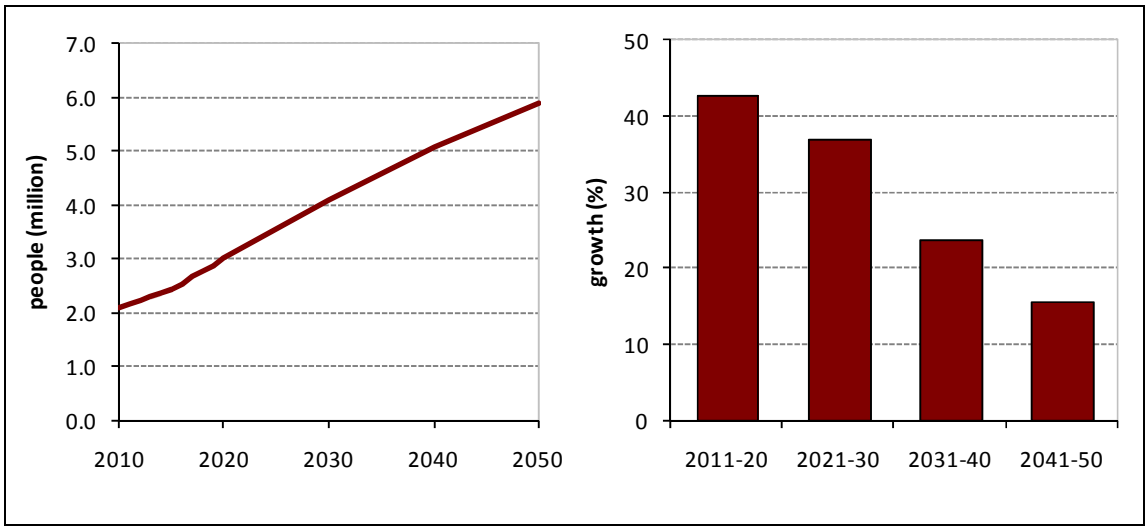
[16] On the 20th April 2010, the Council of Australian Governments (COAG) announced that, with the exception of Western Australia and Victoria, the Commonwealth would assume full funding and policy responsibility for aged care services from the HACC program (COAG, 2010).

The number of aged care services available in 2008-09 were projected using target planning ratios for residential care, and for CACP, EACH and EACH-D programs up to 2011. For years 2012 and beyond, aged care was projected to grow at the expected population growth rate for persons aged 70 years and over.

To project the number of clients in the HACC program, the number of clients in 2008-09 was increased at the growth rate of those aged 70 years and above. This was under the assumption that HACC planning would be the same as other community care packages under the *Aged Care Act 1997* once the Commonwealth Government takes control of the HACC program as agreed by COAG (2010).

The projected number of people aged 70 years and over along with the growth rates for each decade are shown in Chart 3.1. The number of people over the age of 70 years is expected to increase from around 2.1 million in 2010 to 5.9 million in 2050. However, the greatest growth period is within the next decade, with a total growth of around 42.8%. This is due to the baby boomers entering this age bracket. Each subsequent decade up to 2050 is expected to experience a decrease in growth.

Chart 3.1: Projected growth in people aged 70 years and over



Source: Access Economics calculations.

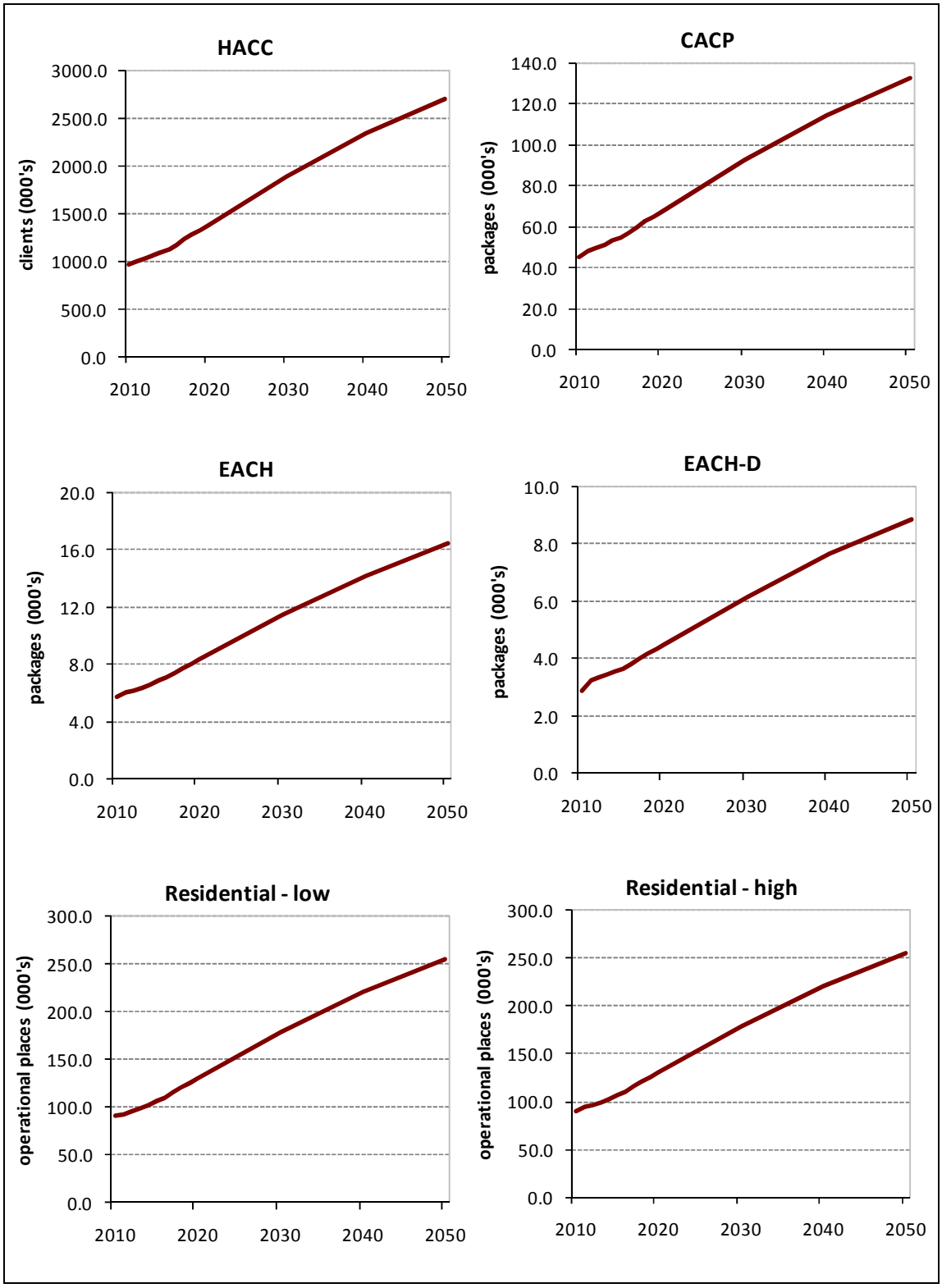
3.2 Supply of aged care under current policy

A summary of projected access to community care and residential care services is presented in Chart 3.2. Under current policy the total number of community care packages is projected to increase from around 54,325 in 2010 to 158,276 in 2050. Of these, there will be:

- 132,952 CACPs;
- 16,461 EACH packages; and
- 8,863 EACH-D packages.

Over the same period the number of HACC clients is projected to increase from around 966,710 to around 2.7 million. In addition, under current policy the total number of operational residential care places will increase from around 181,204 in 2010 to 511,068 places in 2050 distributed equally between low and high care.

Chart 3.2: Projected supply of aged care under current policy scenario



Source: Access Economics calculations.

Projecting low and high residential care based on the current planning ratios suggests there will be an equal amount from 2011 onwards. However, the delivery of high care within residential care facilities is currently much greater with around 72% of permanent residents in

2009 categorised classified as receiving high care, despite some occupying low care places (DoHA, 2009c).

3.3 Supply of aged care by jurisdiction and Aged Care Planning Regions

The projected number of HACC clients and supply of community care packages and operational residential care places by jurisdiction are summarised in Table 3.1. Detailed projections are presented in Table 3.2 to Table 3.7.

As aged care services were projected using growth of the Australian population aged 70 years and over, the projected growth rate in aged care services across jurisdictions will be identical. However, given jurisdictions do not have the same number of aged care services, the growth in the number of HACC clients, community care packages, and operational residential care places across jurisdictions is projected to be different.

Thus, the number of HACC clients will increase from 966,710 to 2.7 million, with Victoria remaining the jurisdiction with the greatest number of HACC clients. Community care programs (CACP, EACH, and EACH-D) are projected to increase packages from 54,325 in 2010 to 158,276 in 2050, whereas operational residential care places are expected to increase from 181,204 in 2010 to 511,068 in 2050.

The projected supply of aged care under the current policy scenario was also disaggregated by Aged Care Planning Regions (ACPRs) and is shown in Table 3.8 to Table 3.10. This was done using the share of people within each age bracket and implicitly assumes the allocation of aged care across ACPRs is based on the care needs of its population. This may not provide a good estimate for some ACPRs as anecdotal evidence suggests a mismatch between aged care supply and demand within specific communities (SCFPA, 2009). For example, breaking down the supply of aged care into specific ACPRs using age will overestimate supply if aged care services do not match the needs of the population within that ACPR.

Table 3.1: Summary of aged care supply projections by jurisdiction

	2010			2050		
	HACC	Community care [(a)]	Residential care	HACC	Community care [(a)]	Residential care
	Clients (000's)	*Packages (000's)*	*Places (000's)*	*Clients (000's)*	*Packages (000's)*	*Places (000's)*
ACT	11.6	0.9	1.8	32.5	2.5	5.1
NSW	272.2	17.9	62.5	762.8	52.0	176.3
NT	3.8	0.8	0.5	10.6	2.4	1.4
QLD	178.8	10.1	32.4	501.1	29.4	91.4
SA	100.8	4.4	17.0	282.5	13.0	47.9
TAS	27.6	1.4	4.7	77.4	4.2	13.2
Vic	302.3	13.4	47.4	847.4	39.0	133.7
WA	69.6	5.4	14.9	195.2	15.8	42.0
Aust	966.7	54.3	181.2	2,709.5	158.3	511.1

Source: Access Economics calculations.

Table 3.2: Projected HACC clients under current policy scenario

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
	000's	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*
ACT	11.6	11.9	12.3	12.7	13.1	13.6	14.1	14.8	15.4	16.0	16.6	22.7	28.1	32.5
NSW	272.2	279.8	288.3	296.8	307.1	318.1	329.9	346.0	360.6	374.4	388.6	532.8	659.2	762.8
NT	3.8	3.9	4.0	4.1	4.3	4.4	4.6	4.8	5.0	5.2	5.4	7.4	9.2	10.6
QLD	178.8	183.8	189.4	194.9	201.7	209.0	216.7	227.3	236.9	245.9	255.3	350.0	433.0	501.1
SA	100.8	103.6	106.8	109.9	113.7	117.8	122.2	128.1	133.5	138.6	143.9	197.3	244.1	282.5
TAS	27.6	28.4	29.3	30.1	31.2	32.3	33.5	35.1	36.6	38.0	39.4	54.1	66.9	77.4
Vic	302.3	310.8	320.3	329.7	341.2	353.4	366.4	384.4	400.5	415.8	431.7	591.8	732.2	847.4
WA	69.6	71.6	73.8	75.9	78.6	81.4	84.4	88.6	92.3	95.8	99.5	136.3	168.7	195.2
Aust	966.7	993.7	1,024.1	1,054.1	1,090.9	1,130.0	1,171.7	1,229.1	1,280.8	1,329.7	1,380.4	1,892.4	2,341.4	2,709.5

Source: Access Economics calculations.

Table 3.3: Projected CACPs under current policy scenario

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
	000's	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*
ACT	0.6	0.7	0.7	0.7	0.8	0.8	0.8	0.9	0.9	0.9	1.0	1.3	1.6	1.9
NSW	15.2	16.2	16.7	17.2	17.8	18.4	19.1	20.1	20.9	21.7	22.5	30.9	38.2	44.2
NT	0.7	0.7	0.8	0.8	0.8	0.8	0.9	0.9	0.9	1.0	1.0	1.4	1.7	2.0
QLD	8.5	9.1	9.3	9.6	9.9	10.3	10.7	11.2	11.7	12.1	12.6	17.3	21.4	24.7
SA	3.8	4.1	4.2	4.3	4.5	4.6	4.8	5.0	5.2	5.4	5.7	7.8	9.6	11.1
TAS	1.2	1.3	1.3	1.3	1.4	1.4	1.5	1.6	1.6	1.7	1.7	2.4	3.0	3.4
Vic	11.3	12.1	12.5	12.8	13.3	13.7	14.3	14.9	15.6	16.2	16.8	23.0	28.5	33.0
WA	4.3	4.6	4.8	4.9	5.1	5.3	5.5	5.7	6.0	6.2	6.4	8.8	10.9	12.6
Aust	45.7	48.8	50.2	51.7	53.5	55.4	57.5	60.3	62.8	65.2	67.7	92.9	114.9	133.0

Source: Access Economics calculations.

Table 3.4: Projected EACH packages under current policy scenario

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
ACT	153	160	165	170	175	182	188	198	206	214	222	304	377	436
NSW	1,779	1,861	1,918	1,974	2,043	2,116	2,194	2,302	2,399	2,490	2,585	3,544	4,385	5,074
NT	105	109	113	116	120	124	129	135	141	146	152	208	258	298
QLD	1,018	1,065	1,098	1,130	1,169	1,211	1,256	1,317	1,373	1,425	1,480	2,028	2,510	2,904
SA	417	437	450	463	479	497	515	540	563	584	607	832	1,029	1,191
TAS	159	166	171	177	183	189	196	206	214	223	231	317	392	454
Vic	1,419	1,484	1,530	1,575	1,629	1,688	1,750	1,836	1,913	1,986	2,062	2,827	3,497	4,047
WA	721	754	777	800	828	858	889	933	972	1,009	1,048	1,436	1,777	2,056
Aust	5,770	6,037	6,221	6,404	6,627	6,865	7,118	7,467	7,781	8,078	8,386	11,497	14,224	16,461

Source: Access Economics calculations.

Table 3.5: Projected EACH-D packages under current policy scenario

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
ACT	56	63	65	67	69	72	75	78	82	85	88	121	149	173
NSW	889	996	1,027	1,057	1,094	1,133	1,175	1,232	1,284	1,333	1,384	1,897	2,347	2,716
NT	43	48	50	51	53	55	57	59	62	64	67	92	113	131
QLD	591	662	682	702	727	753	781	819	853	886	920	1,261	1,560	1,805
SA	219	246	253	261	270	279	290	304	317	329	341	468	579	670
TAS	97	109	112	115	120	124	128	135	140	146	151	207	257	297
Vic	643	720	742	764	791	819	849	891	928	964	1,001	1,372	1,697	1,964
WA	363	406	419	431	446	462	479	503	524	544	564	774	957	1,108
Aust	2,901	3,251	3,350	3,448	3,569	3,697	3,833	4,021	4,190	4,350	4,516	6,191	7,659	8,863

Source: Access Economics calculations.

Table 3.6: Projected low care operational residential care places under current policy scenario

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
	000's	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*
ACT	1.0	1.0	1.0	1.1	1.1	1.1	1.2	1.3	1.3	1.4	1.4	1.9	2.4	2.8
NSW	30.0	30.7	31.7	32.6	33.7	34.9	36.2	38.0	39.6	41.1	42.7	58.5	72.4	83.8
NT	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.5	0.6
QLD	17.1	17.6	18.1	18.6	19.3	20.0	20.7	21.7	22.6	23.5	24.4	33.4	41.4	47.9
SA	7.9	8.1	8.4	8.6	8.9	9.3	9.6	10.1	10.5	10.9	11.3	15.5	19.2	22.2
TAS	2.2	2.3	2.3	2.4	2.5	2.6	2.7	2.8	2.9	3.0	3.2	4.3	5.3	6.2
Vic	25.0	25.6	26.4	27.2	28.1	29.1	30.2	31.7	33.0	34.3	35.6	48.8	60.3	69.8
WA	8.0	8.2	8.4	8.7	9.0	9.3	9.7	10.1	10.6	11.0	11.4	15.6	19.3	22.3
Aust	91.4	93.7	96.6	99.4	102.9	106.6	110.5	115.9	120.8	125.4	130.2	178.5	220.8	255.5

Source: Access Economics calculations.

Table 3.7: Projected high care operational residential care places under current policy scenario

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
	000's	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*
ACT	0.8	0.9	0.9	0.9	1.0	1.0	1.0	1.1	1.1	1.2	1.2	1.7	2.1	2.4
NSW	32.5	33.9	35.0	36.0	37.3	38.6	40.0	42.0	43.7	45.4	47.2	64.6	80.0	92.6
NT	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.6	0.7	0.8
QLD	15.3	16.0	16.5	16.9	17.5	18.2	18.8	19.7	20.6	21.4	22.2	30.4	37.6	43.5
SA	9.0	9.4	9.7	10.0	10.3	10.7	11.1	11.7	12.1	12.6	13.1	17.9	22.2	25.7
TAS	2.5	2.6	2.7	2.7	2.8	2.9	3.1	3.2	3.3	3.5	3.6	4.9	6.1	7.1
Vic	22.4	23.4	24.1	24.8	25.7	26.6	27.6	29.0	30.2	31.3	32.5	44.6	55.2	63.8
WA	6.9	7.2	7.4	7.7	7.9	8.2	8.5	8.9	9.3	9.7	10.0	13.7	17.0	19.7
Aust	89.8	93.7	96.6	99.4	102.9	106.6	110.5	115.9	120.8	125.4	130.2	178.5	220.8	255.5

Source: Access Economics calculations.

