Case study

Australia

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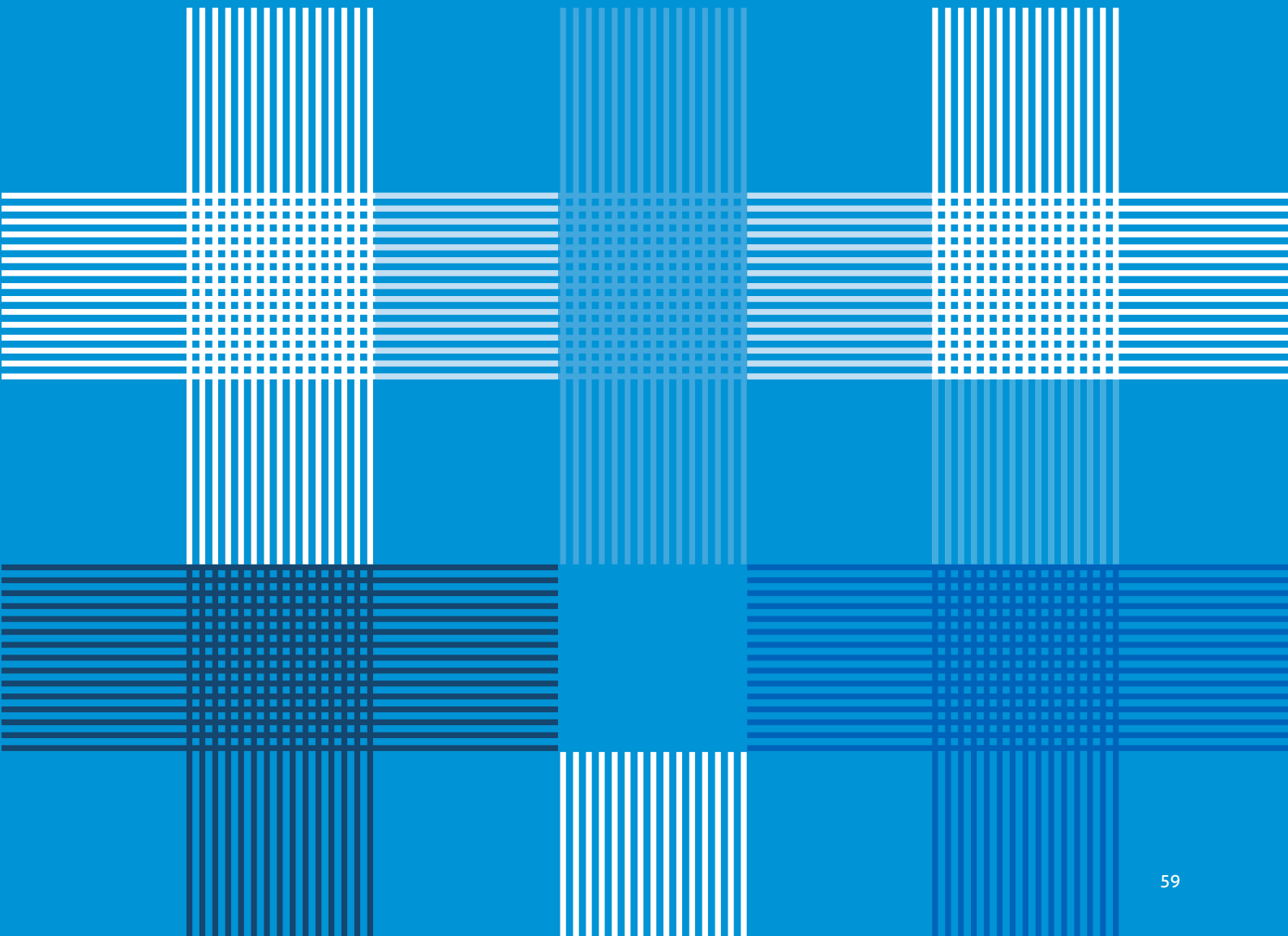


Abstract

The guiding principles of the Australian aged care system are consumer choice and control within a market-based system, but with government oversight of quality, price setting and safety nets. Publicly subsidized aged care services are funded through a mix of government subsidies (the largest share) and consumer contributions, priced using a combination of cost-based and market-based mechanisms, and delivered by not-for-profit, for-profit and government providers. While most consumers are satisfied with the quality of the services they receive, the sector is struggling meet rising demand especially in the staffing models required to provide continuity of care for an older, more clinically complex population. Moreover, the system is difficult to navigate for consumers and places a high administrative costs on providers. This case study describes how the Australian government has grappled with the design of policy and pricing mechanisms, and proposals for fiscally sustainable solutions to long-term care that are in line older people's wishes.

Contents

Introduction		**62**
1	**Interface between health and aged care services**	**63**
1.1	Older people and hospital care	64
1.2	Older people and primary care	64
1.3	End-of-life care	66
2	**Aged care services in Australia**	**67**
2.1	Home support	68
2.2	Home care	69
2.3	Residential aged care	69
2.4	Support for carers and respite care	70
2.5	Transition care	71
2.6	Short-term restorative care	71
3	**Consumers and providers of aged care**	**72**
3.1	Consumer access and eligibility	72
3.2	Provider approval and quality standards	73
3.3	Characteristics of purchasers and providers	75
3.4	Planning and control of supply	76
4	**Structure of payments and pricing for aged care services**	**78**
4.1	Home support payments and pricing	78
4.2	Home care payments and pricing	79
4.3	Residential aged care payments and pricing	81
5	**Challenges for the Australian aged care system**	**84**
5.1	Assessment process	84
5.2	Allocation of residential aged care places	85
5.3	Staffing adequacy and pricing	86
6	**Lessons from the Australian aged care system**	**88**
6.1	Designing services that better reflect consumer wishes and improve fiscal sustainability	88
6.2	Household wealth and the sustainability of aged care financing	89
6.3	Market mechanisms, quality and price	89
References		**92**

Introduction

In this case study, we describe and provide commentary on the Australian approach to the residential and long-term care of older persons. As in other OECD countries, the demand for aged care services in Australia is expected to increase as the population becomes older, frailer and experiences higher rates of dementia. Below replacement fertility levels combined with increasing life expectancy means the proportion of people aged 65 years and over is projected to increase over the next 50 years, from 15% in 2017 to 23% in 2066. Over the same period, the proportion of people aged 85 years and over is projected to increase from 2.0% to 4.4% (ABS 2018). In 2019, an estimated 387 800 Australians had dementia, nearly half of whom were aged 85 years and over. This number is anticipated to grow to around 900 000 by 2050 (Department of Health 2019a).

The guiding principles of the Australian aged care system are consumer choice and control within a market-based system, but with government oversight of quality, price setting and safety nets. Publicly subsidized aged care services (the 'aged care system') are funded through a mix of government subsidies (the largest share) and consumer contributions, priced using a combination of cost-based and market-based mechanisms, and delivered by not-for-profit, for-profit and government providers. A government-funded assessment process determines eligibility for these services and the level of contribution to be paid by consumers. In 2018–19, over 1.3 million people received some form of aged care service, around 5% of the population (Department of Health 2019a).

The funding and regulation of aged care services are primarily the responsibility of the national (Australian) government, therefore, provision varies little between states. The national government funds services from its general tax revenue with expenditure in 2019-20[1] budgeted at A$ 21.6 billion (4.3 percent of its general government sector expenses). This expenditure currently represents 1.08% of Australian GDP and is projected to increase to 1.7% of GDP by 2055 (The Commonwealth of Australia 2019).

The present case study is arranged into six sections:

- **Interface between health and aged care services** differentiates the health and social care services provided under the healthcare and aged care systems. It then briefly describes the specific provisions for older people in Australia's universal healthcare system.
- **Aged care services in Australia** describes the key government programs designed to deliver aged care services at home and in residential facilities.

1 In Australia, the financial year runs over the 12 months from 1 July to 30 June.

- **Structure of payments and pricing for aged care services** describes the payment and pricing arrangements for the mainstream programs of home care, home support and residential care.
- **Consumers and providers of aged care** describes the processes for consumer access and eligibility, provider approval and quality standards, the characteristics of purchasers and providers, and the planning and control of supply.
- **Challenges for the Australia aged care system** discusses the key challenges for Australian policymakers and service providers, along with proposals for reform.
- **Lessons from the Australian aged care system** identifies lessons from the Australian experience that have broader applicability to other countries.

1 Interface between health and aged care services

Aged care programs are managed by the national Department of Health, but are administratively and functionally separate from general health services. Aligned with the OECD's definitions of the health and social care aspects of long-term care (OECD 2018), the health care activities provided under the Australian aged care system may be classified as:

- Personal care (e.g. assistance with personal hygiene, dressing, feeding, taking medication)
- Clinical care (e.g. nursing and allied health services)

Social care activities within aged care provision may be classified as:

- Basic daily living services (e.g. meals, housekeeping, home maintenance and modifications, laundry and social activities)
- Accommodation (for residential aged care only)

Older people in Australia have the same access to Medicare, Australia's system of universal health coverage, as the general population (Barber, Lorenzoni and Ong 2019). The Transition Care and Short-Term Restorative Care Programs under the aged care system aim to manage older people's short-term health and care needs following an episode of injury or poor health and are described later. In this section, we briefly describe how the Australian healthcare system manages older people in hospital care, primary care and end-of-life care.

