



**Australian Government**  
**Productivity Commission**

Caring for  
Older Australians

Productivity Commission  
Inquiry Report  
Volume 2

No. 53, 28 June 2011

© Commonwealth of Australia 2011

ISSN 1447-1329

ISBN 978-1-74037-360-9 (Volume 1)

ISBN 978-1-74037-361-6 (Volume 2)

ISBN 978-1-74037-359-3 (Set)

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**An appropriate citation for this paper is:**

Productivity Commission 2011, *Caring for Older Australians*, Report No. 53, Final Inquiry Report, Canberra.

JEL code: I11, I18, H51

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## 6 Who should pay?

### Key points

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

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

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outlay for governments (with the Australian Government being the largest contributor, chapter 2).

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

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

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

This chapter first looks at whether the funding arrangements are sustainable over the longer term (section 6.1) before unpacking the concept of ‘aged care’ and addressing the questions — who should pay and what should they pay for (section 6.2). Chapter 7 looks at applying the funding principles in practice, while chapter 8 examines alternative (or additional) ways of funding aged care and enabling individuals with the capacity to pay to contribute more to the cost of their care.

## **6.1 Are existing funding arrangements sustainable?**

Although there is some uncertainty about the future costs of aged care, projections in the *2010 Intergenerational Report* are that Australian Government spending on aged care is likely to increase from 0.8 to 1.8 per cent of gross domestic product (GDP) by 2050 on a no policy change basis (Australian Government 2010d). The significantly higher government spending projected for aged care could be paid for by diverting spending from other areas and/or by increasing the average tax burden.

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

It is also true that if there is strong productivity improvement across the economy, growth in real GDP will mean a wealthier community with greater capacity to meet the additional costs associated with an ageing population. This points to the importance of continuing policy reforms which can lift Australia’s productivity performance and thereby more fully exploit the nation’s potential for improved

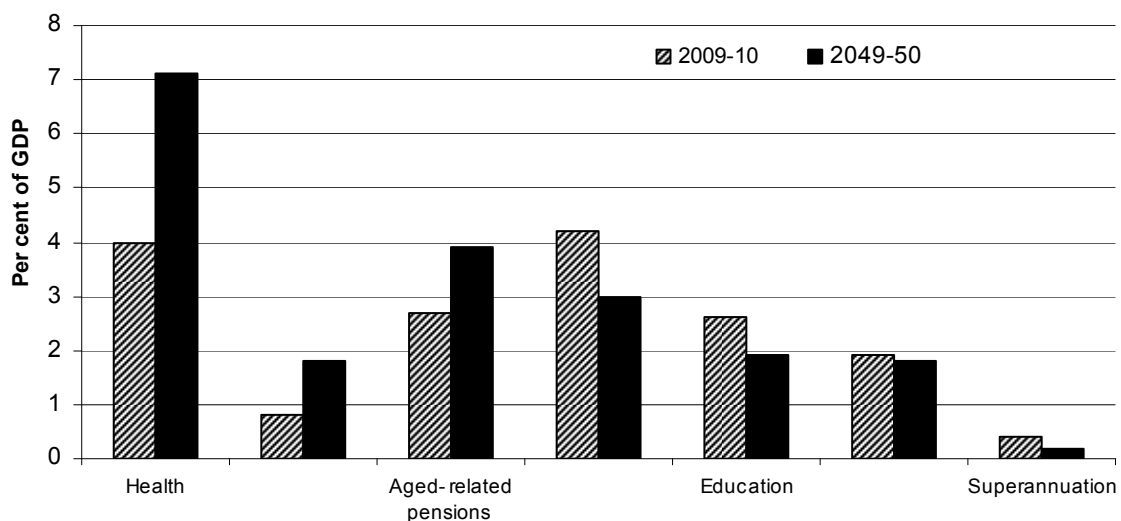


living standards (see, for example, PC 2010a). Stronger productivity growth will help to meet the fiscal demands of a pay-as-you-go financed system, although it is unlikely to fully obviate the need for tax increases and/or a reassessment of government expenditure priorities.

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

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

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



Data source: Treasury projections in Australian Government (2010a).

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## Intergenerational equity

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

### Box 6.1 Participants' concerns about intergenerational inequities

Aged Care Association Australia (ACAA) and Deloitte:

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

Aged and Community Services Australia:

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

Anglicare Australia:

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

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

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

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

The extent of the inter-generational wealth transfer ... should not be exaggerated. An effect of Commonwealth funding of aged care is to protect the bequests made by long term care recipients to their heirs. The exclusion of the family home from the assets

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tests used in determining eligibility for aged care subsidies is of central importance in this respect, as the family home is the primary asset most older Australians own and are in a position to pass on. As a result, the extent of the redistribution effected by the existing 'pay as you go' system depends on the degree to which the taxes used to cover current aged costs are correlated with the bequests that are being preserved. As that correlation seems likely to be quite high, the system may cause fewer intergenerational transfers than commonly thought. (2007, p. 13)

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

To better understand the extent to which tax rates would need to increase to meet future public aged care costs, Hogan (2004a) estimated at that time that if the projected increase was to be funded by taxpayers via a Medicare-style levy, the existing levy would need to more than double by 2043. Based on Australian Government spending on aged care increasing to 1.8 per cent of GDP by 2050, the Medicare levy would need to increase to 3.1 per cent (from 1.5 per cent) to meet this cost.

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

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

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## Box 6.2 The cost of funding government expenditure

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

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

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

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

*Source:* KPMG Econtech (2010).

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

A significant hurdle to increasing co-contributions for aged care is the low incomes of many older people requiring care. Treasury projects that around 36 per cent of the pension age population will receive a full rate Age Pension in 2047 (down from 55 per cent in 2007), while around 40 per cent will receive a part rate Age Pension (Australian Government 2010d). The rate of self-funded retirement is expected to increase only slightly, from 20 per cent in 2007 to around 24 per cent in 2047. These estimates, however, apply to the pension age population as a whole and not those aged 85 or older, among whom the need for aged care is concentrated.

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Even so, as recognised by the Organisation for Economic Cooperation and Development (OECD), the issue of sustainability relates to private expenditure as much as it does to public expenditure:

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

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

Many of the people who will soon qualify as ageing will have significant assets and resources — property ownership in particular, superannuation, savings and investments — with which to purchase the care of their choice where it is available. (sub. 461, p. 6)

If older Australian home owners could draw on their housing wealth, they could contribute more to the cost of their care. Being able to convert housing wealth into an income stream without necessarily selling the home could also mean that they could afford to pay for additional services over and above the approved care. Alternatively, Australians could be encouraged to save for their care costs or to take out insurance. These options are discussed in chapter 8.

### **Scope for better outcomes with the same dollars?**

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

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

... they create an artificial scarcity that limits the scope for competition, blunts pressure for efficiency and innovation and deprives consumers of choice. ... The result is an industry structure which, while it does secure some important policy objectives (such as geographic equity of access), does not make the most efficient use of scarce resources. The consequence is persistent technical inefficiency. (sub. 482, p. 52)

Hogan (2004b) found that aged care providers could be around 17 per cent more efficient if they were to operate at the most efficient level (recognising that it is not possible to have all services operating at this level). This translated into providers being able to care for around 23 000 more people (at dependency levels in

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2002-03). Hogan also estimated that costs could be reduced by a further 7 per cent (or \$470 million in 2002-03 prices) by making structural adjustments that improved the scale efficiency of the sector.

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

Some participants, in response to the claim that older Australians would need to contribute more to the cost of their care if the aged care system was to be sustainable, argued that the inefficiencies within the system needed to be addressed as a priority. Juliette Maxwell, for example, said:

... the Australian government needs to get its act together and get the aged care sector running cost effectively and efficiently BEFORE they can start reaching into older Australians’ pockets to fund aged care (as noted in the draft report, older people are now expecting more e.g. better quality services etc). (sub. DR528, p. 3)

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

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

Encouraging competition across providers, by providing care recipients with an entitlement to care rather than paying a direct subsidy to providers of services, has the potential to improve productivity and the quality of services for care recipients (chapters 9 and 10). Measures aimed at getting the different parts of the aged care system and the health care system to work together as more of a joined-up system are also discussed in chapter 9 and 10. Removing unnecessary regulatory constraints and redesigning regulations that currently increase the cost of providing

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services and/or impair competition also offer the potential for productivity improvements and enhanced efficiency (chapter 15).

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

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

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

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

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

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

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

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

**Box 6.3 Evidence on the effectiveness of reablement or restorative home support services**

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

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

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

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

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

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



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The allocation of aged care funds should be evidence based. Better monitoring and evaluation of programs will ensure that funds for government services are appropriately allocated between preventative and early intervention and care, as well as providing a basis for future policy direction. But the evidence base about what works best needs building further. The OECD recently made a similar assessment and suggested that there may be value in international research and collaboration:

Evidence on what works best remains scarce. There is therefore a strong need for focusing policy attention on the efficiency gaps in the sector. International research and collaboration on value for money and the development of measures or indicators of efficiency in LTC [long-term care] deserve much priority. (Colombo et al. 2011, p. 32)

Options for building a better evidence base are discussed in chapter 16.

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

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

Also, if subsidies for care and some accommodation charges are currently underfunded (as discussed in chapter 5 and 7), then ensuring subsidies accurately reflect the cost of supplying the care and accommodation would mean a larger aged care bill. This again points to the need to consider ways in which each generation can better contribute to the costs of their own care in old age (chapter 8).

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

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

- who should pay
- what should they pay for?

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

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

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

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

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

The Henry Review also recently concluded that:

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

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

### Council on the Ageing (COTA) Australia:

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

### National Seniors Australia (NSA):

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

### Anglicare Australia:

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

### Australian Nursing Federation:

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

### Australian Unity:

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

### Benevolent Society:

Separating the cost of the accommodation component from the care component may be difficult, but it is a vital move which will bring greater equity and choice to the system. (sub. DR805, p. 2)

## Accommodation and everyday living costs

Accommodation costs and everyday living expenses are reasonably predictable expenses of everyday life and are not especially associated with increasing frailty or

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disability. Older Australians living in the community (and Australians at other stages in life) are in general expected to meet these costs themselves and, as such, grounds for government subsidising these costs are weak, except for those of limited means. Indeed, the Australian Government makes provision to cover the costs of these services for those unable to pay for their own accommodation via the welfare system (providing public housing/rental assistance and income support). Subsidy design for aged care accommodation should take into account any additional costs of providing accommodation in residential care facilities and income support and other safety net provisions that may be in place.

Across the OECD countries ‘board and lodging’ costs are generally viewed as a social/housing risk and typically not included in public long term care coverage. Assistance is generally targeted to low-income people as part of existing social assistance or housing subsidy programs. The exception is countries with comprehensive long term care (LTC) systems (for example, Japan and some Nordic countries) but cost-sharing arrangements under these systems see board and lodgings accounting for a high share of residents’ income. As a recent OECD paper said:

It can be argued that all individuals should be required to pay at least for a minimum of their food and shelter-related expenses, regardless of the dwelling where they are living. It is also reasonable to expect that accumulated savings will meet some of the basic expenses related to food and shelter, including when a person moves to a nursing home. The policy debate with respect to the B&L [board and lodging] costs of a nursing home, then, is not on whether residents should pay for it, but *how much* and *what type* of expenses. (Colombo et al. 2011, p. 30)

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

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

Aged and Community Services Australia:

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

Sundale Garden Village:

The Government should remove itself from consideration of accommodation for anyone other than those who need a safety net. This reflects the reality of those in receipt of community care services, and would bring equity and social justice to all consumers seeking to access aged care services. It would also introduce a competitive

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structure to aged care services based upon consumer choice that does not exist under current legislation. (sub. 269, p. 32)

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

Provision of accommodation and provision of care should be separated, so that residential facilities become an accommodation choice, rather than a ‘compulsory extra’ provided in tandem with particular types of care.

The starting point should be that older people are able to provide/look after their own accommodation, regardless of the level of care they need. Residential care then becomes one of the choices they can make ... This approach could then lead to the emergence of different types of accommodation options (eg as in Sweden; smart house units) and/or changes in the way existing accommodation options are accessed/used. (sub. 196, p. 5)

Hal Kendig argued that separating accommodation from care was a priority as it would improve choice and independence for care recipients and reduce costs to taxpayers:

A priority for the Commonwealth government is to ‘unbundle’ the residential care program into separate funding for accommodation and care. ... This separation would provide more choice and independence for older people as they would not have to move into residential care in order to receive high levels of care. The Commonwealth would benefit because it would not have to pay for accommodation components of aged care for those individuals who can afford to meet their own accommodation costs.