Table 3.8: Projected HACC clients by Aged Care Planning Regions (ACPRs)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
ACT														
ACT	11,604	11,928	12,292	12,653	13,094	13,564	14,065	14,753	15,374	15,961	16,569	22,715	28,104	32,523
NSW														
Central Coast	15,262	15,601	16,009	16,409	16,917	17,463	18,037	18,857	19,587	20,282	21,004	28,397	35,086	40,597
Central West	7,041	7,234	7,460	7,673	7,925	8,194	8,486	8,898	9,256	9,576	9,899	12,899	15,403	17,323
Western Sydney	23,529	24,407	25,383	26,358	27,511	28,738	30,064	31,796	33,412	34,981	36,612	54,046	69,573	82,966
Far North Coast	14,129	14,533	14,992	15,433	15,967	16,551	17,160	18,020	18,791	19,515	20,286	28,295	35,580	41,654
Hunter	24,862	25,552	26,320	27,108	28,042	29,035	30,130	31,644	33,021	34,316	35,643	49,382	61,462	71,318
Illawarra	16,844	17,388	17,964	18,528	19,199	19,905	20,619	21,598	22,470	23,281	24,112	31,864	38,784	44,391
Inner West	16,251	16,627	17,030	17,455	17,990	18,569	19,162	19,976	20,705	21,396	22,128	29,445	36,037	41,459
Mid North Coast	15,850	16,361	16,934	17,500	18,159	18,868	19,613	20,645	21,564	22,417	23,314	32,176	40,188	46,845
Nepean	9,533	9,865	10,234	10,607	11,059	11,554	12,084	12,781	13,427	14,052	14,713	21,498	27,040	31,529
New England	7,431	7,605	7,811	8,018	8,275	8,548	8,829	9,236	9,579	9,912	10,238	13,234	15,794	17,785
Northern Sydney	34,320	34,996	35,779	36,563	37,566	38,631	39,789	41,481	42,980	44,390	45,839	59,845	71,554	80,629
Orana Far West	6,097	6,243	6,424	6,575	6,766	6,956	7,183	7,497	7,766	7,992	8,216	10,416	12,191	13,570
Riverina Murray	11,229	11,517	11,853	12,178	12,575	12,995	13,427	14,044	14,601	15,100	15,624	20,638	25,046	28,635
South East Sydney	34,150	34,864	35,679	36,514	37,596	38,732	39,966	41,704	43,261	44,758	46,285	61,958	75,484	86,399
South West Sydney	26,822	27,890	29,019	30,132	31,458	32,876	34,358	36,286	38,057	39,766	41,541	59,939	76,253	89,979
Sthn Highlands	8,816	9,090	9,420	9,731	10,114	10,528	10,972	11,565	12,110	12,624	13,175	18,754	23,705	27,740
Northern Territory														
Alice springs	704	705	716	725	733	752	768	795	822	841	864	1,073	1,276	1,431
Barkly	102	109	111	112	118	125	131	137	143	149	155	193	230	263

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Table 3.8: Projected HACC clients by Aged Care Planning Regions (ACPRs) continued

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
Darwin	2,488	2,566	2,657	2,743	2,857	2,966	3,087	3,252	3,396	3,541	3,682	5,168	6,440	7,494
East Arnhem	194	204	213	224	233	243	252	266	279	290	302	438	566	673
Katherine	294	305	309	319	326	334	345	358	370	382	398	532	648	740
Queensland														
Brisbane North	19,299	19,490	19,733	19,973	20,357	20,763	21,206	21,935	22,575	23,166	23,749	30,003	35,343	39,497
Brisbane South	28,243	28,745	29,339	29,911	30,666	31,468	32,350	33,651	34,775	35,828	36,911	47,576	56,766	64,015
Cabool	14,741	15,323	15,977	16,640	17,401	18,203	19,036	20,125	21,151	22,117	23,123	33,092	41,603	48,488
Central West	452	459	467	468	472	479	486	500	506	511	518	571	619	665
Darling Downs	11,557	11,810	12,083	12,346	12,691	13,071	13,463	14,025	14,505	14,952	15,418	19,799	23,706	26,807
Far North	9,291	9,578	9,896	10,215	10,604	11,015	11,438	12,037	12,580	13,111	13,642	19,105	23,900	27,823
Fitzroy	7,801	7,988	8,203	8,424	8,694	8,991	9,298	9,723	10,105	10,462	10,835	14,764	18,326	21,304
Logan River Valley	9,707	10,141	10,618	11,082	11,622	12,196	12,811	13,608	14,349	15,061	15,795	23,570	30,025	35,245
Mackay	5,123	5,283	5,466	5,647	5,866	6,103	6,355	6,697	7,014	7,307	7,619	10,888	13,855	16,336
North West	1,414	1,448	1,500	1,546	1,603	1,653	1,725	1,820	1,903	1,985	2,074	2,994	3,708	4,271
Northern	8,675	8,898	9,141	9,389	9,670	9,987	10,317	10,802	11,224	11,617	12,029	16,253	19,942	22,913
South Coast	22,706	23,403	24,173	24,932	25,854	26,813	27,856	29,248	30,503	31,719	32,947	45,378	56,328	65,328
South West	1,011	1,021	1,039	1,049	1,073	1,091	1,107	1,136	1,162	1,184	1,205	1,364	1,521	1,647
Sunshine Coast	18,626	19,338	20,097	20,861	21,753	22,696	23,697	24,999	26,198	27,330	28,518	40,135	50,593	59,534
West Moreton	7,466	7,781	8,143	8,519	8,948	9,422	9,935	10,601	11,218	11,815	12,463	19,419	25,787	31,266
Wide Bay	12,665	13,066	13,505	13,944	14,465	15,027	15,608	16,387	17,090	17,738	18,430	25,059	30,972	35,936

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Table 3.8: Projected HACC clients by Aged Care Planning Regions (ACPRs) continued

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
South Australia														
Eyre Peninsula	2,090	2,144	2,202	2,259	2,339	2,428	2,510	2,621	2,731	2,837	2,951	4,032	4,999	5,805
Hills, Mallee & Southern	8,032	8,365	8,735	9,100	9,531	9,986	10,463	11,075	11,646	12,204	12,777	18,623	23,892	28,398
Metropolitan East	15,879	16,209	16,609	17,002	17,519	18,065	18,666	19,507	20,259	20,968	21,705	29,092	35,386	40,361
Metropolitan North	20,512	21,282	22,129	22,963	23,944	24,975	26,051	27,503	28,824	30,074	31,371	44,831	56,820	66,922
Metropolitan South	21,821	22,372	23,018	23,664	24,441	25,288	26,196	27,477	28,646	29,741	30,877	42,430	52,284	60,189
Metropolitan West	15,496	15,769	16,069	16,369	16,754	17,174	17,646	18,329	18,913	19,443	19,997	25,532	30,457	34,324
Mid North	1,847	1,899	1,950	2,000	2,058	2,125	2,200	2,294	2,375	2,451	2,532	3,230	3,792	4,250
Riverland	2,700	2,776	2,856	2,932	3,029	3,124	3,224	3,369	3,485	3,612	3,736	4,810	5,696	6,407
South East	3,802	3,909	4,032	4,154	4,310	4,458	4,622	4,851	5,050	5,249	5,443	7,387	9,068	10,437
Whyalla, Flinders & Far North	2,701	2,789	2,880	2,965	3,071	3,181	3,291	3,444	3,585	3,712	3,841	5,022	6,059	6,902
Yorke, Lower North & Barossa	5,907	6,089	6,286	6,494	6,734	7,010	7,288	7,669	8,015	8,340	8,683	12,308	15,651	18,486
Tasmania														
North Western	6,315	6,483	6,629	6,847	7,075	7,316	7,574	7,923	8,237	8,538	8,836	11,750	14,264	16,264
Northern	7,901	8,120	8,376	8,608	8,919	9,232	9,563	10,019	10,426	10,824	11,225	15,161	18,546	21,297
Southern	13,402	13,787	14,251	14,662	15,171	15,736	16,337	17,171	17,927	18,626	19,375	27,153	34,080	39,846
Victoria														
Barwon-South Western	23,855	24,428	25,086	25,748	26,546	27,395	28,323	29,645	30,800	31,880	32,997	44,144	53,917	61,945
Eastern Metro	59,330	60,831	62,470	64,077	66,091	68,204	70,439	73,562	76,288	78,816	81,390	105,580	125,769	140,750

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Table 3.8: Projected HACC clients by Aged Care Planning Regions (ACPRs) continued

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
Gippsland	17,019	17,523	18,086	18,631	19,302	20,031	20,771	21,799	22,713	23,613	24,519	33,274	40,822	47,041
Grampians	13,811	14,150	14,543	14,942	15,433	15,946	16,506	17,286	17,977	18,626	19,304	25,951	31,633	36,431
Hume	16,371	16,843	17,361	17,881	18,514	19,179	19,882	20,835	21,711	22,517	23,374	31,486	38,348	43,851
Loddon-Mallee	19,726	20,219	20,813	21,367	22,035	22,768	23,556	24,711	25,719	26,658	27,628	37,094	45,242	52,038
Northern Metro	44,132	45,387	46,756	48,107	49,764	51,521	53,347	55,828	58,074	60,167	62,376	84,312	103,734	119,647
Southern Metro	72,720	74,602	76,783	78,967	81,654	84,570	87,699	92,043	96,018	99,803	103,746	145,041	181,450	211,437
Western Metro	35,363	36,795	38,362	39,955	41,818	43,790	45,914	48,669	51,250	53,766	56,363	84,950	111,318	134,220
Western Australia														
Goldfields	1,253	1,286	1,325	1,368	1,410	1,460	1,518	1,602	1,672	1,732	1,800	2,443	3,005	3,440
Great Southern	2,259	2,307	2,365	2,421	2,488	2,554	2,627	2,732	2,830	2,913	3,000	3,785	4,483	5,036
Kimberley	631	655	682	705	732	762	793	827	858	891	927	1,311	1,628	1,869
Metropolitan East	10,038	10,260	10,523	10,792	11,138	11,513	11,920	12,490	13,005	13,503	14,014	19,254	23,771	27,452
Metropolitan North	18,135	18,633	19,212	19,784	20,484	21,229	22,032	23,139	24,137	25,076	26,051	35,783	44,218	51,046
Metropolitan South East	11,186	11,463	11,788	12,114	12,522	12,961	13,434	14,087	14,678	15,242	15,821	21,765	26,987	31,324
Metropolitan South West	15,519	16,016	16,554	17,079	17,726	18,407	19,119	20,069	20,925	21,738	22,582	31,003	38,634	45,090
Mid West	2,095	2,178	2,261	2,325	2,407	2,491	2,566	2,690	2,794	2,891	2,985	3,998	4,889	5,610
Pilbara	650	676	700	736	773	814	857	910	955	1,003	1,054	1,635	2,141	2,555
South West	5,333	5,511	5,717	5,907	6,134	6,384	6,639	6,986	7,299	7,608	7,928	11,132	13,939	16,205
Wheatbelt	2,551	2,610	2,656	2,718	2,781	2,840	2,916	3,020	3,122	3,205	3,290	4,235	4,995	5,585
IO Territories	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Source: Access Economics calculations.

Table 3.9: Projected community care packages by Aged Care Planning Regions (ACPRs)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
ACT														
ACT	855	913	941	968	1,002	1,038	1,076	1,129	1,177	1,222	1,268	1,739	2,151	2,489
NSW														
Central Coast	1,066	1,132	1,161	1,190	1,227	1,266	1,306	1,364	1,416	1,465	1,516	2,030	2,495	2,877
Central West	464	497	513	529	547	567	589	619	645	670	693	918	1,110	1,260
Western Sydney	1,392	1,499	1,558	1,616	1,685	1,758	1,837	1,942	2,040	2,135	2,233	3,297	4,209	4,969
Far North Coast	970	1,040	1,074	1,106	1,146	1,189	1,234	1,297	1,352	1,404	1,460	2,029	2,551	2,985
Hunter	1,662	1,775	1,827	1,883	1,946	2,014	2,090	2,195	2,291	2,381	2,473	3,445	4,308	5,026
Illawarra	1,114	1,202	1,247	1,290	1,341	1,396	1,451	1,525	1,590	1,650	1,713	2,282	2,798	3,227
Inner West	1,039	1,104	1,130	1,159	1,194	1,232	1,270	1,323	1,370	1,415	1,463	1,924	2,339	2,681
Mid North Coast	1,093	1,176	1,220	1,264	1,314	1,369	1,426	1,505	1,575	1,640	1,710	2,386	2,998	3,513
Nepean	571	614	637	660	687	718	752	796	837	877	921	1,389	1,777	2,096
New England	485	516	530	545	563	583	603	632	657	682	706	928	1,126	1,281
Northern Sydney	2,410	2,551	2,602	2,656	2,725	2,796	2,876	2,993	3,097	3,194	3,294	4,283	5,123	5,797
Orana Far West	392	418	432	443	458	472	489	512	531	548	564	732	879	992
Riverina Murray	741	791	815	839	868	898	929	973	1,014	1,050	1,087	1,442	1,757	2,012
South East Sydney	2,255	2,387	2,436	2,488	2,556	2,627	2,705	2,817	2,918	3,015	3,112	4,121	4,975	5,663
South West Sydney	1,634	1,773	1,850	1,924	2,013	2,108	2,206	2,331	2,446	2,557	2,673	3,850	4,881	5,730
Sthn Highlands	566	606	628	649	675	704	734	774	811	847	886	1,277	1,629	1,912
Northern Territory														
Alice springs	163	168	171	172	171	176	178	184	189	192	196	236	282	318
Barkly	21	24	24	25	26	28	30	32	33	34	36	42	49	56

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Table 3.9: Projected community care packages by Aged Care Planning Regions (ACPRs) continued

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
Darwin	556	596	618	639	668	693	723	762	797	832	866	1,225	1,527	1,776
East Arnhem	31	35	37	40	41	43	45	47	50	52	54	80	104	123
Katherine	61	66	67	68	70	71	73	76	78	80	84	111	135	154
Queensland														
Brisbane North	1,152	1,207	1,219	1,230	1,250	1,271	1,293	1,333	1,368	1,400	1,430	1,774	2,076	2,317
Brisbane South	1,657	1,754	1,788	1,820	1,863	1,908	1,959	2,034	2,098	2,159	2,220	2,829	3,370	3,802
Cabool	814	881	921	961	1,007	1,056	1,106	1,171	1,234	1,293	1,354	1,967	2,486	2,896
Central West	24	25	26	26	26	27	27	28	28	28	29	32	35	38
Darling Downs	678	721	738	755	777	802	827	863	893	922	952	1,225	1,475	1,679
Far North	483	519	536	555	576	600	624	658	689	719	749	1,064	1,341	1,564
Fitzroy	413	440	452	465	480	496	513	537	558	577	598	816	1,013	1,182
Logan River Valley	470	512	537	562	591	620	653	695	735	773	812	1,246	1,598	1,874
Mackay	262	280	290	300	312	325	339	357	375	391	408	586	746	881
North West	60	63	66	68	71	73	76	81	85	89	93	143	182	212
Northern	466	498	512	526	542	559	578	605	628	650	673	901	1,101	1,259
South Coast	1,332	1,429	1,477	1,524	1,580	1,638	1,702	1,785	1,861	1,935	2,007	2,741	3,384	3,910
South West	55	59	60	61	63	64	65	67	69	71	72	82	94	103
Sunshine Coast	1,103	1,194	1,244	1,296	1,355	1,418	1,484	1,569	1,648	1,723	1,802	2,563	3,241	3,829
West Moreton	388	418	434	452	473	496	522	556	588	618	653	1,014	1,337	1,607
Wide Bay	735	790	818	847	880	916	954	1,005	1,049	1,091	1,136	1,565	1,945	2,268

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Table 3.9: Projected community care packages by Aged Care Planning Regions (ACPRs) continued

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
South Australia														
Eyre Peninsula	87	93	96	98	101	105	109	114	118	123	128	178	227	267
Hills, Mallee & Southern	347	376	394	412	433	456	479	508	536	563	592	885	1,144	1,362
Metropolitan East	755	798	814	830	853	878	905	944	979	1,012	1,046	1,391	1,686	1,922
Metropolitan North	809	877	915	952	997	1,043	1,090	1,154	1,212	1,267	1,324	1,905	2,416	2,841
Metropolitan South	996	1,060	1,089	1,117	1,151	1,189	1,229	1,287	1,340	1,389	1,440	1,982	2,446	2,821
Metropolitan West	746	790	805	820	839	859	882	915	943	968	994	1,234	1,447	1,616
Mid North	83	90	93	95	98	102	106	111	115	119	123	160	190	215
Riverland	116	125	129	134	139	143	148	155	161	167	174	228	276	314
South East	159	170	176	182	189	196	204	215	224	234	242	334	417	487
Whyalla, Flinders & Far North	97	105	109	113	118	123	128	134	140	146	152	203	247	283
Yorke, Lower North & Barossa	252	271	279	289	299	312	325	342	358	373	389	554	706	833
Tasmania														
North Western	327	349	355	370	383	396	411	431	448	465	483	648	794	911
Northern	413	442	457	468	486	504	523	548	571	593	615	834	1,022	1,176
Southern	694	741	768	788	814	843	873	917	957	993	1,031	1,437	1,796	2,091
Victoria														
Barwon-South Western	1,120	1,192	1,225	1,259	1,299	1,342	1,388	1,455	1,513	1,566	1,622	2,185	2,690	3,121
Eastern Metro	2,671	2,850	2,929	3,007	3,107	3,211	3,321	3,473	3,607	3,732	3,859	5,052	6,081	6,863

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Table 3.9: Projected community care packages by Aged Care Planning Regions (ACPRs) continued

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
Gippsland	781	838	868	896	931	969	1,006	1,058	1,104	1,151	1,198	1,661	2,069	2,414
Grampians	638	680	700	720	745	770	798	836	870	903	937	1,275	1,569	1,825
Hume	737	790	816	842	874	907	942	989	1,032	1,072	1,115	1,528	1,885	2,175
Loddon-Mallee	906	966	996	1,024	1,057	1,093	1,132	1,189	1,240	1,287	1,335	1,818	2,245	2,615
Northern Metro	1,873	2,005	2,069	2,131	2,207	2,288	2,370	2,480	2,579	2,671	2,769	3,685	4,493	5,150
Southern Metro	3,249	3,455	3,547	3,638	3,752	3,877	4,013	4,205	4,379	4,545	4,719	6,571	8,190	9,513
Western Metro	1,402	1,514	1,577	1,641	1,715	1,794	1,880	1,991	2,095	2,195	2,298	3,438	4,448	5,289
Western Australia														
Goldfields	77	82	84	87	90	94	97	103	108	112	117	164	207	239
Great Southern	186	199	204	209	216	222	228	238	247	254	263	332	395	444
Kimberley	37	40	43	45	47	50	52	54	56	58	60	88	110	127
Metropolitan East	778	823	841	860	885	913	943	985	1,025	1,064	1,104	1,515	1,869	2,159
Metropolitan North	1,430	1,527	1,573	1,618	1,673	1,733	1,797	1,889	1,970	2,047	2,126	2,916	3,602	4,159
Metropolitan South East	871	926	950	974	1,005	1,039	1,076	1,127	1,172	1,216	1,261	1,727	2,136	2,479
Metropolitan South West	1,245	1,338	1,385	1,431	1,487	1,547	1,608	1,689	1,762	1,831	1,902	2,596	3,219	3,746
Mid West	156	171	180	186	193	201	208	219	228	237	245	336	418	482
Pilbara	26	29	30	32	34	37	39	42	44	46	49	83	113	136
South West	425	458	477	493	514	536	557	587	614	641	668	942	1,183	1,377
Wheatbelt	194	207	211	216	221	226	232	240	249	255	262	345	413	465
IO Territories	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Source: Access Economics calculations.

Table 3.10: Projected residential care places by Aged Care Planning Regions (ACPRs)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
ACT														
ACT	1,827	1,889	1,946	2,004	2,073	2,148	2,227	2,336	2,434	2,527	2,624	3,597	4,450	5,150
NSW														
Central Coast	3,732	3,835	3,935	4,039	4,161	4,296	4,431	4,631	4,805	4,973	5,149	6,895	8,483	9,791
Central West	1,613	1,669	1,721	1,772	1,834	1,894	1,969	2,072	2,159	2,243	2,324	3,098	3,761	4,276
Western Sydney	4,798	5,004	5,203	5,392	5,614	5,858	6,116	6,463	6,792	7,103	7,423	10,956	14,005	16,531
Far North Coast	3,395	3,532	3,652	3,762	3,898	4,049	4,208	4,425	4,614	4,794	4,990	6,895	8,622	10,052
Hunter	5,808	6,004	6,181	6,374	6,583	6,808	7,062	7,415	7,740	8,041	8,345	11,616	14,522	16,940
Illawarra	3,814	3,995	4,155	4,299	4,483	4,676	4,870	5,126	5,350	5,561	5,784	7,779	9,550	11,036
Inner West	3,636	3,742	3,831	3,928	4,053	4,185	4,314	4,495	4,662	4,819	4,983	6,530	7,908	9,047
Mid North Coast	3,805	3,965	4,111	4,259	4,433	4,624	4,818	5,092	5,333	5,557	5,798	8,145	10,256	12,036
Nepean	1,966	2,043	2,113	2,185	2,274	2,370	2,474	2,613	2,745	2,870	3,014	4,568	5,884	6,972
New England	1,668	1,713	1,757	1,809	1,866	1,931	1,998	2,093	2,176	2,258	2,342	3,111	3,786	4,309
Northern Sydney	8,779	8,996	9,175	9,367	9,613	9,861	10,142	10,543	10,899	11,230	11,568	15,027	18,012	20,446
Orana Far West	1,338	1,380	1,429	1,466	1,515	1,561	1,617	1,695	1,759	1,818	1,872	2,455	2,971	3,360
Riverina Murray	2,569	2,659	2,740	2,816	2,916	3,017	3,122	3,275	3,413	3,538	3,662	4,870	5,925	6,774
South East Sydney	8,010	8,204	8,371	8,544	8,771	9,008	9,273	9,646	9,992	10,316	10,642	14,031	16,899	19,227
South West Sydney	5,614	5,915	6,186	6,442	6,744	7,072	7,409	7,840	8,232	8,614	9,009	12,933	16,352	19,148
Sthn Highlands	1,942	2,011	2,082	2,145	2,233	2,327	2,425	2,558	2,679	2,795	2,924	4,241	5,429	6,377
Northern Territory														
Alice springs	105	104	106	106	105	108	109	113	116	117	120	141	169	192
Barkly	11	12	12	13	14	15	16	16	17	18	19	22	26	30

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Table 3.10: Projected residential care places by Aged Care Planning Regions (ACPRs) continued

