Australian Government

Department of Health and Ageing

Submission to

the Productivity Commission Inquiry
Caring for Older Australians

from the Department of Health and Ageing

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Glossary

ACAT	Aged Care Assessment Team
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
CACP	Community Aged Care Package
COAG	Council of Australian Governments
EACH	Extended Aged Care at Home
EACHD	Extended Aged Care at Home - Dementia
HACC	Home and Community Care

1. Introduction

1. The Department of Health and Ageing welcomes the Australian Government's decision to ask the Productivity Commission to undertake an inquiry into Australia's aged care system and thanks the Commission for the opportunity to make this submission. The Commission's examination of the need for reform of Australia's aged care system, the scope for reform and the benefits that could flow from reform for older people[1], their carers and the taxpayer is timely, given the increasing importance of the aged care sector to the delivery of health care, to the economy and to the Commonwealth budget.

2. The aged care sector makes a significant contribution to the well-being of older Australians. It provided care to about one million older people in 2008-09 – over a third (34.3 per cent) of all older people and about 4.6 per cent of the Australian population. It is also a significant part of the Australian economy. Public and private expenditure on aged care in 2008-09, at an estimated $12.9 billion, accounted for 1.0 per cent of GDP, with the Commonwealth's contribution to that expenditure accounting for about 3.1 per cent of Commonwealth revenues. The aged care sector currently employs 2.7 per cent of the Australian workforce. Capital formation is also significant in the sector, accounting for 4.2 per cent of non-residential building activity over the last decade.

3. The sector's importance to the health system and to the economy is projected to increase sharply over the coming decades as Australia's population ages. Assuming the share of older people who receive aged care remains constant and that current policies remain in place, then the absolute number of people receiving aged care is projected to increase by about 150 per cent in the next forty years. On these projections, over 2.5 million older people (7.6 per cent of Australia's population) would be utilising aged care services by 2049-50, with public and private expenditure on aged care accounting for about 2.5 per cent of GDP and the Commonwealth's contribution to that expenditure accounting for about 7.4 per cent of its revenues. By 2049-50, about 4.9 per cent of the Australian workforce would be employed in the delivery of aged care. Longer term projections of the industry's capital investment requirement are more difficult given the likely significant changes in the types of services that will be demanded by consumers. The Department estimates that the level of new investment required to meet the growing demand for aged care over the next decade will be of the same order as that which has been achieved in recent years.

4. The Australian Government's *Intergenerational Report 2010* projects that Commonwealth expenditure on aged care will increase from 0.8 per cent of GDP in 2009-10 to 1.8 per cent of GDP by 2049-50. This is lower in absolute terms than the projected increase in health costs, from 4.0 per cent of GDP to 7.1 per cent of GDP, and on the age pension, from 2.7 per cent of GDP to 3.9 per cent of GDP.[2] However, the rate of growth in the proportion of GDP is the

[1] Throughout this submission the term 'older people' is used to refer to non-Indigenous people aged 65 or older and Indigenous people aged 50 or older.

[2] Australian Government (2010) *Australia to 2050: future challenges (Intergenerational Report 2010).* Canberra: Treasury, p.56.

highest in aged care expenditure (125 per cent compared to 78 per cent for health and 44 per cent for the age pension).

5. These headline figures underline the importance of the Commission's inquiry, not only to older people and their carers, but also to the Australian economy. This submission seeks to assist the Commission in its inquiry by providing significant, and in some cases previously unpublished, detail on the structure, finances and capacity of the aged care sector.[3] It also discusses some of the policy considerations that will need to inform the evaluation of any proposals for reform.

6. The submission begins with an examination of the context and scope of aged care (Chapter 2). This examination, *inter alia*, provides a typology of aged care services to assist discussion. The submission then provides an overview of Australia's current aged care system and discusses the roles and responsibilities of the Commonwealth, the states and territories, and individuals in the regulation, funding and provision of aged care (Chapter 3). It then outlines some of the demographic, social and economic pressures on the aged care sector and discusses the implications of these pressures for older people, aged care providers and the broader community (Chapter 4). The Submission concludes with a discussion of some of the policy tensions inherent in the current arrangements of which any proposed reforms of aged care would need to be cognisant (Chapter 5).

[3] Except where otherwise indicated, data in this submission is drawn from the administrative and payment systems of the Department.

2. What is aged care?

1. This chapter examines the context and scope of aged care (Section 2.1) and provides a typology of aged care services to assist the Commission's deliberations (Section 2.2).

2.1 Context and scope

2. Ageing affects every person throughout their lifespan at different rates and in different ways as unique individuals. It is inescapable, normal and not necessarily an indication of frailty. Normal ageing brings about a slowing down of functionality, but age-related physical, emotional and social changes can be anticipated and managed through understanding the ageing process, adopting a healthy ageing approach across the life course and adaptation in relation to specific changes.[4] Adaptation can be assisted by the types of interventions offered by care in the community. Conversely, diminishing functionality can be exacerbated by chronic conditions such as obesity, Alzheimer's disease and other forms of dementia, and severe arthritis.

3. Older people may need many different types of assistance at different times, for differing periods of time. These include:

a) retirement income assistance, through public or private pension arrangements, including with basic living expenses;

b) medical assistance, such as treatment or nursing care for an illness, injury or long term medical condition;

c) rehabilitation and support, to help restore function and independence after an illness, surgery, accident or a disruption to living arrangements;

d) functional assistance, because they are no longer able to perform activities of daily living, such as bathing, dressing, eating, shopping, banking or keeping appointments;

e) psychological assistance, including for loneliness, depression, anxiety, memory loss or confused thinking;

f) behavioural assistance, including help in managing aggressive behaviour, wandering, disorientation, withdrawal, or compulsive behaviour;

g) help with social needs, arising from a lack of interaction with people, isolation from family or friends, or an inability to participate in clubs or spiritual and cultural activities; and

h) housing related assistance, for example when the home of an older person is no longer suitable because of a disability, or requires extensive modification.

[4] WHO (2007) *Age-Friendly Primary Health Care Centres Toolkit*. Accessed on 1 October 2010 at: http://www.who.int/ageing/publications/upcoming_publications/en/index.html .

4. Older people in need rarely require just one form of help. Their needs also change over time. Some of the conditions associated with advanced age become progressively worse. For other conditions, older people can benefit from short term rehabilitation and support to improve or restore their independence.

5. At its broadest, therefore, care of the elderly encompasses the network of all support provided to older people as they reach a degree of physical or economic dependency, including informal support by families and friends. That is, it includes assistance with social security, welfare, health and housing.

6. The Commonwealth funds support for older people through three mainstream strategies – strategies that assist older people in concert with all people, and four targeted strategies – strategies designed to assist older people (often together with people with disabilities).[5]

a) The three mainstream strategies are:

- *income support*, through pensions and support for superannuation;
- *support with housing*, through the National Affordable Housing Agreement, the National Affordable Rental Scheme, grants and funding, and rent assistance payments; and
- *subsidised health services*, through the Medical and Pharmaceutical Benefits Schemes, the National Health and Hospitals Network Agreements, and tax offsets for health insurance and net medical expenses.

b) The four targeted strategies are:

- *support for carers*, through income support payments, financial assistance and subsidised information and support services, including respite services;
- *subsidised care at home and in the community*, including through the Home and Community Care Program and through community care packages;
- *subsidised permanent residential care* in aged care homes, including high-level care and low-level care, and care provided on an extra service basis; and
- *support for the development of aged care infrastructure*, including through zero real interest loans, residential care capital grants and establishment grants, and support for the development of the aged care workforce.[6]

7. In 2010-11, total Commonwealth expenditure for 2010-11 on the health and welfare needs of older people against these seven strategies is projected to be $60.2 billion.[7] Over the last

[5] Cullen, DJ (2003) *Historical Perspectives: The evolution of the Australian Government's role in supporting the needs of older people.* Review of Pricing Arrangements in Residential Aged Care Background Paper No.4. Canberra: Department of Health and Ageing, p.1.

[6] 'Support for the development of the aged care workforce' includes funding targeted to the development of the aged care workforce; it does not include funding expended through the education portfolio.

[7] Departmental estimates based on age specific usage rates for relevant Commonwealth programs.

decade, Commonwealth expenditure on the health and welfare needs of older people has more than doubled in nominal terms, from $29.9 billion in 2000-01. In real terms it has slightly increased, from 4.2 per cent of GDP in 2000-01 to 4.3 per cent of GDP in 2010-11. As a share of all Commonwealth income, expenditure on the health and welfare needs of older people has also slightly increased, from 18.5 per cent in 2000-01 to 18.7 per cent in 2010-11.

8. Table 1 indicates the split of Commonwealth expenditure on the health and welfare needs of older people between the seven strategies outlined above in 2000-01 and 2010-11. The data indicates that within the overall growth in expenditure on the health and welfare needs of older people, there has been a rebalancing from income support to the delivery of services. This includes within expenditure on the four targeted strategies a rebalancing of expenditure from residential care towards support for carers, community care and support for the development of aged care infrastructure.

Table 1: Distribution of Commonwealth expenditure on the health and welfare needs of older people, 2000-01 and 2010-11

Strategy	**Expenditure shares**		**Change in share**
	2000-01 (actual)	**2010-11 (projected)**	
Mainstream strategies			
Income support	55.9%	53.0%	- 2.9 percentage points
Subsidised health services	26.9%	27.6%	+ 0.7 percentage points
Support with housing	0.6%	0.7%	+ 0.1 percentage points
Total mainstream strategies	**83.4%**	**81.3%**	**- 2.1 percentage points**
Targeted strategies			
Support for carers	1.6%	2.3%	+ 0.7 percentage points
Community care	2.1%	3.9%	+ 1.8 percentage points
Residential care	12.6%	12.0%	- 0.6 percentage points
Support for aged care infrastructure	0.2%	0.5%	+ 0.3 percentage points
Total targeted strategies	**16.6%**	**18.7%**	**+ 2.1 percentage points**
Total	**100.0%**	**100.0%**	

9. The focus of this submission is narrower than this broad range of services and relates to the four targeted strategies outlined above. Internationally the scope of these strategies is usually referred to as ‘long term care’. For example, the World Health Organisation has defined ‘long term care’ as:

> … the system of activities undertaken by informal caregivers (family, friends and/or neighbours) and/or professionals (health and social services) to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation, personal fulfilment and human dignity.[8]

[8] Ageing and Health Programme, WHO and Millbank Memorial Fund (2000) *Towards an International Consensus on Policy for Long-Term Care for the Ageing*. Accessed on 1 October 2010 at: http://www.milbank.org/000712oms.pdf.

10. The American Institute of Medicine has similarly described long term care as, 'a variety of ongoing health and social services provided for individuals who need assistance on a continuing basis because of physical or mental disability'.[9] Likewise, the US National Library of Medicine's controlled vocabulary (MeSH) defines long term care as 'care over an extended period, usually for a chronic condition or disability, requiring periodic, intermittent, or continuous care'.[10]

11. In accordance with the guidelines of the OECD system of National Health Accounts, health-system-related long-term care has been defined as 'the range of services needed to assist people who are dependent on help for activities of daily living (ADL)'.[11] Under this definition, long term care includes a range of self-care activities, such as bathing, dressing, eating, getting in and out of bed or chair, moving around, using the toilet, and controlling bladder and bowel movements. It also includes long-term nursing and personal care aimed at supporting people with physical, functional or mental restrictions, but excludes basic medical services[12] and social services[13], although it is often provided in combination with these.

12. Basic medical and social services are separately reported in the system of National Health Accounts. However, for the purposes of this submission, long term care is taken to include basic medical services and social services when they are delivered in combination with long-term care services.

13. In general, then, long term care is care for chronic illness or disability for which hospital care is no longer deemed appropriate. Put another way, long term care can be considered as care of chronic conditions where the emphasis is on 'care' rather than 'cure'. While long term care is required for many disabilities, the focus in this submission is on the management of those chronic conditions associated with ageing. In Australia, this form of long term care is generally referred to as 'aged care'.

2.2 Typologies of aged care services

Care typologies

14. Long term care services can be characterised against two dimensions. The first dimension refers to the intensity of the care provided: a notional care continuum passing through three levels of acuity:

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9 Committee on Nursing Home Regulation, Institute of Medicine (1986) *Improving the Quality of Nursing Homes*. Washington DC: National Academy Press. Accessed on 1 October 2010 at: http://www.nap.edu/openbook.php?record_id=646.

10 National Centre for Biotechnology Information (2008) *Medical Subject Headings (MeSH) Browser*. Accessed on 1 October 2010 at: http://www.nlm.nih.gov/cgi/mesh/2010/MB_cgi?mode=&term=Long-Term+Care&field=entry.

11 OECD (2000) *A system of health accounts*. Paris: OECD.

OECD (2005) *Long-term care for older people*. Paris: OECD.

12 Basic medical services include help with wound dressing, pain management, medication, health monitoring, prevention, rehabilitation and palliative care.

13 Social services include less intense interventions such as home help or help with instrumental activities of daily living (IADL), including homemaking, meals, transport and social activities.

a) low intensity levels of support (for example, meals on wheels, domestic assistance, home nursing and respite care), generally delivered in the care recipient's own home as individual and often uncoordinated interventions;

b) low-level (coordinated) care, which provides more intense and coordinated assistance with activities of daily living, generally provided in an institutional setting, but similar levels of care are delivered in the community as a package of care, usually involving case management; and

c) high-level (coordinated) care, which provides nursing care or intensive non-nursing assistance (for example, for people with severe dementia) as well as low-level care, generally provided in an institutional setting, but again similar levels of care are delivered in the community through packaged care.

15. The second dimension refers to the location in which the care is delivered: community care, delivered in the care recipient's own home or a community care centre, and residential care, delivered in purpose-built facilities and including accommodation services.

16. Care recipients can move along this notional care continuum as their ability to cope with the activities of daily living diminishes, from limited interventions to low-level care and then (often for a short period of time) to high-level care. This progression has until recently usually involved a change in the location of care when the care recipient moves from low intensity interventions (in their own home) to low-level care (in an aged care home).

Financing typologies

17. There are four other dimensions against which aged care services can be usefully classified, all of which relate to financing.

a) The first is the extent to which the aged care services are funded by the individual or their family, as opposed to the taxpayer.

b) The second also relates to whether individuals contribute to the cost of their care directly through out-of-pocket payments or indirectly through insurance arrangements.

c) The third concerns with the extent to which Government support is means tested.

d) The fourth relates to whether taxpayer support is delivered through:

- block funding grants to organisations to deliver specified services, noting that these services can include information and assessment services as well as care delivery;
- subsidies paid to service providers in respect of individual care recipients; and
- direct payments to individuals (either carers or care recipients).

18. The next chapter of this submission provides an overview of aged care services in Australia and discusses how the major programs that support the provision of aged care services in Australia fit within the care and financing typologies outlined above.

3. Australia's aged care system

1. This chapter discusses the historical roles and responsibilities of the Commonwealth, the states and territories, individuals, and the not-for-profit and for-profit sectors in the regulation, funding and provision of aged care in Australia (Section 3.1). It also provides an overview of Australia's current aged care system (Sections 3.2 to 3.5). The chapter concludes with a discussion of the changes in roles and responsibilities agreed by the Council of Australian Governments in April 2010 (Section 3.6).

2. Aged care services in Australia traverse the care continuum. In 2008-09 over one million older people and their carers received assistance with their long term care needs through Commonwealth funded aged care programs.

a) With respect to the major Commonwealth funded aged care programs that are not funded through the *Aged Care Act 1997*:

   - 662,100 older people were assisted through the Home and Community Care program;
   - 160,000 people were assisted through the Day Therapy Centre program; and
   - 127,500 carers were assisted though the National Respite for Carers Program.

b) With respect to the Commonwealth funded aged care programs that are funded through the *Aged Care Act 1997*:

   - 203,372 older people received permanent residential care;
   - 40,823 older people received residential respite care;
   - 61,061 older people received care through a community care package (either a Community Aged Care Package, an Extended Aged Care at Home package or Extended Aged Care at Home Dementia package); and
   - 12,635 people were assisted through the Transition Care Program.

c) In addition, older people also received assistance through programs administered by the Australian Department of Veterans' Affairs:

   - 76,100 older people were assisted through the Veterans' Home Care program; and
   - 31,300 older people were assisted through the Community Nursing program.

3. Some older people will have received assistance through more than one of these programs during 2008-09. For example:

a) almost half (46 per cent) of care recipients who receive residential respite care are later admitted to permanent care; and

b) almost half (47 per cent) of care recipients whose carers are assisted by the National Respite for Carers Program also receive assistance from other programs, with the most common other programs through which services were delivered being the Home and Community Care program and packaged community care.

4. The following diagrams analyse the major programs that support the provision of aged care services in Australia against the two-dimensional (care type) typology (Figure 1) and the multi-dimensional financing typology (Figure 2) outlined above.

Figure 1: Typology (care type) of Australian aged care services

	Community care	**Residential care**
Low intensity interventions	Information, assessment and referral services Support for carers Home and Community Care program National Respite for Carers Program Veterans' Home Care Department of Veterans' Affairs' Community Nursing program Day Therapy Centres	Respite residential care
Low-level care	Community Aged Care Packages (some packaged care through HACC) Carer Payment and Carer Allowance	Low-level permanent residential care
High-level care	Extended Aged Care at Home Packages EACH (Dementia) Packages (some packaged care through HACC) Transition care	High-level permanent residential care Transition care

Figure 2: Typology (financing) of Australian aged care services

	Higher degree of co-payment	**Lower degree of (or no) co-payment**
Block funded grants to service organisations		Information, assessment and referral services Home and Community Care program National Respite for Carers Program Veterans' Home Care Day Therapy Centres
Subsidies paid in respect of individuals	*Low-level permanent residential care* *High-level permanent residential care* Transition care	Department of Veterans' Affairs' Community Nursing program Community Aged Care Packages Extended Aged Care at Home Packages EACH (Dementia) Packages Respite residential care
Direct payments to individuals		Carer Payment Carer Allowance

Notes: (1) Private insurance does not currently play a role in financing aged care in Australia.
(2) Means tested programs are indicated in italics

3.1 Roles and responsibilities

Informal carers

5. Informal carers are the principal providers of aged care services in Australia. The Australian Bureau of Statistics' 2003 Survey of Disability, Ageing and Carers found that 95 per cent of people living in households with a severe or profound limitation in one of the core activities of communication, mobility or self-care received help from an informal carer.[14] In 2003, about 239,400 people were primary carers for one or more older people. About two in five formal carers are older people themselves (39.9 per cent) and about two thirds are co-resident with the care recipient (66.0 per cent). Almost all older primary carers of older people are co-resident with the care recipient (93.8 per cent).[15]

6. The Australian Institute of Health and Welfare has estimated that the value of services provided by all informal carers exceeded $27 billion in 2005–06, while Access Economics estimates that if all hours of informal care were replaced with services purchased from formal care providers and provided in the home, the replacement value would be $30.5 billion.[16]

Formal care providers

7. The majority of formal aged care services are provided by private (profit and non-profit) providers, but some state, territory, and local government agencies also provide aged care services. In the main, the Commonwealth does not directly provide aged care services, with the exception of some information services and the provision of financial support to carers.