... New supportive accommodation models offer the advantages of age-concentrated, purpose-built accommodation to which care could be delivered flexibly and economically as needed by residents. (sub. 431, pp. 5–6)

## **Care**

The ‘care’ component of aged care is a mix of health (or medical care) and personal care services.

### *Health care costs*

Aged care can include health services similar to those provided through the health care system. For example, the health component of care could involve a nurse administering injections or managing a care recipient’s pain and complex skin conditions. It could also include access to allied health professionals, such as physiotherapists and occupational therapists.

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The principles underlying the funding arrangements for aged care health services should be the same as those applying to other health care services. The Henry Review made the same assessment:

Governments need to finance the health care-related elements of aged care. Health care provided through aged care should be subject to similar charging arrangements as occurs in the health care system. This means that the health care component should generally be free or accompanied by modest co-payments. (2010, p. 632)

In the context of health care, however, the principles underlying the funding arrangements are not straightforward because a range of approaches apply. As a general rule, the government underwrites a significant proportion of the costs of essential health care for everyone requiring care (irrespective of their ability to pay), but a range of co-contributions apply. For example, there is no co-contribution attached to basic public hospital acute care and emergency department services. On the other hand, for general practitioner services, while all Australians are entitled to a non-means-tested subsidy, because of limited access to bulk-billing, many Australians make a co-contribution.

A further complication is that the distinction between aged care health services and personal care is not always clear, so a practical approach needs to be applied to this principle.

As with health services provided through the health care system, individuals should be able to use their private resources to purchase aged care health care services that are additional to the basic services that attract the universal subsidy.

### *Personal care costs*

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

- ADLs are a core set of self-care or personal care activities that include bathing and washing, dressing, feeding, getting in and out of bed, getting to and from the toilet and continence management
- IADLs relate to domestic tasks such as shopping, laundry, vacuuming, cooking a main meal and handling personal affairs (OECD 2008).

What is included in the ‘personal care’ component of aged care services, however, is contentious as the boundaries between living costs, personal care and health care are often blurred. For example, while food is a cost of everyday living, having someone assist with shopping and food preparation could be classified as ‘care’ (as

the person is unable to undertake these tasks because of frailty or disability), or as an everyday living expense.

Care costs (personal and health aged care costs) vary depending on the needs of the individual. They can range from less than \$1000 per annum for basic home support to around \$50 000 for some people with dementia on an intensive package in the community, and to around \$65 000 per annum for the highest cost of care services in a residential facility.

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

That said, it is reasonable to expect that, if you live long enough, you will need some form of care and support because of frailty. Lifetime risk estimates show that retiring Australians face a reasonably high probability of requiring care in older age. For example, 68 per cent of women and 48 per cent of men at 65 years of age will require some aged care services (CACP, EACH, EACH-D, Transition Care and permanent and respite residential care) at some time in their remaining life (table 6.1). The likelihood of needing these services increases with age up to 95 years.

**Table 6.1 Lifetime risk of requiring aged care<sup>a</sup>, 2006-08**

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

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

Source: Data supplied by DoHA.

For females aged 65 years, the likelihood of entering residential care in their remaining lifetime was 54 per cent and for males aged 65 years it was 37 per cent. The likelihood of entering residential care increases with age, although the risk declines again for the very old — in 2007-08 for females the likelihood of entering residential aged care was highest during their early to mid eighties (likelihood of around 60 per cent) while for males the likelihood peaked during their mid to late eighties (around 48 per cent) (DoHA 2011i).

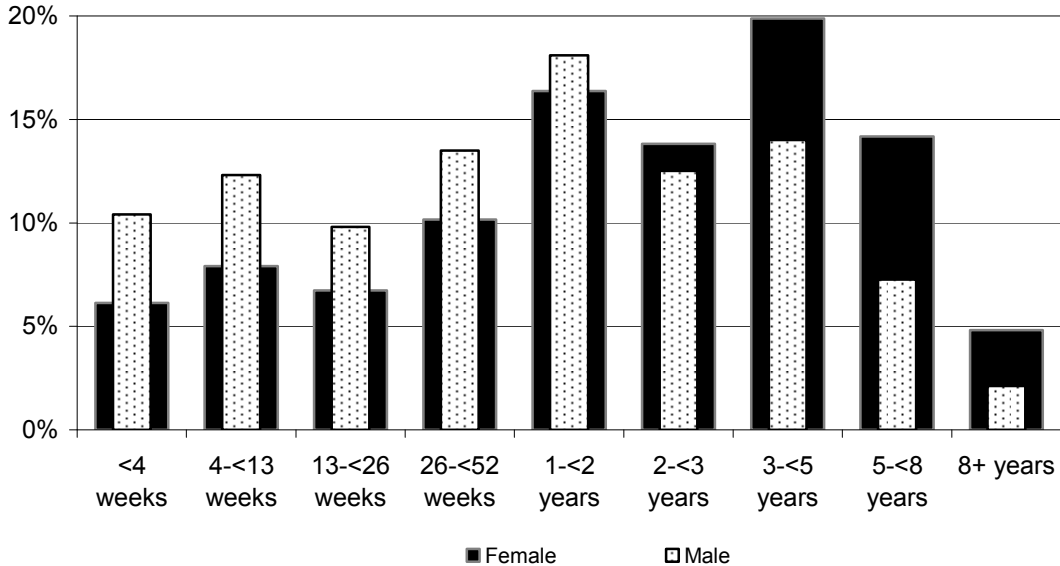
This suggests that some care costs should be considered a normal risk of growing old. And, because they are the more predictable and manageable costs of care associated with ageing, people should anticipate that they will contribute to those costs, except when they do not have the capacity to pay for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

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

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

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

**Figure 6.2 Duration of stay in residential care<sup>a</sup>**



<sup>a</sup> Per cent of people who were in residential care for at least some of the period July 1997 to December 2009. Sources: DoHA Aged Care Data Warehouse, supplied by DoHA on 24 September 2010; DoHA (2011i).



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The lifetime risks of requiring aged care services are not well understood. To make Australians more aware of these risks and the potential costs of such care (so they can be better prepared financially), there would appear to be a role for a public education campaign. This is discussed further in chapters 7 and 16.

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

Uncertainty about whether, when, and for how long an individual might need long-term care services suggests that pooling the financial risk associated with long-term care is a more efficient solution than relying solely on private out-of-pocket payments. Otherwise, the cost of long-term care services and support can rapidly become unaffordable, and not only for low-income seniors. Average LTC expenditure can represent as much as 60 per cent of disposable income for all but those in the upper quintile of the income distribution. The oldest old and those with severest care needs are especially at risk. (Colombo et al., 2011, p. 28)

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

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

To illustrate the potential welfare gains from insurance, if aged care costs were \$30 000 a year and one in six people needed care for an average of two years, the typical person would need care for one-third of a year, at a cost of \$10 000. There are two ways a person could seek to finance the costs:

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

Voluntary insurance, however, is unlikely to work or be equitable or efficient because of problems on both the supply and demand side of the insurance market (chapter 8). The other options are compulsory insurance (which is examined in

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chapter 8), or the government acting as the ‘insurer’ by offering a stop-loss mechanism (see below).

A lifetime stop-loss limit as part of a publicly funded system could protect individuals from very high costs of care. Such a limit could cut in either after a certain period of time of paying care costs (say after three years of intensive care) or after an individual had reached a cumulative level of ‘out-of-pocket’ payments. A key advantage of capping care costs to the individual would be to provide greater certainty for planning throughout life for aged care costs. As NSA said:

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

This issue is explored in more detail in chapter 7.

#### *How much should individuals contribute to care costs?*

As stated above, some care costs are reasonably predictable and manageable (the high probability costs) and others less so (low probability, catastrophic cost events). The more predictable personal care costs should be largely the responsibility of the individual, but there should be some mechanism in place for pooling the risk of the more unpredictable, and potentially catastrophic, costs of care.

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

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

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

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

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

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

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

ACAA and Deloitte also said:

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

The fact that it can be difficult to separate out health care services from personal care suggests that there is a case for providing an entitlement for some services to everyone who has those needs. However, as discussed earlier, within Australia's health care system there are a range of co-payment arrangements (public hospital acute care and emergency department services do not incur a co-payment while there are co-contributions subject to means-testing and a capped safety net for primary care services and pharmaceuticals). Ergas and Cullen noted that this reflects funding features inherited from both the pension and health care systems:

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

It may, therefore, be appropriate for the government to underwrite a significant proportion of the costs of some aged care services (for example, those services closer to health care, such as palliative care), while others would be subject to means testing or specified co-contributions (for example, low level assistance measures such as domestic help). A recent OECD paper noted that:

Determining the basket of domestic-care services generally involves a greater element of subjectivity (e.g. over the frequency of shopping trips, where to and for how long). Support for IADL can also be more readily provided by family, friends or the community, since there is generally more flexibility with their provision. There is therefore a rationale for targeting support on nursing care and basic personal-care needs, since their assessment is less subjective and there are also cost-control considerations. (Colombo et al. 2011, p. 269)

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

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decline in functionality. Also, as recently noted by the OECD, for the increasing number of dependent individuals with cognitive impairments, limiting support to personal care may not enable these people to live independently (Colombo et al. 2011).

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

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

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

### *International approaches*

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

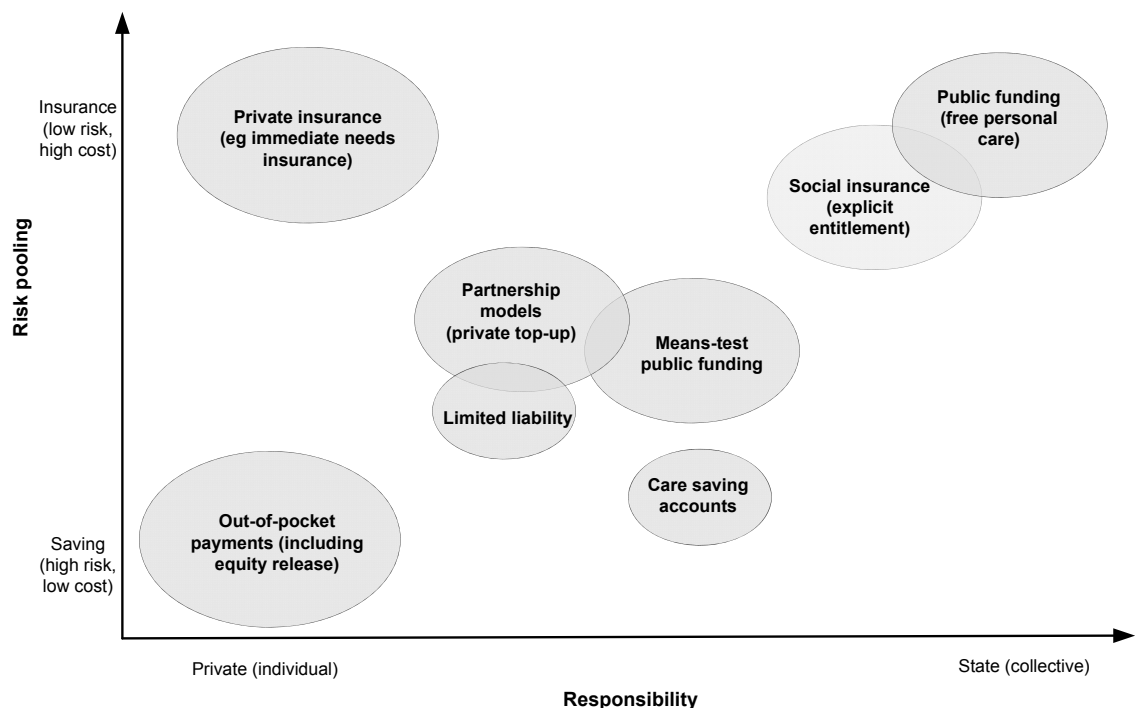
- *universal systems* where the majority of the population is entitled to publically funded care, with little need for private contribution. These include tax-based (such as Denmark, Sweden and Scotland) and insurance models (notably Germany, Japan and the Netherlands).
- *mixed or progressive systems*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

- *means-tested or safety net systems* where there is minimal state intervention with support directed to those who lack the financial resources to pay for services. The United Kingdom and the United States are included in this category (OECD, 2011).

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

At one end of the spectrum, some means-tested, safety-net approaches have been called into question, mostly on grounds of fairness and growing need ... At the opposite end of the spectrum, in comprehensive universal coverage countries, the range of services eligible for coverage has been subject to scrutiny and increased targeting to those on most severe needs. (Colombo et al. 2011, pp. 240–41)

**Figure 6.3 Archetypal funding arrangements**



Source: Wanless (2006, p. 253).