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
Darwin	331	345	357	369	386	401	419	441	461	483	502	716	892	1,037
East Arnhem	16	18	19	21	22	23	23	25	27	28	29	42	55	64
Katherine	35	37	37	37	38	39	40	41	42	44	46	59	71	81
Queensland														
Brisbane North	3,820	3,877	3,916	3,947	4,009	4,077	4,147	4,268	4,378	4,478	4,567	5,608	6,547	7,299
Brisbane South	5,464	5,597	5,707	5,811	5,947	6,086	6,249	6,485	6,684	6,876	7,067	8,966	10,665	12,025
Cabool	2,580	2,700	2,821	2,945	3,088	3,241	3,396	3,595	3,792	3,980	4,172	6,112	7,769	9,064
Central West	71	74	76	76	76	78	79	83	83	83	84	94	103	111
Darling Downs	2,177	2,238	2,289	2,341	2,410	2,488	2,568	2,685	2,780	2,871	2,969	3,833	4,614	5,256
Far North	1,523	1,581	1,632	1,686	1,749	1,822	1,894	1,996	2,090	2,180	2,270	3,226	4,061	4,728
Fitzroy	1,305	1,340	1,380	1,418	1,463	1,513	1,563	1,638	1,706	1,762	1,827	2,494	3,088	3,602
Logan River Valley	1,453	1,527	1,602	1,675	1,756	1,839	1,934	2,057	2,173	2,285	2,399	3,693	4,760	5,584
Mackay	824	853	881	910	948	992	1,035	1,090	1,144	1,191	1,244	1,780	2,256	2,661
North West	180	184	190	197	204	211	221	233	244	255	267	413	529	618
Northern	1,477	1,528	1,573	1,616	1,667	1,720	1,776	1,859	1,929	1,996	2,067	2,747	3,332	3,794
South Coast	4,304	4,471	4,629	4,783	4,966	5,157	5,360	5,625	5,865	6,098	6,324	8,621	10,637	12,288
South West	174	178	184	185	191	196	200	208	214	218	222	258	295	324
Sunshine Coast	3,526	3,696	3,858	4,027	4,217	4,417	4,627	4,901	5,154	5,393	5,652	8,093	10,251	12,137
West Moreton	1,224	1,269	1,313	1,363	1,423	1,489	1,563	1,665	1,758	1,850	1,952	3,056	4,040	4,859
Wide Bay	2,313	2,404	2,488	2,577	2,679	2,790	2,908	3,067	3,203	3,333	3,475	4,835	6,024	7,037

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Table 3.10: Projected residential care places by Aged Care Planning Regions (ACPRs) continued

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
South Australia														
Eyre Peninsula	327	337	348	354	366	380	395	410	424	440	458	642	825	976
Hills, Mallee & Southern	1,298	1,363	1,432	1,497	1,576	1,659	1,744	1,853	1,954	2,055	2,161	3,261	4,244	5,068
Metropolitan East	2,983	3,042	3,099	3,152	3,233	3,320	3,420	3,566	3,696	3,818	3,942	5,215	6,303	7,185
Metropolitan North	2,956	3,109	3,248	3,383	3,547	3,716	3,890	4,121	4,335	4,540	4,750	6,893	8,789	10,360
Metropolitan South	3,857	3,980	4,086	4,195	4,314	4,458	4,604	4,820	5,009	5,182	5,366	7,341	9,054	10,441
Metropolitan West	2,902	2,982	3,043	3,109	3,187	3,262	3,351	3,475	3,588	3,685	3,785	4,671	5,415	6,001
Mid North	313	326	338	350	362	374	389	409	423	440	456	596	704	795
Riverland	439	457	474	490	508	524	541	566	591	615	638	840	1,018	1,163
South East	595	614	637	657	685	711	741	783	819	854	884	1,228	1,539	1,801
Whyalla, Flinders & Far North	343	359	372	385	406	424	443	465	486	507	529	722	890	1,027
Yorke, Lower North & Barossa	946	985	1,014	1,051	1,087	1,134	1,180	1,243	1,300	1,354	1,415	2,021	2,580	3,048
Tasmania														
North Western	1,067	1,104	1,117	1,168	1,209	1,251	1,297	1,360	1,414	1,471	1,528	2,063	2,535	2,916
Northern	1,351	1,398	1,443	1,480	1,536	1,594	1,656	1,732	1,806	1,878	1,946	2,648	3,249	3,743
Southern	2,276	2,357	2,446	2,506	2,588	2,680	2,776	2,917	3,042	3,152	3,275	4,541	5,663	6,587
Victoria														
Barwon-South Western	4,027	4,149	4,260	4,385	4,526	4,674	4,837	5,065	5,274	5,459	5,653	7,633	9,402	10,929
Eastern Metro	9,505	9,808	10,065	10,329	10,674	11,035	11,422	11,943	12,410	12,862	13,307	17,616	21,392	24,249

Continued next page

Table 3.10: Projected residential care places by Aged Care Planning Regions (ACPRs) continued

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
Gippsland	2,700	2,812	2,914	3,012	3,130	3,255	3,379	3,554	3,711	3,865	4,025	5,623	7,035	8,242
Grampians	2,290	2,362	2,433	2,504	2,593	2,678	2,769	2,904	3,021	3,131	3,242	4,401	5,404	6,296
Hume	2,565	2,662	2,752	2,835	2,945	3,052	3,171	3,329	3,473	3,608	3,749	5,146	6,353	7,323
Loddon-Mallee	3,220	3,325	3,431	3,534	3,648	3,764	3,900	4,091	4,270	4,431	4,597	6,300	7,810	9,149
Northern Metro	6,535	6,787	7,027	7,251	7,530	7,824	8,118	8,519	8,877	9,216	9,578	12,678	15,324	17,480
Southern Metro	11,687	12,007	12,312	12,610	12,978	13,396	13,843	14,485	15,051	15,590	16,163	22,360	27,810	32,243
Western Metro	4,888	5,116	5,330	5,550	5,798	6,075	6,370	6,750	7,103	7,442	7,791	11,610	14,988	17,767
Western Australia														
Goldfields	196	199	203	209	217	226	234	247	258	266	279	391	496	575
Great Southern	515	532	545	562	580	596	612	639	665	686	710	898	1,065	1,192
Kimberley	97	102	112	116	123	130	137	140	143	147	151	220	274	310
Metropolitan East	2,140	2,184	2,226	2,270	2,334	2,402	2,473	2,580	2,680	2,779	2,879	3,942	4,858	5,609
Metropolitan North	3,990	4,121	4,244	4,361	4,504	4,659	4,833	5,082	5,304	5,512	5,727	7,878	9,753	11,286
Metropolitan South East	2,426	2,493	2,552	2,617	2,696	2,784	2,884	3,019	3,140	3,254	3,372	4,607	5,690	6,603
Metropolitan South West	3,398	3,539	3,677	3,805	3,962	4,128	4,299	4,520	4,716	4,905	5,103	6,971	8,631	10,035
Mid West	403	430	453	470	490	513	532	563	587	611	632	872	1,085	1,253
Pilbara	62	67	66	74	80	85	91	97	101	105	111	191	265	320
South West	1,173	1,221	1,274	1,322	1,378	1,438	1,496	1,576	1,649	1,721	1,793	2,527	3,173	3,692
Wheatbelt	506	522	529	542	553	562	579	597	618	632	648	848	1,017	1,142
IO Territories	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Source: Access Economics calculations.

4 Alternative aged care supply scenarios

This chapter presents two alternative projections of aged care supply. The first is based on dementia prevalence growth rates,[17] while the second is based on the growth rate of people aged 85 and over to reflect National Health and Hospital Reform Commission (NHHRC) recommendations for aged care planning ratios. The chapter concludes by comparing the two projections with projections using current policy of planning aged care services based on the growth of the population aged 70 years and over.

4.1 Rationale for using alternative planning ratios

The Commonwealth Government aims to provide 113 aged care places covered under the *Aged Care Act 1997* for every 1,000 persons aged 70 years and over by the year 2011. To keep up with demand, the total number of places is increased each year based on the growth rate of the population of persons aged 70 years and over. According to DoHA this demographic is a good predictor of future demand for aged care services (DoHA, 2009b).

However, in recent years there have been revisions to the planning ratios, increasing from 100 places to 108 places in 2004-05 and a commitment by the government in 2007 to further increase aged care places to the current goal of 113 (DoHA, 2009c). This implicitly suggests the supply of aged care services has been falling short of the underlying need for these services.

As a consequence, there has been ongoing debate about the appropriateness of using growth in the population aged 70 years and over as a measure of potential need for formal aged care services. In the Standing Committee on Finance and Public Administration (SCFPA) inquiry into residential and community aged care in Australia, several submissions suggested an alternative planning tool was needed that better represented the increase in demand for aged care services and changing levels of need. The SCFPA recommended the current planning ratio for community care and residential aged care places be reviewed in light of growing and diverse demand for aged care services (SCFPA, 2008).

One alternative planning policy suggested by Alzheimer's Australia is the use of dementia prevalence growth to plan for future supply of aged care. Dementia is known to be a significant demand driver for aged care services, and dementia prevalence projections suggest older Australians will need a larger proportion of aged care services in the future.

Alternatively, the NHHRC recommended care planning ratios should be calculated on the population aged 85 years and over. This recommendation is based on the notion that people aged 85 and over tend to be the main users of aged care services, and rapid growth is expected in this age category over the next 40 years. For example, around 47.8% of permanent residents were aged 85 years and over at the time of their admission in 2007-08, while around 54.7% of permanent residents are aged 85 years and over (AIHW, 2009c).

[17] Projected aged care supply using the growth rate of dementia prevalence was also undertaken by Aged Care Planning Regions (ACPRs) and Commonwealth Electoral Divisions (CEDs). This is presented in Volume 2 of this report, which will be published separately by Alzheimer's Australia in the near future.

Both potential planning policies have been used to project the supply of aged care services up until 2050, and have been subsequently compared to projected aged care supply under current policy.

4.2 Supply of aged care using dementia prevalence growth rates

Although age is a predictor of demand for care services, its use for planning purposes is limited because it does not accurately account for changes to the burden of disease. To illustrate, the growth in people aged 70 years and over may have been steady over the last decade but there has been greater change in the burden of disease driven by higher growth in age brackets where the burden of disease is greatest. In relation to dementia, this has resulted in planning ratios that do not adequately accommodate the increase in complex needs and requirements for intensive and specialised care. Given that the overall change in care needs of a broad age bracket is not necessarily predicted by simple growth in numbers, it is argued that the supply of aged care services should be based on an estimate of the level of need.

The large relative growth rate of people aged 85 years and over is expected to continue into the future, and this will translate into increased growth in dementia prevalence. Using the most recent population parameters from the Australian Bureau of Statistics (ABS) and assuming constant dementia prevalence rates, it is estimated that dementia prevalence in Australia will increase from 256,529 people in 2010 to 981,044 people in 2050 (see Chapter 1). This will directly translate into an increased burden of disease, and therefore an increased need for aged care services.

People with dementia already make up a large proportion of community care recipients, including:

- 5.2% of HACC clients; [18]
- 18.4% of CACP package recipients;
- 31.7% of EACH package recipients;
- 100% of EACH-D package recipients; and
- 63% of residents in residential care facilities (VGDHS 2004; AIHW 2007).

These proportions across both community and residential care will only grow larger in the future given the large expected growth in dementia prevalence.

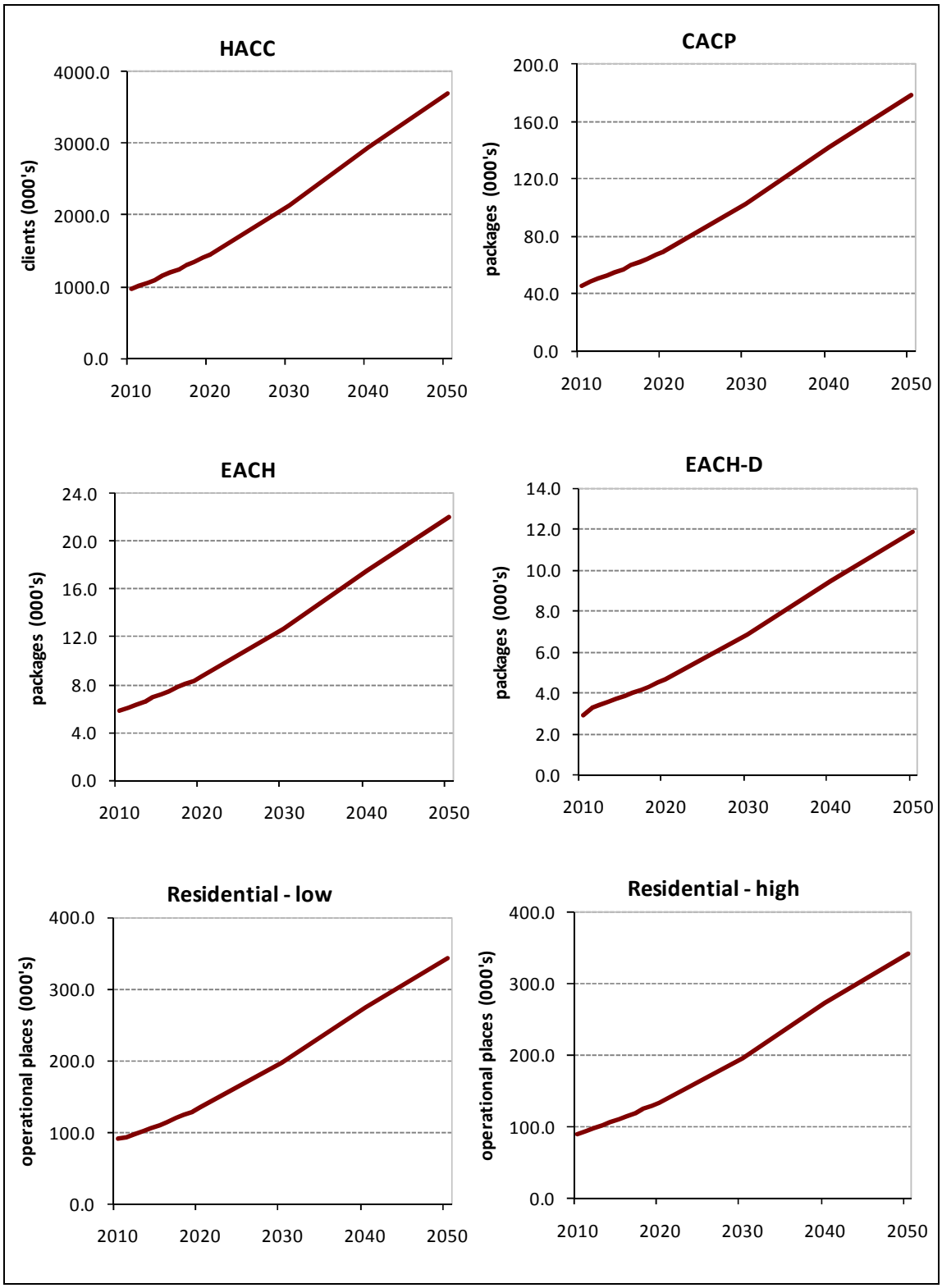
As people with dementia generally have a greater need for aged care services, this scenario projects the supply of aged care services required to ensure that growth in the need for aged care services due to dementia prevalence is met with commensurate increases in available aged care services. As dementia prevalence projections have assumed constant dementia prevalence rates (as outlined in Section 1.2), the growth in dementia prevalence is driven by population growth rates within each five year age bracket. Projected dementia prevalence growth is outlined in Section 1.3.

A summary of projected number of HACC clients and supply of community care packages and operational residential care places using the projected dementia prevalence growth rate is

[18] This data may under represent the number of people with dementia accessing HACC program services due to improvements in diagnosis since 2002 when the survey was undertaken (VGDHS, 2004).

presented in Chart 4.1. It is projected the total number of community care places will increase

Chart 4.1: Projected supply of aged care under dementia growth scenario



Source: Access Economics calculations.

from 54,325 packages in 2010 to 212,035 packages in 2050. Of these, there will be:

- 178,109 CACPs;
- 22,052 EACH packages; and
- 11,874 EACH-D packages.

Over the same period the number of HACC clients is estimated to increase from around 966,710 to around 3.7 million. In addition, the total number of operational residential care places is projected to increase from around 181,204 in 2010 to 684,653 in 2050, distributed equally between low and high care.

Compared to the current policy scenario, the number of HACC clients, community care packages and operational residential care places are expected to be greater using the projected dementia prevalence growth rate. Given the demand for aged care services is expected to more closely follow dementia prevalence, there will be an under supply of aged care if planning continues to use the growth rate of the population aged 70 years and over.

Differences between projected supply using the projected dementia prevalence growth rate and projected supply using current policy are presented in Table 4.1. There are expected to be significant differences in the supply of aged care under the dementia growth scenario compared to the current policy scenario. Differences will first start to emerge in 2011 for HACC clients as dementia prevalence increases more rapidly compared to the population aged 70 years and over. For community care packages and residential care places, differences do not occur until 2012 as the government first reaches their stated planning ratios in 2011 under both scenarios.

In summary, using the dementia prevalence growth rate scenario there is projected to be a substantial increase in aged care supply, and by 2050 this would constitute an additional:

- 987,520 HACC clients;
- 45,157 CACPs;
- 5,591 EACH packages;
- 3,010 EACH-D packages; and
- 173,585 residential care places.

Table 4.1: Additional aged care supply using the dementia prevalence growth rate

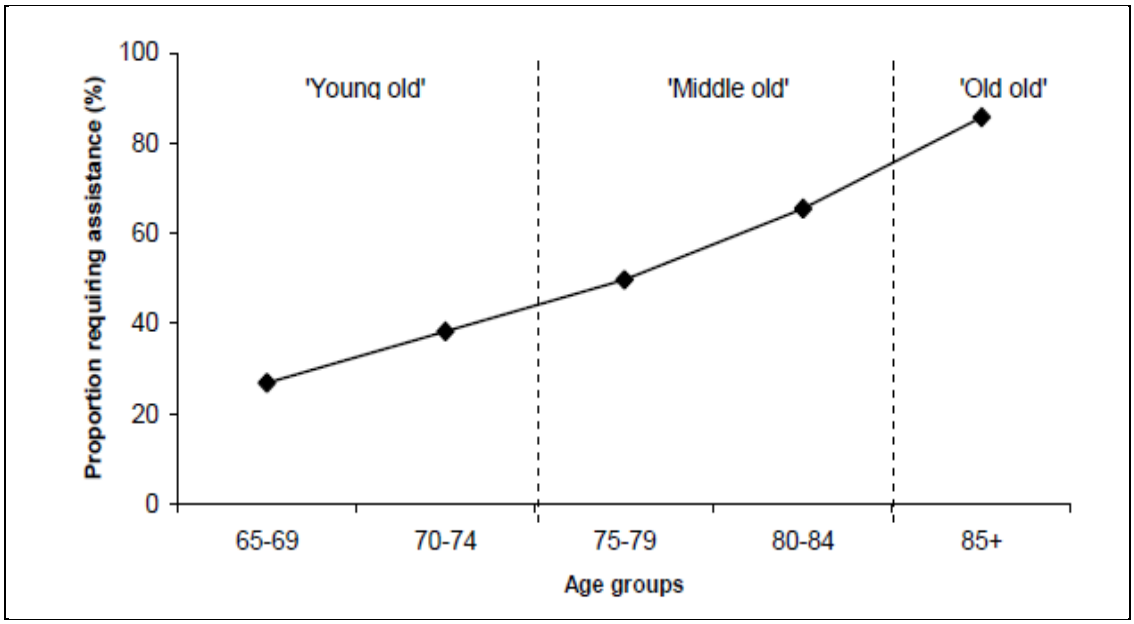
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
	000's	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*
HACC clients	18.4	33.2	47.3	55.3	63.7	71.2	64.8	62.7	64.8	67.8	236.7	609.6	987.5
CACPs	0.0	0.7	1.3	1.7	2.1	2.4	2.0	1.9	1.9	2.0	9.7	27.3	45.2
EACH packages	0.0	0.1	0.2	0.2	0.3	0.3	0.3	0.2	0.2	0.3	1.2	3.4	5.6
EACH-D packages	0.0	0.0	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.6	1.8	3.0
Residential - Low care places	0.0	1.3	2.6	3.3	4.0	4.6	3.9	3.6	3.7	3.9	18.7	52.4	86.8
Residential - High care places	0.0	1.3	2.6	3.3	4.0	4.6	3.9	3.6	3.7	3.9	18.7	52.4	86.8
Community care packages	0.0	0.8	1.6	2.0	2.5	2.8	2.4	2.2	2.3	2.4	11.6	32.5	53.8
Residential care places	0.0	2.6	5.2	6.5	7.9	9.2	7.8	7.2	7.4	7.8	37.3	104.9	173.6
Total – Packages and places	0.0	3.4	6.7	8.5	10.4	12.0	10.2	9.4	9.7	10.2	48.9	137.3	227.3

Note: Compared to the current policy that uses the growth rate of population aged 70 years and over.
Source: Access Economics calculations.

4.3 Supply of aged care using growth of the population aged 85 years and over

Over the years, the age at which people require aged care services has gradually increased. People are living longer but with greater disability towards the latter years of life. Currently, the burden of disease and injury peaks between 85 and 90 years (AIHW, 2007b). As profound or severe limitation correlates with age through the prevalence of disease, people aged 85 years and over generally have the greatest need for aged care services. For example, Chart 4.2 shows 25% of people aged 65-69 years require assistance, which increases rapidly to just over 80% for those aged 85 years and over.