1.1 Older people and hospital care

Public hospitals are managed by the government of each state or territory to provide patients with comprehensive inpatient and emergency care. Under Medicare, all citizens have access to free public hospital care, and no distinction is made on the basis of age. Formerly, the national government allocated a fixed budget to state governments to contribute to the cost of public hospital services. These budgets were based on the size of each state's population, with need-based adjustments including increased funding for states with an older population. With the advent of activity-based hospital funding (ABF) in 2011, the national government contribution became explicitly tied to the number of hospitalizations. Older people are greater users of hospital services, therefore, funding is now directly linked to the demands of an ageing population. People aged 65 and over comprise 15% of the population but account for 42% of hospital separations and 49% of patient days (AIHW 2018). Under ABF, hospitals in an older demographic catchment area receive funding that reflects higher activity levels. Earlier versions of Australia's diagnosis related groups (AR-DRGs), the basis of ABF payments, used age-based adjustments to the price of many hospital episodes. The patient's age (typically those over 65 years) attracted increased funding. With each new edition, the age-adjusted AR-DRGs have given way to classifications that adjust for complexity and co-morbidity.

Limited availability of residential aged care places or appropriate support at home in some areas can impact hospitals through extended lengths of stay for older patients. The Productivity Commission's Report of Government Services shows that, on average, around 1% of all available bed-days are accounted for by patients who cannot be discharged due to a shortage of aged care support, a rate even higher in rural and remote regions and in lower socio-economic areas (Steering Committee for the Review of Government Services 2020).

1.2 Older people and primary care

Primary care (and other out-of-hospital medical care) is mainly funded by the national government through Medicare on a fee-for-service basis with some co-payments. Patients pay the service provider directly and claim back a rebate for services listed on the Medicare Benefit Schedule (MBS)[2] from the government. Doctors' fees are not regulated in Australia, and the MBS rebate is often less than the fee charged by providers resulting in a co-payment for patients. That said, 83% of general practice (GP) visits are charged at the same price as the rebate and therefore do not attract a co-payment. Co-payments for specialist medical services are much higher. Primary care patients in Australia also make co-payments under the Pharmaceutical Benefits Scheme (PBS), which subsidizes medicines for Medicare-eligible patients. Under the PBS, patients contribute up to a maximum fixed amount per script. The government pays the remaining cost of the medication that

2 See http://www.mbsonline.gov.au

is above the fixed co-payment. Prices for medications listed on the PBS are negotiated between the national government and pharmaceutical companies following a rigorous health technology assessment process including cost-effectiveness analysis.

Most older patients are eligible for a Commonwealth Seniors Health Card. These and other concession card holders are entitled to: (i) a substantially reduced co-payment for prescribed medications listed on the PBS; (ii) an incentive paid to GPs to provide consultations with zero co-payments; and (iii) a lower threshold to reach the PBS and Medicare safety nets. To qualify for either safety net, patients have to incur a specified amount of out-of-pocket costs. Once they qualify, the patient is entitled to additional benefits that will reduce their co-payments for the remainder of the calendar year (see Table 1). The national government spends around A$ 9.6 billion on concession card entitlements, with the majority (A$ 8.8 billion) on the prescriptions entitlement. This accounts for around 80% of total national government expenditure on prescription medications.

Table 1
Entitlements for concession card holders and the general population in AUD (as of January 2020)

	Concession card holders	General population
Prescriptions		
PBS listed medication co-payment	$6.60 per script	$41 per script
PBS safety net threshold amount	$316.80	$1486.80
PBS listed co-payment once qualified for safety net	$0 per script	$6.60 per script
Medical Care		
Incentive payment for GP consultations to charge no co-payment to concession card holders	$6.40 per consultation in metropolitan areas $9.60 per consultation in selected rural and regional areas	No incentive
Medicare safety net threshold amount for out of hospital services	$692.20	$2169.20
Co-payments for those who reach Medicare threshold	Up to 80% of all co-payments covered for the remainder of the calendar year	Up to 80% of all co-payments covered for the remainder of the calendar year

As for hospital care, older patients are greater users of the primary care system. Those aged 65 and over account for 29% of GP consultations but account for only 15% of the population. They make more than twice as many claims for GP consultations per annum (10 per person) compared to those under 65 (4.4 per person)(AIHW 2018). In recent years, the national government has sought to encourage doctors to provide services aligned to the changing needs of the ageing population, particularly for those with complex and chronic health problems. There have also been significant problems in

delivering primary care in aged care facilities for residents unable to attend a GP practice. New items have been added to the MBS to encourage doctors to deliver more complex, multidisciplinary care and assessments for elderly patients, and to deliver services in residential facilities (including telehealth and medication reviews). However, many of these items do not offer sufficient financial incentives to substantially increase access for older people in residential care. For example, only around three in ten patients living in residential aged care facilities claimed a medication review that included a GP.

In recognition of the limitations of Australia's fee-for-service system, for complex, long-term care, the national government allocated A$ 448 million in the 2018-19 Budget to a new scheme that will provide additional GP funding in the form of blended payments to encourage older patients to enroll with a GP practice. From 1 July 2020, patients aged 70 years and over will be eligible to enroll with a single, accredited general practice. The aim of the program is to increase continuity of care, which has been associated with improved health outcomes and reduced spending.

1.3 End-of-life care

Public hospitals continue to be the largest providers of end-of-life care in Australia, in specialist hospices, hospital wards and through community health services. While there is increasing provision for end-of-life care to support people to stay at home until their death, Australia has the second lowest proportion of home deaths compared to institutional deaths (in hospital or residential aged care facility) in the OECD (Broad et al. 2013). There is significant unmet need for end-of-life care at home. Surveys consistently show that 60-70% of Australians would prefer to die at home, but only 14% currently do so (Swerissen and Duckett 2014). There is little research on the capacity of aged care services provided at home to support end-of-life care, but the pattern of service usage suggests that many enter residential facilities as their care needs increase. Of the 25 700 people who exited a home care package in 2017-18, the majority (56%) entered a residential aged care facility, while 30% died while still receiving care at home (7710 people) (AIHW 2019c). Palliative nursing and personal care are recognized in the funding instrument that determines the government subsidy for aged care residents. However, there have been challenges in accessing specialist palliative care services in the residential setting, and many age care residents are transferred to hospital when they are near death. The 2018-19 Budget included A$ 57.2 million over six years for the Comprehensive Palliative Care in Aged Care Measure, a cost-sharing arrangement with state and territory governments intended to improve palliative and end-of-life care for older people living in residential aged care, to enable people to die where they want and be supported by increased aged care services.

2
Aged care services in Australia

This section describes the key government programs designed to deliver aged care services at home and in residential facilities across a broad continuum of care. Special programs to meet the challenges of delivering services for older people living in remote and rural Australia are described in *Box 1*. There are three mainstream aged care programs: the Commonwealth Home Support Program (CHSP) to promote continued independent living; the Home Care Packages Program (HCP) for those with more complex needs; and residential aged care for those no longer able to live in their own home. There are also three programs designed for short-term care: respite care for older people and their carers to take a break (administered through the mainstream programs); transitional care for those who have been recently hospitalized; and restorative care to provide early intervention to reverse or slow functional decline in older people.

Recent Australian government policy has aimed to increase the funding and utilization of home care services to allow older people to live at home as long as possible, or 'age in place'. Remaining at home is the preferred option for the vast majority of older Australians. In 2017–18, 71% of Australians aged 65 and over lived at home without accessing government-subsidized aged care services, 22% accessed some form of support or care at home, while just 7% lived in a residential aged care facility (AIHW 2019a). The average age for accessing aged care services at home is 80 years, while the average age on entry to permanent residential aged care is 82.3 years for men and 84.6 years for women (Department of Health 2019a). Community preferences to remain at home as long as possible are aligned with government interests in fiscal sustainability since the provision of aged care at home requires less public funding than residential aged care (Productivity Commission 2015). Table 2 gives the total government and consumer expenditure for each of the three mainstream programs. It shows that residential aged care accounts for 74% of government expenditure on aged care services, but only 20% of consumers, reflecting the higher care needs and resource-intensity of providing care in a residential setting. The current policy goal is to increase the provision of more complex care at home through the HCP to delay or prevent admission into residential care. Table 2 also illustrates that while consumer contributions are an important element in the aged care funding in Australia, government subsidies account for 77% of expenditure.