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

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

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

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

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

#### *Where does that leave us?*

Drawing on the preceding discussion, the Commission considers that the following principles should guide the funding of aged care:

- accommodation and everyday living expenses should be the responsibility of individuals, with a safety net for those of limited means
- health care services provided through aged care (such as nursing and allied health care), should be subject to charging arrangements consistent with those in the health care system
- individuals should contribute to the cost of their personal care according to their capacity to pay, but should not be exposed to catastrophic costs of care.

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

***The Australian Government should adopt separate policy settings (including for subsidies and co-contributions) for the major cost components of aged care, namely care (including personal and nursing care), everyday living expenses and accommodation.***

The next chapter looks at what unpacking the different cost components and applying the above principles mean in terms of changes to the current regulatory arrangements and examines options for improving funding arrangements.





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## 7 Paying in practice

### Key points

- For accommodation charges to reflect the market value of the service, regulatory restrictions on the number of community and residential care places and price controls need to be phased out over time.
- Under current arrangements, the interaction of the Age Pension means test with the accommodation bond instrument means that care recipients and providers are *not* indifferent between bonds and periodic payments. There is a strong bias towards bonds, and bonds that exceed the value of the accommodation provided.
- To avoid distorting choices between accommodation payment options, providers should offer a periodic charge and accommodation bonds that are equivalent (or lower) to that charge. All accommodation charges and bonds should be published.
- Some age pensioners faced with the choice of selling their homes to go into residential care, or a retirement village, could find themselves with surplus funds that would not be exempt from the Age Pension assets test. This is a disincentive to move to more 'appropriate' accommodation. A government age pensioners savings account scheme could be made available to age pensioners for investing any surplus funds from the sale of the principal residence and for those funds to be exempt from the Age Pension assets and income tests. The funds could be drawn upon to fund living costs, aged care and other expenses.
- To ensure adequate provision of an approved basic standard of accommodation for those with limited financial means, providers should continue to be obliged (but compensated) to make available a proportion of their accommodation (set on a regional basis) to supported residents. To improve flexibility, the obligation could be made tradeable between providers.
- While those with the capacity to pay should contribute to the cost of their care, a lifetime stop-loss mechanism could protect individuals against very high out-of-pocket expenses for aged care (recognising that voluntary insurance arrangements to do this are not available or likely to be feasible).

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This chapter looks at applying the funding principles established in the previous chapter to the various cost components of aged care. The funding principles are that:

- accommodation and everyday living expenses are reasonably predictable and should be the responsibility of individuals, with a safety net for those of limited means
- individuals should contribute to the more predictable and manageable costs of their care, but not be exposed to excessive costs associated with extended periods of intensive care.

The first section of this chapter (section 7.1) looks at applying the funding principles to accommodation expenses and what this means for changes to the existing arrangements for paying for accommodation. It also examines the issue of those who do not have the capacity to pay for their own accommodation expenses. Section 7.2 looks at applying the principles to everyday living expenses, while section 7.3 examines the application of the funding principles to the costs of care and how, in practice, individuals might be protected from excessive costs associated with intensive care for long periods of time.

## **7.1 Accommodation costs — applying the principles**

### **What are the current arrangements for paying for accommodation?**

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

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

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

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

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### *Accommodation charges — non-extra service high care*

Residents of high level residential care (not on an extra service basis) can be asked to pay an accommodation charge if they have assets above the minimum asset level of 2.25 times the maximum amount of the annual single basic age pension (\$39 000 at March 2011). The upper limit for any accommodation charge is regulated (currently the maximum amount is \$30.55 per day at an asset level above \$102 544). Accommodation charges are payable by high care residents for the entire period of their admission (with some exceptions), but cannot be charged for more than one-month in advance. In 2009-10, the average accommodation charge for new high care residents was \$22.51 per day (DoHA 2010n).

Residents can agree with their aged care provider to defer payment or pay it from their estate. The aged care provider can charge interest on the unpaid amount but at no more than double the lowest pension deeming rate applicable at the time of entering the facility. Residents who pay an accommodation charge can rent out their former home without the value of the home or the rental income affecting their aged care fees and, if applicable, their pension. The former home is exempted from the pension assets test for two years for all people entering residential care, and longer if the person's partner remains living in the home (DoHA 2011h).

### *Accommodation bonds — low care and extra service places*

An accommodation bond is an amount residents can be asked to pay when requiring low care or an extra service place. Bond amounts are agreed on between a resident and the aged care provider. A resident, however, cannot be charged a bond that leaves them with less than \$39 000 in assets.

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

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

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related to residential care, or to improve the quality and range of aged care services. The Government recently introduced legislation that widens the range of activities from which the income from accommodation bonds can be used (chapter 15).

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

### **Accommodation charges in high care do not reflect costs**

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

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

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

Ageis Aged Care Group also said:

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

Having the same charge for vastly different accommodation is inequitable, limits care recipients' choice, provides little incentive for providers to compete on quality, and fails to provide an incentive for care recipients to take into account the cost of provision in their decision-making. Providers are handing back allocated places, beds that have been approved have not been made operational, and interest in aged care allocation rounds (ACAR) has diminished. A number of industry surveys also

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indicate that the financial returns on high care places (not extra service places) are inadequate to justify future investment (box 7.1).

**Box 7.1 Participants point to evidence of insufficient returns on capital outlays in high care (non-extra service) places**

Toohey and Ansell identified some concerning trends:

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

Regis Group:

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

Government of Western Australia:

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

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

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

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

Stewart Brown's December 2010 survey of residential facilities found that 38 per cent of high care facilities (22 per cent in June 2009) and 44 per cent of low care facilities (39 per cent in June 2009) achieved an operating profit (sub. DR842, p. 12).

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In this context, Access Economics said:

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

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

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

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

### **Bonds in low care and extra service places also do not reflect costs**

Accommodation bonds, because they are only limited by an individual’s capacity to pay (the only limit on the size of the bond is that it must leave the care recipient with a minimum of \$39 000 in assets), and they are the only avenue of the market where providers have flexibility on price, have increased significantly in recent years. Bonds from new residents increased on average from around \$58 000 in 1997-98 to more than \$230 000 in 2009-10. Since 2004-05, the total value of accommodation bonds held by approved providers has doubled from \$4.3 to \$10.6 billion in 2009-10 — an increase of 20 per cent per annum. Since accommodation bonds are typically financed by the sale of the home, the growth in house prices is likely to be the major factor behind the growth in the size of bonds. To provide protection to the resident, the Government guarantees the bonds, for which providers are not charged (chapter 15).

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

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

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

The Henry Review described the bond as a ‘tax’ (levied by the private sector) rather than a user charge:

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

In 2008-09, anyone paying a bond of more than around \$80 000 was paying more for their accommodation than those paying an accommodation charge in ordinary high care. For the accommodation charge to be equivalent to the average bond in 2008-09 it would need to have been more than \$61 per day.<sup>1</sup>

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

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

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<sup>1</sup> Assuming forfeited interest of one year at 8.74 per cent (\$18 612) and the maximum retention in 2008-09 of \$292.12 per month, the annual (pre-tax) cost to the individual providing a bond of \$212 958 was \$22 118 or \$61 per day.

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

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

I was told that there was no maximum fee and that it depended on the assets.

I asked if she had a house worth \$1 000 000 would they take all of that. I was told that would be very unusual but yes they would take that into the equation. They would not give me a ‘retail’ price for the room. ... I don’t feel it is fair for villages to charge people on the basis of their assets with no limit as to what they can charge. It is contrary to the usual way in which our society operates. (sub. 58, name withheld, pp. 1–2)

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

... brings a remarkable discrimination. Those with substantial assets may effectively buy their way into high care by offering substantial bonds. Those lacking substantial wealth — not only pensioner and part-pensioner residents but also those of relatively modest wealth — are not able to offer anything to support the provision of services for them. *Thus the discrimination is against the less well-off in Australian society.* [Author’s italics] (2007, p. 2)

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

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

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

One option is to increase the daily accommodation charge for all high care so that the charge is adequate to cover average capital costs. But, with any new cap there is the risk of getting the price ‘wrong’ and it would need to be appropriately reviewed and/or indexed over time. And an average capped charge cannot accurately reflect the actual building costs of residential care in different regions nor would it allow older Australians to pay different accommodation charges for accommodation of



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different quality/with different features (a refurbished room with a view would have the same charge as an older room without a view). Some participants identified problems with this option. Aegis Aged Care Group, for example, said:

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

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

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

Under this market price option, accommodation costs to high care recipients and taxpayers (the accommodation subsidy for supported residents) are likely to be higher, but consumer choice and industry sustainability would be enhanced. Care recipients, however, would continue to be charged differently according to the level of assessed care need (high or low care) not the standard of accommodation they have chosen. There is also a concern that, as providers could charge what the market would bear, care recipients could be exploited and those with a lower capacity to pay would miss out. This is a greater concern in the short term, particularly in areas where there is limited competition. But in the longer term, provided that the accommodation subsidy is adequate to cover the cost of supply, there should be improved access as providers are more likely to build new places with higher returns on accommodation. Transitional issues are discussed in chapter 17.

### *Bonds for high care?*

The majority of participants saw the extension of bonds to high care as the ‘solution’ to under-investment in high level residential aged care services, and for removing the artificial distinction between high and low care (box 7.2).

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

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## **Box 7.2 Support for removing restrictions on bonds**

### **Australian Unity:**

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

### **ECH joint submission:**

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

### **Clubs Australia:**

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

### **Older People's Reference Group:**

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

### **Aged Care Association Australia — South Australia:**

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

### **Blue Care:**

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

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

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

Community concerns about extending accommodation bonds to ordinary high care places have in the past been a major stumbling block to reform in this area. In 1997, the Government proposed accommodation bonds for high level care but the proposal was quickly retracted as a number of baby boomers (supported by various stakeholder groups) strongly objected to the prospect of losing control over their

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inheritances. A more substantial concern relates to care recipients having to pay large up-front bonds when they are expected to only need high care for a short period of time (for example, the very frail or those entering residential care for end-of-life care).

### *Choice in payment options for accommodation*

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

Many participants called for choice in accommodation payment options:

... because the life time savings of many Australians is in the form of home ownership, flexible payment arrangements will be necessary to cater for individual circumstances. (Catholic Health Australia, sub. 1, p. 13)

Residents need to have a means to be able to choose how they contribute towards their accommodation costs. We need flexible high care accommodation payment arrangements. There will be further pressure on the Aged Care Sector with current and future generations having higher expectations of choice, flexibility and responsiveness in how they use and access aged care services. (Anglican Care, sub. 49, p. 2)

... people should have options for how they pay for accommodation in a residential aged care facility. Options could include paying rent, deferred contributions from estates, a refundable lump sum which in effect is a loan, or other negotiated arrangements. (Aged and Community Services Australia, sub. 181, p. 4)

Residential aged care accommodation could be funded by a periodic charge (for example, daily, weekly or monthly rental payments), a lump sum, a deferred payment, or some combination of these options. Such an approach would be consistent with an aged care system that offers flexibility and choice. But, the payment options need to operate such that they represent equivalent amounts which cover the value of accommodation.

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

As discussed earlier, older Australians entering low care and extra service high care already have the option of paying a lump sum bond or an equivalent periodic

payment or a combination of the two, but care recipients' take-up of the periodic payment option has been low (table 7.1).

**Table 7.1 Method of payment of bonds**  
Percentage of all bond-paying new residents

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

Sources: DoHA (2009e, 2010n).

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

- providers' strong preference for bonds combined with constrained competition (arising from supply restrictions) which has allowed providers to offer care recipients little choice about the method of payment
- income and asset tests within the broader welfare system (the Age Pension in particular) which create incentives for residents to pay lump sum bonds
- evidence that clients are not well informed about their payment options (box 7.3).

Bonds are particularly attractive to providers as a form of accommodation payment because they allow providers to offset bank debt with zero interest debt. The benefits to providers from negotiating large bonds can be significant. As shown in table 7.3, the interest that can be saved on \$200 000 is around \$17 000 a year. As Hogan put it:

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

Bonds also allow providers to leverage their equity — magnifying profits over a relatively small pool of equity and similarly magnifying losses. Thus bonds can systematically increase leverage and providers' risk and return.

### Box 7.3 Complexity of bonds and importance of information

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

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

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

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

As shown in the table 7.2 large bonds can result in poorer outcomes (compared with the other options) for taxpayers and the care recipient/bequest.

**Table 7.2 Big bonds = poor outcomes for taxpayers + individuals<sup>a</sup>**

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

<sup>a</sup> Assumes that the resident stays for one year and a borrowing cost by the residential aged care facility of 8.5 per cent, no transactions costs on the sale of the home and does not account for the cost to the Government of the Commonwealth Seniors Health Card.