Chart 4.2: Need for assistance by age of older persons, 2003



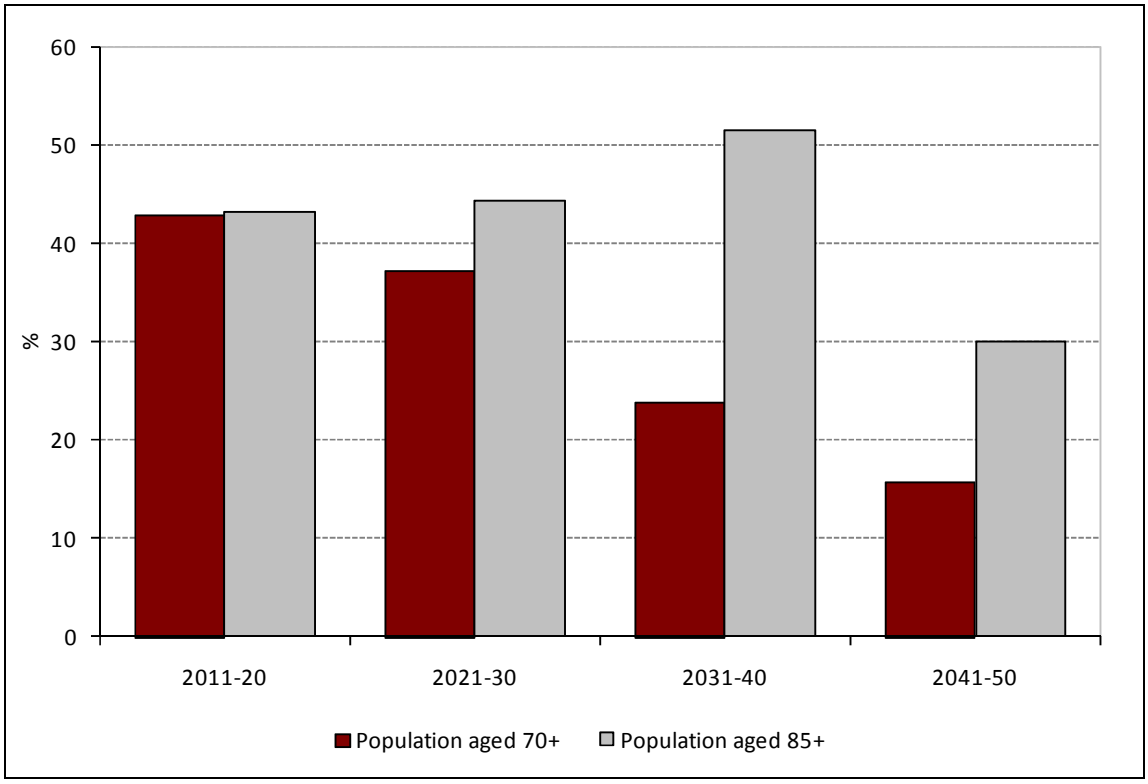
Source: Productivity Commission (2008).

In the last decade the annual growth of people aged 70 years and over has been relatively constant at around 2%. During the same period, the annual growth of people aged 85 years and over has been much higher, from around 3% to 7% (AIHW, 2009).

Greater growth in the population aged 85 years and over is expected to continue until at least 2050. This is shown in Chart 4.3, which compares the projected growth in people 70 years and over to the projected growth of people 85 years and over.

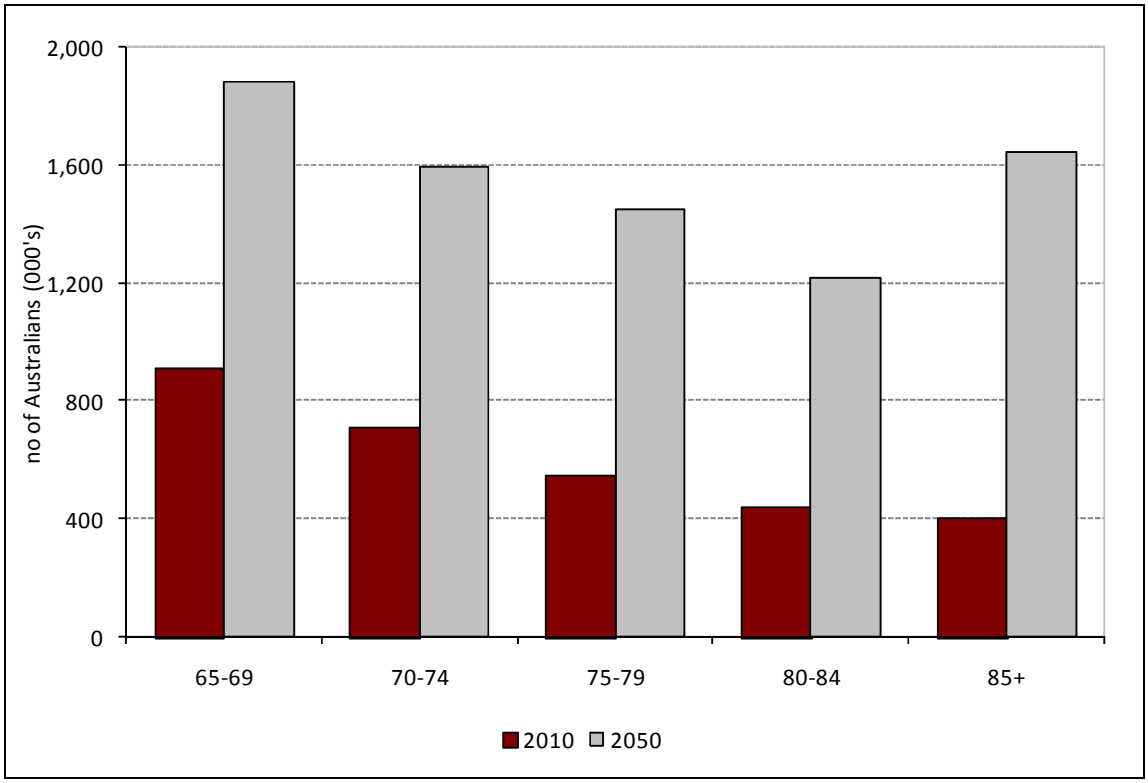
Within the next decade it is projected there will be similar growth in both age brackets, however the population aged 85 years and over is expected to grow substantially faster beyond 2020. Chart 4.4 shows that the number of people aged 85 years and over is projected to quadruple, from around 400,000 to approximately 1.6 million people by 2050. Together with the fact that those aged 85 years and over have a greater need for aged care services than those aged 70-84 years, this suggests that if the current planning ratio remains based on population over the age of 70 years, an under supply of aged care services is likely.

Chart 4.3: Projected population growth of older Australians



Source: Access Economics calculations.

Chart 4.4: Projected number of older Australians, 2010 and 2050



Source: Access Economics calculations.

Currently, the majority of community care recipients are under the age of 85 years (Table 4.2). However, as the 'baby boomer' generation progressively enters this age bracket, the proportion of people aged 85 years and over demanding community care is likely to increase. Furthermore recipients of residential care (both high and low care) are already concentrated in the 85 years or over age group, so an increase in the proportion of people in this age bracket will increase the demand for residential care services by an even greater proportion than for community care.

Table 4.2: Estimated proportion of people receiving aged care services, 2010

Age	HACC	CACP	EACH	EACH-D	Low residential care	High residential care
	%	%	%	%	%	%
<65	23.9	5.2	0.5	0.0	2.9	4.7
65-69	7.8	5.4	8.8	6.3	2.7	3.5
70-74	11.3	8.8	14.1	8.4	4.7	5.9
75-79	15.9	15.0	17.8	19.0	9.8	11.3
80-84	18.6	24.5	22.3	25.7	21.1	20.7
85+	22.5	41.1	36.6	40.6	58.8	54.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: Productivity Commission (2010), DoHA (2009a) and Access Economics calculations.

To better reflect expected demand for aged care services, the National Health and Hospital Reform Commission (NHHRC) recommended planning the supply of aged care based on the growth rate of the population aged 85 years and over (NHHRC, 2009).

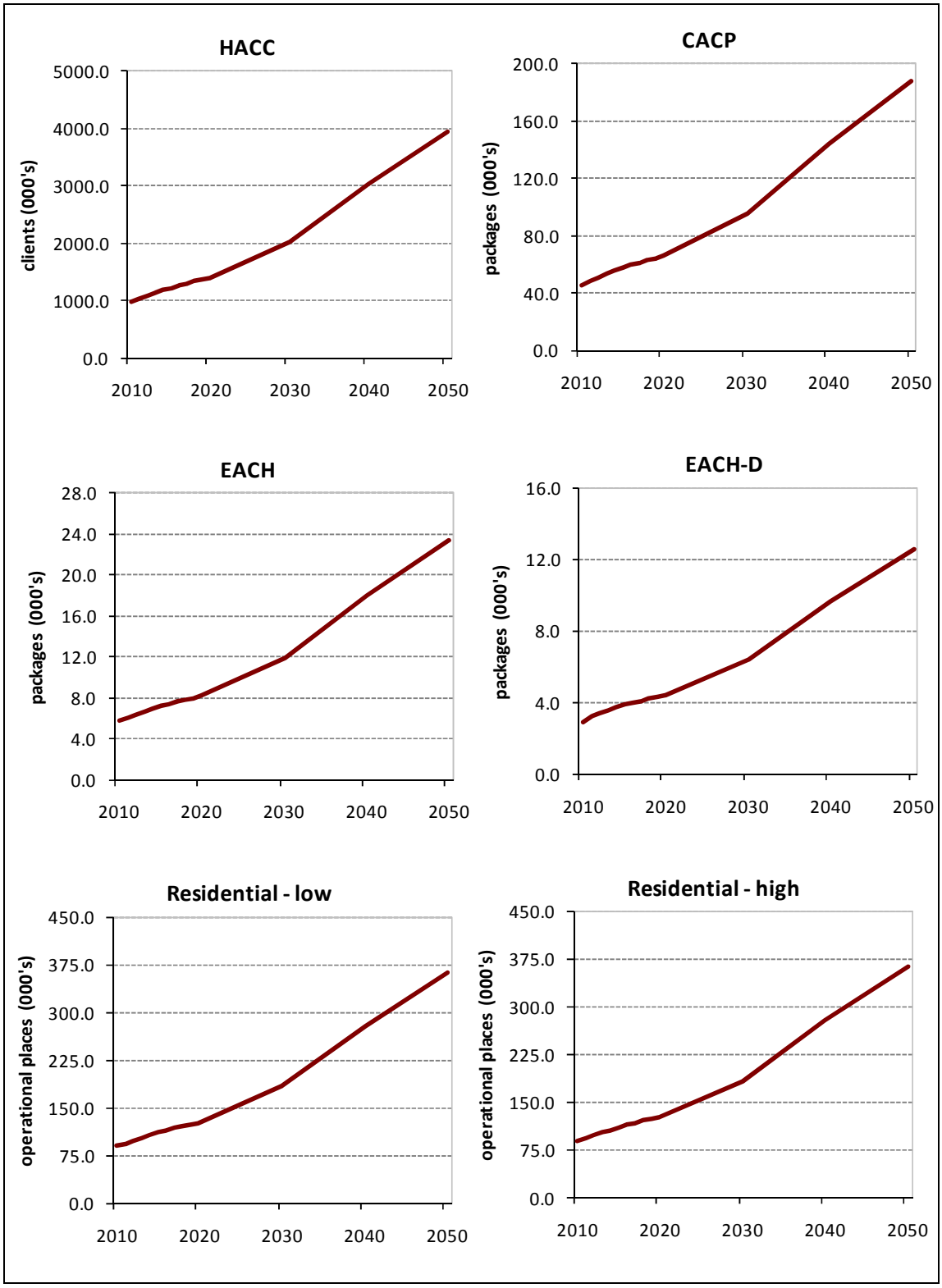
A summary of projected supply of community care and residential care services using the growth rate of the population aged 85 years and over is presented in Chart 4.5. In summary, the number of community care packages will increase from around 54,325 packages in 2010 to 224,241 packages in 2050. Of these, there will be:

- 188,363 CACPs;
- 23,321 EACH packages; and
- 12,558 EACH-D packages.

Over the same period the number of HACC clients is estimated to increase from around 966,710 to around 3.9 million. The total number of operational residential care places is projected to increase from around 181,204 in 2010 to 724,068 places in 2050, to be equally distributed between low and high care.

The number of HACC clients, community care packages and residential care places required based on projected population growth among those aged 85 years and over will far outstrip the supply that would be available through current policy. Additional aged care supply using the growth rate of the population aged 85 years and over compared to the projected supply of aged care under the current policy scenario are presented in Table 4.3.

Chart 4.5: Projected supply of aged care under NHHRC planning recommendations



Note: NHHRC planning recommendations include growing the supply of aged care services by the growth rate of the population aged 85 years and over.
Source: Access Economics calculations.

Table 4.3: Additional aged care supply using the NHHRC recommendation [(a)]

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
	000's	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*
HACC clients	25.2	44.0	63.5	73.0	80.9	82.3	58.3	38.3	20.4	3.8	105.5	685.5	1,226.7
CACPs	-	0.9	1.8	2.2	2.5	2.5	1.3	0.3	-0.6	-1.5	2.8	30.0	55.4
EACH packages	-	0.1	0.2	0.3	0.3	0.3	0.2	0.0	-0.1	-0.2	0.3	3.7	6.9
EACH-D packages	-	0.1	0.1	0.1	0.2	0.2	0.1	0.0	0.0	-0.1	0.2	2.0	3.7
Residential - Low care places	-	1.7	3.4	4.2	4.8	4.8	2.5	0.5	-1.2	-2.9	5.3	57.6	106.5
Residential - High care places	-	1.7	3.4	4.2	4.8	4.8	2.5	0.5	-1.2	-2.9	5.3	57.6	106.5
Community care packages	-	1.0	2.1	2.6	3.0	3.0	1.5	0.3	-0.8	-1.8	3.3	35.7	66.0
Residential care places	-	3.3	6.8	8.3	9.6	9.7	5.0	1.1	-2.5	-5.7	10.6	115.2	213.0
Total – Packages and places	-	4.3	8.9	10.9	12.6	12.7	6.5	1.4	-3.2	-7.5	13.8	150.8	279.0

Note: (a) NHHRC planning recommendations include growing the supply of aged care services by the growth rate of the population aged 85 years and over. Additional aged care supply is calculated by comparing to the projected aged care supply using the NHHRC recommendation to the current policy of using the growth rate of the population aged 70 years and over.

Source: Access Economics calculations.

From 2011, differences will start to emerge in the number of HACC clients as growth in the population aged 85 years and over is expected to occur at a faster rate compared to growth in population aged 70 years and over. This difference decreases toward the end of next decade and into 2020s as the baby boomers enter their 70s. However, the gap widens again once the baby boomers move into the 85 years and over age bracket. By 2050, significant differences in the number of HACC clients are expected to occur.

For community care packages and residential care places, differences do not occur until 2012 as the government first reaches its stated planning ratios in 2011. Additional community care packages and residential care places then follow a similar trend to the additional number of HACC clients. In summary, by 2050 it is projected there will be an additional:

- 1,226,683 HACC clients;
- 55,411 CACPs;
- 6,860 EACH packages;
- 3,694 EACH-D packages; and
- 213,000 residential care places (equally distributed between low and high care).

4.4 Comparison of aged care supply projections

An ageing population will lead to significantly larger growth in the number of older people requiring aged care services. However, different growth scenarios will lead to a substantially different supply of aged care services. Table 4.4 shows the projections of aged care supply using current policy (growth rate of the population aged 70 years and over), the projected dementia prevalence growth rate, and the projected growth rate of the population aged 85 years and over.

Planning the delivery of aged care services using the projected dementia prevalence growth rate will deliver the highest supply of aged care services within the next decade. For example, there would be an increase of around 1.78 million aged care services, compared to 1.72 million using the other two growth scenarios. However, in the long run the growth in aged care services is projected to be greatest using the growth in the population aged 85 years and over.

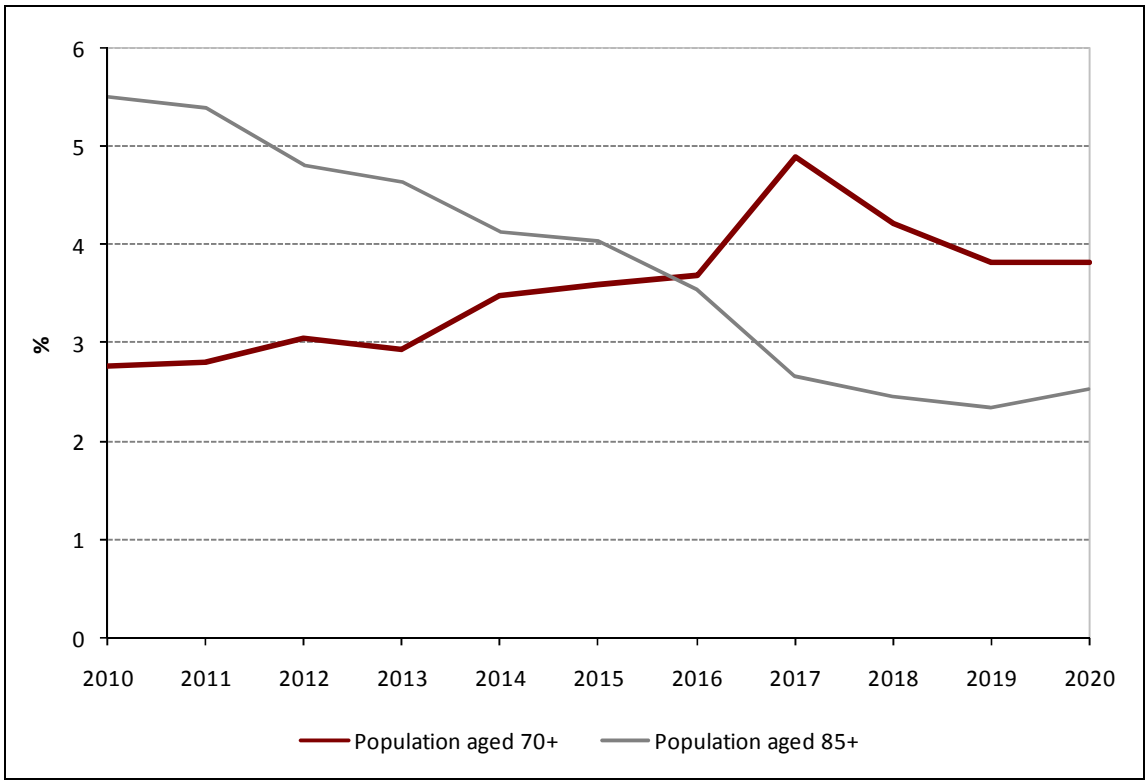
Growth in aged care services over the next decade is expected to be relatively close using either growth in the population aged 70 years or growth in the population aged 85 years. Chart 4.6 shows that annual growth rates steadily increase for the 70+ population, whereas annual growth rates in the 85+ population are projected to be relatively large at the start of the decade but decline until 2019.

Table 4.4: Comparison of aged care supply across three growth scenarios

	Current policy				Dementia prevalence			Population 85 years and older		
	2010	2020	2030	2050	2020	2030	2050	2020	2030	2050
	000's	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*
HACC clients	966.7	1,380.4	1,892.4	2,709.5	1,448.1	2,129.1	3,697.0	1,384.2	1,997.9	3,936.2
Community care packages	54.4	80.6	110.5	158.3	83.1	122.1	212.0	78.9	113.8	224.2
Residential care places	181.2	260.4	357.0	511.1	268.2	394.3	684.7	254.6	367.5	724.1
Total	1,202.3	1,721.4	2,359.9	3,378.9	1,799.4	2,645.5	4,593.7	1,717.7	2,479.0	4,884.5

Source: Access Economics calculations.

Chart 4.6: Annual growth rate of populations aged 70 years and over and 85 years and over

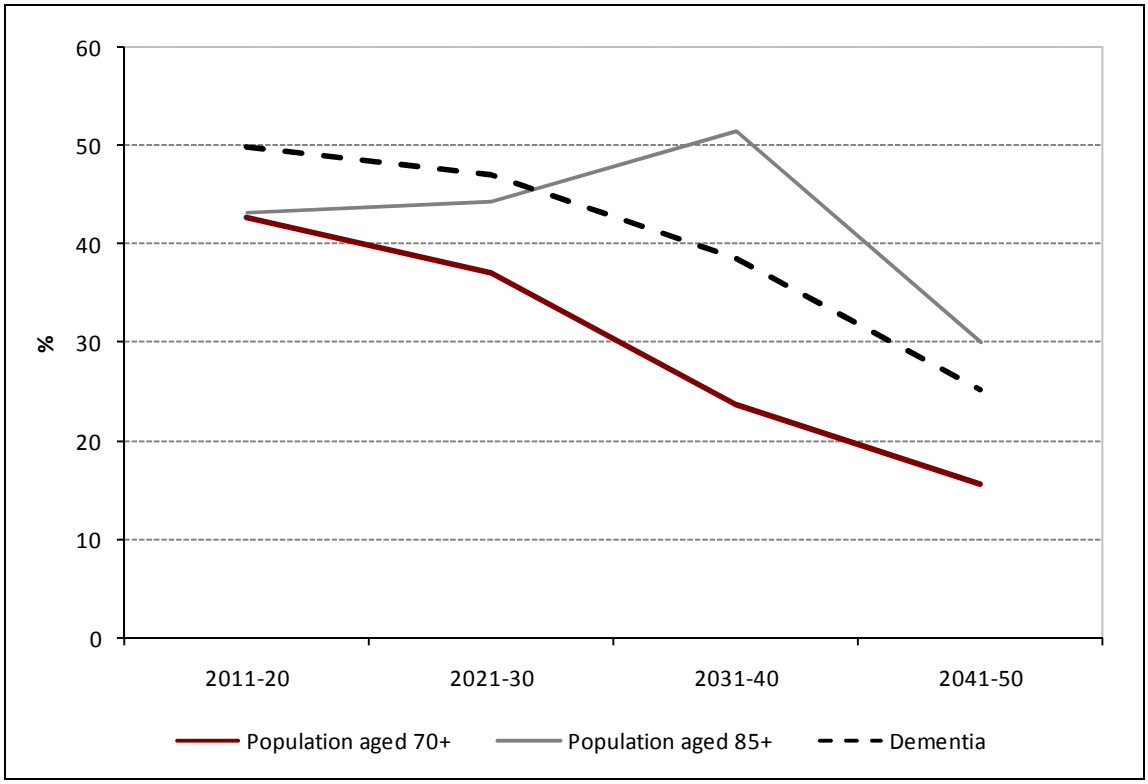


Source: Access Economics calculations using AE-DEM.