8. Formal aged care services are delivered through around 8,000 outlets across Australia, including 3,334 outlets registered as delivering services funded through the Home and Community Care Program, 1,559 outlets delivering subsidised packaged community aged care and 2,783 outlets delivering subsidised residential aged care (as at 30 June 2009).

The Commonwealth

9. The Commonwealth has principal responsibility for regulating and planning the provision of formal aged care services, and for supporting informal carers. Its objectives, as outlined in the *Aged Care Act 1997*, are, *inter alia*, to:

a) promote a high quality of care and accommodation that meets the needs of individuals and protects their health and well-being by encouraging diverse, flexible and responsive residential care services that facilitate the independence of, and choice available to, care recipients and carers;

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[14] ABS (2004). *Disability, ageing and carers, Australia: summary of findings, Australia 2003*. ABS cat. no. 4430.0. Canberra: ABS.

[15] AIHW (2009) *Australia's welfare 2009*. Canberra: AIHW, p.195.

[16] AIHW (2008) *Submission to the Inquiry into better support for carers*. Canberra: AIHW. Accessed on 1 October 2010 at: www.aph.gov.au/house/committee/fchy/carers/subs/sub1033.pdf.

Access Economics (2005) *The economic vale of informal care*. A report prepared for Carers Australia. Accessed on 1 October 2010 at: http://www.carersaustralia.com.au/uploads/Carers%20Australia/CA%20Reports/Access%20Economics%20study%20full.pdf.

b) facilitate access to residential care by those who need it, regardless of race, culture, language, gender, economic circumstance or geographic location and to help care recipients to enjoy the same rights as all other people in Australia;

c) plan effectively for the delivery of aged care services by targeting services to areas of the greatest need and people with the greatest need, avoiding duplication of services and improving the integration of the planning and delivery of residential care services with the planning and delivery of related health and community services; and

d) provide funding in such a way as to take account of the quality and level of care provided, to hold providers of care accountable for the funding they receive and for the outcomes for the recipients of the care they provide and to ensure care is affordable for the people who need it.[17]

10. The Commonwealth also has principal responsibility for funding the provision of aged care and support for carers, with some funding provided by states, territories, and local governments. Individuals often also contribute to the cost of their aged care.[18]

States and territories

11. States and territories also currently have responsibility for regulating and planning the delivery of some (low intensity) aged care services, principally the Home and Community Care program and the planning and administration of the Aged Care Assessment Program. States and territories, and local governments, also have an indirect but significant role in the regulation of aged care services as a consequence of their roles in the regulation of health services, building standards and planning approvals.

3.2 Support for carers

12. The Commonwealth provides support for carers through income support payments (Carer Payment) and financial assistance (Carer Allowance), and also funds a number of services to ensure that older people, their families and carers have access to the information and care they need, as good information and referral and assessment services are important to achieving timely and appropriate access to care. The Commonwealth also provides support for carers through subsidising the provision of respite care.

Income support and financial assistance for informal carers

13. The Carer Payment is an income support payment for people who cannot undertake substantial paid work because of their caring responsibilities. The payment is means tested and paid at the same rate as other social security pensions. About one third of Carer Payment recipients (35.4 per cent) care for older people. In general, they each care for one older person. Commonwealth expenditure on Carer Payments for carers of older people is estimated

[17] Cullen, DJ (2003) *The Commonwealth Legislative Framework.* Review of Pricing Arrangements in Residential Aged Care Background Paper No. 2. Canberra: Department of Health and Ageing, p.iv.

[18] These arrangements are in contrast to those in the provision of disability care, where the states and territories have responsibility for regulating and planning the provision of care and for providing most of the funding, with Commonwealth funding provided through the National Disability Agreement.

to have been $686.9 million in 2008-09. It is estimated that 52,050 carers of older people were in receipt of a Carer Payment.

14. The Carer Allowance is an income supplement for people who provide daily care and attention at home to a person who has disabilities or a severe medical condition. The payment is not means tested and it is indexed annually. About 38.2 per cent of Carer Allowance recipients care for older people. Commonwealth expenditure on Carer Allowances for carers of older people is estimated to have been $484.7 million in 2008-09. It is estimated that 127,600 carers of older people were in receipt of the Carer Allowance.[19]

Information and referral services

15. The Commonwealth also funds a number of services to ensure that older people, their families and carers have access to the information and care they need, as good information and referral services are important to achieving timely and appropriate access to care. Since 1997, the Department has provided an Aged Care Information Line (Freecall 1800 500 853). There were 102,624 calls to the information line in 2008-09. The Department also disseminates a wide range of information on ageing and aged care to consumers, care providers, health professionals and the general community. Over 9.8 million individual information products were distributed to consumers during 2008-09. Information circulars are also regularly sent to service providers and major stakeholders advising of amendments to policy and procedures, changes to fees and charges, and reminders of best practice education and training through the Aged Care Standards and Accreditation Agency.

16. The Department's website (www.health.gov.au) offers information on Commonwealth aged care services and access to a range of publications and fact sheets. Amendments and updates distributed throughout the year to aged care service providers are also published on the website. Major reports and publications from and by the Department are easily accessed through the publications listing. To assist people to make informed decisions for themselves or for family members the Aged Care Australia website (www.agedcareaustralia.gov.au) includes an aged care home finder and community care service finder function for locating services. This site has been active since 30 November 2006. It averaged 23,969 Homefinder searches and 1,899 Community care searches per month in 2008-09.

17. Information and support for carers is also provided through the Commonwealth Respite and Carelink Centres, which provide information and link older people to a wide range of aged care and support services available locally or anywhere in Australia. Fifty-four Commonwealth Respite and Carelink Centres across Australia provided more than 206,000 clients with information about community, residential and other aged care services in

[19] In 2008-09, Commonwealth expenditure on Carer Payments and Carer Allowances totalled $1.9 billion and $1.3 billion respectively. Carer Payment was paid to 146,870 carers, who cared for 147,223 individuals. Carer Allowance was paid to 334,448 carers, who cared for 353,388 individuals. See: Australian Government, Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) (2009) *Annual Report 2008-2009*. Canberra: FaHCSIA, pp.136-138, 297.

For the share of Carer Payment and Carer Allowance recipients who care for older people see: AIHW (2007) *Australia's welfare 2007*. Canberra: AIHW, p.437.

2008-09. Clients included general practitioners, other health professionals, service providers, individuals and their carers. Centres maintain a database of services offered in a local region, from personal care and domestic help to accommodation in nursing homes and hostels, and can also advise on costs of services, assessment processes, and eligibility.

18. Commonwealth Respite and Carelink Centres may be contacted through a national freecall number, 1800 052 222. For emergency respite support outside standard business hours these Centres can be contacted on the freecall number 1800 059 059. Information can also be accessed through their website (www.commcarelink.health.gov.au**).**

19. In addition the Carer Information and Support Program funds the development and distribution of carer information products, tailored specifically to carer's needs, which are linguistically and culturally appropriate and sensitive. This includes education programs for carers and information about government programs that support carers. Products are developed and distributed nationally by the Department. Carers Australia is funded to provide carers with specialist advice and resources, professional counselling through the National Carers Counselling Program, education and training, delivered through the network of Carer Associations in each state and territory.

Assessment services

20. Various assessment services are currently in place to address the broad care needs of older people living in the community. For clients with low intensity needs the majority of assessments are conducted at the service provider level. This is particularly prevalent in the HACC Program, however Commonwealth Respite and Carelink Centres also provide information and direct assessment of clients requiring access to respite services.

21. More complex assessments are carried out under the Aged Care Assessment Program, which is currently funded by the Commonwealth and administered by the states and territories. Commonwealth funding is provided through a national partnership payment arrangement under the Intergovernmental Agreement on Federal Financial Relations. States and territories are responsible for the day-to-day administration of the program, including the employment of assessment staff for Aged Care Assessment Teams (ACATs) and delivery of assessment services in each state or territory. There are 109 ACATs operating across the states and territories (108 funded by the Commonwealth)[20]. They are based in hospitals or in the local community and provide comprehensive assessment for older people.

22. In 2008-09, the Commonwealth provided $74.5 million for the Aged Care Assessment Program. A total of 199,694 completed assessments were recorded in 2007-08 (the last year for which data is available), at an average cost of each completed assessment cost $325. Under the existing funding arrangements, State and territory governments also contribute to the cost of operating the Aged Care Assessment Program by providing in-kind support (for example, office space and IT infrastructure).

[20] One ACAT is funded by a private hospital that does not receive Commonwealth funding through the Aged Care Assessment Program. However, the functions under the *Aged Care Act 1997* are delegated to members of this ACAT.

23. ACATs generally comprise or have access to a range of health professionals including geriatricians, physicians, registered nurses, social workers, physiotherapists, occupational therapists and psychologists. Their role is to expertly assess the care needs of frail older people; work closely with the client, their carer and family to identify the most suitable aged care services available; and assist them to gain access to the types of available services most appropriate to meet their care needs. This may involve referring clients to community care services such as those available under the Home and Community Care program. Alternatively, they may approve a person as eligible for Commonwealth subsidised aged care services provided under the *Aged Care Act 1997.*

24. A person must generally be assessed and approved by an ACAT before they can access Commonwealth subsidised care provided under the Act. Once a person is approved as eligible for aged care services, ACAT assessors normally assist clients by making direct referrals to a service provider or by providing information on how to apply for services. Following up on referrals may be also be part of the care coordination function performed by ACATs, however an ACAT approval does not guarantee a place in a facility or service.

Respite care

25. Respite is a form of support for carers that enables them to attend to everyday activities and have a break from caring. It may be given informally or by formal respite services, which can supply a trained person to provide support at home or at facilities such as day care centres. Support for the provision of respite care is provided through:

a) the National Respite for Carers Program;

b) the Home and Community Care program;

c) the Veterans' Home Care program; and

d) the residential care program.

26. The National Respite for Carers Program supported the provision of approximately 4.7 million hours of respite in 2008-09. This was delivered through over 650 respite services in a variety of settings, including 78 overnight community respite services and 96 new or expanded respite services for employed carers funded under the Overnight Community Respite and Employed Carer initiatives. A total of 127,504 carers were provided with assistance through the National Respite for Carers Program. This figure includes 29,992 carers assisted through respite services and 89,599 carers assisted to receive emergency and short term respite through Commonwealth Respite and Carelink Centres. In 2008-09, Commonwealth expenditure on the National Respite for Carers Program was $193.3 million, equating to an average annual cost of $1,520 per carer.

27. The Home and Community Care program assisted some 31,787 individuals to receive respite care in 2007-08 (the latest year for which data is available at this time). These individuals received a total of 2.7 million hours of respite care through the Home and Community Care program. On average, each care recipient received 86.1 hours of respite care in 2007-08, with each older care recipient receiving 57.5 hours of respite care.

28. The Veterans' Home Care program assisted 11,774 individuals to receive respite care In 2008-09. These individuals received a total of 1.4 million hours of respite care. On average, each care recipient received 116.2 hours of respite care. Commonwealth expenditure on respite through the Veterans' Home Care program was $22.3 million in 2008-09, which equates to an average annual cost of $1,890 per care recipient.[21]

29. Respite care is also provided in aged care homes to people who have been assessed and approved to receive residential respite care by Aged Care Assessment Teams. In 2008-09, there were around 56,965 admissions for residential respite and 42,347 separate individuals were provided with a total of 1.265 million days of care. Almost all care recipients (96.4 per cent) were aged 65 or older. On average, each episode of care is 24 days and care recipients use 30 days of respite care each year. Commonwealth expenditure on residential respite was $147.5 million in 2008-09, equating to an average annual cost of $3,480 per care recipient.

30. Carers and care recipients are able to receive assistance with their respite needs from more than one program so it is not possible to determine the total number of people assisted with respite care or the average number of hours used by each care recipient from all programs.

3.3 Low intensity interventions

31. The Commonwealth funds the delivery of low intensity services to support frail older people through a number of different programs, including the Home and Community Care program, the Veterans' Home Care program and the Department of Veterans' Affairs Community Nursing program, and the Day Therapy Centre program. Funding for services is provided through grants from capped budgets. In some cases a co-payment is required.

Home and Community Care program

32. The majority of recipients of aged care services in Australia, over half a million people, receive quite low intensity levels of support in the community through the Home and Community Care Program, which is jointly funded by the Commonwealth and the states and territories. The Commonwealth coordinates national policy and the states and territories contribute to policy and manage the program on a day-to-day basis. States and territories are accountable to the Commonwealth for the expenditure of Commonwealth funds.

33. The Home and Community Care program subsidises access to a wide range of community care services by block funding service organisations. Fixed budgets are allocated to providers and providers have responsibility for assessing people presenting for services to determine their priority for accessing subsidised services within broadly consistent parameters. Funding agreements would usually specify the type of services to be delivered and require an acquittal of funds expended. Providers range from very large consolidated providers to local community groups with very small budgets (less than $50,000 per annum). In some instances, providers contribute additional resources in kind, or funds to cover the cost of service delivery

[21] Steering Committee for the Review of Government Service Provision (2010) *Report on Government Services 2010*. Canberra: Productivity Commission. See Table 13A.48.

or to increase the level of services available. Most services are delivered by paid workers but volunteers play a substantial role in the delivery of some services.

34. The program supports people with a moderate, severe or profound disability, frail older people, and their carers. The services provided by the program include community nursing, allied health services (physiotherapy, occupational therapy, podiatry, dietetics, etc), personal care (help with showering, dressing etc), domestic assistance, delivered meals and respite/social support at a centre or in a person's home.

35. Total (matched) government expenditure in 2008-09 on the Home and Community Care program was $1.8 billion, consisting of $1.1 billion from the Commonwealth and $698.2 million from the states and territories. Nationally, the Commonwealth contributed 61.1 per cent of the total (matched) government funding, with the share varying slightly between jurisdictions.[22] Clients can be asked to contribute towards the cost of services. It is estimated that these fees account for about five per cent of the cost of delivering services.

36. Most interventions funded through the Home and Community Care program are low intensity although they may be delivered over a long period of time (such as delivered meals). Most (97 per cent) clients receive, on average, services worth less than the level of Commonwealth funded low-level community care packages. These clients receive, on average, services worth about $1,200 per year (in 2004-05 prices).

37. About 2.8 per cent of clients receive services worth more than the level of Commonwealth funded low-level community care packages. These clients receive, on average, services worth about $20,830 per year (in 2004-05 prices). Expenditure on these clients accounts for about 33.4 per cent of all expenditure in the Home and Community Care program.

38. For clients aged 65 or older, most (75 per cent) receive services worth less than the level of Commonwealth funded low-level community care packages. These clients, on average, receive services worth about $1,230 per year (in 2004-05 prices).

39. About 2.1 per cent of clients aged 65 or older receive services worth more than the level of Commonwealth funded low-level community care packages. These clients, on average, receive services worth about $19,230 per year (in 2004-05 prices). Expenditure on these clients accounts for about 25.0 per cent of all expenditure on clients aged 65 or older in the Home and Community Care program.[23]

Department of Veterans' Affairs' aged care programs

40. The Veterans' Home Care Program offers holders of Gold or White Repatriation Health Cards home support services, including domestic assistance, personal care, home and garden maintenance, and respite care. Other services, such as community transport, social support

[22] Several jurisdictions contribute funds over their matching requirement to providers to meet the costs of wage increases and to provide additional funds for a range of services, including community nursing services.

[23] Australian Government, Department of Health and Ageing (2007) *Preliminary findings from data analysis to inform the development of the Packaged Care Tier*. Accessed on 1 October 2010 at: http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-twf-access-preliminary-factsheet.htm.

and delivered meals, are also available under arrangements with states and territories. Eligibility for Veterans' Home Care services is not automatic, but based on assessed need. Some 79,691 people were approved for Veterans' Home Care services in 2008-09, although not all assessed clients took up their care entitlement. Almost all people approved for Veterans' Home Care services in 2008-09 were aged 70 or older (95.5 per cent). The Commonwealth provided $101.8 million in 2008-09 for the Veterans' Home Care program. Care recipients can also be asked to make small co-payments for the services they receive. On average, care recipients received 51.3 hours of service in 2008-09, at an average annual cost to the Commonwealth of $1,245.[24]

41. The Department of Veterans' Affairs' Community Nursing program provides necessary nursing and/or personal care services to eligible members of the veteran community. The services are provided in the veteran's own home to assist them restore or maintain their maximum level of health and independence, and to assist them to avoid premature or inappropriate admittance to hospital or residential care.

42. Eligibility is not automatic, but based on assessed need. Some 32,320 people received assistance from the Community Nursing program in 2008-09. Almost all of these clients (96.8 per cent) were aged 70 or older. The Commonwealth provided $106.0 million in 2008-09 for the program. Services are provided under a casemix model using a 28-day claiming cycle, with clients classified into care categories based on care interventions. On average, care recipients received 6.7 hours of service in a 28-day claiming period in 2008-09, at an average annual cost to the Commonwealth of $3,280.

43. Recipients of services from Veterans' Home Care and Community Nursing programs are also eligible to receive services from other Commonwealth funded programs.

Day Therapy Centre program

44. The Commonwealth's Day Therapy Centre program assists people to either maintain or recover a level of independence, to allow them to remain either in the community or in low-level residential care. Day Therapy Centres provide a wide range of therapy services such as physiotherapy, occupational therapy, speech therapy and podiatry.

45. There are currently 139 Day Therapy Centres across Australia. In 2008-09, about 160,000 older people were provided with assistance through the Day Therapy Centres. Commonwealth expenditure on Day Therapy Centres totalled $38.8 million in 2008-09. Assistance is not means tested but service providers can request a contribution to the cost of the services they receive. In line with similar community care programs it is likely that Day Therapy Centres derive about seven per cent of their revenue from consumer contributions.

[24] Steering Committee for the Review of Government Service Provision (2010) *Report on Government Services 2010*. Canberra: Productivity Commission. See Table 13A.48.

3.4 Low-level and high-level care services

46. In general, the provision of low-level and high-level care is subsidised directly by the Commonwealth and is more heavily regulated. Some clients in the Home and Community Care program also receive packages of care, including case management.