Source: Commission estimates.

**Table 7.3 High bonds — an attractive option for providers**

<i>Bond</i>	<i>Interest<sup>a</sup></i>	<i>Retention</i>	<i>Total</i>
(\$)	(\$ pa)	(\$ pa)	(\$ pa)
100 000	8 500	3 690	12 190
200 000	17 000	3 690	20 690
300 000	25 500	3 690	29 190
400 000	34 000	3 690	37 690
500 000	42 500	3 690	46 190
600 000	51 000	3 690	54 690
800 000	68 000	3 690	71 690
1 000 000	85 000	3 690	88 690

<sup>a</sup> Assumes an interest rate of 8.5 per cent per annum as a conservative estimate of borrowings costs.

Source: Commission calculations.

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

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

Another constraint on the negotiating power of care recipients is the quantitative restriction on bed numbers which enhances the negotiating power of providers by allowing them to charge what the market will bear.

Constrained competition can be addressed by reducing and ultimately removing controls over the number of places that currently reduce competition and restrict consumer choice. As discussed in chapter 5, many participants to this inquiry pointed to the costs associated with supply constraints and recent reviews have argued the need to remove the restrictions on the number of community care and residential places.

Department of Health Australia (DoHA) also acknowledged the costs associated with supply constraints:

Fundamentally, the planning ratios help manage the Commonwealth’s fiscal risk. However, they create an artificial scarcity that limits the scope for competition, blunts pressures for efficiency and innovation and deprives consumers of choice. This, in turn, means that suppliers face little threat of displacement and limited competitive pressure to be efficient, although the regulatory constraints placed on provider’s incomes do provide some incentives to achieve efficiencies. Market power is intensified locally because consumers seeking a place, especially in high-level care, often doing so as a

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time of emergency, and usually have preferences as to the location of the facility. These features further increase the market power arising from rationing, and add to the blunting of pressures for efficiency. (sub. 482, p. 52)

The Commission proposes the removal of restrictions on the number of community care packages and residential care beds as well as removal of the distinction between high and low care, with appropriate transitional arrangements to support this reform (chapter 17). This will improve providers' ability to respond to the needs of users and facilitate greater consumer choice of facilities where care can be received. Price regulations could be gradually relaxed as the level of competition in the sector increases (price regulations are currently in place to prevent the abuse of localised market power).

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

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

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

The legislative framework of the Aged Care Act, and in particular the requirement for an independent assessment of need by Aged Care Assessment Teams, helps support sustainability by targeting services to those with greatest need. The Act's means testing arrangements for residential care also assist in this regard, both by altering the balance of public/private financing and by ameliorating the issue of moral hazard and provider induced demand. (sub. 482, p. 60)

### *Interaction of bonds with the Age Pension assets test*

But, constrained competition is only part of the story. The preparedness of some older Australians to pay large bonds is also driven by them wanting to meet the

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asset test for the Age Pension. They have an incentive to pay a large bond as, like the family home, the bond does not count towards the Age Pension assets test<sup>2</sup>. This overcomes a concern of many older Australians currently in receipt of the Age Pension who, if they sold their house and invested the capital, may no longer be eligible for a pension or part pension (with its attendant benefits, including lower co-contributions for aged care services and access to a health card).

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

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

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

Uniting Care NSW/ACT also said:

... interaction with the pension means test makes it attractive for residents to trade-off higher entry bonds against lower daily fees. This creates opaque, poorly targeted transfers between taxpayers (who bear the costs of increased pension entitlements that result from higher bond payments) and providers of care (who benefit from the reduced price elasticity of demand with respect to entry bonds). While this also occurs in low care, the consequences are especially perverse in high care, where it creates a degree of taxpayer subsidy of extra service places (as only extra service providers can charge bonds, and hence benefit from the transfer). It is difficult to believe that any of these outcomes would be intended or desirable. (sub. 369, p. 22)

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

- to maximise the size of the Age Pension received by the care recipient
- to minimise the cost of care for care recipients

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<sup>2</sup> And, since accommodation bonds are interest free, the income test is not relevant.



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- to maximise revenue for providers.

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

There is also the prudential risk from the accommodation bond regime that is currently taken up by the Australian Government, as it acts as an unsecured creditor for residential care providers (and in turn provides a guarantee to older Australians purchasing a bond). These arrangements impose further costs on taxpayers. The Government has recently committed \$21.8 million over the next four years to support enhanced protections to further safeguard the more than \$10.6 billion of residents' savings held in aged care accommodation bonds by approved providers (DoHA 2010g) — see chapter 15.

The Commission considers that residential providers should be charged a fee to reflect the cost to taxpayers of providing the Government guarantee on accommodation bonds.

### *Where does that leave us?*

Essentially, the interaction of the Age Pension means test with the accommodation bond instrument, means that the care recipient and the provider will *not* be indifferent between payment options. In particular, care recipients and providers will be strongly biased towards bonds, and particularly towards bonds that exceed the cost of supplying the accommodation. To avoid distorting choices between accommodation payment options, the incentives shaping choices for care recipients and providers need to be neutral.

## **Some solutions**

### *A first best option*

A first best option would involve having a means test for the Age Pension that treated income and assets in a consistent manner and did not exclude particular assets (such as accommodation bonds and the principal residence). Such an approach would recognise that an individual's (of family's) financial position is made up of both income streams and assets and that, arguably, it is unfair to treat people with the same financial position<sup>3</sup>, but with different mixes of income and assets, in different ways. The Pension Review Report (Harmer 2009, p. 121), said

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<sup>3</sup> In principle, a person could have exactly the same overall financial position with an income stream or an equivalent asset. A person's financial position comprises their assets and income.

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that ‘means testing needs to target payments in a way that does not induce inappropriate behavioural responses, and which is seen as fair and equitable’. The exemption of accommodation bonds from the asset test for the Age Pension appears to be inducing behavioural responses that are costly to taxpayers.

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

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

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

### *Alternative options*

In the context of the present means test arrangements for the Age Pension, the Commission has considered alternative (or second best) options, including:

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

### *Not allowing bonds*

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

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

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

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

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

The Commission is not attracted to this approach.

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

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

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

A single capped amount carries the risk of getting the cap ‘wrong’ (so the price does not reflect the underlying value of the accommodation) resulting in the same

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problems that arise from the capped accommodation charge. An average capped amount also cannot accurately reflect the actual building costs of residential care across a diverse range of regions.

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

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

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

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

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

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

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

To ensure transparency and maximise competition, providers would be required to offer a periodic accommodation charge (that they set) and for that charge to be published. Providers could also choose to offer a bond option, but the value of the bond would need to be equivalent to (or less than) the periodic accommodation charge. It would also need to be published. This would improve the transparency of accommodation payments and older Australians’ understanding of the prices for accommodation in residential facilities.

The daily charge for those needing short term (including episodic) stays could be the same as for longer-term stays but with additional ‘turnover’ costs of entry and exit as appropriate, much the same as a hotel often charges a lower daily rate for a

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longer stay. Bond retention amounts (in their current regulated form) would be abolished.

Such an approach would mean that accommodation payments would be set by providers according to prevailing market conditions and would reflect different quality/features without requiring valuations of each and every facility. The Commission is attracted to this option as it would make transparent the 'price' of accommodation, provide flexibility on payment options, and give an incentive for providers to be neutral between receiving periodic charges or bonds. While some participants supported the idea of ensuring neutrality between periodic charges and bonds, and the requirement that all accommodation charges be published, others expressed concerns about how such an approach might work in practice (box 7. 4).

**Box 7.4 Participants' view on accommodation charges and bond equivalents**

**Aegis Aged Care Group:**

We agree with the Commission's view that the accommodation charge should be determined by the Provider based on the commensurate cost of the accommodation supplied. ... both the Accommodation charge and an equivalent accommodation bond should be set by the Facility and advertised. (sub. DR564, p. 2)

**Baptcare:**

A risk premium for RAC residents who are charged a bond, instead of an accommodation charge, will be required to ensure the bond covers the cost of accommodation. The two risks that would need to be priced into the risk premium would be the cost of uncertainty associated with the resident's length of stay and fluctuations in interest rates over that period. (sub. DR689, p. 2)

**DoHA:**

The Commission's proposal that residents have the choice to pay an accommodation charge through a periodic rather than a lump sum payment is already part of the current accommodation bond arrangements for low care. Even with such a requirement, there is a risk that care recipients who choose to make a periodic payment may be less 'attractive' to providers and face additional difficulties in negotiating access to care. (sub. DR694, p. 6)

A number of participants called for a 'formula' for calculating the periodic and bond equivalent amounts. Aged & Community Services Australia, for example, said:

Agreement on what is taken into account in determining the cost of accommodation is critical for ensuring payments actually cover the building and ongoing costs of providing residential care. Determining the cost of accommodation should be tied to key construction principles and associated costs. At a broad level ACSA asserts that these principles and the broad cost headings would, as a minimum, include land, construction, financing and a margin for the associated risk given an increasingly

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competitive market place. ... The final report should include these principle level categories for setting the cost of accommodation to guide development and support implementation (sub. DR730, p. 7)

The Commission is deliberately not being overly prescriptive about ‘how’ the periodic payments and bond equivalents should be calculated, rather, allowing providers to flexibly adapt the inputs to reflect their circumstances. The importance of flexibility, as noted by Aged & Community Services Australia, was also stressed by other participants. Catholic Health Australia, for example, said:

CHA supports the removal of the current regulatory restrictions on accommodation payments to allow consumers the choice of a rental or bond payment, subject to providers offering consumers an accommodation bond that is equivalent to, but not more than, ‘the cost of supply’. CHA’s support for this approach is conditional on the ‘cost of supply’ being determined by each provider based on local market conditions and building and room amenity. (sub. DR748, p. 8)

However, flexibility is desirable only to the degree that it does not subvert the objective of the equivalent payment options.

Some aged care providers raised concerns about the requirement to offer a periodic payment leading to a shift by care recipients away from paying bonds. One suggestion was that pensioners would sell their houses, place the full proceeds into the proposed Australian Government Pensioners Bond (now called the Australian Age Pensioners Savings Account, see below) and then pay the periodic payment from the Pensioners Bond (COTA, sub. 565). Others argued that as they rely on bonds to fund the construction of facilities, reduced bond amounts and reduced numbers of people paying bonds will significantly increase their risk profile. DoHA, for example, said:

Given that mismatches between the refunding and receipt of accommodation bonds can give rise to cash-flow and liquidity problems, there are potentially significant risks here. (sub. DR694, p. 5)

Cook Care Group also said:

Low Care or Extra service High Care are at most risk as they have an existing Bond Pool which is in danger of being depleted if bureaucratic interference rather than market forces and public choice are the determinants. They should not be exposed to having a depletion in the Bond Pool as this will activate a call on additional equity by financiers and many providers may not have this as all their assets are already secured by the banks. A call on equity would place the Bond Pool at risk as Bonds going out are not able to be replaced to retain the debt level. Some providers might fail and this is unfair as these providers are the ones whom have invested in new stock under the existing system. (sub. DR850, p. 1)

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In the short term, some providers may have to borrow to fund the payout of existing bonds, but this is a transitional issue as the Commission's proposed approach reduces the overall risk to providers by enabling an adequate return in all segments of the market (whereas currently providers argue that the returns on high care places are inadequate).

One option is to provide transitional assistance to help providers to reduce their reliance on bonds relative to periodic payments during the implementation period. This acknowledges that it may take some time for the commercial lending market to gain confidence in the sector being able to make a reasonable rate of return in all segments of the market (and therefore be able to service and repay borrowings). A proposal is discussed in chapter 17.

Some participants expressed concern about abolishing retention amounts, arguing that it would result in an escalation of current bond amounts as providers seek to compensate for a lost income stream. As Sir Moses Montefiore Jewish Home said:

At the current permissible retention of around \$3700 per annum and assuming a market interest rate of, say 6%, a provider would need to increase the bond amount by \$61 000 in order to recover the lost income. ... there is a compelling argument to suggest that the older person should have the right to pay retention of the amount they choose in order to offset the upfront cost. ... By denying the older person the option to pay retention, the system is effectively protecting the inheritance of the older person's beneficiaries at the detriment to the older person themselves. (sub. DR512, p. 1)

Village Baxter also said:

... we consider that a provider should be able to have retentions from a bond balance as a part of their contract with the consumer. We do not believe that this will lead to unfair contracts as consumers are empowered to move to alternative suppliers for their needs. The benefit of having a retention scheme for a bond is that it will enable providers to adopt creative approaches to the setting of bonds and should result in a lower bond being charged. (sub. DR 852, p. 3)

Provided that any retention amounts are linked to the published charge and bond amount, and care recipients are fully informed about the payment options, the Commission considers that such flexibility in payment options could be allowed. The objective is not to dampen innovation in payment options (it is important that providers can respond to the preferences of care recipients), but rather to have transparent pricing arrangements in place whereby the market value of accommodation is reflected in the accommodation charge.