Chart 4.7 shows that the growth in the population aged 85 years and over will be lower than dementia prevalence growth in the next 20 years, but is projected to become significantly higher between 2031-40 and converge between 2041-50. The difference in growth is due to dementia prevalence being driven by population growth across all age brackets, but especially by the baby boomer bubble. Dementia prevalence growth is higher in the earlier years because baby boomers feed into those age brackets where dementia starts to become more prevalent. This can be seen by the shaded area in Table 4.5, where dementia prevalence growth is substantially larger than the decade prior or the decade after.

Although dementia prevalence rates increase with age, there are fewer people in the older age brackets. Consequently, the significant growth in dementia prevalence for those aged 85 years and over is balanced by the relatively slower growth in dementia prevalence for those aged between 75-84 years.

Chart 4.7: Comparison of aged care supply growth rates under alternative scenarios



Source: Access Economics calculations.

Table 4.5: Growth in dementia prevalence, by age bracket

	2011-20	2021-30	2031-40	2041-50
	people	*people*	*people*	*people*
0-59	686	611	648	646
60-64	2,317	1,275	1,213	3,624
65-69	6,365	4,304	2,767	4,278
70-74	16,463	8,743	5,575	5,812
75-79	17,225	23,986	15,969	10,621
80-84	15,269	51,650	32,126	22,599
85-89	17,022	45,326	60,983	47,378
90-94	30,744	24,539	64,251	45,162
95+	21,663	20,271	34,564	57,842
Total	127,754	180,705	218,096	197,961

Note: Shaded area represents the baby boomer generation moving through the age brackets.
Source: Access Economics calculations.

5 Supply of aged care to bridge unmet needs

This chapter presents aged care forecasts based on increasing the number of community care packages (clients in the case of HACC) and residential aged care operational places to bridge the gap between demand for aged care services and current supply.

5.1 Rationale for bridging unmet need

Australia's aged care policy framework aims to deliver equitable, efficient and sustainable aged care services while providing choice for care recipients. However, access to aged care services is currently constrained throughout Australia due to the use of aged care planning ratios by the government.

Aged care packages in the community are in high demand with occupancy rates for Community Aged Care Packages (CACP) and Extended Aged Care Packages (EACH) averaging 93% and 89% respectively (AIHW, 2009b). Residential aged care facilities are also stretched, with for example, difficulties in retaining staff, inadequate bed supply, and low incentives for private organisations to invest in more beds (Access Economics 2009b; 2009c). Occupancy rates for residential age care facilities average around 93%, ranging from 89% in the Northern Territory to 96% in the case of South Australia. Although there are no official estimates of the optimal occupancy rate for aged care services, high occupancy rates have been considered as evidence of unmet demand and have been attributed to long waiting lists throughout Australia (PC, 2008).

Extended waiting times (the time between a person actively seeking aged care services and first receipt of services) have been recognised by the government, and specific projects are being implemented to speed up the Aged Care Assessment Program (ACAP) (DoHA, 2009c). However, once a person has been approved by an Aged Care Assessment Team (ACAT) they are still required to wait for entry into formal aged care services, and this wait will depend on the regional demand for services and the supply allocated by the government.

Once approved by ACAT, waiting times for formal aged care services once approved by ACAT will also depend on the type of aged care that is to be received. Table 5.1 shows the elapsed time for entry into aged care services across different types of aged care programs and levels of residential care once approval has been granted by ACAT. Waiting times into the EACH-D program are generally the lowest, with around 22% of people having to wait more than three months after approval (median waiting time is 35 days). This is compared to the EACH program with 38% of applicants waiting more than three months (median waiting time is 62 days), and the CACP program with 29% of applicants waiting more than three months (median waiting time is 45 days).

Waiting time for access to residential care depends on the level of need, with much shorter waiting times for high care. Around 19% of people approved by ACAT are required to wait for more than three months to enter high care, whereas around 39% of people are required to wait more than three months for low care. However, there are still a significant number of people waiting more than nine months for access to a residential care facility, with 3% of people requiring high care and 8% of people requiring low care (see Table 5.1).

Table 5.1: Elapsed time between ACAT approval and entry into formal aged care, 2008-09

	CACP	EACH	EACH-D	Residential care	
				Low	High
	%	%	%	%	%
2 days or less	4.7	6.1	6.6	3.9	10.2
3-7 days	6.5	6.1	8.5	6.5	16.1
8 days to <1 month	27.4	21.0	30.5	20.6	30.0
1 month to < 3 months	32.5	28.4	32.0	30.4	24.9
3 months to < 9 months	24.3	30.7	20.2	30.5	15.5
≥ 9 months	4.6	7.7	2.2	8.1	3.3
Median days	45	62	35	63	23

Note: Elapsed time must be interpreted with caution as some people may receive ACAT approval but choose not to access formal aged care services.
Source: SCRGSP (2010) and Access Economics calculations.

Along with people having to wait for services, there is a large number of people with dementia not accessing any type of community or residential care. This may be due to choice, as some people with dementia (especially at the mild stage) may prefer not to receive formal care services. However, it may also be due to limited access to services.

The number of people with dementia not receiving formal care in 2010 was estimated using the difference between the number of people who are receiving formal care and the estimated prevalence of dementia, and is presented in Table 5.2. This estimate must be interpreted cautiously as it is calculated from prevalence rates that are based on international prevalence studies.

Table 5.2: Estimated number of people with dementia not receiving formal care, 2010

	People with dementia	% of people with dementia
HACC clients [(a)]	50,269	19.6
CACPs [(b)]	8,400	3.3
EACH packages [(b)]	1,829	0.7
EACH-D packages [(b)]	2,901	1.1
Residential care residents [(b)]	114,158	44.5
People with dementia receiving formal care	177,557	69.2
Estimated number of people with dementia	256,529	n.a.
People with dementia **not** receiving formal care	78,972	30.8

Note: (a) HACC is a measure between 2009-2010. (b) CACP, EACH, EACH-D and residential care is a measure as at 30 June 2010.
Source: VGDHS (2004), AIHW (2009c) and Access Economics calculations.

Around 63,399 people with dementia receive community care through HACC services or care packages such as CACP, EACH and EACH-D. Another 114,158 people with dementia receive residential care, which comprises approximately 63% of all residents at any one time. Consequently, it is estimated there are 177,557 people with dementia receiving formal care in 2010. Compared to the 256,529 people estimated to have dementia in 2010 (see Section 1.3)

the number of people with dementia not receiving formal care is estimated to be 78,972, or 30.8% of all people with dementia.

Given the significant waiting times for access to formal aged care services it is reasonable to assume that the shortfall in accessing services is due to limited access. This is supported by data presented from the 2003 SDAC that measured the extent to which the needs of people over the age of 60 years are met across various activities. It found 678,800 people requiring assistance (18.1%) either had their needs partly met (11.3%), or not met at all (6.8%) (ABS, 2004). A further breakdown of the extent to which needs were met in 2003 is presented in Table 5.3.

Table 5.3: Extent to which needs are met for persons aged 60 years and over, 2003

	Fully	Partly	Not at all	Total
	%	%	%	%
Self care	84.8	5.2	9.9	100.0
Mobility	82.6	9.9	7.5	100.0
Communication	88.7	9.2	2.1	100.0
Cognition or emotion	77.4	16.1	6.5	100.0
Health care	84.2	8.5	7.3	100.0
Paperwork	89.3	6.2	4.5	100.0
Transport	79.8	9.1	11.0	100.0
Housework	81.4	13.7	4.9	100.0
Property maintenance	77.7	16.6	5.6	100.0
Meal preparation	90.2	7.6	2.2	100.0

Source: ABS (2004).

Without a survey that specifically investigates the level of demand for formal care services it is difficult to estimate the level of unmet need. Therefore this scenario assumed that community and residential care services could be increased by 18.1% to fill the true level of current unmet need in addition to any future increase in supply using estimated dementia prevalence growth.

Unmet need is likely to vary across different types of HACC services, community care packages, and within residential care. Furthermore, increasing the number of aged care services will not necessarily completely fill unmet need if the services offered do not align with preferences of care recipients and their family and friends. According to Alzheimer's Australia, the provision of current, and any additional, care services should be based on a set of core principles, including:

- valuing the worth of every person;
- relating to the person rather than the illness;
- maximising autonomy, independence and participation;
- responding to the needs of the whole person;
- providing an environment and experience that are enriching and meaningful; and
- recognising the importance of working in partnership with family and friends of the person with dementia (Alzheimer's Australia, 2003)

Each person has their own unique relationships with family and friends and care circumstances, which often change as a dementia progresses. Importantly, formal community care should be flexible to meet the individual preferences of people requiring care.

5.2 Supply of aged care using unmet need scenario

A summary of the projected increase in HACC clients, community care packages and operational residential care places projected under the unmet need scenario is presented in Chart 5.1. If unmet need were filled, and aged care supply was increased by the growth rate of dementia prevalence, the total number of community care packages is projected to increase from around 54,325 packages in 2010 to 250,413 packages in 2050. Of these, there would be:

- 210,347 CACPs;
- 26,043 EACH packages; and
- 14,023 EACH-D packages.

Over the same period the number of HACC clients is projected to increase from around 966,710 to around 4.4 million. In addition, the total number of operational residential care places would increase from around 181,204 in 2010 to 808,576 in 2050, distributed equally between low and high care.

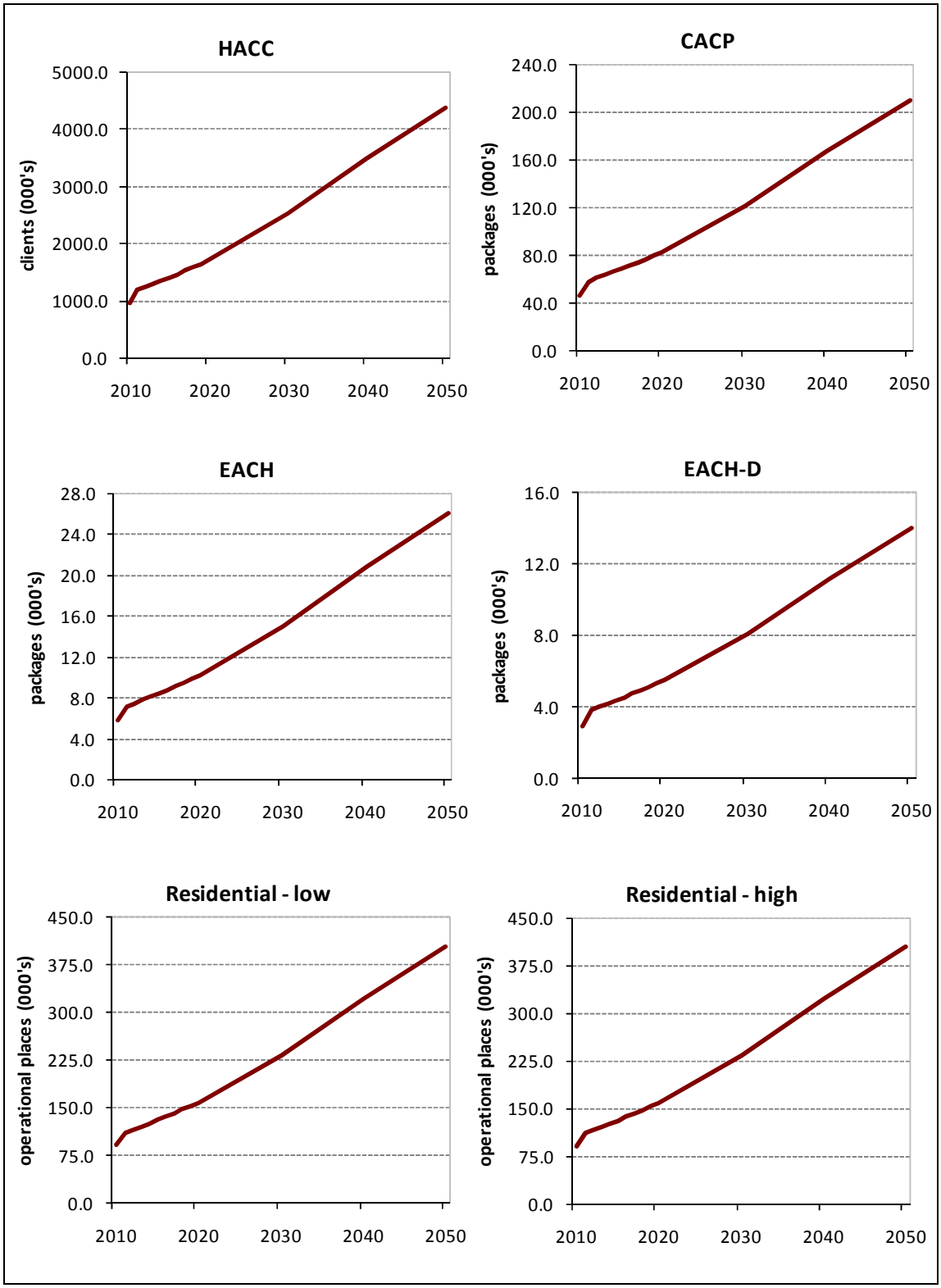
Compared to the current policy scenario, aged care supply is projected to be greater under the unmet need scenario. Additional aged care supply under the unmet need scenario is presented in Table 5.4. In summary, it is projected that in 2011 there would be an additional:

- 201,606 HACC clients;
- 8,826 CACPs;
- 1,093 EACH packages;
- 588 EACH-D packages; and
- 33,927 operational residential care places (equally distributed between low and high care).

By 2050, the additional supply of aged care services under the unmet need scenario compared to current policy is projected to be much greater. In summary there will be an additional:

- 1.7 million HACC clients;
- 77,395 CACPs;
- 9,582 EACH packages;
- 5,160 EACH-D packages; and
- 297,508 operational residential care places (equally distributed between low and high care).

Chart 5.1: Projected supply of aged care under the unmet need scenario



Source: Access Economics calculations.

Table 5.4: Additional aged care supply using the unmet need scenario

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2030	2040	2050
	000's	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*	*000's*
HACC clients	201.6	224.5	246.7	262.8	279.8	296.1	299.0	305.8	317.2	329.9	622.1	1,143.8	1,656.7
CACPs	8.8	9.9	10.9	11.7	12.5	13.2	13.3	13.6	14.1	14.7	28.3	53.0	77.4
EACH packages	1.1	1.2	1.4	1.4	1.5	1.6	1.6	1.7	1.7	1.8	3.5	6.6	9.6
EACH-D packages	0.6	0.7	0.7	0.8	0.8	0.9	0.9	0.9	0.9	1.0	1.9	3.5	5.2
Residential - Low care places	17.0	19.0	21.0	22.5	24.0	25.4	25.6	26.1	27.1	28.2	54.4	101.9	148.8
Residential - High care places	17.0	19.0	21.0	22.5	24.0	25.4	25.6	26.1	27.1	28.2	54.4	101.9	148.8
Community care packages	10.5	11.8	13.0	13.9	14.8	15.7	15.8	16.2	16.8	17.5	33.7	63.1	92.1
Residential care places	33.9	38.1	42.1	44.9	47.9	50.8	51.2	52.2	54.2	56.4	108.7	203.8	297.5
Total – Packages and places	44.4	49.9	55.1	58.8	62.8	66.6	67.0	68.4	71.0	73.8	142.4	266.9	389.6

Note: Compared to projected aged care supply using the current policy scenario.
Source: Access Economics calculations.

6 Cost of aged care supply alternatives

This chapter projects the cost to the government and society of the current policy, dementia growth, and unmet needs supply scenarios presented in the previous chapters using estimates of average cost per client, package, and operational residential care place. Alternative shares of community and residential care are tested to determine the additional supply of aged care services that could be delivered if more focus was given to community care within Commonwealth Government planning ratios. There is also a discussion on the importance of consumer choice in the planning and delivery of care.

6.1 Projected cost of formal care

Aged care services are currently funded through a combination of public and private financing. Community care recipients contribute to the cost of care through fees, which is capped at a maximum of 17.5% of the basic single aged pension[19], or an additional fee limited to 50% of any income above the basic rate of a single pension for people on higher incomes.

A resident in a residential care facility may be asked to pay an accommodation bond if receiving low levels of care or receiving care on an extra service basis in either low or high care. There may also be an accommodation charge (capped at 1/2080th of assets above 2.5 times the single age pension) if the resident is receiving high level care other than extra service care, a basic daily fee (capped at 85% of the single aged pension), and an income tested fee to replace part of the basic subsidy payable for some residents.

However, the bulk of aged care expenditure is funded by the Commonwealth Government, which provides around 68%. Jurisdictional governments contribute 5.4% and individuals 26.2% (Hogan, 2004).

Recurrent expenditure on HACC clients, community care packages and residential care for 2008-09 is shown in Table 6.1, Table 6.2, and Table 6.3 respectively. Public expenditure on aged care is primarily funded from the Commonwealth Government budget, although a large proportion of funds are expended by jurisdictional governments within the HACC program. The Commonwealth Government spent around $829.4 million in 2008-09 on HACC, CACP, EACH, EACH-D, and aged care assessment associated with these programs (e.g. ACAP), and around $6.7 billion on residential care, totalling $8.6 billion for formal care services (PC, 2010b).[20] Jurisdictional governments spent $698.2 million on HACC services over the same period.

[19] As of 20 March 2010 the maximum fee for CACP, EACH or EACH-D community care packages for people on the basic rate of pension was $8.05 per day.

[20] This does not include Department of Veterans Affairs (DVA) expenditure on community care or aged care services provided in a mixed delivery setting.

Table 6.1: Recurrent expenditure on the HACC program, 2008-09

	Expenditure	Clients[(a)]	$/client
	$ (million)	*No.*	
Jurisdictions	698.2	n.a.	n.a.
Commonwealth	1,094.4	n.a.	n.a.
Total	1,792.6	940,731	1,906

Note: The number of clients has been adjusted to account for non-reporting providers within the HACC minimum dataset by assuming these providers service an average number of clients.
Source: DoHa (2009c) and Access Economics calculations.

Table 6.2: Recurrent expenditure on community care programs, 2008-09

	Expenditure	Packages	$/package
	$ (million)	*No.*	
CACP	479.7	40,195	11,934
EACH	172.7	4,478	38,566
EACH-D	83.6	2,038	41,021
Total - Packages	736.0	46,711	n.a.
Aged care assessment[(a)]	93.4	n.a.	2,000
Total – Community care[(b)]	829.4	n.a.	17,756

Note: (a) Includes ACAP programs, carers information and support, Commonwealth Carelink centres and additional COAG funding for ACATs. (b) Does not include other community care costs such as community care grants, assistance with care and housing for the aged, National Respite for Carers (NRCP), or DVA expenditure on community nursing or Veterans' Home Care (VHC).
Source: PC (2010b), DoHA (2009c) and Access Economics calculations.

Table 6.3: Recurrent expenditure on operational residential care places, 2008-09

	Expenditure	Places	$/place
	$ (million)	*No.*	
Low care[(a)]	1,781.3	89,228	19,963
High care[(a)]	4,872.4	85,997	56,658
Total[(b)]	6,653.7	175,225	37,972

Note: (a) The relative cost per resident for low and high care was used to estimate the expenditure for low and high care operational places (b) Includes jurisdiction expenditure on residential care services, such as adjusted subsidy reduction supplement, EBA supplement, and rural small nursing home supplement. Also includes DoHA expenditure and Department of Veterans Affairs (DVA) expenditure.
Source: PC (2010b), DoHA (2009c) and Access Economics calculations.