47. Under the *Aged Care Act 1997*, low-level and high-level care services are funded through subsidies paid directly to aged care providers on behalf of care recipients. However, a provider can only receive a subsidy in respect of a care recipient if four conditions are met:

a) The care recipient must be an *approved care recipient* for the type of care (residential or community, high-level or low-level, respite or permanent) they are receiving. This approval is granted by Aged Care Assessment Teams.

b) Their care must be provided by an *approved provider*. This approval is granted by the Department and takes into account the provider's experience in the provision of aged care as well as its corporate governance.

c) Care must be provided in an *allocated place*. The number and distribution of places is governed by the 'needs based planning arrangements'. These arrangements seek to equitably distribute places subject to an overall national limit of subsidised operational places of 113 for every 1,000 people aged at least 70, with a target balance of care of 44 high-level and 44 low-level residential care places, and 4 high-level and 21 low-level community care packages. Places are allocated through an annual (non price based) competitive tender like arrangement.

d) Care must also be of a *specified quality* (for example, accreditation in residential care). An aged care home must also meet *specified building standards* (certification) before Commonwealth accommodation supplements are payable and before accommodation payments can be levied on residents.

Community care packages

48. In 2008-09, some 64,140 people received packages of subsidised community care through the Commonwealth's Community Aged Care Package (CACP) program and its Extended Aged Care at Home (EACH) program, including the EACH (Dementia) (EACHD) program. Almost all of these care recipients (95.2 per cent) were aged 65 or older. Commonwealth funding for community care packages was $736.0 million in 2008-09. These services differ from those generally provided under the Home and Community Care program as they are delivered as individually tailored packages of care, usually involving case management. CACPs deliver low-level care and EACH and EACHD packages deliver high-level care.

49. Commonwealth funding for community care packages is provided through subsidies paid in respect of individuals, with the level of the care subsidy determined by the type of community care package. These subsidies are not means tested. Care recipients can also be asked to contribute to the cost of the care services they receive up to a maximum level set by the Commonwealth. Table 2 provides details on the average annual costs to the Commonwealth of community care packages in 2008-09.

Table 2: Average annual subsidy for community care packages, by level of package, 2008-09

Level of package	Average annual subsidy per care recipient
Community care packages	$12,094
Extended Aged Care at Home packages	$39,361
Extended Aged Care at Home – Dementia packages	$45,095

Residential care

50. A further 212,067 people received subsidised permanent residential care at some stage during 2008-09, with an average of 157,876 people receiving permanent residential care each night in 2008-09. Almost all care recipients (95.9 per cent were aged 65 or older). Commonwealth funding for residential care was $6.5 billion in 2008-09 (including $147.5 million for residential respite).

51. Commonwealth funding for residential care is provided through subsidies paid in respect of individuals, with the level of the care subsidy determined by the care recipient's care needs as determined by the Aged Care Funding Instrument. These subsidies are subject to an income test. Care recipients can also be asked to contribute to the cost of the care and accommodation services they receive up to a maximum level set by the Commonwealth.

52. Table 3 provides details on the average annual costs to the Commonwealth of permanent residential care in 2008-09.

Table 3: Average annual subsidy for permanent residential care, by level of care, 2008-09

Type of care recipient	Average annual subsidy per care recipient
Residential care (permanent residents) – Low care	$17,770
Residential care (permanent residents) – High care	$48,549
Residential care (permanent residents)	**$40,075**

Transition care

53. Transition care provides time-limited, goal-oriented and therapy-focused care for older people after a hospital stay. It is designed to improve older people's independence after a hospital stay, and can allow them to return home rather than enter residential care. The Transition Care program was established in 2004-05 as a jointly funded initiative between the Commonwealth and the states and territories. Commencing in 2005, the Commonwealth provided a total of 2,000 transition care places to the states and territories, broadly based on the proportion of non-Indigenous people aged 70 or over and Indigenous people aged 50 or over. In 2007-08, the Commonwealth announced that an additional 2,000 transition care places would be provided nationally by 2011-12. The recurrent costs of these places are fully funded by the Commonwealth. In June 2008, the first release of 228 new transition care places was allocated to states and territories and the second release of 470 places was allocated in March 2009 to become operational in 2009-10. Two further releases of 651 places each will become operational in 2009-10 and 2010-11.

54. Under the program, older people are provided with a package of services that includes low intensity therapy (such as physiotherapy, occupational therapy and social work), case management, and nursing support and/or personal care. A person may only enter transition care directly after discharge from hospital and must have been assessed and approved by an Aged Care Assessment Team, while in hospital, as being able to benefit from a period of transition care and as eligible for residential care. Transition care can be provided for up to 12 weeks (with a possible extension of another 6 weeks) in either a home-like residential setting or in the community.

55. The Transition Care Program is jointly funded by the Commonwealth and the states and territories. By 2011-12, the Commonwealth will be providing 75 per cent of the recurrent funding by government for transition care. Commonwealth funding for transition care was $76.1 million in 2008-09. Commonwealth funding for the Transition Care Program is provided in the form of flexible care subsidy for each person receiving transition care. Subsidies are not means tested, but care recipients can be asked to contribute to the cost of the care services they receive up to a maximum level set by the Commonwealth.

56. In 2008-09, some 12,635 people were assisted by the Transition Care Program. When fully established, the program will assist up to 30,000 older people each year and up to 4,000 people at any one time. Currently, access to transition care is more limited in outer regional, remote and very remote Australia. Measures in the 2010-11 Budget will address this issue by relaxing the guidelines governing the program so that transition care can be delivered in hospital settings in these areas.[25]

3.5 Support for aged care infrastructure

57. In general, the capital costs of aged care are met by care recipients through the fees and charges that they pay, including accommodation bonds in residential care. Commonwealth recurrent subsidies (accommodation supplements in residential care) assist those care recipients who do not have sufficient means. The Commonwealth also provides capital grants and zero real interest loans to assist with the establishment of aged care homes in areas of market failure, including rural and remote areas. Grants are also available to support the establishment of aged care homes servicing special needs groups, such as the homeless.

58. In addition, the Commonwealth supports the costs of establishing and maintaining community care services as part of its general grants (in the Home and Community Care program and the National Respite for Carers Program) and through Community care and Flexible Care Grants for community care package providers.

59. The Commonwealth also supports the development of the aged care workforce.

[25] Australian Government, Department of Health and Ageing (2010) *Supporting the care of Long Stay Older Patients.* Accessed on 1 October 2010 at: http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-agedcare-07.

Community Care Grants and Flexible Care Grants

60. These grants assist organisations that may be disadvantaged in meeting the cost of establishing services, including organisations without an established infrastructure, those servicing remote communities where there are limited resources, and services with small numbers of community care places. Individual grants may be up to $65,000 (GST exclusive) for Community Care Grants and $100,000 (GST exclusive) for Flexible Care Grants.

61. A total of 138 Community Care and Flexible Care Grants were made in 2008-09, totalling over $5.9 million in value. The vast majority of these grants (118) were made in the 2008-09 Aged Care Approvals Round, with 20 grants made outside the round. The average grant made in the approvals round was $41,004, while the average grant made outside the approvals round was $50,853.

Residential care capital grants

62. The Commonwealth supports capital grant funding to providers of residential care who require assistance to improve building quality and standards, or to construct accommodation for additional residents. The funding assists in providing older Australians from the special needs groups identified in the *Aged Care Act 1997* access to care that meets the required standards. Capital grants are made available through the annual, competitive Aged Care Approval Round and are allocated to approved providers that demonstrate a lack of capacity to fund the urgently required capital works from all possible sources of funding. Capital grants fund or partially fund new services as well as extensions and building refurbishments, so the amount of grant funding does not correlate to the number of places.

63. The Commonwealth allocated $51.8 million in capital grants to residential care providers in 2008-09, with almost 63 per cent of this funding allocated to services in rural and remote areas. In total, some $19.5 million was allocated as residential care grants, to support fire and safety related improvements and other works required for accreditation and certification, as well as the construction of new accommodation. A further $32.3 million was provided through the Regional and Rural Building Fund to assist aged care homes upgrade the quality of their buildings or expand, thereby increasing access to aged care for rural communities. As outlined in its White Paper, *The Road Home: A National Approach to Reducing Homelessness*, the Commonwealth is allocating one capital grant for a specialist service for older homeless people each year for four years; two such grants have already been allocated.[26]

Zero real interest loans

64. The first tranche of zero real interest loans was advertised in April 2008 and providers were given the opportunity to apply for a share of $150 million in loans in high need areas (defined as areas in which no new bed applications or suitable applications had been received in recent years or in which there had been a rapid growth in the older population).

[26] Australian Government, Department of Families, Housing, Community Services and Indigenous Affairs (2008) *The Road Home: A National Approach to Reducing Homelessness*. Accessed on 1 October 2010 at: http://www.fahcsia.gov.au/sa/housing/progserv/homelessness/whitepaper/Documents/the_road_home.pdf .

65. Applications closed in June 2008 and results were announced in September 2008. Loans were offered to providers to build a total of 1,348 new residential care beds in areas of need as a result of the first round of this initiative. A further 107 community care places were also offered in conjunction with the loans. The second round of the initiative was advertised in the 2009-10 Aged Care Approvals Round, with offers to be announced towards the end of 2010.

66. In the 2010-11 Budget, the Government announced that a further two tranches of loans would be advertised. The conditions applying to these new loans have been improved:

a) providers will be able to apply for loans in respect to areas with relatively high numbers of long stay older patients;

b) providers will be able to apply for loans in respect to existing provisional allocations of places; and

c) the repayment period for the loans has been extended to 22 years. In the first two years providers will repay only the CPI on the amount drawn down, allowing providers to generate revenue from the new places before being required to repay any of the loan principal. Two years after the loan commences, repayment of the principal will be required at five per cent of the original loan amount, plus CPI per year.[27]

Support for the development of the aged care workforce

67. In 2010-11, the Commonwealth will provide $67.7 million to directly support the development of the aged care workforce, by assisting aged care workers to upgrade their qualifications or to obtain qualifications for the first time.

68. The 2010-11 Budget restructured and expanded the Commonwealth's existing aged care workforce programs to deliver more flexible training initiatives focused on improving clinical care, assisting recruitment and retention and the creation of career paths in aged care.[28] Under the restructure, Commonwealth funding to support the development of the aged care workforce will be directed through four programs:

a) the Aged Care Training program will support vocational education and training and short course training to up-skill 25,600 personal care workers and create better career paths at a cost of $99.4 million over four years;

b) the Nurses in Aged Care Training program will support better career paths for aged care nurses by providing 7,100 enrolled nurse training places, scholarships, clinical and graduate placements at a cost of $107.4 million over four years;

c) the Teaching Nursing Homes program will provide funding of $4 million over four years to support the establishment of Teaching Nursing Homes across Australia; and

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[27] Australian Government, Department of Health and Ageing (2010) *More Zero Real Interest Loans for Aged Care Beds in Areas of High Need.* Accessed on 1 October 2010 at: http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-agedcare-05.

[28] Australian Government, Department of Health and Ageing (2010) *Professionalising the aged care workforce.* Accessed on 1 October 2010 at: http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-agedcare-13.

d) the Encouraging Best Practice in Aged Care program will focus on improving care, providing additional skills for staff and promoting sustainable evidence-based practice care for care recipients in both the residential and community care setting at a cost of $24.2 million over four years.

69. An additional $103.3 million was provided in the 2010-11 Budget to:

a) provide an additional 600 fully funded enrolled nursing places and 300 undergraduate nursing scholarships at a cost of $21 million over four years (refer to Building Nursing Careers);

b) support up to 25 projects across the sector to trial different models of practice for nurse practitioners in aged care at a cost of $18.7 million over four years (refer to Aged Care Nurse Practitioner – Models of Practice Projects);

c) introduce incentive payments, at a cost of $59.9 million to encourage aged care workers to undertake additional training and build a career in aged care (refer to Aged Care Education and Training Incentives);

d) commission work to develop a standard Personal Care Worker and Assistants in Nursing scope of practice and competency framework in preparation for potential regulation of these groups ($3.7 million).[29]

70. Over the next four years the Commonwealth will provide more than 31,000 training places and scholarships to care workers and nurses wishing to pursue a career in aged care:

a) up to 7,000 short course skills development training places and 18,600 vocational education and training places;

b) up to 3,200 enrolled nurse training places; 2,820 undergraduate and post graduate nursing scholarships; and 40 aged care nurse practitioner scholarships to build on the Government's MBS and PBS reforms for nurse practitioners;

c) financial incentives for aged care providers to provide up to 400 nursing graduate placements to support graduates as they become fully functioning nursing staff;

d) funding to support improved clinical training and placements in aged care homes for up to 640 students; and

e) seed funding to support a number of Teaching Nursing Homes to strengthen links between the aged care sector and research and training institutions.

71. Together, these initiatives will allow an unskilled worker to progress from personal care worker to nursing studies, helping establish career paths in aged care and supporting sector efforts to recruit and retain nurses, improving care outcomes for older people receiving services. A priority for training and funding would be workers in rural and remote areas.

[29] Australian Government, Department of Health and Ageing (2010) *Supporting nurses to stay in the workforce.* Accessed on 1 October 2010 at: http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-wkforce-02.

3.6 Recent reforms

72. As the above discussion illustrates, Australia's current aged care system is fragmented and responsibilities are divided between the Commonwealth and the states and territories. This has lead to cost shifting and blame shifting between the aged care and disability service systems relating to responsibility for younger people with disabilities in aged care services.

73. From the consumer's point of view the current arrangements can be confusing. Services provided by different programs overlap and have different cost structures and eligibility requirements. Different quality assurance and complaint systems also apply for different programs. As a consequence of this fragmentation, older people, their families and carers can find it difficult to access the services they need and often do not know what services are available. This is exacerbated by the tendency of different programs to offer information only on their own services rather than on the aged care system as a whole. As a result, care can be too closely tied to program and funding criteria and not responsive enough to people's changing needs – with this rigidity also serving to restrict innovation.

Reform of roles and responsibilities

74. At its meeting on 19-20 April 2010, the Council of Australian Governments, with the exception of Western Australia, agreed to address these issues by ensuring that the Commonwealth has full funding and policy responsibility for aged care. These reforms include a transfer to the Commonwealth of current resourcing for aged care services from the Home and Community Care program (except in Victoria).

75. As a result, the Commonwealth will, from 1 July 2012 (except in Victoria and Western Australia), become the sole regulator of aged care services (*qua* aged care services) and the sole government-funder of long term care services for older people, whether in Commonwealth regulated aged care services or in state/territory regulated National Disability Agreement services.

76. Under the new arrangements, the Commonwealth is responsible for:

a) regulating packaged community and residential care delivered under Commonwealth aged care programs, as currently;

b) funding packaged community and residential care delivered under Commonwealth aged care programs for older people, as currently;

c) funding and regulating basic community care services for older people; and

d) funding specialist disability services delivered under the National Disability Agreement for older people.

77. States and territories are responsible for:

a) regulating specialist disability services delivered under the National Disability Agreement, as currently;

b) funding and regulating basic community care services for people under the age of 65 in line with their principal responsibility for delivery of services under the National Disability Agreement, except Indigenous Australians aged 50 or over for whom the cost of care will be met by the Commonwealth; and

c) funding packaged community and residential care delivered under Commonwealth aged care programs for people under the age of 65, except Indigenous Australians aged 50 or under.

78. The Commonwealth and the states and territories share responsibility for providing continuity of care across health, aged care and disability services.[30]

79. These reforms are intended to support the development of a nationally consistent aged care system, covering basic home care through to nursing homes. The Commonwealth and the states and territories have agreed that transition to the new aged care arrangements will occur in a way that ensures there is no disruption to the current recipients of services, including younger people with disabilities who are currently receiving care in aged care services.[31]

80. It is expected that the current mix of community care service providers – a mixture of local government, state agencies and non-government providers, will continue. The Commonwealth and states and territories will involve providers and other stakeholders in the reform process to ensure that the future system of community care builds on the strengths of the existing service infrastructure, the experience of the workforce and the needs of local communities. It is not intended that the changes to roles and responsibilities will be increase the regulatory burden for providers of community care services.

81. Under these reforms, the Commonwealth will be able to build a nationally consistent aged care system allowing older people to seamlessly move from basic help at home through to residential care as their care needs change. This will provide a platform to deliver:

a) seamless transition of care for clients allowing people to move from one level of care to another as their care needs change;

b) simple access to services;

c) greater integration and innovation in services; and

d) a nationally consistent system of services, support, assessment, care and regulation across the country.

82. The National Health and Hospitals Network will also support more consistent cooperation between health and aged care services at the local level. Local Hospital Networks and Medicare Locals will be required to work closely with other local health services, including local aged and community care services.

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[30] Council of Australian Governments (2010) *National Health and Hospitals Network Agreement*. Accessed on 1 October 2010 at: http://www.coag.gov.au.

[31] Council of Australian Governments (2010) *Communiqué of the Meeting of 19-20 April 2010*. Accessed on 1 October 2010 at: http://www.coag.gov.au.

83. The Commonwealth will work with the full spectrum of aged care providers to ensure that they are better supported in:

a) helping older Australians and their families receive different types of care services as their needs change;

b) working with Local Hospital Networks to identify appropriate care options that best suit the needs of older Australians and avoid unnecessary hospital stays, including through sub-acute and step-down care; and

c) working with Medicare Locals to improve older Australians' access to high quality GP and primary health care services in their local community.[32]

Reforming information, assessment and referral arrangements– One stop shops

84. As part of the reform of roles and responsibilities for aged care agreed at the meeting of the Council of Australian Governments on 20-21 April 2010, the Commonwealth will establish a single entry point to the aged care system through a network of one stop shops linked to Local Hospital Networks and Medicare Locals.[33]

85. These entry points will use nationally consistent screening and assessments to direct people to the most appropriate care. They will be able to provide clients and their carers with:

a) Information about the aged care system and services;

b) Needs based assessment services;

c) Simplified access to the aged care system; and

d) Review, monitoring and management of the ongoing needs of care recipients and carers.

86. The network will commence rollover from 1 July 2011 and will take responsibility for directly purchasing aged care assessment services from 1 July 2012.

[32] Australian Government (2010) *National Health and Hospitals Network for Australia's Future – Delivering better health and better hospitals*. Accessed on 1 October 2010 at: http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/report-redbook.

[33] Australian Government, Department of Health and Ageing (2010) *One-stop Shops for Access to Aged Care Information, Assessment and Services*. Accessed on 1 October 2010 at: http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-agedcare-03.