Table 2
Australian Government and consumer expenditure by aged care service type (2017-18)

		Expenditure (AUD)	% government expenditure within program	% program of total government aged care expenditure	% consumers in program
Home Support (CHSP)	Government Consumer	$2.4b $219m	92%	14%	70%
Home Care (HCP)	Government Consumer	$2b $122m	94%	12%	10%
Residential	Government Consumer	$12.2b $4.5b*	73%	74%	20%
TOTAL	**Government** **Consumer**	**$16.6b** **$4.8b**	**77%**	**100%**	**100%†**

Source: ACFA (2019)
*Excludes consumer contributions towards their accommodation paid as a refundable accommodation deposit. Includes consumer accommodation contributions paid as a daily accommodation payment.
† Total number of consumers in the three programs = 1 206 100.

The following provides a description of the main features of the three mainstream programs of home support, home care and residential care followed by the three programs for short-term care: respite, transitional and restorative care.

2.1 Home support

The CHSP provides entry-level home support services to help older people and their carers to live independently at home. The CHSP is underpinned by a wellness approach which aims to build each person's strengths, capacity and goals to promote their independence, mobility and autonomy. The program also aims to prevent or delay the need for a home care package or entry into residential aged care (Department of Health 2018). The CHSP provides funding as a grant to approved providers, and consumers may be asked to contribute to the cost of services.

Services under the CHSP may include daily living services (e.g. housekeeping, home modifications, subsidized transport and meal delivery), personal care (e.g. help with personal hygiene and grooming), and some clinical care services (e.g. basic nursing care, occupational therapy). Services are available on an ongoing or short-term basis and include day and residential respite services so that informal carers may take a break (see *Support for carers and respite care*). As an entry-level, lower cost service, the CHSP provides subsidized support for 70% of aged care consumers but accounts for just 14% of government expenditure (Table 2).

2.2 Home care

The HCP subsidizes a more structured, comprehensive package of daily living, personal care and clinical care tailored to meet the needs of older people living at home with more complex needs than the CHSP can support. The HCP operates under the principle of consumer directed care that encourages older people to be involved in determining how their care budget is spent. Providers must work in partnership with consumers to identify their goals and needs, which form the basis of a care plan. There are four package levels depending on individuals' assessed needs: basic care needs (Level 1); low level care needs (Level 2); intermediate care needs (Level 3); and high care needs (Level 4). Consumers may pay a basic daily fee as well as an income-tested contribution to their care.

The *Increasing Choice in Home Care* reforms introduced in 2017 aimed to increase consumer control by assigning budgets to individual consumers rather than providers, and making them portable between providers. Prior to 2017 providers were allocated 'funded places' through a competitive process, and they retained any unspent funds if a consumer left a service, which created a disincentive for consumers to change providers. Unspent funds now move with the consumer to a new provider or returned to the government if the consumer leaves the HCP. The reforms also stimulated the market in HCP provision by removing supply-side limits, and applying demand-side controls instead. This was achieved by allowing all interested providers who could meet the aged care standards to become an approved provider (see *Provider approval and quality standards*) to enter the market, not just those who had previously been allocated 'funded places'. However, the size of the HCP market is controlled by the government by limiting the annual release of HCP packages to consumers. Even after an individual has been assessed as eligible for a new package, there can be a considerable wait to reach the top of the national prioritization queue for their funds to be released (see *Planning and control of supply*).

2.3 Residential aged care

Residential aged care facilities provide daily living, personal and clinical care and accommodation for those with higher care needs who are no longer able to live at home. Historically, residential aged care places were designated as 'high care' or 'low care' according to residents' level of clinical and daily living dependency, and many facilities specialized in providing one or the other. This distinction was removed in 2014 with the introduction of an 'ageing in place' approach and residential aged care facilities now provide services across the spectrum of care needs. However, as support for home-based services has increased, those who enter residential aged care are older, frailer and more dependent than in the past. As of 30 June 2019, just over half of all residential aged care residents had a diagnosis of dementia (Department of Health 2019a). Few residents would now be classified as 'low care', which has

implications for the nursing skill mix in aged care facilities (see Staffing adequacy).

Residential aged care funding is based on a complex system of government subsidies and consumer contributions that vary according to the older person's care needs and ability to pay, as well as government programs for capital infrastructure. All residential aged care facilities must include the following services in accordance with residents' needs and agreed care plans:

- hotel-like services (e.g. bedding, furniture, toiletries, cleaning, meals)
- personal care (e.g. showering, dressing, assisting with toileting)
- clinical care (e.g. wound management, administering medication, nursing services)
- social care (e.g. recreational activities, emotional support) (see p44 of Department of Health (2019a)).

2.4 Support for carers and respite care

As an increasing number of older people continue to live in their own home, carer support and respite care have become increasingly important for the family members and friends who support them. In 2018 there were 2.65 million carers of older people and people with a disability in Australia, representing 10.8% of all Australians (ABS 2019a). The majority of primary carers (79.1%) reside in the same household as the person for whom they provide the most care (ABS 2019a). There are several government-funded services that provide information and support directly to carers[3]. In recognition of their reduced ability to work, means-tested income support (as a carer payment or allowance) is also available to carers of older people who are ill, frail or disabled. Once the carer reaches age-pension age (currently 66 years) they must choose between continuing to receive carer income support or switch to the age pension (Department of Human Services 2019).

Government-subsidized respite care within the aged care system is available to give informal carers a break from their caring role on an occasional or ongoing basis. Access is through the eligibility of the older person in receipt of care and is available in a range of settings. The CHSP supports flexible respite services at home or in a centre, while HCP recipients may use their package to purchase respite services. Residential respite in approved residential aged care facilities is also available on a planned or emergency basis for up to 63 days per year (more with approval). Some older people also use respite care as an opportunity to "try before you buy" prior to entering a residential aged care facility.

3 See for example https://www.carergateway.gov.au/.

In 2018–19, 51 039 people received respite services through the CHSP, and there were 83 455 admissions for respite care in a residential facility (Department of Health 2019a). The availability of beds for respite care is at the discretion of providers. Despite increasing use of respite services, many older people and their carers report problems in accessing appropriate services (Royal Commission 2019a). A review of respite services conducted by the Aged Care Financing Authority recommended a greater focus on the choice and supply of respite services, especially for older people with special needs, such as those with dementia, and from culturally and linguistically diverse backgrounds. It also recommended that there be 'funding neutrality' between permanent and respite care in aged care facilities. Currently, the respite care consumer does not pay for accommodation, and care funding is not on the same basis as for permanent care, creating a disincentive for providers to make beds available for respite care (ACFA 2018).

2.5 Transition care

The Transition Care Program provides short-term, goal-oriented and therapy-focused services to older people in their own home or residential facility following a hospital stay. Care is provided for 12 weeks, with an extension of up to 6 weeks available subject to a needs assessment. In 2018–19, the average length of an episode of transition care was 53.2 days (Department of Health 2019a). The aim of the program is to improve an older person's independence and functioning and to delay their entry into residential aged care (if they are living at home). It is provided as a package of care services that may include physiotherapy, occupational therapy, social work, nursing care and personal care. Transition Care is funded by the national government and managed by the state and territory governments who determine the service models that best suit local and individuals' care needs. All state and territory governments have arrangements with external providers to deliver transition care. As of 30 June 2019, there were 4060 funded transition care places. During 2018–19, a total of 24 432 people received transition care (Department of Health 2019a).

2.6 Short-term restorative care

The Short-Term Restorative Care Program offers a similar package of services to Transition Care but is available only to older people living in their own home and not on a home care package, and not necessarily following a hospital stay. The program provides early intervention to reverse or slow functional decline in older people. Functional decline is defined as a person having difficulty in performing day-to-day activities such as bathing, dressing and mobility and are slowing down mentally, physically or both. The focus of the program is to promote older peoples' independence and to prevent or delay their admission into residential care. Unlike

Transition Care, the federal government commissions providers directly to provide restorative care. The program provides services for older people for up to 8 weeks, and they may access up to two episodes of restorative care in a 12-month period. During 2018–19, 2543 people received care under the Short-Term Restorative Care program (Department of Health 2019a).

3 Consumers and providers of aged care

This section provides an overview of the consumers and providers in Australia's aged care system: how consumers access government-subsidized aged care services, and the process, quality standards and prudential requirements that providers must satisfy to deliver those services and to manage government subsidies. It then describes the purchaser and provider relationships in each of the three mainstream programs and the ownership profile of the approved providers. The section concludes by explaining the mechanisms for the planning and control of the supply of aged care services.

3.1 Consumer access and eligibility

Access to aged care services in Australia is determined by need rather than age. There is no legislated minimum age for receiving subsidized aged care services, but it is generally considered a service for older people aged from 65 years (50 years for Indigenous Australians). A broader age range is used for Indigenous Australians because of their greater need for care at a younger age due to poorer health status and lower life expectancy compared to non-Indigenous Australians (Royal Commission 2019b). Among those aged 65–74, Indigenous Australians are 3.1 times as likely to use home support, 7.1 times more likely use home care, and 2.1 times more likely to use residential aged care than non-Indigenous Australians (AIHW 2019b). Non-Indigenous Australians may also be deemed eligible for subsidized aged care services under 65 years if, for example, they have early onset dementia, multiple sclerosis or other conditions requiring specialized care not covered under the National Disability Insurance Scheme.