Using the estimates of average community care and residential care costs per client, package and operational place (as presented above),[21] and the share of public expenditure versus private expenditure, total expenditure was estimated for 2010 and projected to 2050 for the current policy scenario (Chapter 4), dementia prevalence growth rate scenario (Chapter 5), and needs based scenario (Chapter 6).

[21] Cost estimates were adjusted to 2010 dollars using the health component of the Consumer Price Index. This was 5.1% for March 2009-March 2010 (ABS, 2010).

It was also assumed that the average real cost per client, package and place would increase by 1.6% per annum, which is a reflection of the rate of productivity growth and is in line with assumptions used by the Commonwealth Treasury in projecting aged care expenditure (The Treasury, 2010a).

Expenditure projections are presented in Table 6.4, Table 6.5 and Table 6.6. The projected cost of HACC clients, community care packages, and operational residential care places is expected to increase in line with the growth of aged care supply, although the increase in expenditure will be slightly greater given average real unit cost is also expected to increase. Results are summarised below.

- Under the current policy scenario annual expenditure on HACC clients, community care packages, and operational residential care places is projected to increase from $11.1 billion in 2010 to $59.6 billion in 2050 (equivalent to 451% growth). Of this, the public budget will expend $44.0 billion while the private sector will expend $15.6 billion.
- Under the dementia growth policy scenario, annual expenditure on HACC clients, community care packages, and operational residential care places is projected to increase to $79.8 billion by 2050, which is equivalent to around 618% growth and $20.2 billion more than the current policy scenario. The public budget will expend $58.9 billion while the private sector will expend $20.9 billion.
- Under the unmet need scenario, expenditure on HACC clients, community care packages, and operational residential care places is projected to increase to $94.2 billion in 2050, which is around 749% growth, $14.4 billion more than the dementia growth scenario and $34.7 billion more than the current policy scenario. The public budget will expend $69.5 billion while the private sector will expend $24.7 billion.

Table 6.4: Estimated expenditure on HACC clients, community care packages and residential care places under current policy scenario

	2010	2020	2030	2040	2050
	$ (million)	*$ (million)*	*$ (million)*	*$ (million)*	*$ (million)*
Public expenditure					
HACC	1,937	3,241	5,207	7,551	10,241
CACP	573	996	1,600	2,320	3,147
EACH	234	398	640	928	1,259
EACH-D	125	228	367	532	721
Total – community care	932	1,622	2,607	3,780	5,127
Low care places	1,918	3,201	5,144	7,459	10,116
High care places	5,346	9,086	14,599	21,169	28,712
Total – residential care	7,264	12,287	19,743	28,628	38,828
Total – Public expenditure	8,196	13,909	22,349	32,408	43,955
Private expenditure	2,910	4,938	7,934	11,505	15,605
Total – Formal care expenditure	11,105	18,847	30,284	43,913	59,559

Note: Real expenditure in 2010 dollars. Assumes aged care supply grows at the same rate as the Australian population aged 70 years and over.
Source: Access Economics calculations.

Table 6.5: Estimated expenditure on HACC clients, community care packages and residential care places under dementia growth scenario

	2010	2020	2030	2040	2050
	$ (million)	*$ (million)*	*$ (million)*	*$ (million)*	*$ (million)*
Public expenditure					
HACC	1,937	3,400	5,859	9,517	13,974
CACP	573	1,026	1,767	2,871	4,215
EACH	234	410	707	1,149	1,687
EACH-D	125	235	405	658	966
Total – community care	932	1,671	2,879	4,677	6,868
Low care places	1,918	3,297	5,682	9,230	13,552
High care places	5,346	9,358	16,126	26,196	38,464
Total – residential care	7,264	12,656	21,808	35,426	52,016
Total – Public expenditure	8,196	14,327	24,687	40,103	58,884
Private expenditure	2,910	5,086	8,764	14,237	20,905
Total – Formal care expenditure	11,105	19,413	33,452	54,340	79,789

Note: Real expenditure in 2010 dollars. Assumes aged care supply grows at the same rate as projected dementia prevalence.
Source: Access Economics calculations.

Table 6.6: Estimated expenditure on HACC clients, community care packages and residential care places under unmet need scenario

	2010	2020	2030	2040	2050
	$ (million)	*$ (million)*	*$ (million)*	*$ (million)*	*$ (million)*
Public expenditure					
HACC	1,937	4,015	6,919	11,240	16,503
CACP	573	1,211	2,087	3,390	4,978
EACH	234	485	835	1,357	1,992
EACH-D	125	278	478	777	1,141
Total – community care	932	1,973	3,400	5,524	8,111
Low care places	1,918	3,894	6,710	10,901	16,005
High care places	5,346	11,052	19,045	30,937	45,426
Total – residential care	7,264	14,947	25,755	41,838	61,431
Total – Public expenditure	8,196	16,920	29,156	47,362	69,542
Private expenditure	2,910	6,007	10,351	16,814	24,688
Total – Formal care expenditure	11,105	22,927	39,506	64,176	94,230

Note: Real expenditure in 2010 dollars. Assumes aged care supply grows at the same rate as projected dementia prevalence and there is an additional increase of 18.1% in 2011 to fill unmet need.
Source: Access Economics calculations.

6.1.2 Alternative shares in community and residential care

Due to the ageing of the population and the growth in dementia prevalence there is expected to be a large increase in demand for aged care services in the future. Furthermore, this demand will not be homogenous, with care needs changing as the population ages and as the proportion of aged care recipients with dementia increases. High care services will need to grow to cope with this change. There will also be a greater demand for greater choice within, and across, community and residential care due to individual preferences and an improved capacity to pay.

The Commonwealth Government has recognised the demand for more community care services and has undertaken many trials through the Aged Care Innovative Pool. This has led to a broadening in the range of services offered, extending access to programs, and introducing condition specific programs to meet specific needs (such as EACH-D) (PC, 2008)

However, the relative supply of community care versus residential care is fixed under Commonwealth Government planning ratios and it is unlikely that current policy will cater to changing care preferences in the future.

The majority of people prefer community care for as long as possible if appropriate services can be accessed. Yet planning ratios have resulted in relatively low levels of community care packages compared to residential care places. For example, it is estimated there are 45,654 CACPs in Australia in 2010 compared to 91,431 low care residential places (see Section 2.2 and Section 2.3). The supply of residential care is favoured even more in high care, with 89,772 operational places in 2010 compared to 8,671 EACH and EACH-D packages. If the use of planning ratios does not change, then a greater gap between the demand for and supply of community care may emerge in the future, forcing more people into residential care against their wishes. Preferences will not be met and the Commonwealth Government will face greater budget pressure from the aged care sector.

It is not possible to specify what the optimal mix of community care versus residential care will be in the future. This is because the ratio will change as factors that impact demand for alternative types of care change, for example care needs and the availability of informal care from family and friends. Furthermore, the baby boomers have changed social norms in every stage of the lifecycle, and it is expected that their effect on aged care will be no different. This generation is accustomed to choice and quality and, with higher wealth and influence than previous generations, it is expected that they will exert significant political and financial pressure to have their needs met. Baby boomers also have weaker family and community ties than previous generations, and it is likely that the consequent lack of available informal care will increase their need for formal care, whether community or residential care (PC, 2008).

Given residential care is more expensive for government than community care, and community care is preferred, one could expect that future supply of care should be focused on delivering a greater proportion of community care packages. However, community care not only costs the government through subsidisation of services, but it also costs the care recipient through charges for service delivery, opportunity cost of housing, housing maintenance costs, and significant costs on others who provide unpaid informal care. This means that a shift from residential care to community care would impose a far greater cost to society than the cost represented in the Commonwealth Government's budget figures. Furthermore these costs

will not be trivial. For example, a greater burden on informal carers directly translates into lost productivity. In 2008, people with dementia received around 203 million hours of unpaid informal care at an estimated cost per annum per person of $5,323 using opportunity cost valuation. The total productivity loss of informal care to people with dementia was estimated to be $881 million per annum (Access Economics, 2009d).

The cost to the care recipient in receiving community care, and the total cost to society from shifting aged care from residential care facilities into the community, should be explicitly recognised in planning the delivery of community care versus residential care.

The number of additional community care places that could be generated from a more community care focused planning policy was modelled by shifting half the projected expenditure on low and high residential care places to community care packages under the current policy scenario. Results are presented in Table 6.7.

Table 6.7: Projected change in aged care supply due to a shift towards community care [(a)]

	2020	2030	2040	2050
CACPs	43,638	100,010	157,332	213,478
EACH packages	19,682	44,437	69,608	94,263
EACH-D packages	18,504	41,777	65,442	88,622
Total - Community care	81,824	186,223	292,383	396,364
Low care places	-26,087	-59,786	-94,054	-127,619
High care places	-26,795	-60,494	-94,762	-128,326
Total - Residential care	-52,881	-120,280	-188,816	-255,945
Net change in aged care	28,943	65,943	103,567	140,419

Note: (a) Assumes half of residential care expenditure growth under the current policy scenario is reallocated to community care. Expenditure savings from low care residential are allocated to the CACP program while expenditure savings from high care residential are allocated equally between the EACH and EACH-D programs.
Source: Access Economics calculations.

If the Commonwealth Government were to shift half the expected expenditure from residential care to community care packages then around 81,824 additional community care packages could be delivered annually by 2020. Of this, there would be 43,638 additional CACPs, 19,682 additional EACH packages and 18,504 additional EACH-D packages. However, it would also result in a reduction of 52,881 residential care places, of which 26,087 would be low care and 26,795 would be high care. In net terms, and bearing in mind the additional social and personal costs that are not accounted for here, the Commonwealth Government could potentially increase the supply of aged care to 28,943 additional people.

By 2050, there would be an additional 396,364 community care packages, comprising 213,478 CACPs, 94,263 EACH packages and 88,622 EACH-D packages. However there would be 255,945 fewer residential care places, resulting in a net increase of 140,419 people accessing aged care services.

The scenario analysis above suggests the Commonwealth Government could increase the number of people accessing aged care services while maintaining the same projected expenditure by simply shifting planning ratios in favour of more community care. This is an important point to consider given spending in aged care is already projected to grow from 0.8% of GDP in 2009-10 to 1.8% of GDP in 2049-50 (The Treasury, 2010a). In effect, by

changing the relative supply of aged care services to favour community care, the Commonwealth Government can generate 'more bang for their buck' in an environment where aged care expenditure will be placing massive pressure on the Commonwealth budget by accounting for a greater proportion in the future. It is important however that any such shift would add value to aged care services (i.e. by better catering to preferences of older people in need of care) rather than simply shifting a proportion of the increased cost of care from government onto the community.

Although CACPs are designed to substitute for low residential care, and EACH and EACH-D packages are designed to substitute for high residential care, both are generally complemented by informal care. For example, around 57% of CACP recipients, 89% of EACH package recipients and 95% of EACH-D package recipients have an informal carer (AIHW, 2010a). Therefore current community care packages may not be exact substitutes for low and high residential care, and any increase in the availability of community care packages may require additional types of services, accommodation options, or a greater amount of care, if they are to meet home care needs and preferences and allow care recipients to stay out of residential care facilities. This is particularly relevant given the projected decrease in the availability of informal care in the future.

There are concerns that under the current system some people in residential care receive a greater level of government subsidies compared to the equivalent level of care in the community (Hogan, 2004). Indeed, the public cost per community care package is lower compared to the equivalent level of care offered in residential care facilities (see Section 6.1).

If expenditure per community care package was increased to be commensurate with residential care equivalents, the quality and amount of care delivered through community care packages could be improved without an increase to government expenditure if the government shifted funds from residential care. For low care this might provide the same level and quality of care as found within a residential care facility with the additional benefit of meeting society's preferences in moving towards a more community care focused aged care system.

6.2 The importance of consumer choice

Adequate and appropriate provision of aged care is complicated by individual preferences in the type and quality of care demanded throughout society. Even people with the same condition may have different preferences for care and how they would like it delivered. Hence, the availability of flexible formal care is important to accommodate varying needs.

It has been suggested that the current aged care system does not have enough flexibility to meet individual preferences. Aged care recipients feel that the current system gives them insufficient control over the type of care they receive, where they wish to receive it and how it is provided (Tilly and Rees, 2007). In a survey of what people with dementia and their carers value in terms of care services and delivery, it was found that they preferred flexibility in service provision, as well as informed choice between what services they are able to access at different times and locations (Access Economics, 2009d).

There are also restrictions placed on offering flexible combinations of aged care that are implicit in planning ratios. Planning ratios are a blunt instrument for ensuring the total amount of care, and the allocation of care across regions, is optimal. Furthermore they are not

appropriate tools to address alternative preferences within, and across, communities throughout Australia given the large disparity in socio economic status, demographics, access to services, ethnicity and expected utilisation of informal care and aged care services (SCFPA, 2009).

In recent years, there has been increasing interest in consumer-directed care (CDC) in the provision of aged care services to address the current lack of consumer choice and flexibility. CDC models provide a spectrum of options that extend from income support (such as cash and vouchers, under direct payment models) to agency services and case management to enable clients and their family or carers to purchase care services. Some programs restrict the use of benefits to approved care services while others are unrestricted.

By giving autonomy to clients and their carers, CDC provides a greater say in the planning of care and in the delivery of services. The recipient of care can be involved (if they prefer) in decisions about the range of services they perceive as most appropriate to their needs including:

- controlling when the care is delivered;
- controlling how the care is delivered such as through community care or residential aged care;
- taking responsibility for their choice of care provider; and
- managing day to day delivery of care.

Under a CDC framework, care recipients and carers can use allocated funds or benefits to purchase services and equipment from traditional service agencies, or they can use the funds for options outside the formal care system. This is particularly relevant for people from Culturally and Linguistically Diverse (CALD) populations for whom mainstream formal services may not be relevant or well suited to their cultural and/or linguistic needs. Similarly, limited availability and issues regarding access to formal services in rural and remote areas may make CDC models particularly attractive to consumers in that it presents the opportunity to arrange flexible, non-traditional care.

Another major advantage of CDC is that it offers more transparency to consumers in the use of allocated funding. Historically, service providers have pooled available funds to be shared across all care recipient based on the service provider's perceived need. Under a CDC program, care recipients have a budget and agencies will be directly accountable for this amount, giving care recipients greater purchasing power.

The effectiveness of CDC will depend on consumers having adequate access to information about available services and provider options. This information is required in order for consumers to make informed decisions about their care. However, collecting information about often disparate services and program can be costly in terms of the amount of time and effort required. Furthermore, informal carers have often noted that under the current system, the information that is available can be complex and frustrating (Access Economics, 2009d). The proposed new information and assessment one-stop shops may reduce these difficulties. Other options include the use of aged care brokers or budget holders, where relevant information is processed and filtered for the client and advice provided, before a decision is made on purchasing aged care services.

It is implicit in CDC that consumers have the choice of the option that would suit them the best. Some may prefer the current system because it delivers the appropriate amount of care and does not require additional effort in managing the delivery of care services. Any move towards a more consumer directed care system must maintain flexibility for people to choose the status quo if they prefer.

6.2.1 Consumer directed community care

Community care in Australia is currently fragmented and the existing structures are rigid. This inhibits the provision of continuous care and impairs the ability of older people to access a wide range of services (PC, 2008). Many care recipients find it difficult to move between community care packages (for example between HACC and CACP) because of higher user charges and loss of continuity of care with known providers. This is particularly problematic for people with dementia who generally require transitions to higher levels of care as the condition progresses.

As a result, there has been increasing pressure to strengthen consumer choice in community care. Elements of CDC already exist in Australia through several community care programs, the most widespread of which is the Carer Allowance paid to carers of relatively young people with a disability and carers of frail and disabled older people. This is a cash allowance paid to carers of people with disabilities to assist with care. However, there are no restrictions as to how the allowance is used and because the carer receives the money the care provided does not technically constitute CDC.

Various direct payment models of CDC have been trialled in Victoria and NSW. The Direct Payments Project in Victoria was undertaken by the Department of Human Services (DHS). Results from the pilot suggested that direct payments were successfully used and that participants in the program benefited from greater flexibility and control. This is because they were able to negotiate the nature of the service provision directly with disability service providers and manage the expenditure of their funding in line with the goals of their funding plan and their changing needs.

The NSW Department of Ageing, Disability and Home Care (DADHC) piloted a direct funding project in conjunction with the Attendant Care Program (ACP). The pilot improved care arrangements in areas of attendant care quality and turnover rate due to improved pay and conditions and also increased training so that attendant carers are more likely to be skilled and knowledgeable.

Direct payments have been used internationally and have shown positive results. In Germany those who qualify for aged care (based on assessed need), have the option to receive their benefit in cash, services or a combination. However, the value of service benefit is almost double the value of the cash, so if the person receives their benefit in cash they are effectively receiving half the value they could have received. In the first year of operation, 84% of those on the lowest level benefit and 64% on the highest level benefit elected the cash option (Tilly and Bectel, 1999).

In a survey of aged care recipients in Germany, a larger proportion of those who elected for a cash benefit reported satisfaction with the choice that it gave them than did those who took the services. Almost half of cash recipients felt that the quality of care that they received had improved. In France and the Netherlands, voucher type schemes were trialled and the results

supported the proposal that participants preferred to have control over their aged care services (Tilly and Bectel, 1999).

The UK is also experiencing escalating health care costs, rising levels of unmet need and dissatisfaction with traditional service provision (Laragy and Naughtin, 2009). As a result, the government has been actively promoting innovative consumer-directed care models in disability and aged care, two of which are summarised below.

- Direct Payments – People with a disability are guaranteed the right to an individual allocation based on a needs assessment. Funding can only be used to employ support workers in some areas but may be used for social participation activities or to purchase goods and equipment in other areas (Riddell et al, 2006).
- Individual Budgets – Individual Budgets were introduced because of the low uptake of Direct Payments and follow the model of integrated care. Each individual's allocation is determined by self-assessment of need and a plan approved by the local authority. Funds can be used for social activities and purchasing equipment, and support workers can be recruited from family, friends and neighbours.

Direct payments to care recipients and individual budgets could potentially increase quality and choice in the Australian aged care system. Competition can generate incentives for providers to be more responsive to preferences, thereby generating more choice in the types of services offered, and promoting greater efficiency.

However, there may be limits to competition benefits if potential providers are lacking (e.g. in rural and remote areas). Moreover, some aged care recipients (particularly those requiring high care) may not have the ability to make fully informed choices about their care, and would therefore need to rely on family, friends, or case managers to make decisions for them and to monitor outcomes. It could be difficult for such people or their families to undertake the administrative tasks involved in hiring and firing carers. Another difficulty is that some people, particularly disadvantaged groups, may not be aware of what kind of care they require and there is the potential for poor outcomes for such people.

Recently the Commonwealth Government announced plans to fund a trial of 1,200 consumer directed aged care places in Australia (DoHA, 2010a). Providers will offer consumers the choice of consumer directed care packages within Australian Government funded packaged care programs of Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACHD). People requiring care will be given individual budgets based on a needs assessment and these budgets will be administered on their behalf by an approved provider for an agreed percentage of the allocated budget. The care recipient will have the same level of entitlements as those specified under the individual packaged care programs but will hold greater responsibility for the delivery of services. Rather than being passive, the role of the care recipient will be to:

- develop a care plan and budget for the year;
- choose their service providers;
- determine any specific training that may be required for workers delivering services;
- manage delivery problems with providers;
- nominate a representative person for care management; and

- allocate funds to providers for case management and general administration in the delivery of care (DoHA, 2010a).

The role of the care recipient is therefore one of management, where the provider is responsible for informing the care recipient of formal care services available and ensuring requested care is delivered, through developing a care plan in consultation with the care recipient, administering the budget, case management, engaging workers, providing specific training, and undertaking reviews of care delivery (DoHA, 2010a).

Assistance with the purchase of aged care services through an experienced aged care intermediary will be essential if consumer directed community care is to become a standard pathway for people with dementia. Aged and Community Services Australia (2008) argue that brokerage through existing agencies, or through new agencies that use existing delivery models, is likely to be the most popular model of consumer directed care in the community.

One of the most important objectives of consumer directed community care is that care recipients have genuine flexibility in program arrangements, such that services can be tailored to the care recipient's individual circumstances. One way this could be achieved is through graduated care packages, whereby care recipients do not receive a set level of aged care services based on the packages they receive, but receive services that can be gradually increased as needs increase (as opposed to the step in community care services currently involved in a transition from a CACP to an EACH package).

Tilly and Rees (2007) note that Australia is well placed to experiment with consumer directed community care because of the comprehensive community care system already in place. They offer three options that could generate greater flexibility in program development, including:

- improving brokerage options to better manage professional services;
- providing cash, vouchers or budgets in place of current packages, and allowing people to choose how these funds are used; and
- giving people with dementia and their carers genuine choice between residential and at-home care.

Increasing flexibility through consumer directed community care is expected to make community care more desirable and accessible for many people. This may mitigate any shortages in residential aged care that may be evident in the future (PC, 2008). In order for this to happen, community care services would need to be expanded at the high-care end of the spectrum to accommodate those with higher care needs (e.g. those with dementia) who prefer to remain at home.