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*Removing disincentives that make pensioners reluctant to move to more appropriate accommodation*

With accommodation bonds reflecting the market value of the accommodation, rather than their ability to pay, some age pensioners selling their homes to go into residential care or a retirement village could find themselves with surplus funds that would not be exempt from the Age Pension assets test (so they could lose part or all of their pension). This already acts as a significant disincentive for older people to move to more ‘appropriate’ accommodation for their care needs. The introduction of periodic accommodation charges in residential care, and bonds which more closely align to the value of the accommodation will add further to this disincentive. As Australian Unity argued:

According to current Centrelink arrangements, retirees moving into a retirement village are penalised for selling their existing house to move into a retirement village, since the equity released from the family home is added to their assets and decreases their pension amount. This has led to a tendency among pensioners to ‘arrange’ their finances in such a way that they can retain assets/income to pass on and maximise the pension.

The government should, in fact, be rewarding pensioners to better use their own income to maintain their own health and wellbeing, where it is possible for them to do so. (sub. 459, p. 1)

Chapter 12 discusses the broader welfare and health benefits from living in age appropriate accommodation. There can also be savings made from the delivery of care in congregate and age-friendly accommodation. There are sound public policy reasons, therefore, to remove such disincentives.

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

One option, favoured by the Commission, is to establish a pensioners savings scheme, provided or backed by the Government, that would be available for age pensioners selling their homes. Under this arrangement any surplus funds from the sale of the home could be invested in the Government scheme. It would offer an alternative (or supplement) to an accommodation bond and be exempt from the Age Pension assets test. Older Australians using this facility could draw upon it to fund their day-to-day living expenses, their aged care costs or any other expenses. The scheme would be free of entry, exit and management fees. The Government could



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guarantee the capital and maintain its real value through indexation at the consumer price index (CPI) rate to make it more attractive than an accommodation bond which does not pay interest. However, further deposits to the savings scheme — beyond those realised from the sale of the principal residence — should not be permitted to ensure that the exemption from the Age Pension assets test is quarantined to the presently exempt principal residence.

The Government could directly provide the product, or contract the private sector to do so. But if the latter, the liability should stand on the Government's balance sheet. The savings scheme would only be available to age pensioners who wished to sell their own home. Many participants supported the idea of such a scheme (titled a Pensioners Bond Scheme in the draft report). COTA, for example, said:

The proposal that if you sell your house the money left over after the loan can go into an indexed government deposit and be exempt from the pension income and assets tests should be very welcome. It will significantly assist many people to pay for care and accommodation. (sub. DR565, p. 11)

Australian Unity suggested that it would boost interest in the retirement sector:

I think the pensioner bond scheme will really help to increase interest in the retirement sector. One of the most common reasons that people who are part-pensioners face is actually 50 to 300 thousand dollars, the general difference in price between their home and the unit that they purchase, so that can have a significant impact on their pension. (trans. p. 9)

Some questions, however, were raised about the adequacy of the CPI rate as the interest rate applied. For example, National Seniors Association argued the need for a positive rate of return on investment and suggested the long term Treasury bond rate on the basis that:

First, over the long-term, wealth invested in housing or other asset classes would be expected to achieve a real, positive rate of return, that is, a return above the rate of inflation (CPI). Without this prospect, many older people would be reluctant to sell their home and invest the proceeds in the Bond, even if otherwise this would be a sensible course of action to fund their expenses as they age.

Second, ... Government subsidies and the life-time stoploss limit on care costs will all rise over time. ... It is highly likely that such prices and costs would rise faster than the Consumer Price Index, quickly eroding the purchasing power of the capital invested in the Bond. This scenario makes it imperative that the Bond scheme deliver some measure of growth for consumers. (sub. DR832, p. 21)

The Commission considers the CPI to be the appropriate rate because of the significant advantage of funds under the associated scheme being exempt from the Age Pension assets and income tests (recognising the benefit to pensioners of retaining the Age Pension and associated benefits). Older Australians would

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continue to have the option of investing their funds elsewhere and earning the commercial rates available in the market.

Because of some confusion around the term ‘bond’, the Commission proposes that the scheme be retitled the **Australian Age Pensioners Savings Account** scheme. In implementing the proposed scheme, the Government should consider any necessary compliance measures to ensure that the scheme is used as it is intended and not abused. The Commission also suggests that the scheme should be kept as a Government-backed scheme (with private providers under contract) rather than allowing the private sector to offer competing products with an assets test exemption.

Introducing such a scheme that is exempt from the Age Pension means test, in conjunction with the Commission’s other proposals, will change the dynamics of the age care market including incentives for paying large accommodation bonds for three reasons:

- the market power of providers will be reduced with the freeing up of supply
- residents will not be able to avoid assessed care co-contributions by paying large bonds
- the Australian Age Pensioners Savings Account will be more attractive than an accommodation bond as it will maintain its real value over time.

Providers may seek to exploit the continuing exemption of accommodation bonds from the Age Pension assets test and the government guarantee on accommodation bonds in response to the new competition from the Savings Account. One response might be to pay interest on accommodation bonds, which would still be a more attractive form of debt to providers than bank debt. However, as the Government is providing considerable concessions to providers by allowing the assets test exemption and providing the guarantee, it should not allow providers to pay interest on accommodation bonds.

### **What about accommodation costs for short-term stays?**

A further issue is the approach to charging for accommodation for shorter stay transitional residents such as those using facilities for residential respite, transitional care, reablement, rehabilitation and sub-acute care. Typically individuals requiring care in such facilities also continue to pay for the cost of their principal residence and this provides a rationale for not requiring them to pay the full cost of the extra accommodation. This point was recently made in an OECD paper:

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Higher user charges for the cost of B&L [board and lodgings] in a nursing home contrast with the significantly lower charges paid for the accommodation in hospitals or other short-stay acute care settings. The main rationale for the difference in cost treatment lies in the notion of what is considered as a principal residence. Typically, for those receiving care on a temporary basis, either in hospital or in a nursing home, one's principal residence continues to be the house or apartment. (Colombo et al. 2011, p. 273)

For those services more closely aligned to health care, the costs of accommodation could be included in a total care package of costs that are largely publicly funded — drawing on the policy adopted for acute care in public hospitals. For residential respite, daily or weekly subsidised accommodation charges could apply.

### **What about those people who can't pay for their accommodation?**

One of the objectives of the *Aged Care Act 1997* (the Act) is to facilitate access of older Australians to residential aged care where they do not have the financial capacity to meet accommodation costs (box 2.1). To meet this objective, the Australian Government has obliged residential aged care facilities to meet a supported resident ratio and pays accommodation supplements to approved providers for eligible residents.

An assets test is used to determine eligibility for a supported resident.<sup>4</sup> A sliding scale of accommodation charges applies as the level of assets increase. Hardship provisions are also available for care recipients (DoHA 2010n).

Facilities are expected to meet regional targets (set by DoHA) for places for supported residents. The targets range from 16 per cent to 40 per cent and are calculated using the Socio-Economic Indexes for Areas. The amount of the accommodation supplement paid for a supported resident depends on:

- the level of the resident's assets
- whether or not the service meets fire and safety requirements
- the proportion of supported residents in the facility.

Facilities with more than 40 per cent of supported residents receive the full rate of the accommodation supplement. Facilities with 40 per cent or less of supported residents receive only 75 per cent of the accommodation supplement.

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<sup>4</sup> There are also some grandfathered categories: concessional and assisted residents. For the purposes of this inquiry, these are treated generically as 'supported' residents (see DoHA 2010n).

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Many facilities with extra service status are exempted from the supported resident ratio requirement (extra service status is only granted if the arrangement will not affect the access of supported residents to residential accommodation in their region). However, the ratio does apply to the non-extra service places in a service where the extra service is a distinct part of the overall facility. In 2010, around 310 or 8 per cent of all Residential Aged Care Facilities (RACF) provided extra service places.

In 2009-10, \$515.4 million was paid to providers as accommodation supplements for residents who were unable to meet the full cost of their accommodation. At June 2010, accommodation supplements were provided to 63 218 supported residents (including concessional and assisted residents). This equates to around 39 per cent of residents receiving supplements for accommodation costs (DoHA 2010n).

### *Participants raised concerns about supported residents*

Some participants raised concerns about services being maintained in areas of high socio-economic disadvantage if planning ratios and bed licences were phased out. For example, Mercy Health said:

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

A number of participants were also critical of the current mandatory requirements and the structure of the accommodation supplements. Aged Care Association Australia SA, for example, said:

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

Melbourne Citymission stated:

We are regularly moving backward and forwards across this 41% threshold level, at times achieving only 38% to 40.7%. In these situations, the Supplement rate that we currently receive is only \$12.31 per day rather than the \$18.82 full rate. This represents a 35% penalty. For Melbourne Citymission, the annualized impact of this penalty is \$42,000. (sub. 173, p. 22)

The requirement to have more than 40 per cent supported residents in a facility to access the full rate of the accommodation supplement means that the payment is based (to some extent) on the proportion of supported residents rather than the cost

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of supplying the accommodation. The significance of the 25 per cent discount is also likely to distort providers' decisions about supported residents. As Hogan said:

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

### *The Commission's proposals for supported residents*

The supported resident payment should be a clearly defined payment for accommodation and the payment should be sufficient to meet the full cost of providing an approved basic standard of accommodation (so that providers are prepared to offer places to supported residents without a minimum supported resident ratio requirement). If the payment is set at a level to meet the costs of supply, providers would not need to rely on cross-subsidies in order to provide supported resident accommodation.

Accordingly, the Commission proposes that the proposed Australian Aged Care Commission (AACC), on a periodic basis, make transparent recommendations to the Australian Government on the subsidy rate for an approved basic standard of residential care accommodation covering supported residents on a regional basis (or subregional basis where there are significant cost variations within regions). The subsidy would also need to be adjusted over time based on independent evidence about the cost of supply including an appropriate allowance for regional differences.

In the draft report, the Commission proposed that the accommodation subsidy for a supported resident could be based on the cost of a two-bed room with a shared ensuite. This proposal was rejected by many participants. Many providers argued that it was less than the current building certification standard for new residential facilities. Also, that it was a lower standard than that being provided in new developments in response to expectations by care recipients and their families. The South Australian Government, for example, said:

Most adults do not share accommodation with people who are not family, let alone bedrooms and bathrooms. ... Dignity, respect and privacy, as well as, health, safety and infection control etc are significant for all residents irrespective of their ability to pay and should be recognised. Basic standard accommodation should be set to meet

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community standards on the basis of single rooms with bathrooms to ensure older people maintain as much as a ‘normal’ life as they age. (sub. DR847, p. 12)

Catholic Health Australia also argued that single rooms are more appropriate given the higher and more complex care needs of residents:

The rising prevalence of dementia, the increasing proportion of residents with higher levels of acuity and complex care needs (which is expected to continue if people are given the chance to receive care in their own homes) and the requirements of sensitively providing palliative and end of life care, are also driving an accommodation standard which allows care to be delivered with greater privacy and dignity. With regard to dementia care and other forms of care, there are also behaviour management and clinical reasons for single room accommodation. (sub. DR748, p. 10)

Other participants recognised that there can be advantages for residents from shared room arrangements (such as social connectedness) as well as for taxpayers. The Returned & Services League of Australia Ltd, for example, said:

Placing every resident ... in single rooms would place financial pressures on government, and thus taxpayers, and has the potential to impact on the sustainability or viability of the aged care system into the future. It can also be argued that in today’s society those with limited finances are generally accommodated in less lavish surroundings, thus having tiered levels in aged care facilities reflecting circumstances in the general community. ... By setting the Government contributions at the level of a two bed room, accommodation options could potentially be limited for those who are financially disadvantaged. (sub. DR705, p. 3)

A significant proportion of people in high level care are not well placed to benefit from a single room with dedicated ensuite. A high proportion of high level care recipients are incontinent or require assistance with toileting and showering. For assisted toileting and showering a large bathroom, that can facilitate a wheelchair, is generally more appropriate than an ensuite. While families can feel better about relatives being in single ensuite rooms, as noted by a number of providers and care staff, this is not always in the best interest of the person receiving the care.