Every older person must undergo a free standardized assessment to receive a publicly subsidized aged care services. Older people can access the open market for a range of care and support services without an eligibility assessment if they are willing to pay the full cost of the services. The Department of Health's 'My Aged Care' website[4] and contact centre is the entry point to the aged care system. To receive an assessment, an older person (or their carer or health service provider acting on their behalf) must register with My Aged Care. Assessment is a two-stage process. The first is a simple eligibility check completed online or over the phone to establish if, and what

4 https://www.myagedcare.gov.au/

type of aged care service the older person may require. The second is a more in-depth, face-to-face assessment to establish the older persons' health status, functionality within the home environment, and any existing supports they have. Face-to-face assessments usually take place in a person's home or in a hospital if they have been admitted for inpatient care and are likely to be discharged soon. There are currently two types of face-to-face assessments, one for home support (CHSP) and the other for home care (HCP), residential care and short-term care. Both assessments are funded by the national government but are conducted by assessors employed by state and territory governments or not-for-profit organizations who are independent from aged care providers.

If the My Aged Care eligibility check establishes the older person only requires entry-level home support (CHSP), the face-to-face assessment is conducted by a Regional Assessment Service (RAS). If the assessor deems the older person is eligible for one or more home support services, consumers receive a separate referral code for each of those services. Eligible consumers may take each of these referral codes to a range of providers who view the client's record and decide whether they have funding, skills and workforce capacity to deliver the required services. Consumers must often wait for services or receive only some of the services for which they are eligible. Around 54% of CHSP consumers receive one type of service, 41% receive between two and four types of service, and 5% access five or more types of services (ACFA 2019).

Assessments for home care (HCP), residential care and short-term care (i.e. respite, transitional and restorative care) are performed by an Aged Care Assessment Team (ACAT). The ACAT usually includes a nurse plus another healthcare professional (e.g. occupational therapist or social worker). The assessment criteria are specified in the *Approval of Care Recipients Principles 2014*[5], and provide a comprehensive picture of an older person's physical, medical, social and psychological needs and preferences. The ACAT makes a recommendation for the type (home support, home care or residential) and level of support the older person requires and a priority level for receiving care. The eligible person is then placed on the waiting list for home care or referred to a service for home support or residential care (See *Planning and control of supply*).

3.2 Provider approval and quality standards

Providers are responsible for the delivery of quality aged care, assisting consumers to make decisions about their care, and the financial management of government subsidies and consumers' fees. Only approved providers that meet the suitability requirements of the *Aged Care Act 1997* and meet the *Aged Care Quality Standards* can receive government subsidies to deliver aged care services. On 1 January 2020, the provider approval and regulatory functions of various agencies were transferred

5 https://www.legislation.gov.au/Details/F2017C00134

to the Aged Care Quality and Safety Commission[6] (the Commission). The Commission oversees provider approval[7], accreditation of residential aged care facilities, quality reviews, monitoring and complaints handling for all aged care services. It also provides information and education to providers.

When assessing an applicant's suitability to become an approved aged care provider, the Commission considers the applicant's experience of providing aged care or other relevant services, their demonstrated understanding of their responsibilities as a provider, the suitability of their systems and staff, and financial management practices. Approved providers must continue to meet these suitability criteria to maintain their approved provider status and notify the Commission of a material change that affects their suitability, though there is no formal review of compliance with these suitability criteria once approved-provider status is attained.

Since July 2019, the initial and ongoing assessment of the quality of aged care services has been against the unified *Aged Care Quality Standards*[8], which have an increased focus on consumer outcomes rather than providers' compliance with processes. There are eight individual standards: (i) consumer dignity and choice; (ii) ongoing assessment and planning with consumers; (iii) personal care and clinical care; (iv) services and supports for daily living; (v) organization's service environment; (vi) feedback and complaints; (vii) human resources; and (viii) organizational governance. Each of the standards is expressed as a statement of outcome for the consumer, a statement of expectation for the organization, and the organizational requirements to demonstrate that the standard has been met. Providers must demonstrate that they meet the standards prior to approval, and that they are committed to continuous improvement. There are processes for regular independent quality reviews (at least once every three years), and ad hoc reviews (announced and unannounced) if the Commission has cause to suspect that the standards are not being met (e.g. following a complaint). If the Commission deems that the service has failed to meet standards, it can direct a service to outline a plan for improvement and set a timetable for that improvement. The Commission must notify the Department of Health if it deems that non-compliance with the standards is a serious risk to the health or well-being of consumers. The Department may take action when providers do not comply, through the aged care legislation or through the funding agreement with the organization.

6 https://www.agedcarequality.gov.au/

7 The Commission oversees provider approval for all government programs except the Commonwealth Home Support Program, the Multi-Purpose Services Program and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Those services must still comply with the Aged Care Act and Aged Care Quality Standards.

8 https://www.agedcarequality.gov.au/providers/standards

3.3 Characteristics of purchasers and providers

There are different purchaser and provider relationships within each of the three mainstream aged care programs. As a grant-funded program, the federal government is the purchaser of **home support** services from providers under the CHSP. Eligible consumers then seek services from those providers. Some providers deliver a single service such as meal delivery, transport assistance or domestic services, whereas others provide a wide range of support services. Consumers who are assigned an entitlement to **home care** under the HCP are the purchasers of services since the care budget is assigned to individuals rather than to specific providers. Under the principles of consumer-directed care, consumers combine their national government subsidy and their own means-tested contribution to purchase services from a market of competing and approved providers and have control over how their budget is spent. Consumers with assessed entitlements to **residential aged care** subsidies may choose from approved providers in the market place. However, the government is the purchasing body since providers must apply to the Department of Health government for an allocation of subsidized bed licences (See Planning and control of supply).

Table 3 gives the number and ownership of approved aged care providers in Australia for home support, home care and residential aged care. The majority of providers are not for-profit organizations across all three programs, especially in the grant-funded CHSP where 70% are not-for-profit. However, data from the Aged Care Financing Authority suggest there has been a recent shift in ownership from not-for-profit to for-profit providers in the home care sector, stimulated by the 2017 *Increasing Choice in Home Care* reforms which uncapped supply-side controls. In June 2014, 20% of home care providers were for-profit, increasing to 35% in 2018, while the proportion of government providers remained stable at 12% (ACFA 2019).

Table 3
Number and ownership of aged care providers at June 2018

	Providers (n)	Services** (n)	Ownership (% providers)		
			Not-for-profit	For-Profit	Government
Home Support (CHSP*)	1,547	n/a	70%	7%	23%
Home Care (HCP)	873	2,599	53%	35%	12%
Residential	886	2695	56%	33%	11%

Source: ACFA (2019)
* includes equivalent program in Western Australia.
**number of home care services and residential aged care facilities.

3.4 Planning and control of supply

The national government applies three main types of planning and supply controls within the aged care system, aligned to the three mainstream programs described ins this paper.

The supply of home support is controlled by the national government capping the annual CHSP funding grants to providers. The annual budgetary determination of the quantum of grants available to service providers is based on a broad assessment of need and the government's fiscal setting. After years of low growth in funding, in the 2018-19 Budget the national government applied a real (after inflation) growth rate of 3.5% aligned with the rate of growth of the population aged 65 and over. However, providers advise that there remains unmet demand for entry-level home support services (ACFA 2019).

For home care and residential aged care (as well as the short-term care programs), the national government manages the planning of and expenditure on services by specifying a national target provision ratio. The 'aged care provision ratio' is the number of subsidized aged care places for every 1000 people aged 70 years and over and is an estimate of consumer demand. The current target is set at 125 places by 2021-22, comprising 78 residential aged care places, 45 home care places and two short-term care places (transition care and short-term restorative care) (Department of Health 2017). The national government also exercises individual program-level controls for the provision of home care, residential aged care and short-term care.

In home care, the 2017 *Increasing Choice in Home Care* reforms uncapped the supply of home care provision by assigning funding to individuals rather than providers (see *Home care*). This resulted in a significant initial surge in the numbers of providers from around 500 in the years up to 2016 to over 900 by 2019, and a shift in provider ownership toward the for-profit sector (ACFA 2019; Department of Health 2019a). However, the government exercises control over the size of the home care market through demand-side queuing. Older persons who have had an ACAT assessment and are eligible for a home care package are placed on a national prioritization queue for their package level according to the date of approval and their priority level ("high" or "medium" depending on care needs and personal circumstances). They are assigned a package when they are the next eligible consumer on the queue for that package and priority level.