4. Demographic, social and economic pressures

1. Australia's aged care sector has developed very considerably in the last decade. Growth in aged care places has grown faster than the growth in the older population. The range of care options has been expanded significantly, beginning with community care packages to offer low-level care at home, the development of carer policy and respite care to better support the carers of the frail elderly and disabled in their own homes, and more recently the development of high-level care at home through the EACH and EACHD programs. This period of innovation has responded very considerably to emerging client needs and preferences.

2. Access by consumers across the income spectrum is ensured through a universally available system of government subsidies. Regional access is excellent compared to many other programs, with 32.4 per cent of aged care places delivered in regional and remote areas where 34.7 per cent of Australians live. Australia also has one of the most comprehensive quality frameworks for aged care in the world, with universal accreditation, spot checks and a complaints investigation scheme.

3. A number of pressures are growing to challenge this framework. First, population ageing will significantly increase the demand for aged care services as demand for aged care services increases with age.[34] The impacts of population ageing on the structure of demand for care and the appropriate workforce to deliver this care are also important, though more complex. In particular, changes in the health status of the population will have direct and indirect impacts on the demand for aged care. These issues are discussed in Section 4.1 below. Section 4.2 examines the direct and indirect impacts of population ageing on the availability of informal carers, and discusses the consequences of these pressures for the aged care sector. Sections 4.3 and 4.4 respectively examine the implications of population ageing for the formal aged care workforce and for investment in aged care infrastructure.

4.1 Implications of changes in the health status and preferences of older people

4. Older Australians are tending to live longer and, increasingly, are more likely to reach ages at which they experience chronic and complex health conditions. Changes in life expectancy mean that the number of the very elderly is expected to rise especially sharply. In 1983, life expectancy at age 65 stood at 14 years for men and 18 years for women; by 2001-2, it had increased to 18 years for men and 21 years for women; it is expected to have increased further to 21 years for men and close to 24 years for women by 2021. As a result, the number of Australians aged 85 and over will increase from 330,000 in 2006 to 580,000 in 2021 and then to over 1.6 million in 2051.[35]

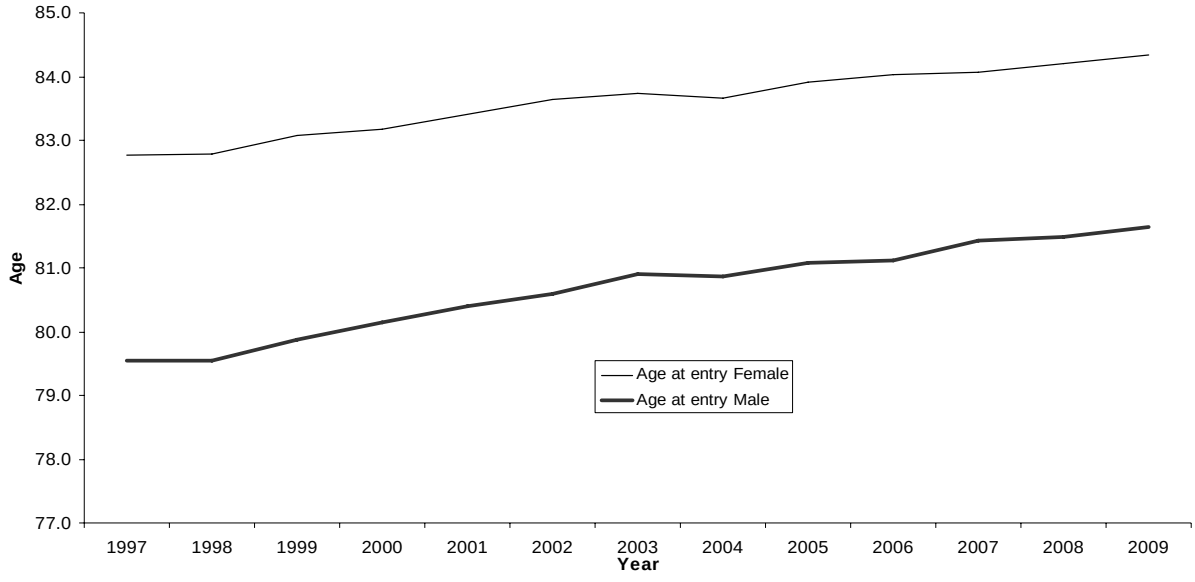
[34] In 2003, 32 per cent of those aged 65–74 years needed some form of assistance, compared with around 86 per cent of those aged 85 or older. See ABS (2004). *Disability, ageing and carers, Australia: summary of findings, Australia 2003*. Canberra: ABS.

[35] Linacre S (2006) 'Caring for an Older Australia', *Economic and Social Outlook Conference*, Melbourne. Accessed on 1 October 2010 at: http://www.melbourneinstitute.com/conf2006/pdffiles/Session%207D/Lincare%20Susan_ppt.pdf .

5. Older Australians are, already, on average, frailer on entry to aged care homes and, on average, frailer while living in them. In 1998-99, for example, 56.1 per cent of residents were appraised as having high-level care needs and 9.2 per cent of residents were appraised as having needs at the highest possible level. By 2007-08, the proportion of residents appraised as having high-level care needs had increased to 69.5 per cent and the proportion of residents appraised as having needs at the highest possible level had almost tripled to 24.3 per cent. In addition, the majority of residents enter residential care from hospital (56 per cent enter high-level care from hospital) and many live only a short time afterwards (40 per cent survive less than six months).

6. The impacts of population ageing on the structure of demand for care and the appropriate workforce to deliver this care are also important, though more complex. In particular, changes in the health status of the population will have direct and indirect impacts on the demand for aged care. Demand for formal aged care may be reduced by improved health among the 'younger elderly'.[36] Demand for residential aged care among the younger elderly may also be further reduced by the availability of alternative services. In 1997-98, the average age of entry into residential care for females was 82.8 years; by 2008-09 this had increased to 84.3 years. For males, over the same period, the average age of entry into residential care increased from 79.5 years to 81.6 years (see Figure 3).[37]

Figure 3: Average age at entry, by sex and year



[36] The 'younger old' are commonly defined as those between 65 and 74, with the 'older old being older than this (see, for example, Alexander KP *et al* (2001) 'Post-Myocardial Infarction Risk Stratification', *American Heart Journal* **141**(1).

[37] The average age of entry to community care packages is also increasing. In 2000-01, the average age of people admitted to Community Aged Care Packages was 79.7 years. By 2009-10, this had increased to 81.4 years. Between 2003-04 and 2009-10 the average age of people admitted to Extended Aged Care at Home Packages increased from 80.8 years to 82.2 years.

7. It is also noteworthy that the inter-quartile range of the age at entry to residential aged care has been narrowing. While both the lower quartile and upper quartile age at entry are increasing, the lower quartile is increasing at a faster rate than the upper quartile. Given there is no clear trend in the median length of stay, the increasing age at entry will result in demand for services not increasing as rapidly as the population is ageing.

8. Underlying the increasing age at entry has been a change in the age-specific first ever admission rates (see Figure 4 and Figure 5).

Figure 4: Male age specific first admission rate and number of admissions, 1997-08 and 2007-08

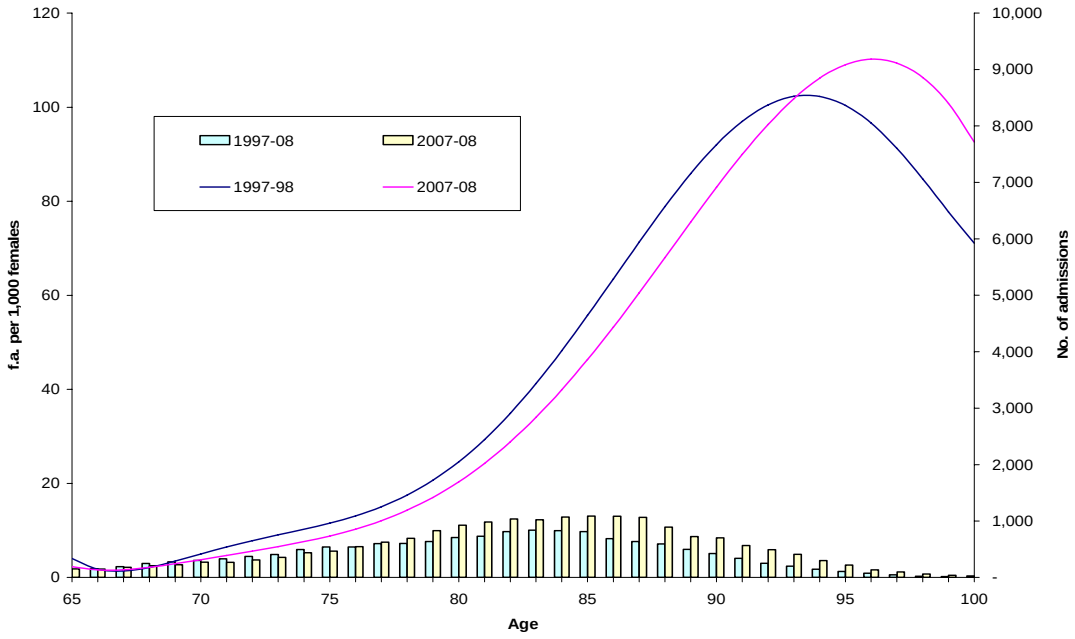
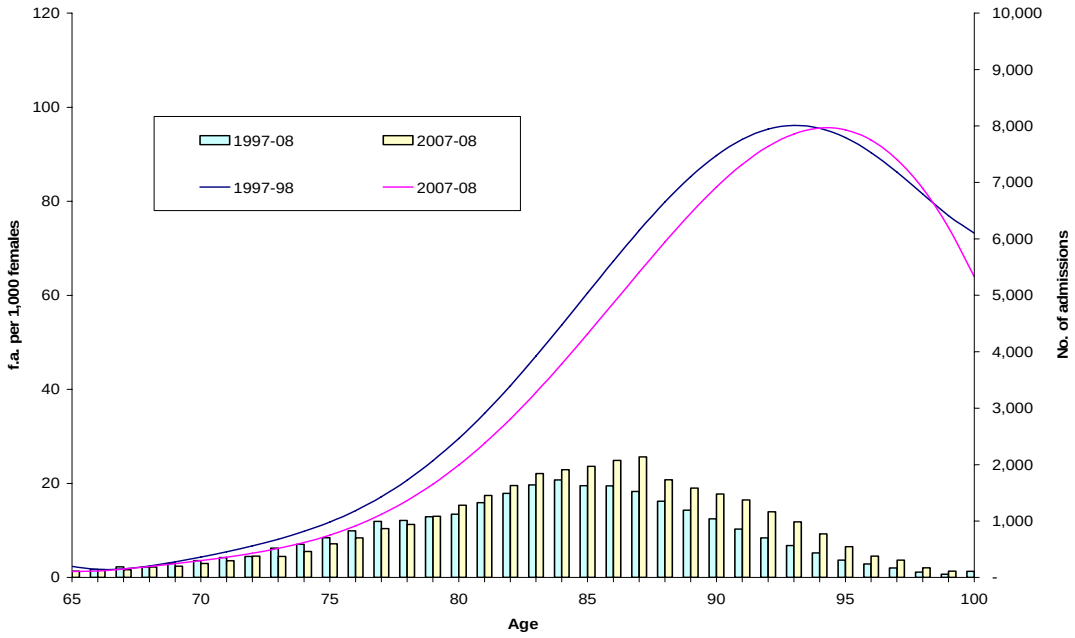


Figure 5: Female age specific first admission rate and number of admissions, 1997-08 and 2007-08



9. The age-specific first ever admission rates has been decreasing at younger ages for both males and females. For males there has been a pronounced increase in the age specific rates in the very old, whereas there has been little change for females at these ages. This change in first ever admissions rates can be decomposed into changes due to population ageing and changing age specific first ever admissions rates. It is clear from the decomposition that the demand for residential care is not accelerating at the same rate as the population is ageing due to the increasing age of first entry. For both sexes there is very little difference in the first admission rates, the decomposition shows that population ageing would have increased the female first admission rate by about 20 per cent and the males by 30 per cent, however, the changing age specific rates significantly dampened these increases (Table 4).

Table 4: Decomposed first admissions rates between 1997-98 and 2007-08, by sex

	First admission rates per 1,000 population			Change due to:		
	1997-98	2007-08	Total change	Population age structure	Changing age specific rate	Interaction
Female	2.96	3.05	+0.09	+0.59	-0.44	-0.06
Males	1.71	1.87	+0.08	+0.52	-0.29	-0.07

10. The first ever admission rates increases rapidly after the age of 80 years old for both sexes. If the current first ever admission rates continue into the future, the number of first ever admissions will increase at around the same rate as the population of people aged 80 or over is increasing. If the trend in the delayed age of first admission continues, the number of first admissions will increase at a slower rate than the population is ageing.

11. The rate of growth in demand for formal aged care services may also be ameliorated (or at least modified as to the type of care sought) by the likely strong aversion of the 'baby boomers' to institutionalised living and institutional forms of care. A 2007 survey focused on people aged between 58 and 61 by Fujitsu Australia and New Zealand found that 80 per cent of respondents preferred independent living, with this preference apparent even for people with significant health problems and an associated high dependence on health services. [38] This preference for independent living was slightly higher than that found in an earlier survey of people aged 70 or over, namely that 59 per cent of people aged 70 years or over would prefer to receive formal care in their own home in the event they were unable to care for themselves, compared to 28 per cent who would prefer to receive residential care. [39]

12. There is some evidence, however, that 'baby boomers' may require more rather than fewer formal care services, especially if they are to achieve their expectation of avoiding institutional forms of care. It has been argued that reduced levels of bonding and bridging

[38] Fujitsu Australia and New Zealand (2007) *A Generational Shift; The Next Wave of Aged Care.* Accessed on 1 October 2010 at: https://www-s.fujitsu.com/nz/whitepapers/form_aged_care.html .

[39] McCallum J (2003) *Submission to the House of Representatives Standing Committee on Ageing Inquiry into Long Term Strategies to Address the Ageing of the Australian Population over the Next 40 Years*. Accessed on 1 October 2010 at: http://www.aph.gov.au/house/committee/ageing/strategies/subs/sub132.pdf .

social capital in baby boomers could lead to increased social isolation, leading to greater mortality and a lower likelihood of tangible assistance and care, and greater levels of depression.[40] As a result it has been argued that one impact of the ageing of the baby boomer generation may be an increase in demand for specially designed retirement communities.[41]

13. However these factors play out, it is clear that the growth in numbers in the very elderly is likely to be associated with an increased number of people with dementia, extreme fragility and other serious impairments to the capacity to perform daily living activities, all of which usually require some form of intensive care, especially residential care if there is no co-resident carer.[42]

14. The overall result seems likely to be a growing need for three types of care provision. The first is care that is provided in a person's home (no matter what type of housing that is) that seeks to integrate home and care. This type of care, which corresponds to the various forms of community care, should suffice for the growing numbers of older people with a reasonable, ability to carry out basic daily activities, especially when they have spousal or family assistance.

15. The second is care in residential facilities that provide for older people who have little or very little ability to undertake basic daily living activities, and who need a high-level of support – as in current 'high-level care'. Demand for this kind of care will also be influenced by the continuing increase in the incidence of chronic conditions that greatly reduce ability to live without continuous assistance.

16. A third type of care providing intermittent residential care services, probably oriented to relatively low-levels of disability, is also likely to increase. Older people living in the community at times require additional assistance, including residential care, for short periods, for example, to allow carers to take holidays or temporarily reduce their load. Providing more services such as respite care will allow more older people to stay in, or return to, the community after a period of more intense care. The provision of facilities for respite care is an important element in a strategy aimed at facilitating primary reliance on community care.[43]

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[40] Berkman LF and Glass T (2000). 'Social integration, social networks, social support and health'. In Berkman LF and Kawachi I (Eds.) *Social epidemiology*. New York: Oxford University Press.

Brown G and Harris T (1978). *The social origins of depression*. London: Tavistock.

[41] Golant SM (2002). 'Deciding where to live: The emerging residential settlement patterns of retired Americans'. *Generations*, **26**(2):66-73.

Jones A *et al* (2010) *Service integrated housing for Australians in later life*. Australian Housing and Urban Research Institute. Accessed on 1 October 2010 at: www.ahuri.edu.au/publications/download/20287_fr .

[42] The prevalence of dementia, for example, appears to double every five years after age 65. As a result, if current age-specific dementia rates remain unchanged, the prevalence of dementia will double by 2030. See: Henderson A and Jorm J (1998) *Dementia in Australia*. Aged and Community Services Development and Evaluation Report No. 35. Canberra: Department of Health and Ageing.

[43] Prevention of diseases and disabilities will be crucial in dealing with their increasing incidence. The promotion of good health earlier in life will be essential in preventing or reducing dependency in later years. Particularly helpful strategies include discouraging smoking and the overuse of alcohol and other drugs; prevention of falls; promotion of physical exercise and a healthy diet; dental care and eye health; and stress management.

17. As a result, demand for care is likely to shift from being a continuum that moves from home, into low-level residential care and then (often for only a short time) into high-level residential care, towards a pattern concentrated at the two ends of the spectrum.

18. At the same time, the period over which older people receive low or high-level care is likely to change. In residential care, at all levels of frailty, residents with dementia now remain in care for longer than other residents. In part reflecting the rising incidence of dementia, over the last four years the proportion of discharges from permanent residential care that were in care for at least two years after admission has risen from 38.6 per cent to 40.5 per cent. However, short stays will remain common, and may become more so, both because of the greater prevalence of intermittent care and because many admissions continue to be as a result of acute events. As a result, there is likely to be an even greater bunching at both the relatively short and relatively long ends of the duration spectrum.

4.2 Implications of changes in the availability of informal carers

19. The gap between male and female life expectancy is diminishing. This will translate into a changing male to female ratio in the older population. For the population aged 65 and over, there were 72 males per 100 females in 1984; by 2004, the ratio had increased to 81 males per 100 females. However, the difference in life expectancy for the very old population remains significant, with the ratio for those aged 85 and over being of 47 males per 100 females.

20. Smaller differences in life expectancy between men and women may reduce the demand for formal aged care (and especially residential care) as they translate into fewer years of widowhood – since loss of a family care-giver often precipitates a need for formal care.[44] At the same time, the increased numbers who have never married, or who are divorced or separated, will at least partially offset that increase in supply.[45] Younger cohorts are also having fewer children[46], which among other things, means they will have fewer voluntary carers to draw on when they reach old age. Additionally, the greater scarcity of working age people in the future population will increase the opportunity cost of the choice to engage in

There is also potential for reducing the pressure on the aged care system by the early detection and treatment of potentially long term disorders — such as diabetes, hypertension, osteoporosis, depression, incontinence, Parkinson's disease, Alzheimer's disease, hearing impairment and vision loss. General practitioners and allied health professionals will be key here. Another significant factor in preventing long term disability is rehabilitation after an accident, injury or medical treatment. Adequate rehabilitation is particularly important after incidents that restrict movement, such as hip fractures and strokes.