There is no right or wrong answer to the question of what standard of accommodation the subsidy for supported residents should cover. What is relevant for policy is striking an appropriate balance between the needs of people who are unable to pay for their accommodation, community views about ‘acceptable’ standards of accommodation and the burden on taxpayers. The standards established for new aged care facilities give some indication of community views about what is considered an appropriate standard of accommodation.

As outlined in chapter 12, all new buildings constructed since July 1999 are required to have on average (for the whole aged care facility) no more than 1.5 residents per room and no room is to accommodate more than two residents. There

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is also a mandatory standard of no more than three residents per toilet, including those off common areas, and no more than four residents per shower or bath. Aged care facilities constructed prior to July 1999 are required to have no more than four residents accommodated in any room, no more than six residents sharing each toilet and no more than seven residents sharing each shower or bath.

In the draft report, the Commission sought views on whether the level of accommodation payment for supported residents should vary according to the age of the facility. A number of participants (see, for example, the Combined Pensioners & Superannuants Association, sub. DR760) were not in favour of this proposition. Catholic Health Australia, while agreeing with the proposed variation in the supported resident accommodation subsidy in principle, also said it:

... does not consider that the age of the building should be the measure used as age is not necessarily correlated with amenity, including privacy and dignity. (sub. DR748, p. 11)

The Commission acknowledges that accommodation that fails to meet the July 1999 standard of accommodation could be provided at a lower cost but that this assumption may not always hold true. For example, some buildings constructed prior to the new standards may have had extensive renovations but cannot be modified to meet the new standard. In such cases, providers should be able to make a case for the higher subsidy rate to the proposed AACC based on evidence about the costs of providing the accommodation.

Overall, the Commission proposes that the subsidy for supported residents accommodation be based on the 1999 accommodation standard of 1.5 beds per room. The Commission also proposes that accommodation payments based on care needs (such as for people requiring end-of-life care, those with challenging behaviours or those arising from social disadvantage) be subsidised via care entitlements (as well as block funding in some circumstances).

#### *A better targeted supported resident payment?*

Access to either a full or partial supported resident accommodation supplement is — and should continue to be — subject to means testing. The burden on taxpayers of a higher subsidy for supported residents could be lessened by tightening the eligibility criteria for supported residents. A tightening of these criteria would also be consistent with the principle that individuals who can afford to pay for their accommodation should meet these costs (chapter 6).

Currently, the assets test for a supported resident includes their former principal residence. However, the resident's former principal residence is not counted as an

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asset if, at the time of the assets assessment or the date of entry into care (whichever is earlier):

- a partner or dependent child is living there
- a carer eligible for an income support payment has lived there for at least two years
- a close relative who is eligible for an income support payment has lived there for at least five years (DoHA 2011h).

These exemptions ensure that these ‘protected persons’ are able to remain living in the resident’s home.

The exclusion of the principal residence from the assets test for the supported resident payment (under the above conditions) is inconsistent with the Commission’s principle that care recipients with the financial means to do so should pay for their accommodation. The ‘protected person’ exclusion also has equity implications. Two people of equal means could receive different levels of taxpayer-funded accommodation support depending on whether or not a ‘protected person’ remains in the resident’s (former) principal residence. To better target the assets test and align the current arrangements with the Commission’s funding principles (chapter 6), the Commission proposes that a resident’s share of the value of their principal residence be included in the total assets test. Accordingly, the exclusion of the principal residence from the total assets test where a ‘protected person’ remains in the principal residence should also be abolished.

To achieve the important objective of allowing an existing ‘protected person’ to continue to remain in the principal residence, the Commission is proposing that there would be guaranteed access to its proposed Government-backed Australian Aged Care Home Credit scheme (AACHCS) and the existing option of deferred payments (chapter 8).

DoHA was approached for data on the number of people currently qualifying as supported residents on the basis that a ‘protected person’ was living in their former principal residence. Unfortunately, that data is not collected. Instead, DoHA suggested that an approximation could be made by examining ACAT records for people who had been assessed between 1 July 2007 and 29 October 2010 and who subsequently took up an intensive aged care place (which could have been in either residential or community care). These data suggest (if each person were equally likely to enter residential care) that:

- around 30 per cent of supported residents would be assessed as a home owner with a ‘protected person’ living in their former principal residence (and



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consequently the person's former principal residence is not counted as an asset in the total assets test)

- 25 per cent would be assessed as a home owner who did not have a 'protected person' living in their former principal residence
- 45 per cent would be assessed as a non-home owner.

The limited data on the value of assets (ABS Household Expenditure Surveys (HES), used in Bradbury (2010), the Survey of Income and Housing, and the Household, Income and Labour Dynamics in Australia Survey (HILDA)) point to the significant capacity of some older people to contribute, in part, to the costs of aged care, as well as to the growing wealth of those aged 85 years and over. But, as noted in chapter 3 and appendix E, these data are at best indicative for older people due to the small sample size.

Tightening the criteria for the supported resident status as discussed above would reduce the cost to taxpayers. Such savings may provide scope to change the current total assets test thresholds (a minimum of \$39 000, tapering out at \$102 544 as of March 2011). Alternatively, these savings could be directed elsewhere.

Because the Commission was unable to obtain current and robust data on the value of the principal residence, it was unable to draw any conclusions about the implications of applying different assets test thresholds. The Commission proposes that the Australian Government undertake further research and modelling to consider the scope to amend the thresholds in the current total assets test for supported resident accommodation payments.

Abolishing the exemption of the principal residence from the asset test as a result of the presence of a 'protected person' is likely to have some flow-on effects for the proportion of supported residents in each region. The Commission suggests that the Government review the supported resident ratio in each region to ensure they reflect the level of need for such places. Chapter 9 discusses the use of Medicare Locals or Local Hospital Networks as the basis for determining the regional distribution of the offices of the Australian Seniors Gateway Agency (the Gateway). The Commission is proposing that the calculation of the regional supported resident ratio be aligned with the region used for the Gateway. However, in some cases, a subregion may be a more appropriate geographical area because of heterogeneity in asset prices in a region.

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*Are mandatory requirements still needed?*

A subsidy that reflected the full cost to providers of offering accommodation for supported residents should mean that providers would be prepared to offer sufficient accommodation and, therefore, the supported resident ratio obligation could be abolished (as recognised by Hogan 2004b). But some participants expressed concerns about whether existing social inclusion objectives underlying the ratio obligation could be met in its absence. DoHA, for example, said:

Clearly, an important element underpinning the Commission's reform proposal is that the changes will engender a positive response from the market, with competition leading to greater consumer choice and efficient pricing. However, as the Commission acknowledges, some areas of market failure are inevitable. Further consideration could be given to how to address these issues. ... In particular it is worth noting that almost 40 per cent of aged care services, representing more than 30 per cent of places, are located in such areas, which is a significant achievement noting that these areas account for around a third of aged care services. (sub. DR694, p. 5)

To maintain aged care places for the financially disadvantaged and those in rural and remote areas after the planning ratios are phased out, the Commission proposes that mandatory requirements for providers to make places available for supported residents should continue — at least during the transition period. However, the supported resident supplement should be payable in full irrespective of whether a facility has 40 per cent of its places taken by supported residents, provided it has achieved the relevant regional ratio.

Where providers do not meet the supported resident ratio in their region, the Commission proposes that a sliding scale of fines be levied — the size of which would depend on the severity of the non-compliance. (That is, financial penalties would become progressively larger the greater the shortfall against the required ratio.) This arrangement is consistent with the proportionality principle (chapter 15) and would mean that the current arrangements (which discounts the full subsidy by 25 per cent when a supported resident ratio of 40 per cent is not met) would become redundant.

Some participants supported the removal of the exemption for extra service providers in meeting the supported resident obligation. For example, ECH, Eldercare and Resthaven said:

Provided lead times are adequate, and in view of the proposed uncapping of prices and supply, there should be no reason why existing Extra Service providers should not be subject to the same requirements as all other providers in relation to the care of Supported Residents (say after 5-10 years). (sub. DR616, p. 4)

Others, however, were of a different view. For example, Advantaged Care said:

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Whilst the removal of [extra service] status is identified it is imperative that existing extra service places remain exempt going forth from the concessional ratio requirements, otherwise these facilities may become retrospect[ively] fully unfeasible. (sub. DR780, p. 2)

The Commission proposes that with the removal of the extra service status provision that the current supported resident ratio obligation exemption available to such extra service facilities (or parts of facilities) also be phased out and be part of a negotiated settlement (chapter 17).

*Should the supported resident ratio obligation be tradeable within regions?*

To improve the scope for providers to tailor services to different client groups, the Commission proposed in the draft report that facilities should be able to trade their supported resident ratio obligation with others in the same region so that facilities could provide more or fewer supported resident places in line with their preferred service model approach. To support these arrangements, the Commission also proposed that the AACC would approve all proposed trades and administer any related regulations and compliance with these quotas.

A number of participants expressed concern about this proposal. A common concern was that it would result in ‘ghettos’ developing. Benetas, for example, said:

... we have some concerns about this in terms of the possibility of setting up ghettos within regions — if they were tradeable — and particularly in large regions where trades are made. All of a sudden there’s only a few facilities left with a large number of supported residents. (trans. p. 14)

In the context of quota trading arrangement, the size of a region would matter. Supported residents should not be required to move unreasonably large distances in order to access a place. On the other hand, moving voluntarily to be closer to family should not be precluded. Accordingly, this is one consideration that the proposed AACC could consider in determining whether or not to approve a proposed trade between providers. Medicare Australia suggested a register of supported residents could be established that was ‘user friendly for providers and flexible enough to allow for possible future policy changes’ (sub. DR804, p. 10).

Catholic Health Australia (sub. DR748) also raised questions about the practicality of tradeable quota obligations, particularly if the quota policy was to be subject to review within a five year period. Having considered the issues raised, the Commission proposes that during the first stage of the five year transition period, the Australian Government should introduce a pilot scheme whereby providers could transfer up to 50 per cent of their obligation per facility with other providers within the same region. A review during the second stage of the transition period

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would assess the performance of the pilot scheme and the desirability of applying a trading regime more generally (chapter 17).

For the pilot quota trading arrangement to work, it would need to enable the proposed AACC to:

- authorise and register the trading of supported resident ratio obligations within a region
- develop a system of tracking and verification to ensure the required number of supported resident places in each region was continuously being met.

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

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

Under this approach, the market would determine the value of the subsidy, which would eliminate the need for an independent body to determine the appropriate value of the subsidy by region. But many participants raised concerns about competitive tendering for supported residents (for example, COTA Australia, sub. DR565; Mercy Health Aged Care Services Brisbane, sub. DR788; NSA Knox Branch, sub. DR580; UnitingCare Australia, sub. DR788). Practical considerations such as what would happen to those people who became eligible for supported resident status if they were in a facilities that had not bid for supported resident places were raised.

The option of competitive tendering to cover the ongoing provision of accommodation to supported residents could be considered at the time of the proposed five year review. The Commission's study *The Contribution of the Not-for-Profit Sector* (PC 2010b, chapter 12) provides guidance on appropriate issues that should be considered by the Government when contracting services.

*Should the supported resident subsidy be provided to individuals or providers?*

Currently, the supported resident supplement is paid directly to providers and the Commission proposes that this arrangement would continue, at least during the

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transition phase. However, similar to other Australian Government entitlements made to individuals (including those proposed in this report), it is reasonable to consider the costs and benefits of paying the supported resident accommodation subsidy directly to individuals.

The Commission considers that the pros and cons of paying the supported resident subsidy to individuals as part of their entitlement, rather than directly to providers, should be reviewed during the transition period (chapter 17).