6.2.2 Greater choice in residential care

Currently there are constraints in consumer choice within the residential care market (Hogan, 2007; PC, 2008). This is primarily driven by the lack of incentives for providers to offer alternative types of care due to caps on pricing imposed by Commonwealth Government regulation. Although care recipients may be asked to contribute to the cost of their accommodation and living expenses such as meals and refreshments, cleaning, laundry, heating and cooling, daily fees and income tested fees are capped, while accommodation bonds and accommodation charges are asset-tested and based on the level of need.

From a provider perspective, the current aged care system does not promote competition since the Commonwealth Government controls the number and allocation of available places and constrains provider capacity to raise and expend revenues. This limits provider ability to offer different types of care services, or offer care in different settings, thereby weakening the incentive to innovate in the delivery of services. This in turn distorts the provider's decision making regarding the optimal amount and allocation of investment, and leads to restricted consumer choice.

Due to service restrictions imposed by residential care regulations, and limited capacity for care recipients to express their willingness to pay for care, care recipients are limited in their capacity to reveal their true preferences for services, distorting 'market signals' for residential care. This means some preferences are not met and there is a need to correct for this by allowing for more flexibility in funding residential aged care. By extending some of the concepts found in CDC to residential care, care recipients will be able to signal their true preferences for certain preferred features within the residential care market more easily.

It is important to offer choice within the residential care market to promote flexible care arrangements and improve the ability of residents to remain in a familiar environment as their care needs increase. The capacity to pay for services through increased asset values such as superannuation and housing wealth is also likely to generate greater diversity in aged care recipient preferences.

Consumer choice in residential aged care means residents have access to a range of differentiated services to which they can form preferences. These could be differentiated by:

- accommodation type, such as shared versus private bedrooms;
- location of accommodation, such as nearer to other health service needs;
- provider type, such as profit versus non-profit;
- payment arrangements, such as periodic payments versus lump sum payments (bonds); and
- additional service options, such as private bathrooms, outdoor living and larger rooms (PC, 2008).

An important consideration is quality. In particular, other non-traditional types of residential care services and settings should not be allowed unless they meet quality assurance standards in the delivery of care (e.g. an appropriately skilled workforce) and result in quality outcomes (e.g. resident satisfaction). Quality aged care services is not a matter of choice, but a matter of necessity.

A survey undertaken by Access Economics (2009d) suggests the most valuable attributes of residential care are those that ensure the person can retain their dignity and be properly cared for by staff. These attributes included private facilities such as a room and bathroom and staff who are specifically trained in providing dementia care. Furthermore, residential care facilities that can accommodate all stages of dementia and provided cultural and recreational needs on an individual basis are highly valued. Comments suggest respondents would like a more individualised service that provides respect to care recipients.

There is a clear need for a review of residential care regulations and how they impact consumer choice. Policy should focus on freeing up the residential care market to allow

greater market signals and more incentives to innovate and differentiate. Policy should include:

- addressing current concerns with inadequate government subsidy arrangements and the consequential financial instability and lack of return associated with the provision of aged care services;
- the lack of adequate capital funding;
- the inappropriate level of the accommodation charge and the cross-subsidisation of low care bonds to fund high care residents;
- the cross-subsidisation of capital expenses with funds intended for operational costs, such as daily Aged Care Funding Instrument (ACFI) subsidies;
- the inadequacy of using the Commonwealth Own Purpose Outlays (COPOs) as an indexation formula;
- the appropriateness of Conditional Adjustment Payments (CAPs) to address rising costs;
- the inflexibility of aged care pricing to meet differentiated demand for residential accommodation and services; and
- an improved ACFI to promote an optimal skill mix in residential care.

Of course, any market within aged care should operate within a framework that ensures quality of care and equity in access.

7 Funding future aged care

This chapter looks at the current tools used to fund aged care and explores alternative funding models that have been canvassed by the government at various points in time or are currently used in other developed countries.

7.1 Current arrangements in Australia

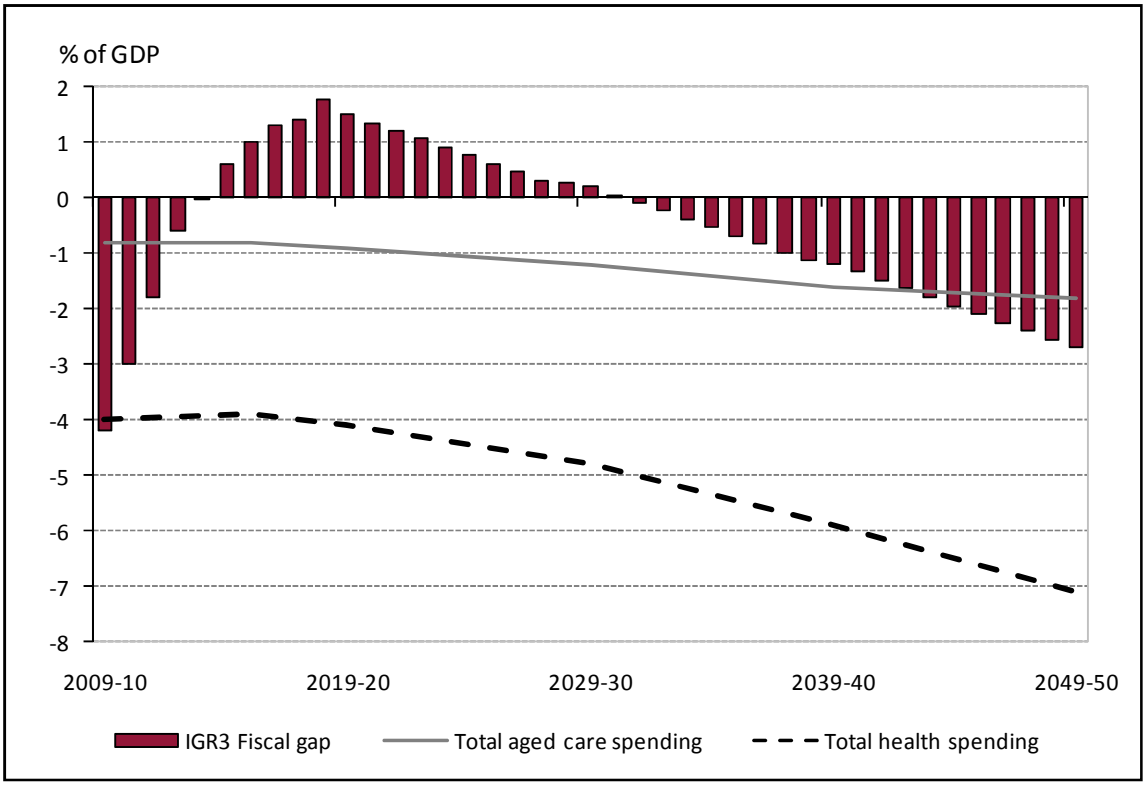
Community care packages and residential care places are mostly publicly funded by the Commonwealth Government. A broad estimate suggests the Commonwealth Government currently funds 69% of aged care, with jurisdictions funding around 5% (for HACC services) and the private sector funding around 26% (Hogan, 2004). Recent policy change outlined within the National Health and Hospital Network (NHHN) noted that the Commonwealth Government, with the exception of Victoria and Western Australia, will take full funding responsibility of the HACC program starting 1 July 2011 and operational responsibility from 1 July 2012.

Expenditure on HACC clients, community care packages and operational residential places is expected to increase from $11.1 billion in 2010 to $59.6 billion in 2050 (see Section 6.1). However, additional expenditure on aged care services by the Commonwealth Government will also occur, through funding of community care grants, assistance with care and housing for the aged, National Respite for Carers Program (NRCP) and Department of Veterans Affairs (DVA) expenditure on community nursing or Veterans' Home Care (VHC).

According to the Treasury, population ageing pressures will reduce fiscal sustainability. Although the Commonwealth budget is projected to have a positive net revenue position from 2018-19, expenditure on health and aged care is expected to gradually reduce net government revenue, until a fiscal gap is once again reached in 2031-32. By 2049-50 this gap is expected to be 2.75% of gross domestic product (GDP) (The Treasury, 2010a). This is under the assumption that the Commonwealth Government can restrain real spending growth to 2% in years when the economy is growing above trend. The projected Commonwealth Government fiscal balance along with projected health care spending and projected aged care spending is shown in Chart 7.1.

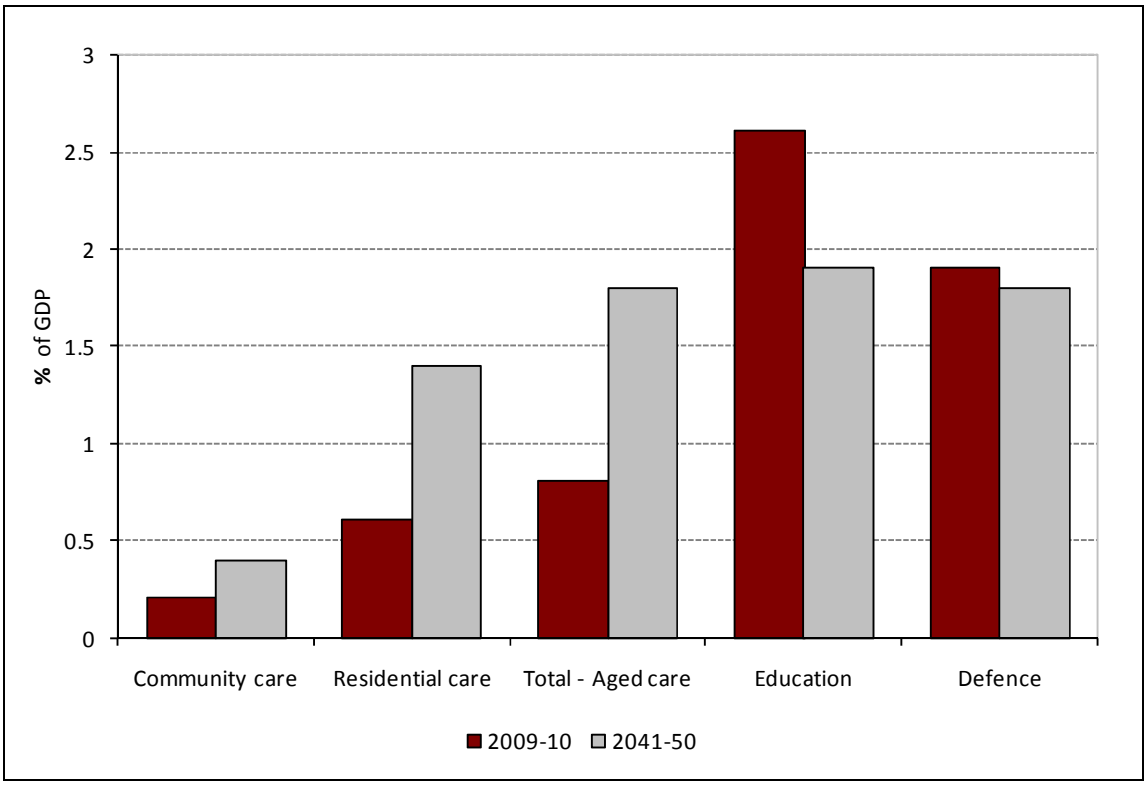
Around one third of increased expenditure related to ageing is due to the expected demand for aged care services and aged related pensions. Spending by the Commonwealth Government on aged care is projected to increase from 0.8% of GDP in 2009-10 to around 1.8% in 2049-50, driven mainly by an increase in spending on residential aged care. In 2049-50, Commonwealth Government spending on aged care is expected to be the same as defence and only slightly less than expenditure on education (1.9% of GDP) (The Treasury, 2010a). This is shown in Chart 7.2, which also breaks down projected aged care expenditure into community care and residential care.

Chart 7.1: Projected Commonwealth Government fiscal balance



Source: The Treasury (2010a).

Chart 7.2: Projected aged care expenditure as a proportion of GDP



Source: The Treasury (2010a).

An increase in aged care spending (public and private) is not a problem in itself and should be considered within the context of outputs and health outcomes. An increase in spending is only a concern if the commensurate return is deemed unacceptable by society. Debate needs to focus not on the level of aged care spending, but on whether the aged care system is delivering cost effective services.

Whether society believes too much Commonwealth Government funds are being spent on aged care, or more cost effective aged care services should be provided, there are five options that could reduce pressure on the budget from population ageing. These include:

- higher taxation and/or reduced spending on other parts of government budgets (debt is not a long term option);
- further rationing of publicly funded, less cost effective aged care services;
- increased efficiency in service delivery;
- increased role of private financing; and
- a combination of the above.

Higher taxation will only be feasible if society is willing to pay more for aged care through this means. To date this debate has not occurred. However, increasing taxes comes at an expense to social welfare, through a further distortion of the market being taxed (e.g. the labour market through personal income tax), and the associated inefficiencies.

Further rationing of less cost effective aged care services could be achieved through a reduction in access to public subsidies. This could occur implicitly through greater restrictions on government spending and planning ratios, or redefining the universal entitlement and service obligation met by the public sector. However, both of these options are likely to be politically challenging. It may also be problematic from a social perspective, in terms of fairness and equity within the process of delivering aged care, and the negative externalities created through poorer health of family and friends and a greater reliance on informal care.

Given the difficulty of finding greater resources through increased taxation or reallocating funding, increasing efficiency in service delivery and increasing the role of private financing are likely to play the most important roles in meeting the financial challenges created by population ageing. Increased efficiency will produce more aged care services, or better quality aged care services, for the same level of resources. Allowing consumers to pay for more tailored aged care services brings in more private funding for aged care expenditure, thereby lifting some of the burden from the public budget. It can also reduce constraints on providers in delivering differentiated aged care to better meet individual preferences.

Thus, as the capacity of the older population to fund their own care increases in the future, and the demand for differentiated aged care increases, there will be mounting pressure on the Commonwealth to review the current share of aged care expenditure between public and private. Out of necessity, the government may be forced to reconstruct an aged care market that allows greater market signals in order to promote choice and efficiency.

Currently, the means for a privately funded aged care system are through superannuation, accommodation bonds and reverse mortgages.[22] These are further discussed below in relation to equity, efficiency, and sustainability within the context of a greater share of private funding covering future increased aged care expenditure.

7.1.2 Superannuation

An alternative model to a publicly funded aged care model is to encourage people to save for their own cost of aged care. Although regular savings accounts, or investment in other types of assets (e.g. housing and equities), can be used to save for the future cost of aged care, superannuation has been specifically designed to ensure income is not spent prior to retirement. Once a person retires and they reach the 'preservation age' of 55 years, superannuation income can be accessed in post retirement life for all types of purchases, including aged care.

One limitation with relying on superannuation for the purposes of funding aged care is that there is no restriction on how superannuation income is spent. While it is already used by some people for health and aged care expenditure, there are also incentives to spend this income on other goods and services (e.g. leisure) and fall back on public safety nets rather than provision for their own care needs. This is because under the current system, the government still subsidises aged care services and caps the price aged care providers can charge for their services. As long as government subsidies continue to make up a large proportion of aged care cost, are widely accessible, and prices are structured based on the level of age pension income, the incentive to save for aged care expenditure in the future will remain low.

Recently the Commonwealth Government introduced plans to boost national savings by encouraging people to save more in superannuation to help offset the growing cost of an ageing population. The proposed changes under the Henry Tax Review will see compulsory contributions by employers increase from 9% to 12% by 2019 (The Treasury, 2010b). As well, workers over 50 with low super savings will be able to make contributions at a concessional rate. Low income earners will also have their superannuation account topped up by $500 per year by the government. If these changes pass through the Senate, they will potentially increase the availability of savings to privately fund aged care in the future.

7.1.3 Accommodation bonds

Aged care residents may be required to pay an accommodation bond if the resident enters an aged care facility to receive low level care, or care on an extra service basis, or high level care if the resident is transferring from another aged care home to which an accommodation bond was paid.

Aged care providers are not allowed to ask for an accommodation bond that does not leave the resident with assets worth at least 2.5 times the annual single basic aged pension. However, given a large proportion of people entering aged care facilities have wealth locked

[22] A large proportion of aged care is funded through age pension payments, with aged care fees and charges capped to ensure people can pay for aged care using this source of income. However, as age pension payments are funded by the government it can be considered an indirect public funding of aged care and has therefore not been discussed as an alternative private financing option.

away in their homes, accommodation bonds can be large amounts of money, requiring the sale of assets, such as housing.

A resident may choose to pay an accommodation bond upfront or in instalments and the aged care provider deducts payments from the bond on a regular basis (retention amounts) for up to five years up to a fixed maximum amount. The remaining balance of the bond is refunded back to the resident or their estate when they leave the aged care provider. The amount of the bond varies and may be negotiated between residents and the aged care provider, or determined by an asset assessment.

The use of bonds for low care residential places and extra service high care residential places poses a number of capital allocation problems. Because bonds are not capped under the current system, capital received from low care services are increasingly being used to cross-subsidise high care places (PC, 2008). This is because the capital required to maintain and upgrade high care facilities is much larger than low care places, but accommodation charges for high care facilities are capped by the government. This is placing upward pressure on the level of bonds in order to fund high care places, with the average income from bonds per low care resident substantially higher than the average income derived from charges per high care resident (PC, 2008).

Cross-subsidisation of ordinary high care places through accommodation bonds distorts the allocation of resources across different care types. This leads to inequitable residential care as those required to pay bonds are forced to expend more than their cost of care. Cross-subsidisation also creates inefficiencies as market signals are distorted, for example, the supply of low care places will increase when it is high care that is required. Furthermore it is unlikely to be sustainable. As bonds may need to increase to fund an increasing need for high care (e.g. as dementia prevalence increases), the demand for low care places will decrease, thereby reducing access to funds for high care places.

Several other issues have been recognised in regard to the current aged care bond and accommodation payment financing structure. These include:

- discrimination against people with low asset values from providers looking for people who can pay large accommodation bonds;
- perverse incentives to push new residents into low care places even though they require high care; and
- a muted incentive to invest in ordinary high care places despite the increased need for high care in the future (PC, 2008).

7.1.4 Reverse mortgages

A reverse mortgage allows people to borrow money against the equity in their home (i.e. the difference between what the home is worth and what is owed). The difference between a reverse mortgage and a regular mortgage is that the borrower does not need to make any repayments until the house is transferred into another name (ASIC, 2010). Interest and fees are covered by the accumulation of the debt. A reverse mortgage allows borrowers that could not service a regular mortgage (such as retirees who do not earn income) to release the equity held in their house without selling it.

Reverse mortgages have been growing in popularity in Australia over the last ten years as the Australian property boom has caused household wealth to soar. A Deloitte report commissioned by the Senior Australians Equity Release Association of Lenders (SEQUAL), found the reverse mortgage market in Australia almost tripled in size from about $1.0 billion in June 2006 to over $2.6 billion in June 2009 (Deloitte, 2009). However, it is unclear whether these reverse mortgage products are being used to fund aged care or to fund other consumption.

A reverse mortgage allows people to draw down on their housing wealth to fund retirement but remain living in their own home (Reed and Gibler, 2003). However, because the current generation of people was not covered by compulsory superannuation, many older asset rich people are finding themselves with little regular income after retirement.

The main advantage of a reverse mortgage scheme for aged care funding is reduced reliance on public money, thus decreasing pressure on government aged care spending. Government funded safety nets would still need to apply for people without home equity or other assets. Thus wealthier people would fund their aged care costs with their own assets and the less wealthy would still be protected. Consumers would then have more choice in accessing aged care services without having to sell their homes to finance it.

However, reverse mortgages are complicated financial products and so it is important to ensure that vulnerable people are not taken advantage of when subscribing. Several factors inhibit good decision making by consumers when they assess reverse mortgage products (ASIC, 2010). To facilitate good decision making there needs to be clear and transparent information given to consumers about the structure and operation of reverse mortgage products and increased access to financial advice when evaluating products. Factors that that need to be clearly explained include:

- the amount of the principal;
- the term of the loan;
- the loan structure and whether the payment is a lump sum or a regular income stream;
- interest and fees; and
- whether or not there is a no negative equity guarantee (NNEG).

Complexities generally arise in relation to the interest rates, fees and the NNEG (ASIC, 2010). There are often terms and conditions in the loan agreement that can result in the imposition of additional fees. For example, reverse mortgage holders are typically required to undertake necessary maintenance to preserve the value of their house. The NNEG guarantees that the sum of the loan and the fees and interest will not exceed the value of the equity in the house. Although costly, it is important to ensure people are not left with debt to be serviced through retirement savings. Thus it is necessary to ensure people do not end up borrowing more than the equity in their house and are then left with insufficient funds to meet obligations or to move to alternative accommodation.