[44] The impact of differential mortality on demand for long term care is examined in Lakdawalla D and Philipson T (2002) 'The Rise in Old-Age Longevity and the Market for Long-Term Care', *American Economic Review* **92**:295-306; and Lakdawalla D and Schoeni R (2003) 'Is Nursing Home Demand Affected by the Decline in Age Difference Between Spouses?', *Demographic Research* **8**:279-304.

[45] ABS (2007) 'Lifetime marriage and divorce trends.' *Australian Social Trends 2007*. ABS Cat.No.4102.0. Accessed on 1 October 2010 at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/26D94B4C9A4769E6CA25732C00207644?opendocument.

[46] Productivity Commission (2008) *Trends in Aged Care Services: some implications*. Commission Research Paper. Canberra: Productivity Commission. See summary of this trend at page 34.

informal caring, reducing the supply of informal care services. On balance, the supply of informal care is likely to diminish relative to the size of the older population.

21. This will have implication for the delivery of formal care services, as community care often relies upon the presence of a co-resident informal carer.[47] Given that demand for community care is likely to increase strongly, reduced supply of informal carers could impose substantial costs on the community care sector. Already the opportunity cost of informal care, measured as the reduction in paid employment due to caring, is estimated to be about 0.6 per cent of GDP – that is, about 9.9 per cent of the contribution to GDP (gross value added) of formal health care.

22. If their services were no longer available, the cost of replacing the work done by informal carers would be much higher. It has been estimated that if all hours of informal care were replaced with services purchased from formal care providers and provided in the home, the replacement value would be about 3.5 per cent of GDP (that is, about 62.2 per cent of the contribution to GDP of other formal health care). [48]

23. The resulting difficulties will be made all the more acute by the fact that the supply of the formal aged care workforce will also face considerable pressure as the share of the population requiring care increases.[49] In effect, population aging seems likely to create an increased demand for hospital care, with here too, the sheer weight of the numbers moving into the higher age brackets more than offsetting possible reductions in the number of annual hospital bed-days required for each person in each age class.[50] The resulting growth in total hospital bed-days will require a corresponding increase in the medical labour force, forcing the aged care sector to compete for nurses and other specialised labour inputs in a tight labour market

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[47] When assessed by Aged Care Assessment Teams, older people living alone are more likely to be recommended for residential care than those living with a spouse or other informal carer. There is also evidence that older people who have access to informal care can remain living in the community for longer and enter residential care at a higher level of frailty.

See, for example, Lincoln Gerontology Centre (2002) *Aged Care Assessment Program National Minimum Data Set Report, July 2000-June 2001*. Melbourne: La Trobe University.

Projections of the availability of informal care are presented in: AIHW (2004) *Carers in Australia: Assisting frail older people and people with a disability*. Canberra: AIHW ; and National Centre for Social and Economic Modelling (2004) *Who's going to care? Informal care and an ageing population*. Report prepared for Carers Australia. Canberra: University of Canberra.

[48] Access Economics (2005) *The Economic Value of Informal Care*, *op.cit.*

[49] See Stone R and Wiener J (2001) *Who Will Care For Us? Addressing the Long-Term Care Workforce Crisis*. The Urban Institute. Accessed on 1 October 2010 at: http://www.urban.org/publications/310304.html.

[50] While 2005-2050 growth in the number of annual public hospital bed-days is expected to be slightly negative for those under the age of 50, that number is expected to rise by 150 per cent for the population aged 60 and over, and by 320 per cent for the population aged 85 and over. As a result, the share of hospital bed-days accounted for by the population aged 65 and over is projected to increase from 47 per cent in 2005 to 67 per cent in 2050. See Schofield D and Earnest A (2006) 'Demographic change and the future demand for public hospital care in Australia, 2005 to 2050', *Australian Health Review* **30**(4):507-15.

4.3 The future formal care workforce

24. Aged care is necessarily labour intensive and an adequate and well-qualified workforce is fundamental to the delivery of quality aged care. The Department estimates that there are currently more than 305,000 employed in the delivery of aged care services, with 205,750 people employed in the residential care sector and 98,395 people employed in the delivery of community care (see Table 5 below).

Table 5: Aged care workforce – Estimated numbers of employees, by occupation and sector, 2010

Level of worker	Residential care workforce	Community care workforce
Registered nurses	26,355	8,500
Enrolled nurses	19,170	2,000
Personal carers / Community care workers	99,715	68,815
Allied health	11,620	4,415
Non direct care staff	48,890	15,085
Total	**205,750**	**98,395**

25. The aged care sector currently accounts for 2.7 per cent of all employees in Australia. At the occupational level, the sector employs 15.3 per cent of registered nurses, 21.9 per cent of enrolled nurses and 63.9 per cent of personal carers and community care workers.

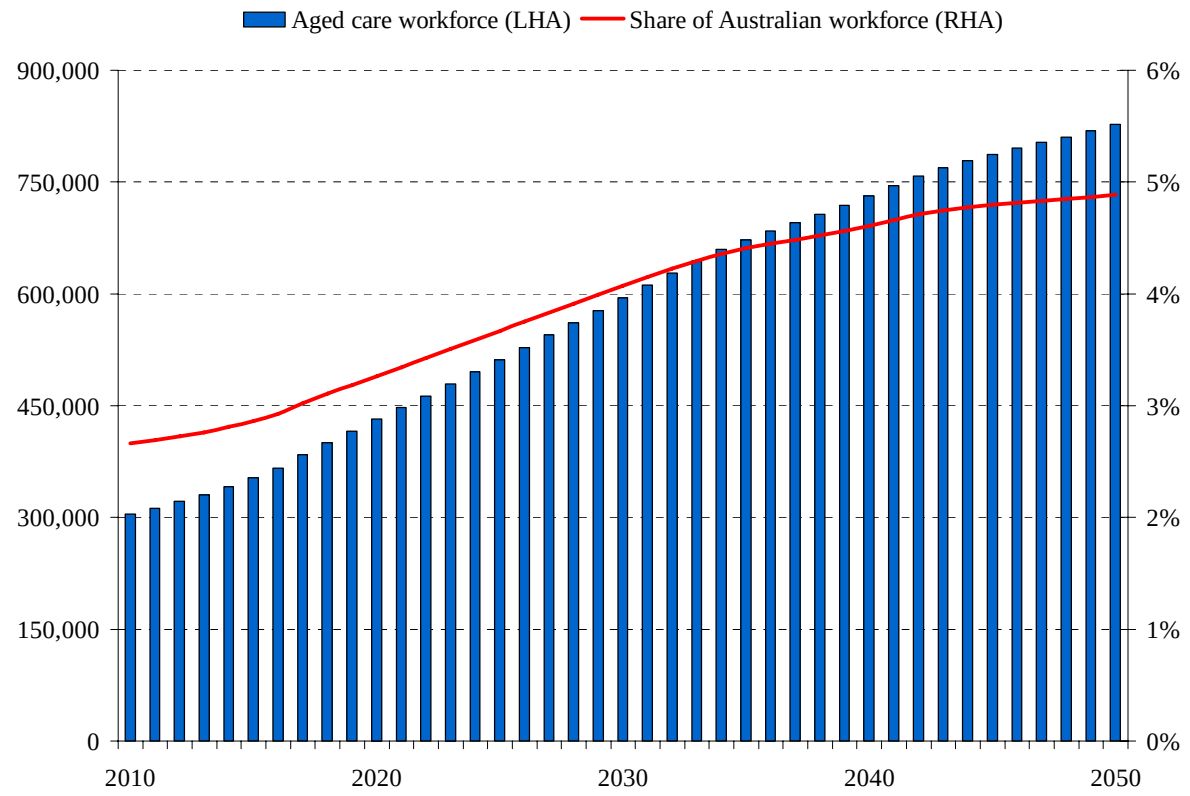
26. Assuming that the ratio of number of aged care workers to the size of the population aged 70 or over remains constant, then by 2050 a total of 827,100 will be engaged in the provision of aged care. Based on the projected workforce participation rates from the *Intergenerational Report 2010*, this implies that by 2050 the aged care sector will account for about 4.9 per cent of all employees in Australia.

27. As Figure 6 indicates, growth in the absolute number of aged care workers can be expected to be strong throughout the next four decades, with an average annual growth rate of 2.5 per cent. Growth will most likely be strongest in the next decade, with an average annual growth rate of 3.6 per cent, and slowest in the fourth decade, with an average annual growth rate of 1.2 per cent. A slightly different pattern is likely to obtain with respect to growth in the proportion of the Australian workforce that is employed in aged care. Over the next four decades this proportion is projected to increase, on average, by 0.06 percentage points per annum. Growth over the next decade will likely be at this long term rate but growth will then tick up in the second decade (2010 to 2020) to an average of about 0.8 percentage points per annum. Between 2020 and 2030, the rate of average growth of the proportion of the workforce employed in aged care is likely to slow to about 0.05 percentage points per annum, declining further to about 0.03 percentage points per annum between 2040 and 2050.

28. The sector's future workforce requirements will, however, not just be determined by demographics. There are a range of factors that can impact on the required number and skills sets of the aged care workforce, including the increasing age and acuity levels of care recipients, and the service models to best meet their needs. This may not only increase the overall size of the workforce required but also change the relative proportions of various

occupations. That is, it may see an increased demand for specialised nursing expertise or behavioural management skills.

Figure 6: Aged care workforce – Estimated size of workforce, 2010 to 2050



4.4 Projected investment requirement

29. Figure 7 illustrates the Department's estimates of the industry's annual investment requirement for each year in the next decade, in terms both of the amount of required investment (in real terms) and the number of places that will need to be built. These estimates are based on several key assumptions, namely that:

a) the current planning policies continue;

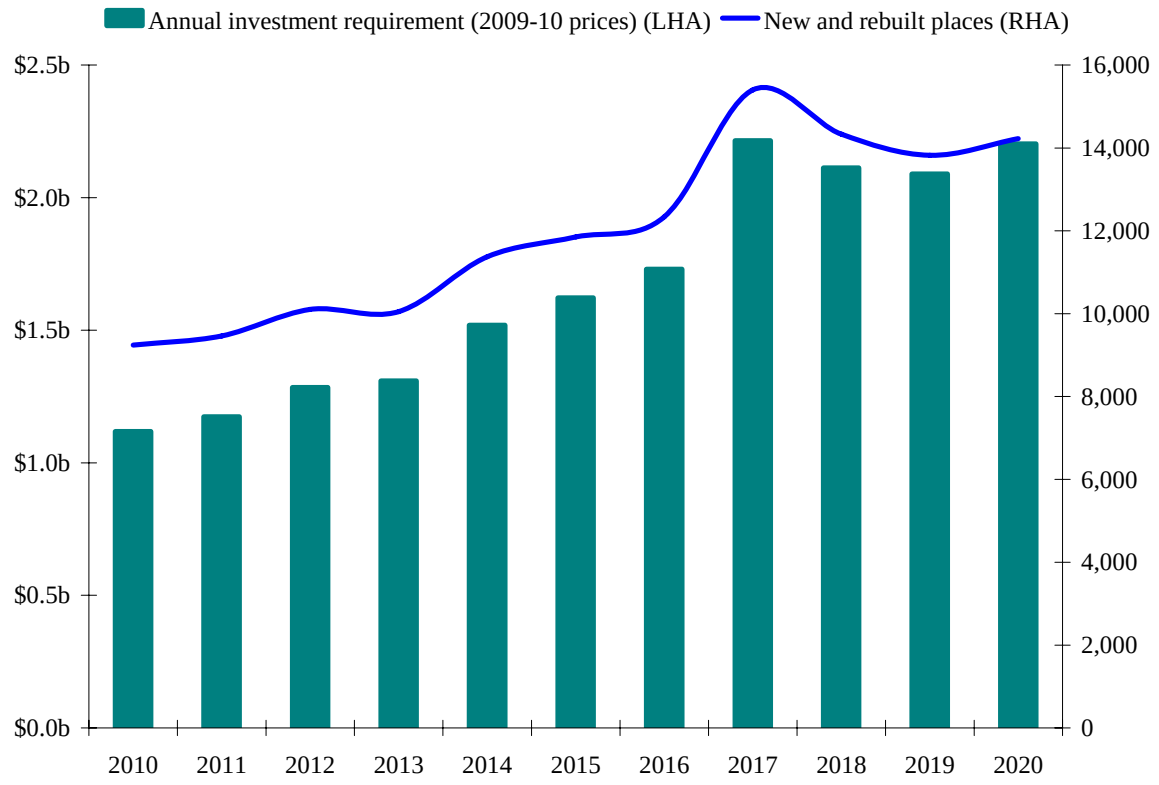
b) the cost of construction continues to grow at about 2.5 per cent real each year[51]; and

c) the average lifetime of an aged care building is about 40 years so that the current stock will need to be replaced over the next four decades.

[51] The Department has derived estimates of the full cost of constructing an aged care home based on the results of the Department's 2007-08 and 2008-09 surveys of aged care homes. In total, 393 construction projects for new or rebuilt aged care homes were reported in these surveys. The median cost of construction of these projects was $173,000 per place.

Trends in aged care construction costs are derived from Rawlinsons (2010) *Australian Construction Handbook*, various editions. Perth: Rawlinsons.

Figure 7: Estimated investment requirement for the residential care industry, 2010 to 2020



30. Based on current policies, the Department estimates that the residential care industry will need to build in the order of 82,500 additional places over the next decade. At the same time, the industry will need to rebuild some of its current stock. Assuming that the cost of construction continues to grow at about its current rate, and that about a quarter of the current stock of building is rebuilt at an even rate over the next decade, the Department estimates that the investment requirement of the industry over that period to be in the order of $17 billion (in 2009-10 prices). This is in line with the level of new investment in the aged care industry in recent years. The Department's estimate is necessarily indicative, but provides a useful insight into the magnitude and likely timing of the industry's investment requirement over the next decade. Over the longer term, even with a significant shift towards community care, population ageing and the need to refresh the industry's capital stock will still require significant new investment in the residential care industry.

5. Discussion

1. As the previous chapter shows, demographic, social and economic pressures will impose a large and continuing adjustment burden on the aged care sector. Over time, responsiveness by the aged care sector to changes in the level, structure and duration of demand will be needed. The total supply of care will need to increase, with large absolute rises being required in the level of provision in each part of the aged care spectrum. At the same time, the structure of supply will need to shift, with larger increases in both community care and high-level care residential care. Supply side adjustments will also be driven by changes in the costs of the different types of aged care.

2. While the absolute scale of service provision will need to increase sharply, the nature and composition of supply will also need to change. Far-reaching innovation in service delivery will be needed if these structural pressures are to be dealt with efficiently and community expectations are to be met. Innovation will affect both the venues in which care services are provided – with forms of congregated, but not institutional, living likely to be important in reconciling the need for care with the baby-boomers demand for independent living – and the manner of service delivery (for example, in terms of the use of IT).

3. Although the aged care sector has proven to be robust in meeting the challenges it has faced in the past, it is increasingly clear that it is not well placed to address the challenges that are currently arising and that will arise over the coming decades. This chapter analyses, at a high level, the strengths and weaknesses of the current regulatory and funding arrangements in the achievement of its objectives. Section 5.1 outlines the development of the current aged care policy framework and highlights some of the tensions inherent in this legacy. Section 5.2 outlines the stresses on the current arrangements and the extent to which those arrangements are robust enough to meet those stresses. The submission concludes with a discussion of some of the key policy issues inherent in any move towards a more consumer centred arrangement for aged care (Section 5.3).

5.1 Legacies

4. The Commonwealth's involvement in the funding of aged care arose at the intersection of pension (and more generally, income support), housing and health care policy. This section traces how the tensions between these three policy areas played out in the ways in which the Commonwealth became (and remains) engaged in funding and regulating the provision of aged care services. The Commonwealth's direct involvement in the capital funding of aged care was essentially a housing initiative and began with the *Aged Persons Homes Act 1954*. Its first direct involvement in the recurrent funding of aged care, *qua* aged care rather than as *quasi* income support, began with the introduction of nursing home benefits in 1963. The growth in that involvement over the last six decades is illustrated in Figures 6 and 7 below. In real terms, expenditure on aged care has grown over the last four decades from 0.2 per cent to 0.9 per cent of GDP. Over the same period, expenditure per person aged 70 years or older has grown (in 2009-10 prices) from $1,000 to $4,500.