The national prioritization queueing system allows the government to exercise fiscal control over the HCP while maintaining a consistent and equitable national approach to consumer access. The total number of packages available increases when the national government releases additional funding at the four package levels. The number of people assessed as eligible for home care exceeds the number of packages released by government, especially for those with

high care needs (Level 4). A funding boost to the HCP saw the number of people receiving packages increase by 30% between September 2018 and 2019, and a decline in the number of people waiting for a package at their assessed level (Department of Health 2019d). As at 30 September 2018, there were 112 000 people on the national prioritization queue awaiting a package at their assessed level, though the majority of these consumers already receive basic home support services through CHSP or a lower level home care package while they wait (Department of Health 2019d). Waiting time data for 2018-19 show that most people (90%) assessed as "high priority" by the ACAT accessed a Level 2 package in 2 months[9], Level 3 in 9 months and Level 4 in 13 months. Waiting times have tripled for those assessed as "medium priority" (Steering Committee for the Review of Government Services 2020).

The national government controls the size of the residential aged care market through supply-side capping of the number of places allocated to providers, known as bed licences. The number of additional residential aged care places made available in each state and territory is controlled by a periodic competitive allocation round for approved providers (the Aged Care Approvals Round). The number of places released in each allocation round is determined by the target aged care provision ratio for each state and territory. It is also influenced by: the level government funding expected in the forward estimates (budget projections for the three years beyond the current fiscal year); demographic projections; current levels of service provision (i.e. number of operational places, occupancy levels); and newly allocated places from previous rounds that are not yet operational. The number of places bid for by providers regularly exceeds the numbers of places released through each allocation. The median waiting times for future residents from the time of their ACAT assessment to accessing a residential aged care place in 2018-19 was 152 days (Steering Committee for the Review of Government Services 2020), though the provider or location of the aged care facility may not meet their preferences. Many people assessed as eligible for a subsidized residential aged care place choose to remain at home with their existing care arrangements. As noted earlier, many people waiting for a place in an aged care facility are in hospital awaiting discharge (see *Older people and hospital care*).

9 Some of those accessing a Level 2 package may have been assessed as in need of a higher level package.

4
Structure of payments and pricing for aged care services

Aged care services in Australia are paid for through a mix of government subsidies and supplements (77% of funding see Table 2) and consumer contributions. The level of government subsidies and some elements of consumer contributions are cost-based and government-regulated. For these regulated elements, consumer contributions are also means-tested. Market-based prices may be charged for some consumer contributions to some services and accommodation when the resident is required to pay the full amount.

The Minister for Aged Care determines the rates for subsidies, supplements and maximum allowable consumer contributions each year, and these are published as a schedule of fees and charges (Department of Health 2019c, 2020). This price-setting function is underpinned by a number of legislative instruments (e.g. *Aged Care Act 1997*, *Subsidy Principles 2014*, *Aged Care (Subsidy, Fees and Payments) Determination 2014*). In addition, the Aged Care Pricing Commissioner[10] has a role in regulating accommodation payments for residential aged care. The Aged Care Financing Authority[11] provides independent advice to the national government on aged care funding and financing issues. The following explains the structure of payments and pricing for home support, home care and residential aged care services.

4.1 Home support payments and pricing

The national government pays for home support services through CHSP grants to providers which are indexed annually[12]. Providers may be awarded a grant by the Department of Health through an open or targeted competitive tendering: responding to requests for expressions of interest or through direct selection by the Department. Table 4 shows that the distribution of grants issued under the CHSP in 2017-18 was weighted towards smaller grants: 58% were for less than half a million Australian dollars. Analysis by the Aged Care Financing Authority shows that, on average, CHSP consumers received services to the value of A$ 2762 per annum in 2017-18 with significant variation between consumers (ACFA 2019).

10 http://www.acpc.gov.au

11 https://www.health.gov.au/committees-and-groups/aged-care-financing-authority-acfa

12 Wage Cost Index 3 – composite index that comprises a wage cost component (weighted at 60%, based on increases in the national minimum wage) and a non-wage cost component (weighted at 40%, includes the consumer price index).

Table 4
Home support government payments and consumer contributions in AUD (2017-18)

Government Payments		Consumer Contributions
Size of grant issued	**%(n)**	**Client Contribution**
Less than $500 000	58% (845)	Non-compulsory fee charges in line with the *Client Contribution Framework.*
$500 000-$1 million	17% (244)	
$1-10 million	23% (336)	
$10 million plus	2% (31)	

Providers may charge a consumer contribution for home support services in line with the *Client Contribution Framework* so that those who can afford to contribute to the cost of their care do so while protecting those who cannot. Providers must publish a client contribution policy and a list of any fees charged. However, the client contribution element within the CHSP is currently non-compulsory, and many providers seek no or only minimal contributions from consumers regardless of ability to pay. Consumer contributions account for just 8% of total expenditure on home support services (see Table 2). A 2017 review of aged care services recommended that mandatory consumer contributions based on a consumer's ability to pay be introduced for home support services to improve equity between programs, but this is yet to be actioned (Department of Health 2017).

4.2 Home care payments and pricing

The level of government subsidy and supplements allocated to an individual consumer on a Home Care Package and paid to their chosen provider is determined by the comprehensive ACAT assessment (see Consumer access and eligibility above). This is combined with consumer contributions to give an overall care budget to spend on services with their chosen provider. Table 5 provides a description of the government payments and consumer contributions that comprise the HCP, with current daily rates. The largest component of a home care budget is the home care subsidy which is indexed annually[13]. There is no publicly available information on how the quantum for home care subsidies and supplements were originally set by government.

13 Wage Cost Index 9 – wage cost component (75%), non-wage cost component (25%).

Table 5
Home care package daily rates for subsidies, supplement and fees in AUD (2019-20)

Government Payments	Consumer Contributions
Home Care Subsidy Set by level of assessed need. Level 1: $24.07 ($8785 p/a) Level 2: $42.35 ($15 458 p/a) Level 3: $92.16 ($33 638 p/a) Level 4: $139.70 ($50 260 p/a) **Home Care Supplements** Payable to consumers with additional care needs or those who live remotely. Indexed annually. *Dementia and Cognition and Veteran Supplements* $2.77 - $16.07 by package level *Oxygen and Enteral Feeding* $11.72 - $20.86 by complexity *Viability supplement* $0 - $18.71 by geographical remoteness	**Basic Daily Fee** Non-compulsory fee priced at a maximum of 17.5% of the government age pension for a single person. Applies to all consumers unless they prove financial hardship, but is not collected by many providers. Maximum $9.52 - $10.63 by package level **Income Tested Care Fee** Dependent on income, applied as reduction to the home care subsidy paid by government. Annual and lifetime caps apply. **Additional Services Fee** Consumers can choose to pay for additional care and services that the Home Care Package would not otherwise cover. Charged at market prices.

Source: Department of Health (2019c, 2020) schedule of daily subsidies and fees.

The consumer-directed care approach within home care enables consumers to have choice, flexibility and control over the types of services they receive, how and when they are delivered, and who provides them. Consumers may also purchase additional care and services not covered by the home care package if they are willing to pay the market price. People who have not had an ACAT assessment may also access non-subsidized home care services on the open market.

Providers of subsidized home care must set out an individualized budget and issue monthly income and expenditure statements to provide transparency over what budget is available and how funds are spent. They are also required to publish the prices they charge for individual services within a package on the government's My Aged Care website. The published pricing schedule must include the basic daily fee, care management costs and approximate hours of service available within each package level for common home care services (e.g. personal care, care by a registered nurse, cleaning and household tasks). It must also include other costs such as package management, any exit fees, staff travel costs and any extra costs involved in obtaining services from other providers.

4.3 Residential aged care payments and pricing

Operational funding and capital financing of residential aged care facilities are provided under separate programs. The national government contributes to operational funding through a care subsidy for personal and nursing care (based on residents' assessed need), supplements to support any additional clinical and social needs, and an accommodation supplement for those residents who cannot afford to pay the full market price for their accommodation.

Residents make a means-tested contribution to the cost of their care, and this amount is deducted from the level of subsidy paid by the government. Residents pay a set rate for their basic daily services (set at 85% of the single age pension) as well as fees for any additional services that facilities may offer at market prices. Residents who are required to contribute to or pay the full cost of their accommodation can do so through a lump sum Refundable Accommodation Deposit, a rental-style Daily Accommodation Payment, or a combination of both. Table 6 provides a summary of the government payments and consumer contributions in residential aged care for 2019-20. Payments are usually indexed[14] biannually (accommodation-related) or annually (care-related). There is no publicly available information on how the government originally set the quantum of the residential aged care subsidies and supplements.

14 Accommodation-related payments indexed with the Consumer Price Index, care-related payments indexed with the Wage Cost Index 9 – wage cost component (75%), non-wage cost component (25%).