RECOMMENDATION 7.1

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

RECOMMENDATION 7.2

***The Australian Government should remove regulatory restrictions on accommodation payments, including the cap on accommodation charges in high care. It should also abolish the charging of regulated retention amounts on accommodation bonds. The Government should mandate that residential aged care providers:***

- ***offer and publish periodic accommodation charges***
- ***where offered, publish accommodation bonds and any combinations of periodic charges and bonds.***

***The Australian Government should require that, when a provider offers an accommodation bond, the bond does not exceed the equivalent of the relevant periodic accommodation charge. The paying of interest on accommodation bonds should be prohibited.***

RECOMMENDATION 7.3

***The Australian Government should establish an Australian Age Pensioners Savings Account scheme to allow recipients of the age and service-related pensions to establish an account with the Government (or its agent) with some or all of the proceeds of the sale of their principal residence.***

- ***The account would be exempt from both the Age Pension assets and income tests and would pay interest equal to the prevailing consumer price index to maintain its real value. All accounts would be free of entry, exit and management fees.***

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- *Apart from the proceeds from the sale of a principal residence (including the sale of any subsequent principal residences), no other amounts should be able to be deposited into the account.*
  - *Account holders would be able to flexibly draw upon the balance in the account.*

RECOMMENDATION 7.4

*The Australian Government should charge residential providers a fee to reflect the costs of providing the Government guarantee on accommodation bonds.*

RECOMMENDATION 7.5

*To ensure sufficient provision of the approved basic standard of residential aged care accommodation for those with limited financial means, providers should continue to be obliged to make available a proportion of their accommodation to supported residents. The Australian Government should set the level of the obligation on a regional basis.*

*Where providers do not meet the supported resident ratio obligation in their region, a sliding scale of penalties should be levied, where the size of the penalty would depend on the severity of the non-compliance. The current pricing arrangements (which apply a 25 per cent discount to the full rate of the accommodation supplement when facilities do not have more than 40 per cent supported residents) should be abolished.*

RECOMMENDATION 7.6

*For supported residents, the Australian Government should set a subsidy level for the approved basic accommodation standard of residential care which reflects the average cost of providing such accommodation. The subsidy should be set regionally and on the basis of the July 1999 building standard (an average of 1.5 beds per room). A lower subsidy level should be paid to those facilities which do not meet the July 1999 building standard. The Australian Aged Care Commission should be empowered to consider exceptional circumstances for those facilities which do not meet the July 1999 building standard and make an appropriate recommendation to the Australian Government to increase the level of the supported resident accommodation subsidy for these facilities.*

*To better target the supported resident accommodation subsidy, the relevant share of a person's former principal residence should be included in the total assets test and the exemption of the principal residence when there is a 'protected person' remaining in the former principal residence should be abolished. To allow an existing 'protected person' to continue to remain in the former principal residence, there should be guaranteed access of the resident to the Government-backed Australian Aged Care Home Credit scheme and the existing option of deferred payments. Further research and modelling should be undertaken to consider the scope for assessing the total assets test thresholds for supported resident accommodation payments.*

## **7.2 Everyday living expenses — applying the principles**

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

'Extra services' or lifestyle extras (such as increased food choices, newspaper delivery, massages, etc.) attract an additional extra service daily fee. This charge reduces a provider's residential care subsidy by 25 per cent of the extra service fee they charge clients (box 7.5).

And, as discussed above, a further regulatory implication is that if a high-care resident receives extra services their provider can charge them a bond for their accommodation. Such funding arrangements can act as a disincentive to use extra services, although with constrained supply, some Australians are effectively forced to buy an extra service place because an alternative is not available.

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

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### Box 7.5 About extra service places

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

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

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

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

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

Sources: DoHA (2009f, 2010h).

Catholic Health Australia described extra services as:

... a flawed and unsustainable concession towards choice in a system of rationed supply. Choice should not be reserved for a minority; its delivery begets even more regulatory complexity and perverse outcomes. Funding individuals eligible for assistance under the *Aged Care Act 1997* on an entitlement basis, allowing people choice of services and who delivers them and lifting restrictions on what services providers can offer, is a much more effective model for the provision of aged care services. (sub. 217, p. 13)

Blue Care, commenting on the supply restrictions for extra services, said:

The regulation of extra services, rather than allowing supply to be determined by the market, has resulted in market imperfections with over supply in some market catchments, and deprivation in others. (sub. 254, p. 10)

Participants were generally supportive of removal of the regulatory restrictions on extra services and the retention of the 84 per cent of the single Age Pension as a minimum charge for basic daily living expenses in residential care (Aged &



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Community Care Victoria, sub. DR735, Aged & Community Services Australia, sub. DR730).

BlueCross Community and Residential Services (sub. 441) recommended that the daily care fee for pensioners remain at the current percentage of the Age Pension, but that the daily living expenses fee for non-pensioners should be uncapped and negotiated between the care recipient and facility operator. Others, such as Aegis Aged Care Group, argued that while residents should continue to pay for the daily cost of living with their pensions, or equivalent, they ‘should be allowed to pay for additional services as required without those services being classed as “extra services” in distinct facilities or distinct parts of the facility’ (sub. 206, p. 2).

Alkira Aged Care questioned the basis for the daily living expenses fee:

Presently the everyday living expenses are a set amount simply based on 84% of the aged pension. It is not based on what real costs are and it is not based on anything else except the single aged pension and not what people have a capacity to pay.... In essence there is a great deal of difficulty in containing the costs of everyday living expenses within the \$39.50 per day that is allocated. That system is not sustainable and therefore the recommendations to proceed to paying for additional services is appropriate but certainly needs to be looked at in the light of real costs. (sub. DR696, p. 3)

Stewart Brown and Co also provided some evidence to suggest that, in a residential aged care setting, everyday living expenses can differ between people at the lower end of the frailty scale and those at the higher care needs end (sub. DR842).

The Commission considers that the minimum regulated daily charge could remain for all residents (the Age Pension is designed to ensure access to an adequate basic standard of living). However, care recipients should be able to negotiate for services (type, quantity and quality) that are additional to those covered by the basic daily fee. The Commission’s proposed AACC should also assess and provide transparent advice to the Australian Government about the appropriateness (or otherwise) of charging 84 per cent of the Age Pension for basic living expenses.

In a less regulated market, aged care providers would be able to better respond to the preferences of a wider range of care recipients. Restrictions on the purchase of additional services not only means that individuals may not be able to purchase services they value but it also stifles competition in the delivery of higher quality services. The Commission recommends the removal of the extra service category so that any care recipient wanting additional everyday living services can purchase them.

*The Australian Government should remove the regulatory restrictions on supplying additional services in all residential aged care facilities, discontinue the issuing of extra service bed licences and remove the distinction between ordinary and extra service bed licences.*

## 7.3 Care costs — putting the principles into practice

### Current co-contribution arrangements

Many older Australians currently receiving care make some contribution to the cost of their personal and health care (whether in the community or in residential care), with these co-contributions dependent on means testing using income and assets tests. But, as discussed in chapter 5, one of the problems with the current arrangements is the inconsistency in co-contributions charged to older Australians using aged care services. As acknowledged by DoHA, under current arrangements:

There is [also] considerable dissonance between the approach taken to fees and means testing in the Home and Community Care Program and in the Commonwealth's packaged community care and residential care programs. (sub. 482, p. 50)

### *Co-contributions for community care*

The Australian Government and the state and territory governments have developed a draft National HACC Fees Policy (which sets out principles and explanatory notes) to provide a consistent framework for collecting fees. However, there appears to be little consistency in the application of the principles across the states and territories. For example, in Victoria care recipients are charged low level fees if their income is less than around \$33 000, while in Western Australia those with income below \$45 000 are charged the lowest level fees (table 7.4).

Scheduled fees for services also vary between the states — for example, the suggested scheduled fee for respite for someone with income above \$71 000 in Victoria is \$29.40, while in Western Australia for someone with income above \$50 000 the schedule recommends full cost recovery.

**Table 7.4 HACC income ranges and scheduled fees for selected services, Victoria and Western Australia, 2010**

	Victoria			Western Australia		
	Low	Medium	High	Level 1	Level 2	Level 3
Individual	<\$33 233	>\$33 233 <\$71 343	>\$71 343	<\$44 922	<\$44 923 <\$50 000	>\$50 001
Couple	<\$54 044	>\$54 0144 <\$95 374	>\$95 374	<\$73 047	>\$73 048 <\$80 000	>\$80 001
Domestic assistance (per hour)	\$5.30	\$13.10	\$28.40	\$8.00	\$10.00	Cost recovery
Personal care (per hour)	\$3.90	\$7.90	\$32.50	\$8.00	\$10.00	Cost recovery
Respite (per hour)	\$2.60	\$3.90	\$29.40	\$8.00	\$10.00	Cost recovery

Sources: Victorian Government, Department of Health (2010); Western Australian Government, Department of Health (2010).

Care recipients receiving several support services per week from one or more HACC providers are protected from paying excessive fees through a ‘fees cap’. In Western Australia the fee cap is \$56 per week for care recipients on the lowest income range and \$138 per week for the highest income level. HACC fees are lower than those set for Australian Government care packages (table 7.5).

**Table 7.5 Aged care services funding by funding source**

	Average public cost per recipient in 2010	Average private contribution per cent <sup>a</sup>	Average Government share per cent
Residential high care	51 550	26	74
Residential low care	20 150	53	47
EACH packages	39 250	4	96
EACH-Dementia packages	43 450	4	96
CACPs	12 700	10	90
HACC		5	95
Other Australian Government programs (for example, National Respite for Carers)	Variable	No compulsory contribution	100

<sup>a</sup> Earlier estimates provided by DoHA to the Senate Finance and Public Administration Committee Inquiry into Residential and Community Aged Care in Australia suggested that the average private contribution for community care packages was around 16 per cent for CACPs and 5 per cent for EACH and EACH-D packages.

Sources: Henry (2010); DoHA (2009h, 2010e, 2010n).

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The 2008 Community Care Census reports that the average private contribution for CACPs is around 10 per cent of the cost of supply and around 4 per cent for EACH and EACH-D packages. While the majority of care recipients paid a fee for a packaged care service, there were variations in the overall proportion paying fees across these programs:

- 89 per cent of CACP recipients
- 94 per cent of EACH recipients
- 95 per cent of EACH-D recipients.

The average fee paid overall by packaged care recipients was \$29.01 per week — \$27.86 for CACP, \$36.61 for EACH and \$36.51 for EACH-D (2010e).

Full Age Pension care recipients cannot pay more than 17.5 per cent of their income for an Australian Government-provided community care package (around 90 per cent of community care package recipients received some form of government pension or benefit in 2008) (DoHA 2010e). While some services provided through community care packages may cover everyday living expenses (for example, meals), a flat rate of 17.5 per cent of pensioners' income is unlikely to reflect the cost of providing these services (services for which it would be appropriate to charge pensioners and that would be consistent with charges in residential care). However, if the services covered by a 17.5 per cent flat rate were for personal care services, this would involve charging for a service that the income of a full-rate pensioner is not designed to cover (and full pensioners in residential care are not required to contribute to personal care costs). Personal care costs represent a high proportion of the costs of EACH and EACH-D packages.

Clients with income above the full rate of the Age Pension can be charged up to 50 per cent of that additional income for community care packages and the amount that can be charged is uncapped by the costs of care. As such, providers have an incentive to 'cherry pick' wealthier recipients of care and face weaker incentives to provide care for the least well-off. If wealthier recipients pay for more than the cost of their care, they effectively cross-subsidise lower paying recipients. This is inequitable and involves providers playing a redistributive role. The Henry Review questioned whether this was an appropriate way to ensure people with limited means can access care:

Ensuring that people with limited means can access care would be more appropriately financed through broad-based taxes, rather than through an effective tax on care users. (2010, p. 640)

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### *Co-contributions for residential care*

In residential care, the Government pays a basic care subsidy which may be augmented with supplements, such as for oxygen and enteral feeding. Residents who have sufficient income can be asked to contribute to the cost of their care through an income-tested fee. The amount of subsidy payable is reduced by the amount of the income-tested fee.

The Aged Care Funding Instrument (ACFI) is used to determine the level of assistance for both personal care and some health care costs. The ACFI divides care into three domains and each domain has three funded levels. The subsidy paid to providers is the lesser of the sum of the amounts payable in each domain (activities of daily living, behaviour supplement and complex health care supplement) and the maximum ACFI rate (currently \$172.89 per day). For example, the cost of care for a resident assessed as requiring a high level of care for activities of daily living, a low level of care in relation to the behavioural supplement, and medium level of care under the complex health care supplement would be \$137.26 per day or \$50 099.90 per year (table 7.6).

**Table 7.6 Daily ACFI rates, 1 July 2010 to 30 June 2011**

<i>Level of care</i>	<i>Activities of daily living</i>	<i>Behavioural supplement</i>	<i>Complex health care supplement</i>
Nil	\$0.00	\$0.00	\$0.00
Low	\$30.32	\$6.93	\$13.64
Medium	\$66.03	\$14.36	\$38.86
High	\$91.47	\$30.25	\$56.11

*Source:* DoHA (2010o).

Residents with total assessable income above the full pensioner rate pay an income tested fee as a contribution towards the cost of their care. While an income rather than an assets test applies, the income test deems a certain rate of return on assets depending on the type of asset. The maximum income tested fee payable is calculated as 5/12<sup>th</sup> of assessable income above the maximum income of a full single pensioner (DoHA 2010n). However, a resident's income tested fee cannot be greater than the lesser of:

- 150 per cent of the basic Age Pension
- the cost of their care as determined by the ACFI (DoHA 2009e).