Figure 8: Commonwealth expenditure on aged care (2009-10 prices)

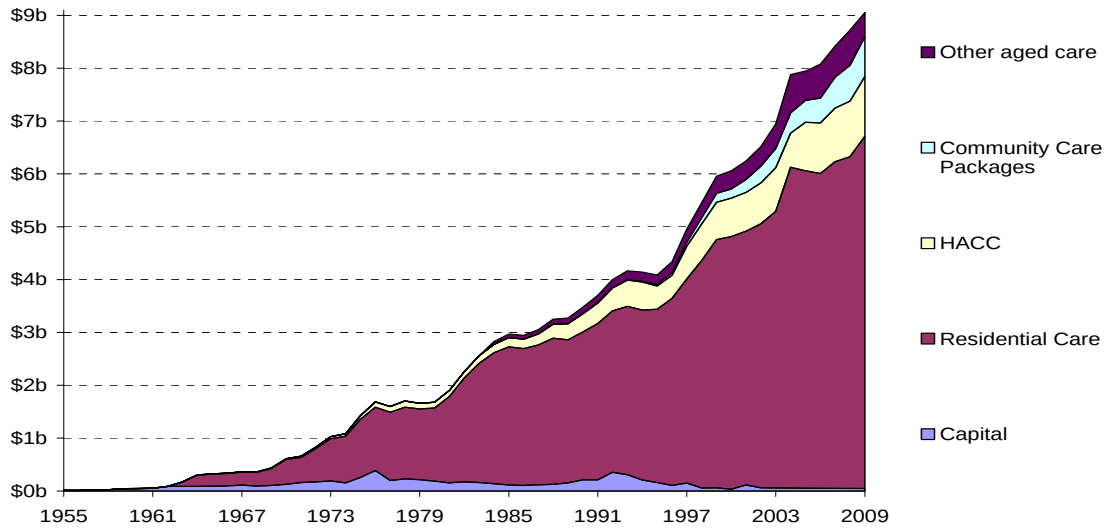
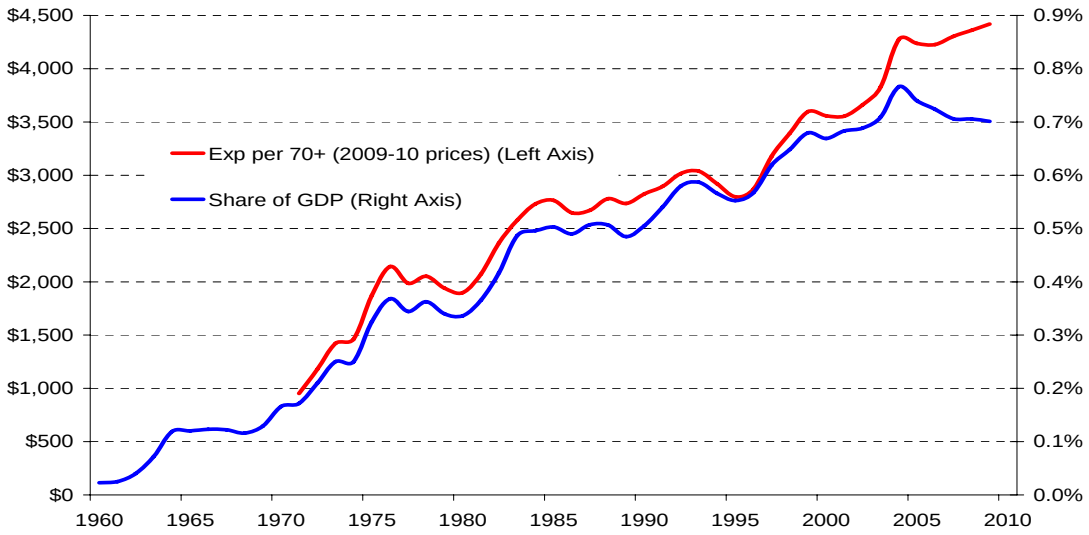


Figure 9: Commonwealth expenditure on aged care, as a share of GDP and per person (2009-10 prices)



5. Initially, the Commonwealth's involvement in aged care was purely as funder, instantiated through the maintenance subsidies paid on behalf of pensioners in Benevolent Asylums from 1909 to 1963. These payments were provided as a substitute for the age pension. Later, as the costs of purchasing aged care outgrew the level of the age pension, the Commonwealth became more directly involved in the funding of aged care, first in terms of housing and later in terms of care, as a cost effective alternative to broad-based increases in the age pension.[52]

[52] On 1 January 1963, the pension was 15 shillings per day and nursing home fees were of the order of 35 shillings a day. Increasing the pension for all older Australians to a level whereby those in nursing homes could have met their fees would have entailed a 133.3 per cent increase in the Commonwealth's expenditure on pensions, which in 1963-64 was £157 million. The introduction of the nursing home benefit therefore represented a saving of around £191 million per year over the alternative strategy of raising all pensions to a level that would have allowed residents to meet their own fees.

6. As well as being the genesis of the Commonwealth's involvement, the income support and housing policy arrangements have also left a significant policy legacy in aged care that contrasts it from most of the health system, namely a strong emphasis on means testing.

7. Aged care's links with the health system, from the Commonwealth's perspective, essentially begin with the introduction of the nursing home benefit in 1963.[53] This policy development was also largely driven by economic considerations, namely the need to the ameliorate some of the unintended consequences of the then public hospital funding arrangements, which were drawing large numbers of chronically ill older people towards the public system where larger benefits were available.[54]

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[53] Prior to 1946 the Commonwealth's engagement with the health needs of its citizens were based on:

- the insurance power – Section 51(xiv) of the Constitution empowered the Commonwealth Parliament to legislate on 'insurance, other then State insurance; also state insurance extending beyond the limits of the State concerned' – see, for example, *National Health and Pensions Act 1938* (No. 25 of 1938); and
- the States Grants Power – see, for example, the *Hospital Benefits Act 1945* under which the Commonwealth paid State hospitals 6 shillings a day (raised to 8 shillings a day in 1948) in respect of any patient occupying a bed in a public ward, in return for which the States agreed to no longer levy charges on such patients.

In 1946, the Chifley Government put a referendum question to the people, carefully phrased to extend the Commonwealth's power only to health and welfare payments made to individuals (or on their behalf). The referendum added the following subsection to the list of matters concerning which the Commonwealth Parliament had power to make laws.

> *The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription), benefits to students and family allowances [s.51(xxiiiA)].*

From 1952, the Commonwealth's hospital benefit payments were extended to approved private hospitals, including approved nursing homes. State hospitals were also allowed to reimpose charges but in general these were covered by the combined Commonwealth and private insurance benefit available to insured patients.

By 1957, the charge for public ward hospitalisation had increased to 36 shillings per day in all States except Queensland where public ward treatment continued to be free. To meet this situation, while conforming to its private insurance principles, the Commonwealth introduced in 1958 a 12 shillings a day additional Commonwealth hospital benefit for contributors who insured for a fund benefit of at least 16 shillings per day. Accordingly, a person insured for a fund benefit of at least 16 shillings a day received, together with the Commonwealth ordinary and additional benefits amounting to 20 shillings a day, a total benefit of 36 shillings a day. This generally covered the public ward charges throughout the Commonwealth. In 1959, three quarters of contributors were qualified for the higher level of Commonwealth additional benefit by virtue of paying contributions that entitled them to a fund benefit of at least 16 shillings a day.

[54] One of the difficulties of any insurance scheme is the treatment of 'bad risks' – in the case of health insurance, the chronically ill. Insurance organisations sought to exclude such bad risks through their rules. They did this directly through pre-existing ailment and chronic illness exclusions and indirectly through the imposition of maximum benefit levels. The end result of the arrangements was that, because the Commonwealth's additional hospital benefit was only available to insured patients:

> *People who [suffered] from chronic illness [were] compelled to join a Medical Benefit Fund in order to be eligible for government subsidy, but they [could not] collect benefit from the fund.* (Australia. Parliament. Senate. Parliamentary Debates. 1954, p.35.)

The inability of some older people to collect benefits from their insurance organisations was addressed by the Commonwealth paying higher hospital benefits in respect of uninsured members of the Pensioner Medical Service. However, this arrangement did not apply to approved nursing homes, which tended to draw older people needing nursing home care into the public hospital system.

8. Like the linkages to the pension system, the linkages with the health system have also left policy legacies within the aged care system. In particular, an emphasis on universality of access, tempered by quantity rationing (enforced through the restrictions on the number of places). However, counterbalancing the principle of universal access to taxpayer subsidised health care has always been the need to ensure that the cost of care should also be affordable to the taxpayer. One common health strategy in this regard has been to make access to assistance subject to a clinical necessity requirement, which policy legacy is reflected in aged care's gate-keeping role for Aged Care Assessment Teams.

9. Concomitant on the Commonwealth's acceptance of the role of funding nursing homes came the need to ensure that taxpayers were receiving value for money and that funds were being directed towards those most in need. These considerations saw a series of ad hoc reforms over the first twenty years of the Commonwealth's direct involvement (to the early 1980s). These included the establishment in 1969 of different funding arrangements for hostels, which were designed to enable frail older people who might otherwise enter nursing homes to continue to live in more homelike conditions, at a lower cost to both themselves and the Commonwealth.

10. They also included the introduction of the Domiciliary Nursing Care Benefit in 1972, which was aimed at providing incentives for people to care for their older relatives at home and the beginnings of the Commonwealth's involvement in the delivery of community care through the *Home Nursing Subsidy Act 1957,* the *States Grants (Home Care) Act 1969,* the *States Grants (Paramedical Services) Act 1969,* and the *Delivered Meals Subsidy Act 1970.*

11. By the mid-1980s a number of problems had been identified with the aged care arrangements. These included access, targeting to need, quality, affordability and sustainability issues. Many care recipients faced difficulties in accessing nursing home care, partly because of an uneven geographic distribution of nursing homes and hostels, and partly because of an over-emphasis on nursing care compared to personal care and inappropriate and undesirable admissions to nursing homes. There was also growing concern at the inadequate quality of care in nursing homes and hostels. This included criticism of the lack of focus on user rights and concern over the level of the fees that individuals were sometimes asked to pay. Finally the rapidly increasing costs to the Commonwealth were also a cause of concern.[55]

12. In the decade beginning 1985, the Commonwealth acted to address these issues – in particular, to contain the growth in high-level care residential places and to shift the balance of care, through benchmarking residential care provision and by funding a large expansion in

[55] Australia, House of Representatives, Standing Committee on Expenditure (1982) *In a home or at home: accommodation and home care for the aged.* Parliamentary Paper 283/1982. Canberra: Government Printer.

Australia, House of Representatives, Standing Committee on Expenditure (1984) *In a home or at home: accommodation and home care for the aged: follow-up report.* Parliamentary Paper 292/1984. Canberra: Government Printer.

Australia, Senate. Select Committee on Private Hospitals and Nursing Homes (1985) *Private nursing homes in Australia: their conduct, administration and ownership.* Parliamentary Paper 159/1985. Canberra: Government Printer.

low-level residential care and community care.[56] The Hawke Government introduced needs-based planning arrangements for residential care to ensure an appropriate balance of services, including services in residential care for people with lower levels of need, and to directly link the planning of care to the numbers of older people in a region. The planning ratios sought to ensure a fairly even distribution of services, across Australia within an overall national limit of 100 subsidised operational places for every 1000 people aged at least seventy ('the provision ratio'), made up of 40 high-level residential care places and 60 low-level residential care places (the 'balance of care ratio').

13. The reforms also improved accountability and targeting by establishing the Aged Care Assessment Program to approve people for different forms of residential and community care based on their care needs, thereby better targeting funding for care and ensuring that different forms of care are delivered based on levels of client need.

14. An important aspect of the aged care reform strategy was its emphasis on quality of care and quality of life. Specific outcome standards and quality of care requirements were introduced for nursing homes together with a process to monitor the quality of care and quality of life in individual nursing homes, with the power to impose penalties on homes not meeting specified standards. The standards monitoring process concentrated on quality of life issues, with its role in monitoring the quality of care being complemented by providing homes with earmarked funding for nursing and personal care staff, and requiring that this funding be returned if not used. Until 1988, the funding provided by the Commonwealth for nursing home staff varied considerably between States and between charitable sector homes and homes operated by private enterprise. It also varied considerably between individual homes for historical reasons. Quality therefore varied in the same way. The first aged care reform strategy addressed this issue by introducing a standard funding system that funded the same number of hours of care for all residents of the same level of frailty. Standards monitoring was introduced for hostels in 1991. A 1993 review of the standards monitoring process concluded that the standards monitoring program had improved the quality of life for Australian nursing home residents, and stood a better chance than systems in other countries of securing substantial improvements in the quality of nursing home life.

15. There was also an increased emphasis on protecting and promoting the rights of elderly people who lived in nursing homes and hostels. Initiatives that were implemented included the integration of the User Rights philosophy into the program, including:

a) increased information to residents and relatives on their rights and care choices;

b) development of Charters of Residents' Rights and Responsibilities for nursing homes and hostels and Agreements between Residents and Proprietors to protect the rights and responsibilities of residents in nursing homes and hostels;

c) phased introduction of advocacy mechanisms;

[56] Australia, Department of Community Services and Health (1986) *Review of Nursing Homes and Hostels*. Canberra: Australian Government Publishing Service.

d) phased introduction of a Community Visitors Scheme to help provide nursing homes residents with companionship and contact with the community; and

e) establishment of aged consumer forums.

16. The reforms of the mid-1980s also expanded the range and availability of community care services, while at the same time substantially improving its coordination and integration. The community care programs delivering different service types and funded through four separate pieces of legislation were amalgamated into a single Home and Community Care program, jointly funded with the states and territories, to provide an integrated and comprehensive range of services. Under the new arrangements service providers could be funded to deliver a variety of services with more flexibility to meet individual needs. Amalgamation also improve planning, as the then Minister for Community Services, Senator the Hon DJ Grimes, said in his second reading speech:

> The Home and Community Care Program signals a new approach to the planning of community services in Australia, an approach which will hold out the possibility of achieving a more caring and equitable society. Services which are appropriately planned, distributed and financed provide an essential complement to other social policies in achieving social equity and needed support to ensure that our society functions properly (Hansard, 14 November 1985).

17. The basic structure of Australia's aged care system has been in place since 1985, with a continuing emphasis on access, affordability, targeting and quality. The system operates at four tiers, each intended to delay progress towards more intensive and expensive care:

a) support for carers, through subsidised respite care and financial support;

b) low intensity levels of support (for example, meals on wheels, domestic assistance, home nursing and respite care), generally delivered in the care recipient's own home as individual and often uncoordinated interventions;

c) low-level (coordinated) care, which provides more intense and coordinated assistance with activities of daily living, generally provided in an institutional setting, but similar levels of care are delivered in the community as a package of care, usually involving case management; and

d) high-level (coordinated) care, which provides nursing care or intensive non-nursing assistance (for example, for people with severe dementia) as well as low-level care, generally provided in an institutional setting, but again similar levels of care are delivered in the community through packaged care.

18. In general, the provision of low-level and high-level care is more heavily regulated and again the key features of that regulation have been in place, with minor changes, since 1985. Low-level and high-level care services are funded through subsidies paid directly to aged care providers on behalf of care recipients, and a provider can only receive a subsidy in respect of a care recipient if four conditions are met:

a) the care recipient must be an *approved care recipient* for the type of care (residential or community, high-level or low-level, respite or permanent) they are receiving; this approval is granted by independent Aged Care Assessment Teams;

b) their care must be provided by an *approved provider*, with this approval granted by the Department based on the provider's experience in the provision of aged care as well as its corporate governance;

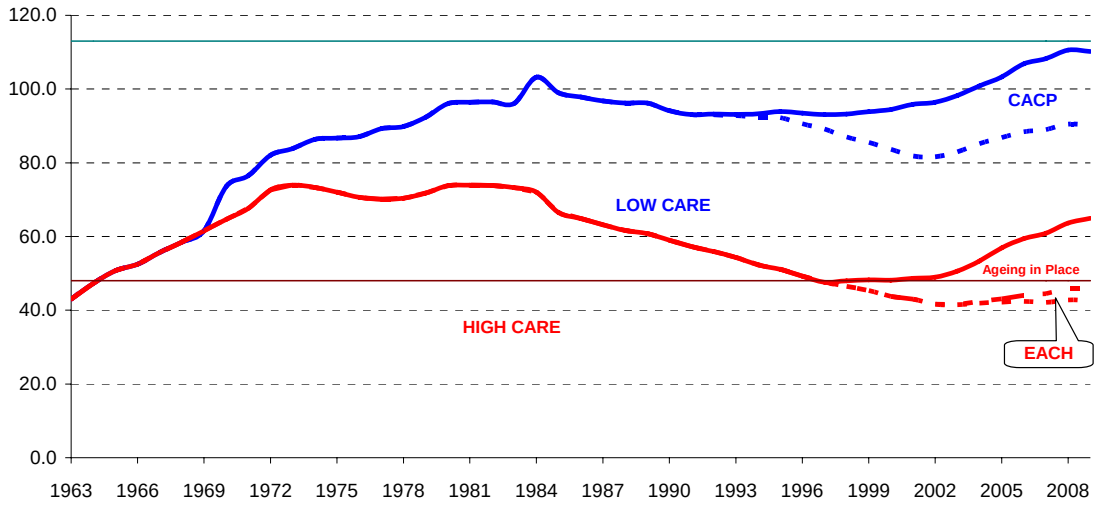
c) care must be provided in an *allocated place*, where the number and distribution of places is governed by the 'needs based planning arrangements' which seek to equitably distribute places subject to an overall national limit of subsidised operational places of 113 for every 1,000 people aged at least 70, with a target balance of care of 44 high-level and 44 low-level residential care places, and 4 high-level and 21 low-level community care packages; places are allocated through an annual (non price based) competitive tender like arrangement; and

d) care must also be of a *specified quality* (for example, accreditation and certification in residential care, and quality reporting community care packages).

19. The range of care options has been expanded significantly in the 25 years since 1985, beginning with community care packages to offer low-level care at home, the development of carer policy and respite care to better support the carers of the frail elderly and disabled in their own homes (the National Respite for Carers Program), and more recently the development of high-level care at home through the EACH and EACHD programs.

20. This period of innovation has responded very considerably to emerging client needs and preferences, and especially the desire of older people to remain living in the community for as long as possible. The impacts of these changes for the balance in the delivery of low-level and high-level care, and for community and residential care, are illustrated in Figure 8 below.

Figure 10: Size of the subsidised (intensive) aged care sector (places per 1,000 people aged 70 or older)



21. Despite these achievements, there is still considerable overlap in the services available for frail older people through Commonwealth funded community care packages and the HACC program, which have different access points and different assessment arrangements. There is also a lack of clarity about when it is appropriate for people to move between programs and when it is appropriate for care recipients to access more than one program. In the case of

respite care, the overlap between the HACC program, the NRCP and the Commonwealth's residential care program result in a lack of clarity for carers and a significant administrative program burden on providers of respite services. The implications of these issues are discussed further in the next section.

5.2 Stresses

22. Over the last quarter of a century the aged care sector has also adapted itself to significant changes in its environment. In particular, deinstitutionalisation in the mental health sector saw a significant burden placed on the aged care sector to increase its capacity to deliver psycho-geriatric care. Similarly, the move in the hospital sector towards earlier discharge from acute care and less emphasis on medical admissions and sub-acute care required the aged care sector to increase its capacity to deal with significantly frailer older people than those for which it had previously cared.

23. Although the aged care sector has proved robust in meeting the challenges it has faced in the past, it is increasingly clear that it is not well placed to address the challenges that are currently arising and that will arise over the coming decades. In short, demographic, social and economic pressures will impose a large and continuing adjustment burden on the aged care sector, with developments in other areas of social policy (health, housing and retirement incomes) continuing to impact upon the aged care sector. While the absolute scale of service provision will need to increase sharply, the nature and composition of supply will also need to change. Far-reaching innovation will be required if community expectations are to be met. It is unclear that current business models can respond appropriately to this need.

Accessibility, including equity of access

24. The needs based planning arrangements for services provided under the *Aged Care Act 1997*, including the planning and balance of care ratios and the allocation framework, ensure that these services are reasonably geographically distributed. They also address access inequities faced by disadvantaged groups, including economically disadvantaged, Indigenous, rural and culturally and linguistically diverse populations. This is done, for example, through conditions of allocation that require service providers to meets the needs of specified communities; accommodation supplements for those without the means to meet their own accommodation costs; and the viability supplement to address the additional costs of delivering aged care services in rural and remote areas and to Indigenous communities. The Act's fee controls and means testing arrangements also help ensure that access to these services is affordable for all.