Another disadvantage of a reverse mortgage is that the amount of money a person receives is limited to the amount of equity in their house. There is also a risk that housing equity is an important resource for funding non-aged care costs of retirement (Bruen, 2006). Reverse mortgages do not encourage additional savings. Once the equity has been drawn down,

people not only require access to the public system but may also need an alternative place to live.

It could be difficult to design a sustainable and equitable aged care system around reverse mortgages. With adequate safety nets in place there could be a substantial distortion in the incentive to save, or to invest in housing for aged care purposes. If people believe they can rely on safety nets for their aged care costs then it might be optimal to invest in non-housing assets or not invest at all. There would also be a need to prevent people from selling their house and spending it on goods and services not related to aged care, or gifting money to children, and then falling back on safety nets when aged care is required.

From an equity standpoint, reverse mortgages provide a greater opportunity to access aged care services to those with greater valued assets. This could lead to discrimination against those with only modest wealth as providers look to servicing people with a greater capacity to pay. However, it does reduce the need for future generations of taxpayers to fund aged care services, and therefore represents an increase in intergenerational equity.

A reverse mortgage is not expected to impact the efficiency within the aged care system as current restrictions on the price charged for aged care limits the capacity of providers to react to any change in the willingness to pay for alternative types of services. If the government were to provide greater flexibility in service provision and allow people to pay for alternative types of aged care services, then reverse mortgages are likely to promote a shift towards an aged care sector with greater allocative efficiency, where services are more appropriately allocated to people who value them the most.

Under the current aged care system, the primary benefit of reverse mortgages is that they provide an additional source of funds if the Commonwealth Government were to shift the share of aged care expenditure towards more private funding. This would increase the ability of the government to meet spending commitments and to better balance the aged care budget against ageing pressures.

7.2 Alternative models of funding

As Australia's population begins to age and life expectancy increases, the problem of ensuring adequate financing and provision of aged care services will rise exponentially. Hence, new products to provision for the risk of high aged care costs should be explored.

Two private funding mechanisms presented here are long term care insurance (LTCI) and Healthy Ageing Savings Accounts (HASAs). These mechanisms have the potential to alleviate expected pressure on public finances. Essentially, whether an insurance or savings model is more appropriate depends on how the variability and predictability of aged care costs are perceived.

7.2.1 Long term care insurance

Long term care insurance (LTCI) is insurance that covers aged care services not covered by private health insurance or Medicare, such as community care services, accommodation in residential care, or additional care services not otherwise subsidised by the government. Essentially, LTCI would pool the risk of aged care costs across participants in the scheme, thereby limiting the costs incurred by any one person.

LTCI has already been introduced in other countries where population ageing is a major concern. For example, the Japanese government introduced a LTCI system in 2000 to meet the challenges presented by their ageing population. The scheme is funded by a combination of general tax revenue and additional payroll tax levied on those over the age of 40. Anyone over the age of 65 who is deemed to need aged care is granted access, with eligibility determined by the government. Limiting participation to people over the age of 40 reduces some of the intergenerational inequity of insurance schemes. In recent years however, the Japanese social insurance scheme has begun to face increasing cost pressure because pricing contributions have been problematic.

The US LTCI system is voluntary and privately provided. While tax incentives are provided to encourage the purchase of LTCI, fewer than 10% of the population have taken out a LTCI policy (Gleckman, 2010). Some reasons cited are the high cost of policies, mistaken beliefs about the risk of incurring high aged care costs and myopic behaviour (LifePlans, 2007). Another possible explanation is that people may choose to self-insure if there are limited incentives to purchase LTCI due to relatively expensive premiums.

In Australia there may be several barriers to establishing a LTCI market. Private insurance is more useful when aged care expenditure is random and costly as people are not good at determining the level of savings required to self insure. Yet the incentive to purchase LTCI in Australia is likely to be small under the current aged care market structure because the government funds a large proportion of aged care and there are price caps on services relative to aged care pensions. This effectively caps expenditure risk for people requiring aged care in the future.

Although the need for aged care may be random (i.e. based on whether a person develops dementia or some other limiting condition), the cost to that person will be relatively small. Furthermore there are other imperfect and cheaper substitutes, such as financial transfers from children or informal care provided by family and friends. To encourage demand, there would need to be greater incentives. For example, a LTCI market would be more viable within an aged care market that offers greater choice but comes at a higher private cost.

Like all insurance systems, there is the risk of adverse selection and moral hazard within an LTCI market, which both stem from asymmetric information. Adverse selection occurs when people with a high risk of requiring long term aged care take out insurance. This drives up claims and hence premiums, thereby reducing the value of insurance to low risk individuals and pushing them out of the market. This, in turn, reduces the capacity of insurers to cross subsidise, thereby further increasing premiums and further precluding low risk people from the market.

Moral hazard occurs when insurance results in over-consumption because the person insured does not face the true marginal cost. Within aged care, moral hazard will be *ex post* such that once the decision to purchase aged care has been made then people are likely to consume more. Like private health insurance, *ex post* moral hazard could be mitigated through the use of copayments.

Accurate pricing of LTCI premiums could also be problematic given the long time period between purchasing cover and the event occurring, and given the uncertainty surrounding technological advances, price changes and government regulation. This may make premiums costly, or reduce the value of LTCI, because insurers will pass on this risk through premiums or

copayments. The higher the premiums, the more government assistance required to encourage people to take out LTCI, which would reduce the sustainability gain from an LTCI relative to a tax funded system. Otherwise, insurers could cap aged care payments to mitigate risk, but this would reduce the attractiveness of LTCI and therefore demand.

A LTCI market would not resolve intergenerational inequities in the funding of aged care. Insurance premiums cover the expected cost of the event that has been insured against at each point in time. As the proportion of the population that requires aged care increases, the total risk of high aged care costs increases, thereby increasing premiums. This means that each generation will pay a greater proportion of their lifetime income towards aged care or receive less care, or lower quality care, than the generation before. There is also some risk associated with this system for younger generations, as there is no guarantee that the insurance provider will remain financially viable.

LTCI may provide significant benefits provided it is structured appropriately and operates within an aged care market where private costs are high (e.g. for more services or better accommodation). Under such conditions it may result in more diverse provision of aged care services, since competition between providers should result in an aged care market that generates greater incentives for providers to innovate.

7.2.2 Healthy ageing savings accounts

Healthy Ageing Savings Accounts (HASAs) are a system where individuals contribute income throughout their life to a savings fund, which is then used to cover their own aged care costs when the need arises. Savings are generally restricted to be used for purchasing health care and aged care qualified by the government.

A HASA would be voluntary, to be used as a complement to superannuation (and other financing vehicles) in funding aged care. For a successful HASA market to exist there are many factors that need to be considered. These are outlined below.

- The Commonwealth Government would need to restrict the use of funds to expenditure on qualified items associated with aged care needs.
- To reduce the incentive for individuals to use a HASA as a tax haven, any income distributed from the account not used for qualified aged care would have to incur a significant penalty that is greater than the tax rate for the highest income tax bracket.
- To encourage the use of HASAs, a reduced tax rate would need to be applied to contributions that is lower than the tax rate applied to superannuation contributions (currently at 15% for the majority of contributions). This is because people need an additional incentive to save money in an account that restricts the use of funds to health and aged care spending.
- HASA contributions and balances would need to be unlimited to provide flexibility in savings for different aged care risks and preferences for risk. Greater flexibility could be attained by offering tax advantages on contributions made into *any* HASA account (i.e. to another person's account). For example, carers could contribute to the HASA of the person receiving care.

- HASA balances would need to be invested in the same range of assets allowed within superannuation. Any investment income earned should be automatically added to the HASA balance at the reduced tax rate. This provides an equal footing with superannuation in terms of return on investment.

To supplement the demand side, and to promote competition between aged care providers, HASA administrators could negotiate prices with suppliers and provide quality information, cost information and decision support tools for the appropriate level of care. This would help to reduce information asymmetry between care recipients and providers, thereby enabling consumers to 'comparison shop' for aged care services and products.

In terms of equity, HASAs favour those who have the capacity to save throughout their life, which is typically the wealthy. Consequently a greater reliance on HASAs to fund aged care services may reduce access to aged care for people who had modest incomes throughout their working years. Another concern is that HASAs would favour higher income earners if a flat tax rate benefit was applied to HASA contributions, or if the reduced tax rate was higher than that faced by low income earners. Of course, this would depend on the level of tax break and whether it was flat or regressive. This inequity could be mitigated by tax-financed contributions made by the government directly into a HASA. HASAs do provide greater intergenerational equity because the person funding the aged care is the person using the aged care.

HASAs serve to smooth the burden of health and aged care spending across a person's life by allowing for an accumulation of funds during the early stages when the person is typically healthy, and the purchase of health and aged care during the later stages of life when health starts to decline. However, private saving is not the best mechanism for funding random and costly aged care expenditure. For example, if people have difficulty in estimating their costs associated with health and aged care, then some will end up with excess savings while others will not have enough. This will represent an inefficient allocation of resources. Furthermore, others may simply want to avoid having to consider the unpleasant implications of old age and the possibility of ending up in a residential care facility. Finally, if a person experiences large out of pocket health care costs that are funded from HASA balances within retirement, but before aged care is necessary, there may not be sufficient funds in the HASA to cover private aged care expenditure in the latter stages of life.

As current restrictions on the price charged for aged care limits the capacity of providers to react to any change in the willingness to pay for alternative types of services, a HASA market is not expected to impact the efficiency within the aged care system. However, increasing private financing of aged care expenditure could redirect the responsibility and choice for purchasing aged care goods and services to the care recipient who, with their carer, would have their best outcomes as core goals. Consumers would also face greater price signals if more aged care funding responsibility was shifted to the private sector , thereby creating a greater incentive for individuals to shop around and reduce the use of borderline (or unnecessary) aged care (Baicker et al, 2006; Feldstein, 2006).

Alternatively, increased price sensitivity may cause HASA members to forgo necessary aged care as individuals may not be well equipped to decide on the level and type of care required (Minott 2009). Information asymmetries within the aged care market, and high search costs in collecting information (e.g. the time spent looking at alternative residential care facilities) means consumers may not be completely informed when making decisions. This reduces the

capacity and incentive to shop around, thereby reducing competition within the market and the associated benefits of greater consumer choice.

One benefit of a HASA system is that it will provide the capacity to increase the private share of funding for aged care expenditure and therefore improve sustainability of the aged care budget. However, it is unclear whether the benefit from reduced government expenditure for aged care due to more private funding compared to the loss in income tax for the government would result in a positive net position for the government. This would depend on contributions made into the account, the tax that would have otherwise been collected on those contributions, and the amount of public spending that is avoided through greater private financing of aged care expenditure. Furthermore there would be a significant delay in building up HASA balances to the point where there were enough funds to sustain private aged care funding to be used in an aged care facility.

8 Implications for the future of dementia care

On the basis of prevalence, disability burden and economic cost, dementia poses serious challenges for health and aged care systems in the future. Exactly how the system should adapt to ensure that adequate services are provided is an issue that requires much research and careful consideration. This chapter draws out some of the policy implications from the modelling results and places the analysis in the context of designing and planning an aged care system to meet future challenges.

8.1 Planning aged care supply

Growth in the supply of aged care services is currently planned using the growth rate of the population aged 70 years and over. Although this has led to an increased supply of aged care, its use as a reliable proxy for estimating increased demand has been limited. This is evident from the ad hoc adjustments made to the planning ratio since its inception in 1985.

Planning ratios are administratively simple, allowing control over the supply of aged care services. Although the current planning ratio may yield a shortfall in aged care as the burden of disease among older Australians continues to shift towards dementia, some have argued this does not necessarily mean the ratio needs to be overhauled, rather it could continue to be adjusted on an ad hoc basis (Hogan, 2004). The Department of Health and Ageing (DoHA) has also argued in favour of the current system. DoHA maintain that growth in the population aged over 70 provides a steady growth path in the supply of age care places funded, allowing industry the necessary time to adjust supply (DoHA, 2009).

A major disadvantage of ad hoc changes to the planning ratio is that it creates uncertainty for providers, and could therefore result in a lack of long term investment in infrastructure. For example, a new aged care provider might find the marginal cost of adding additional rooms to a new facility cheaper than trying to add additional rooms further down the track, but might not undertake this investment because access to subsidised places cannot be guaranteed (even if the demand for more aged care places is evident).

One alternative to the current policy is to increase the supply of aged care by the growth rate of the population aged 85 years and over. This strategy was recommended in NHHRC (2009) and discussed in submissions to SCFPA (2009). The argument is that growth of an older population better reflects the average age of people entering aged care services.

However, planning aged care supply based on the growth rate of the population aged 85 years and over will only meet expected demand if the correlation between age, disability, and the need for aged care is strong. Disability and the need for aged care are driven by the epidemiology of disease and the availability of informal care. These factors are constantly evolving, for example, as medical technology develops, workplace arrangements change (e.g. technology has created greater flexibility in workplace arrangements), and people live longer (AIHW, 2006). The relationship between age, disability and the need for aged care is likely to evolve over time, and therefore a planning ratio must account for this change if ad hoc adjustments are to be avoided.

One alternative is to plan for the supply of aged care services based on a measure of the epidemiology of disease in the population. This report based estimates of the demand for aged care on the growth rate of dementia prevalence in the Australian population. There are a number of reasons why this may serve as an appropriate planning tool, including:

- People with dementia already make up a large proportion of aged care recipients, including:
  - 5.2% of HACC clients;[23]
  - 18.4% of CACP recipients;
  - 31.7% of EACH package recipients;
  - 100% of EACH-D package recipients; and
  - 63% of residents in residential care facilities (VGDHS 2004; AIHW 2007).
- dementia results in complex care requirements; and
- disability associated with dementia can complicate the treatment of other chronic diseases, for example through the reduced capacity of the person to self medicate.

Planning aged care supply on the growth rate of dementia prevalence will reduce the potential disconnect between age and disability compared to an aged based growth rate. For example, if aged care supply was based on the growth rate of dementia prevalence, but some intervention was developed that could stop the progression of dementia (or even reverse the disabling effects), then the growth rate of dementia prevalence would induce an appropriate reduction in the supply of aged care places. In contrast, if future aged care supply were still dictated by the growth of the population over a certain age in the event of such an intervention, there would be an inappropriate increase in future places leading to a potential oversupply.

However, using the growth rate of dementia prevalence would not avoid the potential disconnect between disability and the need for formal care (i.e. through changes to the availability of informal care), or a change in preferences between alternative types of care. Planning the supply of aged care based on the growth rate of dementia prevalence would increase the quantity of aged care (thereby keeping up with care needs), but the quantity of community versus residential care, and low versus high care, would be based on the preferences of the population when those ratios were made. Planning supply using the growth rate of dementia prevalence could not account for a possible shift in care preferences, such as towards home care through consumer directed care, without ad hoc adjustments.

A more complex planning tool that considers needs at the regional level could also be developed. SCFPA (2009) recommended that research be undertaken to develop planning ratios that take into account various demographic and socioeconomic factors across regions. This recommendation could also be applied if the growth rate of dementia prevalence was used. However, the reliance on international studies to estimate dementia prevalence (given the lack of dementia prevalence data in Australia) means there would need to be further detailed research and data collection before a system based on dementia growth rates could be used. Given the importance of accurate prevalence and incidence numbers for planning,

[23] This data may under represent the number of people with dementia accessing HACC program services due to improvements in diagnosis since 2002 when the survey was undertaken (VGDHS, 2004).

epidemiological studies on dementia would need to be undertaken within Australia across different population types, and across all planning regions.

Using the growth rate in dementia prevalence for planning is likely to result in a more accurate picture of the need for age care services in the near future, when compared to alternative population growth measures. Of course, the use of dementia prevalence as the foundation of the planning tool would need to be reviewed as care needs and preferences change. Nevertheless, consideration for a move towards a planning system directly based on the prevalence of disease rather than a rough proxy such as population growth is warranted.

The use of planning ratios, and the consultative process employed for the allocation of places across regions, aims to provide a transparent planning mechanism that can allocate aged care to best meet the needs of the community (DoHA, 2009d). Although debate has generally focused on what type of planning ratio is appropriate, and on what basis growth in the supply of aged care should be made, it is not clear why the use of planning ratios (in any form) is the best approach for meeting future aged care needs.

A market oriented approach that removes the need for central government planning and allows providers to supply aged care services (without government allocations) based on demand has the potential to introduce greater flexibility into the supply of aged care services, and could allow providers to directly respond to changing needs within the region where they operate. Subsidies could be attached to people, rather than packages or places, thereby promoting greater competition for clients among aged care providers. Coupled with relaxed caps on pricing, greater competition has the potential to increase technical and allocative efficiencies within the aged care market, and could promote further long term investment in the delivery of services through reduced risk that is currently associated with government dictated allocations.

However, the use of a market mechanism in the aged care system could also lead to non-optimal resource allocation. The aged care system has special characteristics which fall short of the optimal competitive preconditions for a well functioning competitive market. Such characteristics can lead to market failure, for example:

- information asymmetries between providers and clients. People may not know what constitutes quality care, or may not be able to find aged care services that meet their needs, thereby limiting competitive outcomes;
- large barriers to entry in some regions may create market power for providers. These may be generated by local planning restrictions; and
- externalities associated with aged care cannot be priced into the market (e.g. improved health of older Australians).

Furthermore, a market would not be concerned with distribution of aged care from a societal perspective, so important social constructs such as equity and fairness might not be incorporated within a market mechanism approach. Government regulation would still be required to mitigate some market failures associated with an imperfect market.

Government subsidisation does not preclude the operation of market forces. Rather, it requires government involvement in the design of the market. There are already subsidised funding arrangements where the government subsidises the delivery of care by private providers without restrictions on the supply of care. For example, private hospitals are able to

meet the demand for their services without supply restrictions imposed by the government, even though a large proportion of private hospital care is subsidised by the Medicare Benefits Schedule. It is unclear why the delivery of aged care through private providers should be substantially different and require supply planning when a much larger market mechanism is already being used successfully in Australian health care.

In a market based system the government could still control consumption of subsidies through the use of ACAP or similar process. An ACAT could assess the need for aged care and allocate a subsidy based on the cost of the most cost-effective service. Individuals could then take this allocation to the market and purchase the services they require.

Aged care regulation is currently based on addressing potential inequality of access to aged care services. Although there could be some areas where market failure could occur under a more market oriented approach, these could be addressed through appropriate market regulation, while still allowing the principles of competitive markets to dictate the supply of aged care. Consequently, any review of alternative growth rates for the supply of aged care services using planning ratios should also consider the need to use planning ratios, and the possibility of introducing a more market oriented approach that is coupled with regulation to ensure social objectives are met.

8.2 Consumer choice

Both in the work of the Productivity Commission and the final report of the National Health and Hospital Reform Commission (NHHRC) there is a welcome focus on increasing the flexibility of aged care services and their responsiveness to the needs of older people through consumer directed care (PC 2005; NHHRC 2009). The 1,200 trial CDC packages funded as part of the recent COAG agreements on the National Health and Hospital Network (NHHN) are a welcome first step in shaping the underlying philosophy and model of care to services in the Australian environment (COAG, 2010).

The evidence base in aged care for greater consumer choice and improved outcomes in the Australian environment is yet to be established. However, overseas experience suggests that improved outcomes and consumer satisfaction have resulted from consumer directed care approaches, albeit often in differing health and care systems. In a policy context, it will be important to look at the strategic potential of three different but related approaches to greater consumer choice. These include:

- the adoption of consumer directed care to promote flexibility of service response to the needs of older people and their families and carers;
- separating accommodation from care in funding to enable older people to have the mix of community and residential care that they may need; and
- ensuring that there is flexibility in the way community care is provided for those with limited needs through approaches such as Community Options.

The issues that arise in consumer choice have been well documented in terms of adequate information for consumers, the need for case management and care coordination, avoiding abuse, and ensuring quality care. There are other cultural issues in being less risk adverse in providing services. Arguably the full potential of these approaches will be achieved not only through better administration and more flexible service structures, but a change in the culture

of service provision for older people and their families and carers. This must reflect a genuine partnership between the service provider and the older person and their families and carers.

Even if consumer directed care were not fully adopted, there is scope to improve flexibility under the current system. This is because planning factors are applied inconsistently between community care and residential care. For example, under the current subsidy structure residential and community care are not comparable in terms of content. Residential care can be described in terms of accommodation, everyday living expenses (such as food) and personal care services, all of which are effectively subsidised. However, community care only provides personal care services, the costs of the other components are met privately.

A possible solution would be to base aged care planning on the amount of care required rather than on a set number of community care packages or residential care places. The Productivity Commission (2008) noted that the accommodation and living expense components of the residential care subsidy should be covered through the welfare system. The aged care system could then focus on subsidising the personal care component. In doing so the government could plan for the amount of care it expects would be required, and allow greater choice in whether or not aged care is provided in community or residential care settings. In their review of residential and community care in Australia, the Standing Committee on Finance and Public Administration recommended that this idea merited further consideration (SCFPA, 2009).

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