Table 6
Residential aged care daily subsidies, supplement and fees in AUD (2019-20)

Government Payments	Consumer Contributions
Basic Care Subsidy Set by assessed cost of providing care using the Aged Care Funding Instrument. Average daily subsidy* $178.21, varies considerably **Residential Aged Care Supplements** Supplements paid to services for residents with additional financial, clinical and social needs. *Accommodation Supplement* Means-tested for those eligible for assistance with accommodation payments. Maximum $59.47 *Hardship Supplement* Paid on behalf of care recipients in financial hardship unable to pay their aged care costs. *Homeless Supplement* $21.30 *Veteran Supplement* $7.18 *Oxygen and Enteral Feeding* $11.72 - $20.86 by complexity *Viability supplement* $0 - $74.98 by geographical remoteness	**Basic Daily Fee** Fee paid for day-to-day services e.g. meals, cleaning and laundry. Applies to all residents, priced at a maximum of 85% of the government age pension Maximum $51.63 ($18 845 per/annum) **Means-Tested Care Fee** Ongoing fee paid to the provider to contribute to cost of personal and clinical care. Dependent on income and assets, applied as reduction to the basic care subsidy paid by government. Maximum $252.20 (annual and lifetime caps apply) **Additional Services Fee** Provision of additional hotel-type services, e.g. a higher standard of food and services. Charged at market prices. **Accommodation payments** Payments made as a contribution to the cost of accommodation, means-tested. Paid as a lump sum refundable deposit, daily payment or a combination of both. Charged at market prices up to a maximum of $550 000† (lump sum).

Source: Department of Health (2019c, 2020) schedule of daily subsidies and fees.
* As of September 2019 (Department of Health 2019b).
† Higher with approval from the Aged Care Pricing Commissioner.

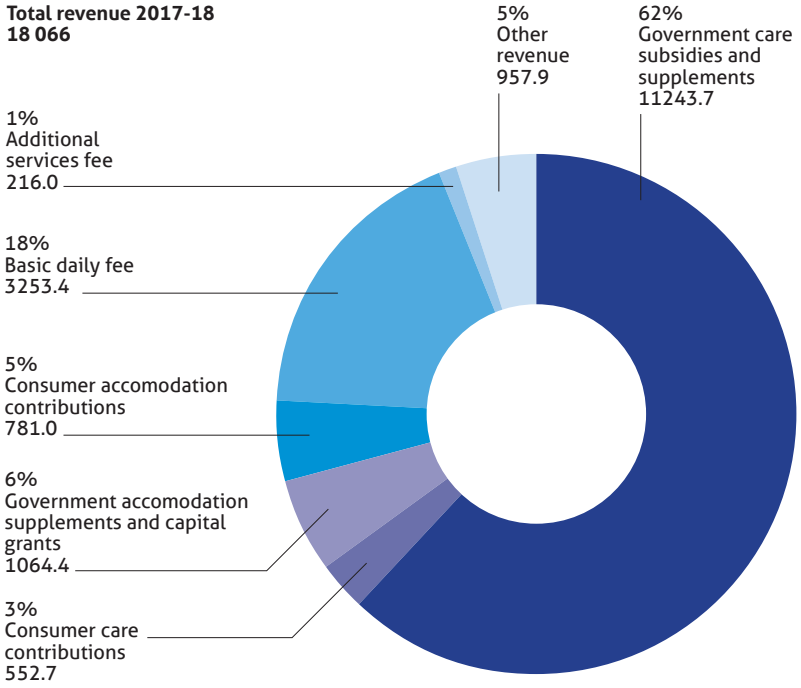
As for home care, the basic care subsidy comprises the largest government payment for residential services. The Aged Care Funding Instrument (ACFI) determines the level of care subsidy paid to a provider for a resident's care using assessment tools to establish their personal and clinical care needs. Currently, providers conduct the initial and subsequent ACFI assessments but are subject to audits by the Department of Health.

Capital financing for residential care providers is comprised of equity, including: retained earnings; loans from financial or other institutions; interest free loans from residents in the form of lump sum Refundable Accommodation Deposits; capital investment support from government through capital grants for eligible projects; and capital endowments. There has been a steady decline in the level of capital financing available to providers through lump sum Refundable Accommodation

Deposits and a commensurate increase in their income stream, as many residents choose to make their accommodation contribution as a rental-style Daily Accommodation Payment instead. Driving factors in this change include the length of stay of many residents and the time it can take for them to sell their home. For-profit providers place greater balance sheet reliance on Refundable Accommodation Deposits (62% at June 2018) and other liabilities (borrowings) (28%) than not-for-profit providers (54% and 12%, respectively). Conversely, not-for-profit providers had a net worth (equity) of 34% on their balance sheets, while for-profit providers were more highly geared and had a net worth (equity) of only 9% (ACFA 2019).

The balance between residential care providers' multiple sources of revenue is shown in Figure 1. The basic care subsidy and other supplements paid by government comprises the highest proportion of providers' revenue. The reliance on the basic care subsidy means pricing decisions around these ACFI-based payments have a major impact on providers' financial performance. An indexation freeze on ACFI payments implemented when the government believed inflation in ACFI claims exceeded the real increase in residents' acuity, resulted in profits in the sector reduced from A$ 1006 million in 2016-17 to A$ 435 million in 2017-18 (ACFA 2019). Despite indexation being restored, providers assert that increases in care costs still outstrip the level of funding received through ACFI, as discussed further in Staffing adequacy and pricing.

Figure 1
Proportions of total residential care provider revenue 2017-18 in AUD (in millions)



Source: ACFA (2019).

5
Challenges for the Australian aged care system

The funding and provision of aged care services in Australia has increased substantially in recent years, including a shift towards support for older people to remain in their own home, in line with community preferences. There have also been significant improvements in the choice and control consumers exercise over their care, especially in the home care sector. The majority of aged care consumers report they are satisfied with the range (71%) and quality (84%) of the services they receive (Steering Committee for the Review of Government Services 2020).

However, a number of high-profile failings in the quality of care provided in residential facilities and at home prompted the national government to establish the Royal Commission into Aged Care Quality and Safety[15] in 2018. The Royal Commission interim report (2019b) provides some personal accounts of poor quality care and inadequate social support for older people in the aged care system. It also emphasizes the unacceptable time many wait for a home care package, and the problems older people and their carers face in choosing a residential facility. A 2018 national survey confirms there remains significant unmet need for aged care services in the community: 34% of people aged over 65 living at home and in need of assistance reported that their needs were not fully met. This proportion was higher for those with a profound or severe disability (41.7%) than for those without a disability (20.5%) (Steering Committee for the Review of Government Services 2020). A consistent theme from the evidence provided to the Royal Commission (2019b) is that consumers and carers perceive Australia's aged care system to be complex and difficult to navigate.

In common with many other countries, successive Australian governments have grappled with the design of policy and pricing mechanisms that will stimulate innovation in delivering quality and sustainable aged care services. The following discusses three of the key challenges and proposals for reform in the Australian aged care system.

5.1 Assessment process

Getting the assessment process right is essential for ensuring timely and equitable access to appropriate aged care services and the sustainability of national budgets. There is a great onus on the assessment workforce, which is primarily trained in personal support and health care, to rigorously apply the eligibility criteria set by the government and to do so consistently across regions and over time.

15 https://agedcare.royalcommission.gov.au. A Royal Commission is the highest form of public inquiry in Australia. It is established by but independent from government and has powers to call evidence and witnesses in line with its specific terms of reference.

Aged care assessment in Australia is currently a complex, multi-stage assessment process, which evolved as different government programs were introduced, each with their own eligibility criteria and assessment workforces (see *Consumer access and eligibility*). For consumers, this means they face multiple assessments and delays in accessing the services they need. A further challenge for the assessment process is balancing the dual function assessors serve in determining the nature of the services an older person requires against a range of health, social and wellbeing indicators, while also acting as gatekeepers to government subsidies. Means-testing for determining the level of consumers' financial contribution is conducted independently from aged care assessments. There is some evidence to suggest that while there are many older Australians with unmet needs, others may have been assessed as eligible for a higher level of care than their current need would indicate. Data on the uptake of services show a number of people on waiting lists refuse a home care package when offered (Department of Health 2019d). Another indicator of possible 'over-assessment' is that there are large sums of unspent funds in consumers' packages. As of 30 June 2018, home care providers reported holding unspent funds of A$ 539 million, equating to an average of A$ 5898 of unspent funds per consumer (up from A$ 4613 on 30 June 2017). Other reasons for the accumulation of unspent funds include consumers 'saving' funds for possible future events, the lack of availability of desired services, a reluctance of consumers to use services, and misconceptions that the money not spent under the package belongs to the consumer (ACFA 2019).

A new framework for a streamlined consumer assessments for all aged care programs to be implemented in 2021 aims to reduce the number of assessments a consumer is subject to, make the assessment more targeted to consumers' likely level of need and improve the timeliness of access to appropriate services (Department of Health 2019a). Consultations with the aged care sector on the new framework emphasized the importance of consistent national training for the assessment workforce. Further, that training should focus on reablement and restorative approaches to prevent or delay the need for higher level care. Prevention and reablement will be the focus of future Australian government policy and investment across mainstream services and the short-term care programs (*Transition care* and *Short-term restorative care*), which currently comprise a small proportion of aged care spending. Creating the right framework and incentives for assessors to balance the needs of consumers with the fiscal impact on public funds is an ongoing challenge for the Australian government.