25. On the other hand, the planning of services offered through HACC, NRCP, VHC and similar programs does not always take into account the availability of services from other programs. This can result in a maldistribution of services that can affect equity of access. Other inequities arise because of the variety of ways in which clients can enter the (low intensity) community care system. For example, in HACC and NRCP clients themselves approach specific service providers and these providers determine if a client is eligible for any of the programs that they are funded to deliver and assess the client' s need for the specific

service. Eligibility criteria may not be the same for each of the services, depending on the funded arrangements. The fee structures of community care programs are also not consistent.

26. For example, the Commonwealth currently subsidises the provision of respite care for carers through the National Respite for Carers Program, the Home and Community Care program, the Veterans' Home Care program and the Residential Care program (see Table 6).[57]

Table 6: Commonwealth support for the provision of respite care, 2008-09

Program	Number of clients	Total respite care provided	Average support per annum	
			(duration)	(cost)
NRCP	115,591	4.7 million hours	40 hours	$1,520
HACC (2007-08 data)	31,787	2.7 million hours	86 hours	na
Veterans' Home Care	11,774	1.4 million hours	116 hours	$1,890
Residential Respite	42,357	1.3 million days	30 days	$3,480

27. There are arguably structural and allocative inefficiencies in the current arrangements for supporting respite care. For example, the different Commonwealth respite programs are subject to differing planning and quality assurance arrangements and operate under different subsidy and fee arrangements. As a result, it can happen that carers supported by different programs may receive different levels of support and their contribution levels may vary, even when they have the same means. However, the variation in approaches taken by the different programs also offers choice to carers and provides flexibility to meet individual needs.

28. There are also variations within programs. For example, the average number of hours of respite care received through the Home and Community Care program varies considerably by jurisdiction, from 67.1 hours per year in Queensland to 117.2 hours per year in Tasmania.

29. With respect to the NRCP, as the Australian National Audit Office has observed:

> The National Respite for Carers Program is not the direct result of one single policy decision, but rather is the umbrella title for many disparate programs arising from successive government policy and funding initiatives to support carers in the community. These policy announcements generally specify target groups for funding, with resulting policy specific objective(s).[58]

30. As a result the situation can arise that a client of a respite provider may seek additional respite from their provider, but the provider is unable to meet this need even though they have spare capacity, because that spare capacity is related to a separate funding initiative with a different target group. This is clearly suboptimal for both the client, who cannot access the respite they need, and the provider, who is required to return the funding for the unused respite to the Commonwealth while meeting the fixed costs of operating their service.

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[57] In some cases, carers may access multiple programs for support, and may even access support from multiple agencies within a given program. It is therefore not possible to determine the total number of people assisted with respite care or the number of hours used by a carer from all programs.

[58] Australian National Audit Office (ANAO) (2005) *Helping Carers: the National Respite for Carers Program.* ANAO Audit Report No.58 2004–05. Canberra: ANAO. Accessed on 25 June 2010 at http://www.anao.gov.au/uploads/documents/2004-05_Audit_Report_58.pdf.

Assessment and allocative efficiency

31. There are also significant issues of allocative efficiency in the current arrangements. For example, in (low intensity) community care, clients can face multiple and inconsistent assessment processes as they are referred to different organisations depending on their care requirements. In addition, service specific assessments may not be designed to identify other issues that the client (and their carer) may be experiencing therefore reducing the chances for appropriate and timely referrals within the system.

32. This failure to assess client needs holistically can both positively and negatively induce allocative inefficiency. For example, there is good evidence that the provision of a small number of HACC services to a larger number of clients provides more value for money than the provision of a larger number of HACC services to a smaller number of clients.[59] However, the interests of providers do not necessarily align with the allocatively efficient solution, as they may well prefer to deal with a smaller number of clients, especially when those clients do have unmet needs. On the other hand, clients sometimes receive a level of HACC services which is insufficient to prevent their condition from deteriorating. From the point of view of pure allocative efficiency it might be preferable to deny these clients any HACC services, however this judgement cannot be made by an individual HACC provider as they cannot judge what other services the client is, or may, receive.

33. Inequities and structural and allocative inefficiencies also arise in the current arrangements for supporting the provision of low intensity services because of the myriad of programs supporting the delivery of these services. Even within the Home and Community Care program, there is a lack of consistency between states and territories with respect to assessment, eligibility, planning, quality assurance and user contributions.

34. There are also overlaps between the Home and Community Care program and several Commonwealth programs. At the low intensity level, there is considerable overlap with the Commonwealth's Day Therapy Centres, which provide a range of therapies including occupational therapy, physiotherapy, hydrotherapy, speech therapy, podiatry, diversional therapy, social work and nursing services. At the level of high-level and low-level coordinated care there is overlap and dissonance with the Commonwealth's community care packages. For example, care recipients can access levels of care equivalent to a Community Aged Care Package through the Home and Community Care program without their care needs being fully assessed by an Aged Care Assessment Team.

35. There is also considerable dissonance between the approach taken to fees and means testing in the Home and Community Care program and in the Commonwealth's packaged community care and residential care programs.

36. Another area of allocative inefficiency in with respect of continuity of care. Current arrangements within aged care, both care funded under the *Aged Care Act 1997* and care provided through low intensity interventions in the community, do not enable efficient and

[59] Howe, A and Gray, L (1999) *Targeting in the Home and Community Care Program,* Aged and Community Care Services Development and Evaluation Report No.37. Canberra: Department of Health and Aged Care.

seamless transitions between care sectors or between services within a care sector, including enabling information and data to accompany the care recipient. This can result in repetition or omission. Similar issues arise at the interface of the aged care system with the acute, sub acute and primary care sectors. For example, discharge plans are not always provided for care recipients leaving hospital and entering an aged care home, and where they are they are provided in paper form and do not include the wealth of diagnostic information that may have been collected during the hospital episode.

37. The funding arrangements for community care packages are particularly inflexible with respect to continuity of care. Unlike residential care, where residents are assessed against a the Aged Care Funding Instrument and receive subsidies at different levels according to their assessed care needs, the three community care package programs each offer only one subsidy level. As a result, clients whose care needs increase may be discharged from one provider (of CACPs, say) and seek a place with another provider (of EACH packages, say).

38. A final issue with respect to allocative efficiency is that the distribution of emphasis between community and residential care, between treatment and prevention, and between early intervention and ongoing care are currently determined largely by the history of program development rather than on the basis of evidence. There is a general consensus that prevention involves low levels of investment for significant impacts. At the next level, early intervention aims to maintain the health and wellbeing of older people who are at risk of developing long-term needs, by helping them to maintain their independence. In the United Kingdom, recent evaluations have demonstrated that early interventions have helped people to maintain their independence and delivered measurable savings through reduced health care needs.[60] Studies have also shown that early intervention in cases of dementia can improve quality of life and cut the need for residential and nursing care.[61]

39. Overseas studies have also shown a positive relationship between receiving community services and delay/avoidance of residential care admissions.[62] They have also shown that the earlier that older people receive community care services the longer their admission to residential care can be delayed.[63]

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[60] United Kingdom, Department of Health (2010) *National Evaluation of Partnerships for Older People Projects: final report*. Accessed on 1 October 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111240

[61] United Kingdom, Department of Health (2009) *National Dementia Strategy*. London: Department of Health.

[62] Elkan R, *et al.* (2001) 'Effectiveness of home based support for older people: systematic review and meta-analysis.' *British Medical Journal* 323:1–8.

Gaugler JE, *et al.* (2005) 'Early community-based service utilization and its effects on institutionalization in dementia caregiving.' *The Gerontologist* **45**(2):177–85.

Long SK, *et al.* (2005) 'Getting by in the community: lessons from frail elders,' *Journal of Aging and Social Policy* **17**(1):19–44.

[63] Desai MM, *et al.* (2001) 'Unmet needs for personal assistance with activities of daily living among older adults.' *The Gerontologist* **41**(1):82–8.

Gaugler JE, *et al.* (2005) 'Unmet care needs and key outcomes in dementia.' *Journal of American Geriatrics Society* **53**(12):2098–105.

Lack of competitive pressure for efficiency

40. The need for supply side adjustments will bring into stark relief the policy tensions inherent in the current planning (rationing) arrangements, which are already becoming more apparent. Fundamentally, the planning ratios help manage the Commonwealth's fiscal risk. However, they create an artificial scarcity that limits the scope for competition, blunts pressures for efficiency and innovation and deprives consumers of choice. This, in turn, means that suppliers face little threat of displacement and limited competitive pressure to be efficient, although the regulatory constraints placed on provider's incomes do provide some incentives to achieve efficiencies. Market power is intensified locally because consumers seeking a place, especially in high-level care, often doing so at a time of emergency, and usually have strong preferences as to the location of the facility. These features further increases the market power arising from rationing, and add to the blunting of pressures for efficiency.

41. The result is an industry structure which, while it does secure some important policy objectives (such as geographic equity of access), does not make the most efficient use of scarce resources. The consequence is persistent technical inefficiency.

42. The Review of Pricing Arrangements in Residential Aged Care estimated that in 2001-02, the average technical inefficiency of the residential care industry, measured in terms of the difference between average practice and the technical efficiency frontier, was 17 per cent. It appears that the level of inefficiency in the industry has not diminished since then.

43. An analysis of trends in the level of efficiency in the residential care sector shows that the average rate of efficiency across the residential care industry, which had remained reasonably constant between 2001-02 and 2004-05, fell after the introduction of the Conditional Adjustment Payment – from 64.1 per cent in 2004-05 to 60.2 per cent in 2006-07 – and has remained at the same level in 2008-09 (see Table 7).

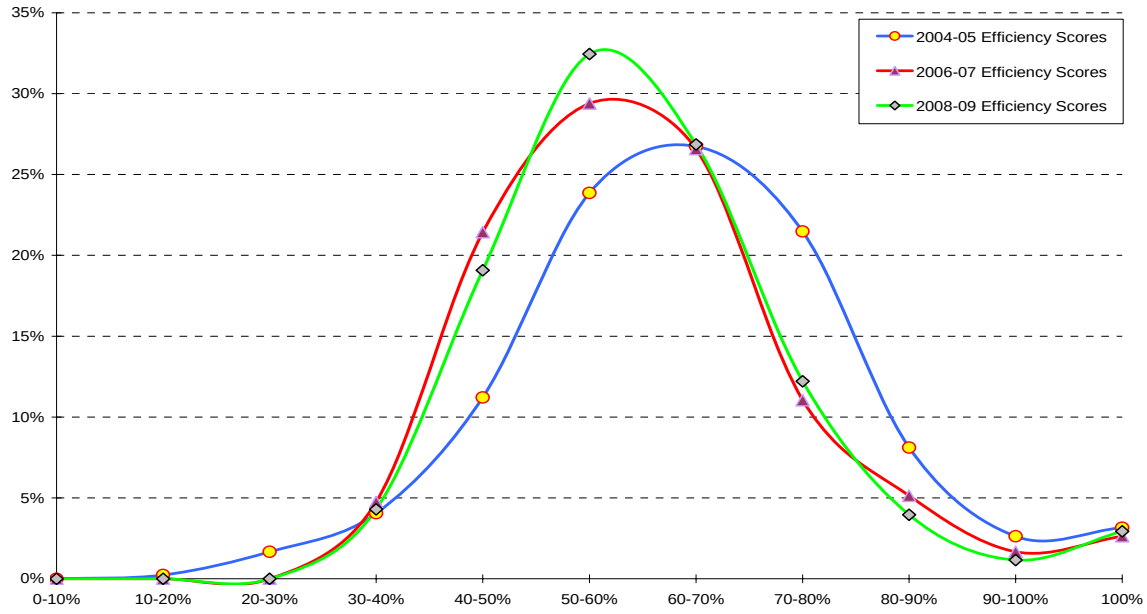
Table 7: Results of DEA efficiency analysis using constant returns to scale, 2001-02 to 2008-09

	2001-02	2004-05	2006-07	2008-09
Average technical inefficiency	65%	64.2%	60.2%	60.2%
Standard deviation	16%	15.1%	14.2%	13.5%
Distributional statistics				
95th percentile		91.2%	87.9%	86.0%
75th percentile		73.4%	67.8%	67.3%
Median efficiency score	64%	63.9%	58.9%	59.0%
25th percentile		54.7%	49.8%	50.9%
5th percentile		38.5%	40.0%	40.5%
1st percentile		26.2%	34.8%	36.2%
Minimum		14.6%	31.9%	34.0%

Stuck AE, *et al.* (2000) 'A randomized trial of in-home visits for disability prevention in community-dwelling older people at low and high risk for nursing home admission.' *Archives of Internal Medicine* **160**(7):977–86.

44. This trend in efficiency is illustrated in **Error! Not a valid bookmark self-reference.** which shows that the distribution of efficiency scores shifted markedly to the left between 2004-05 and 2006-07 and subsequently remained persistent with the efficient providers retaining their median course in 2008-09.

Figure 11: Distribution of efficiency throughout the industry

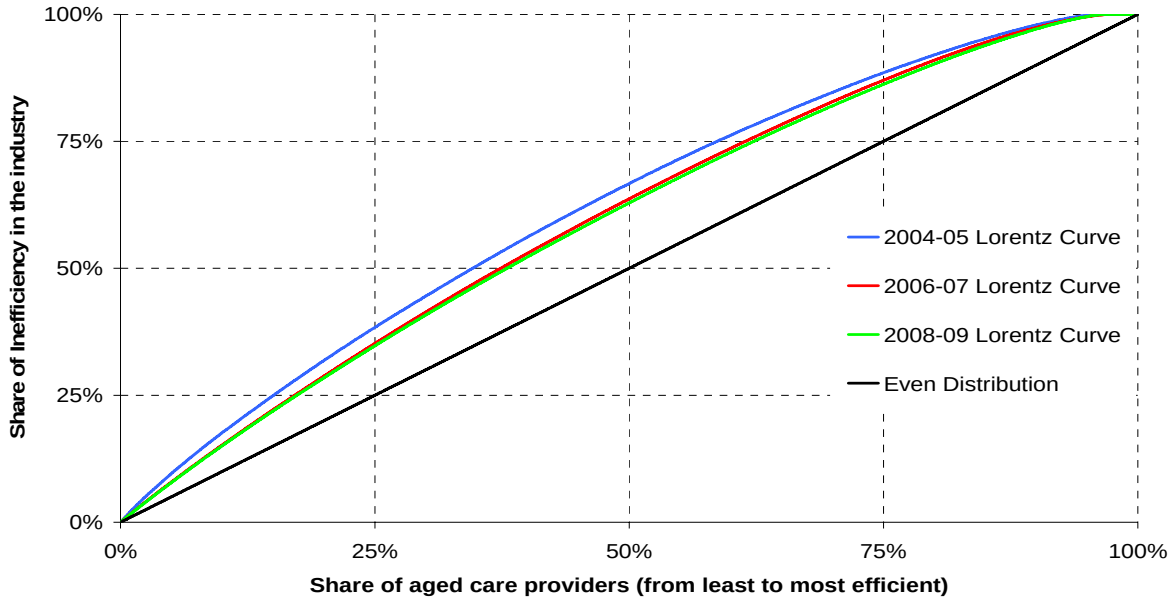


45. In addition, inefficiency became more widely spread throughout the industry between 2004-05 and 2006-07. As Figure 12 indicates, the worst performing 50 per cent of providers in 2004-05 accounted for 66.7 per cent of the inefficiency in the industry, while in 2006-07 and 2008-09 they accounted for 63.7 per cent and 63.0 per cent, respectively, of the inefficiency in the industry. At the other end of the scale, in 2004-05, the best performing 25 per cent of providers accounted for 11.5 per cent of the inefficiency in the industry. By 2006-07 this share had grown to 12.9 per cent and further grew to 13.7 per cent by 2008-09.

46. This increase in the dispersion of inefficiency can be seen by examining the Gini coefficient of the distribution of efficiency scores.[64] Figure 12 illustrates a slight decrease in the Gini coefficient of inefficiency distribution, from 0.134 to 0.130, between 2004-05 and 2006-07 with a further decrease to 0.123 between 2006-07 and 2008-09.

[64] The Gini coefficient is a measure of statistical dispersion. A low Gini coefficient indicates more equal distribution of efficiency, while a high Gini coefficient indicates more unequal distribution. 0 corresponds to perfect equality (each provider having exactly the same level of efficiency) and 1 corresponds to perfect inequality (where one provider has all the inefficiency).

Figure 12: Distribution of efficiency throughout the industry (Gini coefficient)



47. Over the next four decades, the residential care industry will require significant additional investment to replace the existing stock of aged care buildings and to construct new buildings for the expanding aged care population. Currently aged care is seen as relatively low risk investment, and hence investors require a relatively low return in their investment given the security offered by the needs based planning arrangements (limited competition) and the guarantees associated with a government income stream. Reform to improve the efficiency of the industry through greater competition would increase the risk of the industry and hence the required rate of return. It will be important to ensure that the gains to efficiency from greater competition are at least sufficient to meet these additional costs.

Implications for choice

48. As well as blunting incentives for efficiency, consumers' limited ability to exercise choice means that some form of price control is needed to prevent the abuse of localised market power. Reflecting this, most of the prices that can be charged by care providers are regulated. As with all forms of price control, there is a risk of allocative inefficiency, as the limited number of places may not be allocated to those who value them most highly. Additionally, there is a longer-term risk that prices will not be allowed to reach levels that cover efficient costs, compromising the incentives to invest, at least in those locations with high costs of service. The inefficiency created by the rationing of places may then be accentuated by distortions to the pattern of investment, with places ultimately not being available when and where they are needed. The fact that the regulated prices are largely geographically uniform, despite some variations in costs, makes the risk of inefficiencies all the greater. There is also the risk that the Commonwealth (as principal funder) may be paying above the level needed to cover efficient costs in some areas.

49. In short, the current policies, while likely relatively effective in providing for equitable access to aged care services, achieve that goal through a complex tangle of quantitative restrictions that impedes supply flexibility and limits competition. The lack of

competition and the desire to limit the Commonwealth's fiscal exposure, then give rise to price controls, that though extensive are of very differing degrees of effectiveness. Consumers face restricted (and distorted) choices in terms of the range of care available, and charges that are often difficult to understand as a result of the interaction of complex prices with even more complex income and assets tests.

Outdated business models

50. Current business models in residential aged care are, in the main, premised on the delivery a significant amount of low-level care, allowing access to inexpensive capital financing through accommodation bonds, and high occupancy levels. Neither of these premises is likely to maintained in the future. The expansion of community care packages, in line with community expectations, is acting to ensure that older people delay their entry to residential care until they require high-level care. It is also acting to lower occupancy rates so that providers are needing to learn to operate with greater uncertainty.

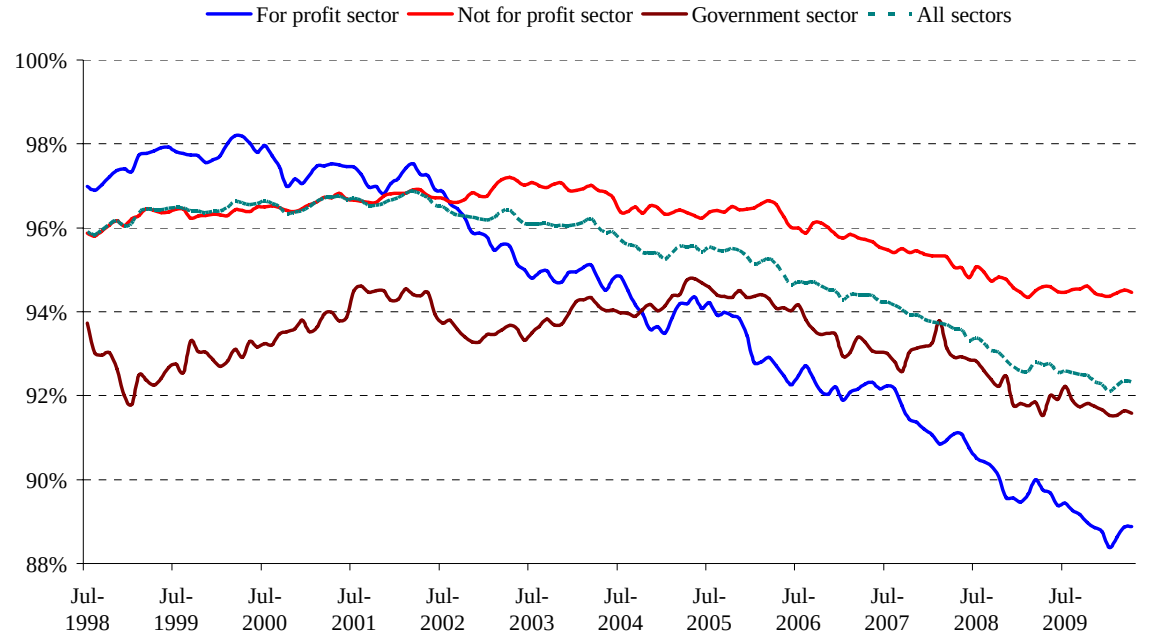
51. The average level of occupancy for aged care homes has been declining since March 2002. Over the last eight years it has declined from 96.9 per cent to 92.3 per cent.

52. The decline in occupancy rates has not been uniform across sectors. It has been most dramatic in the for-profit sector, with an average decline in occupancy of 1.0 percentage points per year. Currently, the average occupancy rate in the for-profit sector is 88.9 per cent. By contrast, the average occupancy rate in the not-for-profit sector is 94.5 per cent – some 5.6 percentage points higher than in the for-profit sector. Average occupancy rates in the government sector have been above those in the for-profit sector since October 2004.

53. However, although there has been a decline in occupancy rates, on average, this does not seem to have affected all services. It is still the case that two in five aged care homes are operating with occupancy rates above 98 per cent and, indeed, one in ten aged care homes are operating with an occupancy rate above 99.8 per cent. At the other end of the scale, the proportion of aged care homes operating with occupancy rates below 85 per cent has increased by only 2.9 percentage points in the last 12 years – from 10.4 per cent in June 1998 to 13.4 per cent in December 2009.

54. These challenges also represent opportunities for innovation. For example, there are increasing opportunities for providers to utilise their unused capacity in the delivery of related health services – such as medical admissions or respite care.

Figure 13: Average occupancy rate, monthly, by sector, July 1998 to April 2010



The changing economics of community care

55. The planning ratios, which initially applied to residential care but now also apply to packaged community care, have also been altered by a series of reforms, especially over the last decade. Currently, the overall national limit of subsidised operational places is 113 for every 1000 people aged at least seventy, with a target balance of care of 44 high-level residential care places, 44 low-level residential care place, 21 low-level community care packages and 4 high-level community care packages. These revisions to the planning ratios have not been evidence based. In particular, it is unclear that the significant increase in emphasis that has been placed on community care will continue to be economically feasible given the longer term pressures discussed above.

56. Care recipients tend move along the notional care continuum as their ability to cope with the activities of daily living diminishes, from limited interventions to low-level care and then (often for a short period of time) to high-level care. In the past, this progression usually involved a change in the location of care when the care recipient moves from low intensity interventions (in their own home) to low-level care (in an aged care home).

57. This usual progression reflected the underlying economics of care provision. Low intensity interventions in the community allow care recipients to retain the comfort of their own home, but impose transport costs on non co-resident carers and forego scale and scope economies in the supply of care. In contrast, residential care secures economies in specialised infrastructure (including accommodation that is purpose designed in terms of mobility and safety) and in the use of specialised resources (such as nursing staff), but at the cost of standardised accommodation arrangements and loss of close contact with the external community. As higher levels of disability require ever more use of the specialised inputs, relative to more general inputs such as conventional accommodation, it is generally cost effective to provide the more intense levels of care in a specialised residential environment.

58. Notwithstanding these economic considerations there has been a move towards the provision of low-level care, and more recently high-level care, in the community. In general, the delivery of this level of care in the community is made cost effective by the presence of an informal (and unpaid) carer. A strict accounting for the cost of this care option would also take into account any financial assistance or income support received by the informal carer and any foregone income to that carer, as well as the cost of any respite care received by the care recipient. These considerations may significantly alter the cost effectiveness equation.

59. Conversely, the cost effectiveness equation must also take into account the impact of caring on informal carers, and the costs of ameliorating that impact. Extensive research has investigated the impact on carers of caring for a loved one. While carers may have willingly entered into a caring relationship, their lives are still impacted by their caring role and they have poorer mental health and less social support than non-carers.[65] Having less social support leads to feelings of social isolation and loneliness and there are significant associations between loneliness, weak social networks and low mental quality of life amongst caregivers as well as older people in general, indicating that this is a crucial issue in the care of older people.[66] Another study revealed that carers experience a feeling of a loss of identity, mostly as a result of having to drastically reduce hours of work or stop working altogether; they also reported a significant change in their personal relationship with the care receiver particularly if the care receiver loses the capacity to communicate; carers also experienced an ongoing grieving cycle that was difficult to navigate, and a loss of privacy.[67]

60. Of concern also are the studies that show carers have much poorer physical and mental health than non-carers. Studies have reported that there is strong consensus that caring for an elderly individual with disability is burdensome and stressful to many family members and that caring can contribute to psychiatric morbidity in the form of increased depression. These researchers also suggested that the combination of loss, prolonged distress, physical demands of care giving, and biological vulnerabilities of older caregivers may compromise the carer's physiological functioning and increase their risk for health problems. Further, they found that caregivers are less likely to engage in preventive health behaviours, have decrements in immunity measures compared with controls, exhibit greater cardiovascular reactivity and experience slow wound healing. They concluded that some caregivers are at increased risk for serious illness and therefore they may also be at risk for increased mortality.[68]

61. Additionally, as noted earlier, the greater scarcity of working age people in the future population will increase the opportunity cost of the choice to engage in informal caring,

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[65] McKenzie S, *et al.* (2009) *Carrying the load: Transitions, needs, and service use of Australian women carers*. Stage 2 Project Report for the Australian Government Department of Health and Ageing Carers Project. Australia Longitudinal Study on Women's Health.

[66] Ekwall AK, *et al.* (2004) 'Loneliness as a predictor of quality of life among older caregivers.' *Journal of Advanced Nursing* **49**(1):23-32.

[67] Sawatzky JE & Fowler-Kerry S (2003) 'Impact of caregiving: listening to the voice of informal caregivers.' *Journal of Psychiatric and Mental Health Nursing*. **10**(3):277-86.

[68] Schulz R & Beach SR (1999) 'Caregiving as a risk factor for mortality: the caregiver health effects study.' *Journal of the American Health Association* **282**(23):2215-9.

reducing the supply of informal care services. Finally, low birth rates in recent decades mean that the average older person will have fewer children from whom informal care can be sought. On balance, the supply of informal care is likely to diminish relative to the size of the older population.

62. Given that demand for community care is likely to increase strongly, reduced supply of informal carers could impose substantial costs on the community care sector. The resulting difficulties will be made all the more acute by the fact that the supply of the formal aged care workforce will also face considerable pressure as the share of the population requiring care increases. In effect, population aging seems likely to create an increased demand for hospital care, with here too, the sheer weight of the numbers moving into the higher age brackets more than offsetting possible reductions in the number of annual hospital bed-days required for each person in each age class. The resulting growth in total hospital bed-days will require a corresponding increase in the medical labour force, forcing the aged care sector to compete for nurses and other specialised labour inputs in a tight labour market.

63. There are also a range of factors that can impact on the required number and skills sets of the aged care workforce, including the increasing age and acuity levels of care recipients, and the service models to best meet their needs. This may not only increase the overall size of the workforce required but also change the relative proportions of various occupations. That is, it may see an increased demand for specialised nursing or behavioural management skills.

Workforce issues

64. The residential aged care industry alone is estimated to employ about 305,000 people (or about 2.75 per cent of the Australian workforce. Registered and enrolled nurses account for about 25 per cent of the workforce in high-level residential care and about 10 per cent of the workforce in low-level residential care. Put another way, the industry employs about 15.3 per cent of all registered nurses and about 21.9 per cent of all enrolled nurses.

65. Ultimately the training of the aged care workforce is a matter for the aged care industry. However, the Commonwealth has a role to play in ensuring that sufficient training places are available – for both nursing and non-nursing staff. Over the next decade, for example, it is estimated that the aged care sector's gross replacement requirement will equal about 125 per cent of its current registered nurse workforce and about 150 per cent of its enrolled nurse workforce. It is unclear to what extent the current quality regulatory requirements will hinder one of the main options to address this workforce shortage, namely productivity improvement through the reallocation of work currently done by nurses to less skilled staff.

66. Progressive reforms to the health sector, including deinstitutionalisation in the disability and mental health sectors, and the increasing emphasis on short stays in acute care resulting from the introduction of casemix funding, and increasingly sophisticated and "high-tech" treatment strategies, have resulted in aged care services providing care that would have previously been provided in other arenas.

67. Under the National Health and Hospital Reform Strategy the direction of these reforms are continued and there is an increasing reliance on provision of primary care, and an

increasing emphasis on aged care services being able to take on roles in restoring and preventing functional decline.

68. Increasingly, aged care services care for people with more complex and chronic conditions, including people with severe dementia and behavioural disorders. They are also required to provide palliative care including ongoing pain relief and symptom management through to end of life care. Given these trends, a professional aged care workforce, able to deliver such care and to effectively interface with and coordinate care across other elements of the health care system is essential.

69. While aged care nursing is often seen as requiring less skills than in other parts of the sector the reverse is in fact true, with registered nurses requiring advanced assessment and analysis skills and the capacity to provide clinical leadership and governance. Particularly in residential care, nurses are required to exercise the full range of generalist clinical nursing assessment and analysis skills and often also develop specialised areas of expertise such as wound management, continence and dementia care. Liaison skills to work in multidisciplinary teams and communication skills to work with older people and their families, and support coordinated care are also essential.

70. Enrolled nurses are also a key element of the health care team working under the direction and supervision of a registered nurse to deliver patient centred health care. Enrolled nurses provide support and comfort, to assist residents with activities of daily living to achieve an optimal level of independence. They administer prescribed medicines and maintain intravenous fluids in accordance with scope of practice. Enrolled nurses also monitor and evaluate a resident's health and functional status while communicating regularly with a registered nurse.

71. The changes in the composition of the aged care workforce identified by NILS in 2007, in which registered nurses dropped from 21.4 per cent to 16.8 per cent of the workforce, and enrolled nursed dropped from 14.4 per cent to 12.5 per cent, may in part represent efficiencies being made in the sector. Models of service which ensure the effective use of nursing expertise, and enable registered nurses to provide clinical leadership and overall care management for residents rather than a focus on tasks which can be undertaken by other staff with appropriate skills are essential for an efficient system. However the need for sufficient registered and enrolled nurses (and other allied health professionals) to ensure that aged care services can deliver the necessary level and quality of care into the future cannot be understated.

Interfaces

72. Aged care interfaces with health, mental health, disability, housing and retirement income policy. Significant points of intersection include older people accessing hospital care, young people with disability being supported in residential aged care and changes in retirement income policy that impacts on the capacity of older people to contribute to their community.

73. The acute care, mental health and disability sectors have all engaged in system reforms which have impinged on aged care services. These reforms have resulted in a changed client

group in residential aged care for example, where residents are older, frailer, more dependent and more cognitively disabled than before. Traditional boundaries of 'health care' and 'residential care' are blurring, particularly in the treatment and management of issues such as mental health including challenging behaviours where environmental, social, medical and psychiatric care, require coordinated intervention for the best outcomes.

74. The downstream impact on aged care of the developments in both the acute and mental health sectors has been very pronounced. The role of acute hospitals, for example, has changed in line with the developments in medical care and pharmacology. The introduction of casemix funding, and the increasing use of 'high-tech' treatment strategies has led to a high throughput service model but without commensurate planning for the downstream impact in terms of long term care provision. Aged care homes have to a large extent taken on the burden of providing care to people with increasingly complex medical conditions and behavioural disorders who would have previously been cared for in the medical or psychiatric hospital environments.

75. In general, aged care services have successfully absorbed the changes imposed by other sectors. However, it is unlikely that they can absorb further pressures without changes in their business models. Conversely, continuing changes in the delivery of hospital services will also offer opportunities to residential aged care providers to diversify their business models, to utilise their infrastructure to, for example, cater for medical admissions or dialysis treatment.

Sustainability

76. There is also the issue of sustainability and whether the current arrangements place an appropriate responsibility on care recipients to meet, wherever possible, their own care costs, with Government support better targeted through more effect means testing arrangements. On the demand side, the current lack of choice has also fostered the view that the costs of aged care, since they are out of the control of the consumer, should not be borne by the consumer. On the supply side, the inability of important segments of the industry to manage their own revenue and cost streams has entrenched the belief that it is Government that must underwrite the provision of aged care. The overall effect has therefore been to firmly lodge perceived responsibility in the Government for every aspect of the system's funding and performance.

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

78. The funding arrangements for community care packages are particularly inflexible with respect to continuity of care. Unlike residential care, where residents are assessed against a Resident Classification Scale (to be replaced by the Aged Care Funding Instrument) and receive subsidies at different levels according to their assessed care needs, the three community care package programs each offer only one subsidy level. As a result, clients

whose care needs increase must be discharged from one provider (of CACPs, say) and seek a place with another provider (of EACH packages, say).

79. On the other hand, the lack of means testing arrangements in the three Commonwealth funded community care package programs increases the public cost of those programs, vis-à-vis residential care. In addition, the different means testing treatment of community and residential care will, over time, induce greater demand for community care, as recipients of that care are not required to bear as a large a portion of the cost as they would be required to bear if they were receiving residential care.

5.3 Focussing on the consumer

80. Australia's current aged care system can be confusing for consumers, who can find it difficult to know how to find the services that they may need and hard to navigate their way through the system as their care needs change. Older people and their carers can find it hard to access the right mix of services and often do not know what services are available. They report problems accessing information, undergoing assessment, finding and receiving the most suitable service. They are also often required to provide a number of service providers with the same information.

81. Effective information and assessment arrangements are crucial to ensuring the efficiency of the Government's aged care programs. Not having a consistent point of entry and eligibility and needs assessment (and reassessment) process creates a number of problems for clients. For example, clients with the same profile of needs can get very different service responses, both in terms of service types (organisations will offer what they provide) and amounts of service. Similarly, waiting times may not reflect urgency of need as there is limited regional coordination and individual service providers keep waiting lists. There is also potential for confusion about who people need to contact to get the service that they need, for example there may be several different organisations in one region funded for domestic assistance. This is exacerbated by services providers often not being in a position in provide about the support that is available to consumers outside of the service type of the provider. Clients can face multiple and inconsistent assessment processes as they are referred to different organisations depending on their care requirements and service specific assessments may not be designed to identify other issues that the client (and their carer) maybe experiencing therefore reducing the chances for appropriate and timely referrals within the system.

82. The Australian Government is moving to address these issues through the creation of a national aged care system for community and residential care. The first step to strengthen the Australian Government role in the delivery of the spectrum of community and residential care services for older people was taken earlier this year at the Council of Australian Governments. The new arrangements will also simplify accountability of governments to the community by delivering clearer responsibility of a single level of government for policy and service provision to older people.

83. The consumer is the focus of the new national aged care system, the development of which will be guided by the following principles:

a) simple access to services: delivered by streamlined assessment and eligibility criteria;

b) continuity of care for clients, which is responsive to changing needs: delivered by seamless and responsive services tailored to changing care needs; and

c) seamless transition of care for clients: delivered by an assurance of client choice to receive ongoing 'care in place', and smooth interfaces between care systems.

84. Consumers have an important role to play in ensuring that the care they receive is appropriate and responsive to their needs. Unfortunately, a downside of the current planning arrangements is that consumers tend to be disempowered, as care is rationed. This can remove incentives for providers to ensure that their care is consumer-focused. Options to improve consumer choice require careful consideration, however, given the important role of the planning ratios in managing fiscal risk.

85. The current financing arrangements also tend to concentrate the mind of providers on the immediate need to meet current regulatory arrangements rather than encouraging them to prepare for future challenges and emerging needs. The new Aged Care Funding Instrument for residential care will help ensure that financial incentives are aligned with care practices to promote responsiveness and flexibility of care delivery systems. In particular, providers will reap a financial benefit from improving the health status of their residents. Similar incentives do not currently operate within the Commonwealth three community care package programs, but could be developed by merging the programs and introducing a tiered assessment tool.

86. The legislative framework of the Aged Care Act, and in particular the Specified Care and Services arrangements in residential aged care, operates well to ensure that care is appropriate to the client's needs, effective and safe. It also helps address information and power asymmetries by monitoring compliance with established standards and providing information to consumers. This could be further strengthened by additional support for the development of the evidence base and standards. Quality assurance arrangements are less well developed in the three community care package programs and in the (low intensity) community care programs, although work is underway on these issues.

87. Internationally there would appear to be a general consensus that the ageing of the population will drive the need for reform in long term care. However, any reform of long term care in the Australian context needs to balance the needs of social policy – for example, ensuring equity of access, including in geographic regions not normally amenable to market forces, and addressing the information asymmetries inherent in health markets and especially prevalent in the long term care market – with those of fiscal policy, while providing greater scope for competition, service differentiation and innovation than current arrangements permit. In short, though the Australian aged care system performs well in terms of the quality and scope of service provision, the important issues of the system's sustainability and efficiency also need to be addressed.