5.2 Allocation of residential aged care places

Australia has moved to a market-driven model for the allocation of home care places, albeit within the constraints of demand-side controls over the release of funds. In residential care, however, the national government manages its fiscal exposure

through the periodic competitive allocation of additional places (bed licences) to providers (Aged Care Approvals Round – see *Planning and control of supply*). A significant consequence of this supply-side capping of subsidized residential aged care services is that providers have historically regarded the government, rather than consumers as the customer. The allocation process itself has lacked transparency and has supported the building and operation of standardized aged care facilities that have little appeal to many older people. There is little incentive to improve infrastructure beyond compliance levels. Around 14% of aged care residents in Australia are still in a 'ward style' shared room with a shared bathroom (Department of Health 2019f). The allocation process has also had the effect of limiting consumer choice, as providers can obtain bed licences to crowd-out local competition. Conversely, providers can sell bed licences and circumvent the planning process and rationale underpinning the release of places. Further, there is an ongoing problem of allocated places not being made operational in a timely manner, as providers apply for places before they are 'bed ready'. Overall, the Aged Care Approvals Round process has resulted in a lack of competition between providers and limited innovation in the design of facilities and services which better reflect consumers' needs and preferences (Department of Health 2019f).

The national government has commissioned a review into the impact of transitioning from allocating subsidized residential aged care places to providers to assigning them to consumers, bringing residential care in line with home care. However, the challenge for government will be to retain fiscal control when supply is uncapped without imposing the demand-side queuing which has proved problematic in the home care sector. Any reforms to supply would also have to consider the challenge of designing an assessment process that supports equitable, appropriate and sustainable access to age care services. The threshold for eligibility for residential aged care may have to be increased and the assessment of approved providers made more rigorous, since a more open market may result in residential care being delivered in a wider range of accommodation settings.

5.3 Staffing adequacy and pricing

Adequate staffing is crucial for the provision of quality aged care. Staffing adequacy is determined by a number of factors including the number of staff per consumer, continuity of staff providing care to individuals, skill mix (proportion of care provided by registered health professionals versus vocationally trained care staff) and appropriate training (OECD & European Union 2013). Staffing adequacy is also determined relative to the personal, social and clinical needs of the consumers receiving care.

Australia currently has no specific minimum standards for the number, skill mix or qualifications of staff providing aged care

services at home or in a residential facility. Standard 7 of the 2019 Aged Care Quality Standards stipulates that providers must have "a workforce that is sufficient, and is skilled and qualified to provide safe, respectful and quality care and services". There are associated requirements on providers to demonstrate they have a workforce planning and utilization process, regular reviews of staff competency and performance, and appropriate training. This self-regulation approach to staffing was introduced in 2014 when the distinction between high care and low care facilities was removed, along with the requirement for a registered nurse to be on duty 24 hours a day in high care facilities.

An international comparison of staffing levels and skill mix in Australian residential aged care facilities conducted by Eagar, Westera et al. (2019) suggests that self-regulation has not resulted in adequate staffing. Using the casemix adjusted USA Centers for Medicare and Medicaid system for comparing staffing levels, that study found that more than half of Australian aged care residents (57.6%) are in facilities with 'unacceptable' levels of staffing. Of the remaining, 27% were in facilities with 'acceptable' staffing, 14.1% with 'good' staffing, and 1.3% with best practice staffing. The study estimates that raising the standard so that all Australian aged care residents are in a facility with 'good' staffing levels would require an overall increase of 37.2% in total care staffing. There is no comparable research on staffing levels in aged care services delivered at home. However, the Royal Commission (2019b) reports that providers experience significant challenges with labour supply, access to quality training, and providing continuity of care for individual consumers.

Staffing accounts for around 70% of the cost of aged care services, therefore, it is crucial that the price paid by government and consumers reflects the staffing required for quality services. In Australia, the indexing of government payments has a broad wage cost element based on increases to the minimum wage. Price-setting policy, through ACFI and home care package levels, attempts to reflect the relativities of providing care for consumers of different levels of dependency and acuity. However, the relationship between the prices paid and the actual staffing costs needed to provide quality care is tenuous. There is no publicly available information on how the quantum of the care subsidies in residential and home care packages programs were originally set. A proposed new resident classification system, developed by Eagar, McNamee et al. (2019), calculated real staff time use data and input from experts to strengthen the link between staffing costs and prices. It also aims to overcome some of the other limitations of the ACFI system by separating the fixed costs of providing care within a facility from the variable costs associated with the different acuity levels of residents. It proposes that the assessment process for funding purposes (to be conducted by external assessors) be separated from assessment for care planning purposes (to be conducted by providers). An

independent assessment process for funding purposes would remove the current financial incentives for providers to assess residents at a higher level of support than their current need, and incentivize a reablement approach to care. At the time of writing, the Australian Government is piloting the new classification system, but there are no similar reforms proposed in the home care sector.

6
Lessons from the Australian aged care system

The delivery and funding of aged care services in Australia have undergone significant reform over the last decade, with further changes planned. This section identifies three lessons from the Australian experience which may have broader applicability to a range of other countries, particularly those with less publicly funded resources to draw on.

6.1 Designing services that better reflect consumer wishes and improve fiscal sustainability

The Australian Government is in the process of transitioning its policy and public funding emphasis from services that provide residential care for older people to those that support people to live in their own home for as long as possible. Residential care will always be required for the most frail and dependent in the community, including those with high level symptoms of dementia and chronic and complex health conditions. However, the level of public funding for the 'care' component in residential care does not reflect the cost of the skilled staff required to deliver quality services for those with higher care needs. At present, a little over 50 percent of all aged care homes in Australia are operating at a loss, as providers are squeezed between meeting the minimum quality and safety standards and paying for sufficient numbers and skill levels of staff (StewartBrown 2019). The level of financial losses in rural and remote areas are even more acute.

Investment in quality and tailored home care services offers a more fiscally sustainable solution to long-term care and one that is in line with the wishes of most older people and their families. However, for home care services to perform their function of preventing or delaying admissions to costly residential facilities and hospital care, they must also be delivered by a skilled workforce and organized to promote continuity of care. Challenges in labor supply and the variable funding associated with individualized care budgets make it difficult for providers to achieve this quality and continuity of care. A system designed to prioritize home care must also consider financial and social support for informal carers, since this too improves the sustainability and acceptability of long-term care at home.

Australia is beginning to shift from a reactive approach to service provision that responds when older people experience a deterioration in their health, function or cognition, towards services directed at preventing or delaying admission to expensive residential or hospital care. Such services must provide earlier access to supportive technologies, interventions to prevent or slow older peoples' decline in health and function, as well as reablement approaches in response to health and other crises. As discussed earlier, the lesson from the Australian system is that the assessment process and payment system must support these more sustainable interventions, rather than incentivize the use of more costly, reactive services.

6.2 Household wealth and the sustainability of aged care financing

Australia's median adult wealth is among the highest in the world (Credit Suisse Research Institute 2019). A large part of this wealth is explained by a high rate of home ownership combined with high real-estate prices, as well as a compulsory superannuation scheme. The value of the family home is usually exempt from an extensive range of government means tests. One notable exception is in the calculation of the government's contribution of residential aged care accommodation fees, but only if no partner or dependents are living in the home. A person whose home is valued in excess of A$ 169 079 must pay full accommodation costs, a low threshold value given the mean dwelling price in Australia is in excess of A$ 660 000 (ABS 2019b).

There have been calls to widen means-testing to a broader range of aged care services and to include assets such as the family home to improve both sustainability and equity (Woods 2020). This is particularly important in countries like Australia, which have relatively low levels of taxation, are heavily reliant on income tax and have high household wealth. Further, financial instruments are needed to help older households unlock their assets. The Australian Government's Pension Loans Scheme is an example of this, but is currently limited to those who qualify for an aged pension and therefore have limited means. Broader eligibility criteria would make it simpler and less costly for wealthier older people to contribute to their aged care needs as they become frailer.

6.3 Market mechanisms, quality and price

Australia's approach to the long-term care of older persons uses consumer choice and control within a market-based system to drive competition on quality and price. While the majority of consumers are satisfied with the quality of the services they receive, evidence from the Royal Commission into Aged Care Quality and Safety suggests that market mechanisms and the regulation of the sector have not had a universally positive effect on quality. In the delivery of home care services, there is some evidence that providers are instead competing on

price. Given government subsidies are set at a fixed rate according to need and consumers are typically price-sensitive and on fixed pension incomes, this competition is achieved in part by providers lowering the rates of consumer contributions. At the same time, the consumer-directed care approach for stimulating competition has increased administration costs in the implementation of accounting systems to manage and report individual care budgets. Consequently profits in the sector have fallen significantly since the introduction of consumer-directed care (ACFA 2019).

The experience of providing services in remote and rural Australia illustrates the limitations of market-based systems for sparsely populated, geographically remote areas (see *Box 1*). The Multi-Purpose Service Program offers an example of a viable model for more sustainable, integrated health and residential aged care services for sparsely populated areas. In contrast, the market-based HCP does not work well for remote and rural Australia, since there is often little choice between providers and travel costs consume a high proportion of individual care budgets. Alternatives, such as a competitive grant scheme to become the preferred provider for a defined population, may improve access and sustainability in rural and remote areas, especially if combined with the delivery of other services, such as disability care.

Box 1: Aged care programs for regional and remote Australia

Providing health and aged care services in regional and remote communities is a significant challenge for Australian national and state governments. The population in regional Australia is older than in the cities due to younger, regional migrants settling in the cities, while in remote Australia the population is younger due to Indigenous Australians having relatively high birth-rates and lower life expectancy. People living in regional and remote communities have higher levels of disease and injury compared to people living in cities due to lifestyle and social disadvantage factors, as well as poorer access to health services (AIHW 2019d). These demand factors are compounded by supply side challenges for health and aged care providers: a limited professional workforce; high costs of travel, freight and utilities; ageing infrastructure; and limited population catchment areas resulting in smaller scale services. Within current funding arrangements, larger residential aged care facilities (over 40 beds) can achieve economies of scale and, generally, financially outperform smaller facilities (ACFA 2016). Seventy percent of residential facilities in rural and remote have under 40 beds. In home care, travel costs can consume much of a home care package budget, while assigning the funding to consumers means providers can no longer pool funding to manage limited resources within small communities (Royal Commission 2019b). These financial pressures mean there are few for-profit aged care providers and limited consumer choice. Under

the following two programs, funding is paid to providers as a grant for a set number of 'flexible care places'. This funding is used flexibly to deliver residential and home care for each community.

The **National Aboriginal and Torres Strait Islander Flexible Aged Care Program** supports culturally appropriate residential and home care services to older Indigenous Australians on Country (ancestral land), close to family, community and language, mainly in remote areas (Department of Health 2019e). In 2018–19, 35 aged care services received funding of 44.1 million Australian dollars to deliver 1072 flexible places (Department of Health 2019a). However, there remains a significant shortfall in culturally appropriate aged care service for Indigenous Australians, especially in remote locations (Royal Commission 2019b).

The **Multi-Purpose Service (MPS**) Program was developed in 1993 as a joint initiative between the national and state governments to support sustainable health and aged care services in sparsely populated communities. The national government's grant for aged care places is 'pooled' with state government funding for hospital and community health services. Most MPS have residential aged care beds for permanent and respite care, and provide home support. In addition, MPS usually have an emergency department, a small number of inpatient beds, and deliver community health services. State governments are responsible for the health and aged care infrastructure and staffing. Users of MPS aged care services do not have to complete ACAT assessments, nor are they assigned an ACFI classification. The level of consumer contributions is limited and varies between states, creating a lack of parity with mainstream services.

The special arrangements for MPS funding have a number of benefits and drawbacks. The certainty of grant funding protects services against the fluctuation in income caused by variable occupancy, essential when fixed costs are relatively high. The ability to pool health and aged care funding creates the economies of scope needed to sustain services in sparsely populated areas. However, the standard flexible care subsidy is not linked to acuity although the age and complexity of aged care consumers is increasing. The lack of national government support for aged care infrastructure is a legacy of the original program where there was an excess of hospital beds and low-care hostels. This infrastructure no longer meets community expectations or aged care quality standards, and many state governments are forced to invest in new aged care infrastructure, usually a national government responsibility.

References

ABS (2018). Population Projections, Australia, 2017 (base) - 2066, vol. 3222.0. Australian Bureau of Statistics, Canberra.

ABS (2019a). Disability, Ageing and Carers, Australia: Summary of Findings 2018. Australian Bureau of Statitcis, Canberra, 4430.0.

ABS (2019b). Residential Property Price Indexes: Eight Capital Cities, Sep 2019, vol. 6416.0. Australian Bureau of Statistics, Canberra.

ACFA (2018). Report on respite for aged care recipients. Aged Care Financing Authority, Canberra.

ACFA (2019). Seventh report on the Funding and Financing of the Aged Care Industry. Aged Care Financing Authority, Canberra.

AIHW (2018). Older Australia at a glance. Australian Institute of Health and Welfare, Canberra, (https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/health-aged-care-service-use/health-care-gps-specialists)

AIHW (2019a). Aged care. Australian Institute of Health and Welfare, (https://www.aihw.gov.au/reports/australias-welfare/aged-care)

AIHW (2019b). Aged care for Indigenous Australians. Australian Institute of Health and Welfare, (https://www.aihw.gov.au/reports/australias-welfare/aged-care-for-indigenous-australians)

AIHW (2019c). People leaving aged care 2017–18. Australian Institute of Health and Welfare, (https://www.gen-agedcaredata.gov.au/Topics/People-leaving-aged-care)

AIHW (2019d). Rural and remote populations. Australia's health 2018. Australian Institute of Health and Welfare.

Barber SL, Lorenzoni L and Ong P (editors) (2019). *Price setting and price regulation in health care: lessons for advancing Universal Health Coverage*. Geneva: World Health Organization, Organisation for Economic Co-operation and Development.

Broad J, Gott M, Hongsoo K, Chen H and Connolly M (2013). Where do people die? An international comparison of the percentage of deaths occuring in hospital and residential care settings in 45 populations, using published and available statistics. *International Journal of Public Health* 58:257-67.

Credit Suisse Research Institute (2019). Global wealth report 2019 (https://www.credit-suisse.com/about-us/en/reports-research/global-wealth-report.html)

Department of Health (2017). Legislated Review of Aged Care. Australian Government Department of Health, Canberra.

Department of Health (2018). 2017-18 Report on the operation of the Aged Care Act 1997. Australian Government Department of Health, Canberra.

Department of Health (2019a). 2018-19 Report on the operation of the Aged Care Act 1997. Australian Government Department of Health, Canberra.

Department of Health (2019b). ACFI Monitoring Report - September 2019. Commonwealth of Australia, Canberra.

Department of Health (2019c). Aged Care Subsidies and Supplements. New Rates of Daily Payments from 20 September 2019. Commonwealth of Australia, Canberra.

Department of Health (2019d). Home Care Packages Program. Data Report 1st Quarter 2019-20; 2019d. Commonwealth of Australia, Canberra.

Department of Health (2019e). National Aboriginal and Torres Strait Islander Flexible Aged Care Program: Program Manual 2019. Australian Government Department of Health, Canberra.

Department of Health (2019f). Residential aged care: Proposed alternative models for allocating places. Discussion Paper;. Commonwealth of Australia, Canberra.

Department of Health (2020). Schedule of Fees and Charges for Residential and Home Care: From January 2020. Commonwealth of Australia, Canberra.

Department of Human Services (2019). Caring for an older Australian. Canberra. (https://www.humanservices.gov.au/individuals/subjects/caring-older-australian)

Eagar K, McNamee J et al. (2019). The Australian National Aged Care Classification (AN-ACC). The Resource Utilisation and Classification Study: Report 1. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong., Wollongong.

Eagar K, Westera A, Snoek M, Kobel C, Loggie C and Gordon R (2019). How Australian residential aged care staffing levels compare with international and national benchmarks. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong., Canberra.

OECD (2018). Accounting and mapping of long-term care expenditure under SHA 2011. Health Division.

OECD & European Union (2013). A Good Life in Old Age?: Monitoring and Improving Quality in Long-term Care. OECD Health Policy Studies. OECD Publishing, Paris.

Productivity Commission (2015). Housing Decisions of Older Australians. Commission Research Paper. Canberra.

Royal Commission (2019a). Carers of older Australians. Background Paper 6. Royal Commission into Aged Care Quality and Safety. Canberra.

Royal Commission (2019b). Interim Report: Neglect, vol. 1. Royal Commission into Aged Care Quality and Safety. Canberra.

Steering Committee for the Review of Government Services (2020). Report on Government Services 2020. Productivity Commission. Canberra.

StewartBrown (2019). Aged Care Financial Performance Survey Sector Report. http://www.stewartbrown.com.au/images/documents/StewartBrown---ACFPS-Sector-Financial-Performance-Report-September-2019.pdf

Swerissen H and Duckett S (2014). Dying well;. Grattan Institute. Melbourne.

The Commonwealth of Australia (2019). Budget 2019-20: Overview: Our plan for a stronger economy. The Commonwealth of Australia Treasury. Canberra.

Woods M (2020). Home-owning older Australians should pay more for residential aged care. The Conversation. Australian Edition. 18 February 2020.