The cap on charges for personal care in residential care currently provides benefits to wealthier care recipients which are not available to their high wealth counterparts receiving care in the community. Taxpayers pick up the care cost bill for care

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recipients who, given their income levels, could pay more for the care. The Henry Review recommended a consistent effective marginal tax rate for these costs of care:

For higher income ranges, ... the total effective marginal tax rate can fall. ... A more consistent approach to means testing would be to target a consistent effective marginal tax rate until these costs are covered. (2010, p. 638)

### **Is there a fairer and more efficient way of sharing the costs of care?**

Care costs need to be affordable both for people needing care and for taxpayers. Given that over the next few decades the overall cost of providing aged care is expected to grow significantly, the challenge is to design a system that balances the need to protect care recipients from the financial risks associated with requiring aged care with ensuring that expenditure on aged care is sustainable for taxpayers.

As discussed in chapter 6, on both equity and efficiency grounds, there is a case for providing some basic universal coverage for age care services (because of the close link between aged care and health care) and not exposing individuals to the high costs of extended intensive care (catastrophic costs), irrespective of their capacity to pay. But the call on taxpayer funds and the issue of fairness across generations also calls for the targeting of subsidies to those people with the highest care needs. This raises the question — how should subsidies be targeted?

#### *What should be in the basket of subsidised aged care services?*

Restricting what is in the basket of subsidised services and ‘who’ can access the services is one way of ensuring that care is directed to those with the highest need and the community gets the best value for the limited pool of taxpayers’ money. But what services should be included in the basket of subsidised services and why? As discussed in box 7.6, this question should be answered via an analysis of the costs and benefits.

That said, while often the costs to taxpayers of providing services can be estimated with some degree of certainty, the benefits (particularly in terms of the wellbeing of care recipients and carers and avoiding adverse outcomes), can be more difficult to quantify. As Grabowski, in an article on the cost-effectiveness of non-institutionalised care, said:

Although costs are typically straightforward to measure, gauging the effectiveness of long term care services is more nebulous. ... Effectiveness may include such dimensions as health and functioning, longevity, unmet needs, satisfaction with care, informal caregiver (e.g., spouse) support, life satisfaction and morale, and the degree of

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social interaction. ... Thus, even if noninstitutional services are associated with higher aggregate costs, the services may still be cost-effective because of an even greater increase in aggregate effectiveness. (2006, p. 5)

And, the benefits that are relevant in this equation are those that are additional to the benefits that would arise through private decisions (known as ‘additionality’).

### **Box 7.6 Decision rules for allocating resources**

Governments face a difficult task in deciding on what aged care needs to support and hence what services should be subsidised. This task is made more complex where the main returns to the increasing expenditure come in improved wellbeing for older people resulting in reduced costs to the government in the future. But even in this case, such savings are uncertain and this uncertainty should be taken into account.

Economists have long argued for a cost-benefit approach to such decisions. On the cost side of the ledger are the costs to taxpayers (including any deadweight loss in raising taxation revenue), while on the benefits side are the improvements in wellbeing of older people and their carers and any future savings in costs. While the costs of providing a service can be estimated with some degree of certainty, the benefits are more uncertain. They need to be measured wherever possible to reduce this uncertainty and improve the allocation of resources within the aged care budget and across the public budget.

The net benefits are highest when resources are allocated to those services that have the greatest expected return. This return depends on the:

- effectiveness of the service in reducing the future need for care (change in the probability of an adverse outcome given the service), or in improving wellbeing
- risk of an adverse outcome that will require care, or reduced wellbeing, in the absence of the service
- value of avoiding the adverse outcome, or the value of avoiding a loss in wellbeing.

As the effectiveness of the service, the risk of adverse outcomes, and the value of avoiding the adverse outcome are not common to all those needing care, screening to identify which services should be provided to a client is needed to get the best returns to aged care funding. But more broadly, governments need to decide which services should attract a subsidy and which should not. In doing this, governments need to weigh the cost to taxpayers against the benefits of including a service.

Where there is uncertainty about effectiveness, risk, or value, governments need to invest in analysis to reduce this uncertainty. This may involve trials and controlled experiments, or targeted data collection from providers and their clients. Better analysis of existing data, especially if data sets can be linked, will also improve the understanding required to ensure the system is funded at a level that maximises wellbeing.

*Sources:* Weissert, Chernew and Hirth (2003); Hubbard. (2007).

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There are some good reasons for targeting support on nursing and basic personal care needs, including that there is greater scope to crowd out private provision of domestic care services than personal care (hence the issue of ‘additionality’). Assessment of the need for domestic care is also more subjective than that for personal care and health care services (Colombo et al. 2011). In a number of OECD countries, subsidies for domestic care or practical help (IADL) are less comprehensive than those for health and personal care (ADL) and care assessment mechanisms give more weight to the inability to perform ADL than IADL.

That said, making the distinction between personal and domestic help can be difficult, especially where services are jointly provided to high-care-need users. Also, limiting the basket of services to support personal care may not enable older people with particular conditions, such as early stages of dementia, to remain living in the community as often they do not require assistance with personal care but need support with domestic care (such as assistance with shopping and financial affairs).

The risk of moral hazard and ‘free riding’ is also likely to be a bigger concern in the low-level community services (such as home maintenance and meals) than for personal care services. For example, individuals are unlikely to demand assistance with showering and toileting unless they really need it, but cleaning, household maintenance, and gardening services are generally services considered desirable (box 7.7). An effective assessment tool for determining the actual need for aged care services is one way of dealing with the moral hazard/free rider problem (chapter 9).

An additional way of dealing with this problem is to only provide an entitlement for low level community services to those care recipients who have high level needs. This would overcome concerns about people with early stage dementia who may largely require assistance with domestic activities. The OECD reports that coverage of support for some IADL activities, as in Sweden, Denmark, Germany and Luxembourg, has helped to prevent dependent people with relatively high care needs from moving to even more expensive care settings (Colombo et al. 2011).

One possible downside to this approach is that if subsidised low level care services are only available to those people with high-level needs as part of their overall service menu, this could give people an incentive to argue they have higher level needs and could crowd out informal care. A good assessment process, however, should mitigate this.



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### **Box 7.7 Moral hazard and free riding in aged care**

Any government program that provides services to people at a subsidised (or no) cost should ensure that those, and only those, who need the service receive it. In the aged care context, a free rider is someone who accesses a service that they do not need, while moral hazard arises because a person's needs may not be easily observable (asymmetric information), and the costs arising from this behaviour are not borne by the person making the choices.

Free riding raises the costs of the aged care system without commensurate benefit. Few people would accept help with personal care (showering, toileting) unless they really needed it. However, cleaning, household maintenance, and gardening services are generally desirable. Offering a substantial subsidy to anyone over the pension age could see a massive growth in demand for these subsidised services. An effective gatekeeping system that approves subsidies on the basis of need is necessary to manage free rider problems.

Effective gatekeeping requires verification of the need for the service. For home help services, gatekeeping is currently undertaken by HACC providers who allocate their fixed budgets to those they assess as having the greatest need (i.e. by queuing). Under the proposed gateway, the data provided on a person's assessment form needs to be validated to manage the risk of free riding in these low level support services.

In aged care, one concern is that people who do not really need a service will withhold information in order to access the subsidised service. For example, a person may have a need for home help, but has this service provided by family or friends, or has purchased this service on an on-going basis. As with free riding, when this happens the public cost of providing this service to the person will exceed the incremental benefit.

Moral hazard can also arise when people do not access a service despite the potential for this service to reduce their longer-term care needs. The moral hazard arises where the person aims to avoid an immediate cost to themselves (including intrinsic costs such as admitting they need care), while recognising that this is likely to result in higher costs borne largely by others later on. If people do not believe that their choice will influence their future costs of care it is not technically moral hazard, but the problem of under use of lower intensity 'preventive' services is still of concern. Moral hazard is best addressed by aligning the incentives for people to apply for a program with the net benefits of their accessing the program — giving them an incentive to fully share information on their situation and their needs. The role of the gate keeper in extracting this information will be improved if the risks arising from withholding information fall on those with the information.

*Source: Pauly (1968).*

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Many participants, however, argued the importance of encouraging people to access services that promote independence and avoid dependence which in turn would improve the sustainability of the aged care system. Silver Chain Nursing Association, for example, argued that:

The new paradigm should be based on the premise that early intervention to optimise functioning and promote healthy ageing can delay or prevent the development of further disability and reduce the subsequent need for home care and other aged care and health services. Research indicates that 70 per cent of restorative care recipients do not require ongoing support services and their quality of life is significantly enhanced as a result of receiving these services.

This new paradigm could be operationalised within a service model in which older individuals referred and assessed as eligible for funding for home care services are referred to a community restorative program prior to the care recipient being provided with 'standard' support and maintenance services if they still require it. (sub. DR796, p. 4)

The Royal District Nursing Service, Victoria also said:

Our experience working in promoting wellness and restoration with the Active Service Model (within the Health and Community Care (HACC) program in conjunction with the Victorian Department of Health, and in New Zealand as a provider of Home Based Support Services) has shown that an active service model approach can delay and indeed reverse the level of care required. Initial figures from our work with Auckland District Health Board have indicated an increase in volume of discharges from care as a result of this approach, which has led to increased client independence, and larger numbers of clients graduating to a lower level of care need. (sub. DR546, p. 2)

Clearly one of the most fundamental ways to reduce the costs of aged care and improve the wellbeing of older Australians is to help them remain independent. However, one of the criticisms of current low-level community services is that they create dependency rather than promote independence. Hence the push for more short term reablement programs.

Building the evidence on what forms of low level community services are most effective at both containing expenditure on aged care over the longer term and improving the wellbeing of care recipients and carers is crucial for securing the best value from taxpayers' money in this area.

#### *What about targeting by applying different subsidies (or co-contributions)?*

When thinking about what level of subsidy should apply to what services, it is important to balance the incentives generated by requiring people to contribute an amount for a service (when people pay for, or contribute a material amount for a

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service they are more likely to value the service and demand quality) with the benefits that the service provides. A number of participants raised the possibility of co-contributions (if set too high) being a deterrent for people to access services, which could mean that older people would not access care or seek less care than was appropriate. For example, South Eastern Migrant Resource Centre said:

When costs are prohibitive for those at the disadvantaged end of the care spectrum, there is a delayed drain on the public health system. Problems that could be dealt with earlier and less expensively develop into more costly and drastic health difficulties. (sub. 126, p. 3)

Australian Meals on Wheels also said:

If our meal price to clients rises to a level where clients cut their spending and reduce the number of meals they need to sustain their nutrition requirements, their health will be compromised and the likelihood of requiring higher and more expensive hospital care is inevitable. (sub. 209, p. 1)

This reinforces the need for the design of any targeting or co-contribution regime to take into account the variability of the capacity of older people to pay. But, there is also a trade-off to be made between targeting and the complexity of the regime. The more steps there are in a co-contribution scale the better the targeting and equity of the regime. The fewer the steps in a co-contribution scale the easier it is to apply and the easier it is for people to understand.

The level of co-contribution could also be varied for different types of services. One option is to vary the subsidy according to how close the service is to health care. To be consistent with the principles set up in chapter 6, health services provided as part of aged care should attract the same subsidy in aged care as they do in health care. This approach could see a lower subsidy (higher co-contribution) for basic support (such as transport and home maintenance), a higher subsidy for personal care, with the highest subsidy for the health care component of aged care (nursing, palliative care). Under such an approach, the total number of subsidies available would depend on the specified service types and the number of levels in the capacity to pay test. For example, if there were three levels in each, there would be 9 levels of co-contribution to be administered. There is a trade-off to be made between fine tuning incentives (by having different levels of subsidies by service type and avoiding cost shifting between aged care and health care) and complexity.

Another option is to exempt some services, such as restorative programs, from co-contributions. A number of OECD countries (including Canada and the United Kingdom) have recently moved to providing some short term home-care services free of charge. For example, the United Kingdom recently announced that reablement would be free for everyone who could benefit from it when they need

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home care for the first time on the basis that it was a way to keep people independent and well for longer (HM Government, 2010, p. 95).

Based on the evidence on reablement programs (see chapters 6 and 9), the Commission considers that in addition to health and personal care services and low level community support services for high level care recipients, the aged care service basket should include an intensive reablement program and such a program should be highly subsidised, if not free of charge (see chapter 9 for further details).

### *What test for capacity to contribute to care costs?*

On both equity and fiscal sustainability grounds, co-contributions for aged care should be linked to a person's financial capacity to contribute to the cost of their care, with a greater contribution from those better able to pay.

A person's capacity to pay is shaped by their income and wealth and the majority of older Australians' wealth is held in their home (box 7.8).

As discussed earlier in the chapter, the means test for the Age Pension includes an assets test which excludes the value of the owner-occupied home or an accommodation bond. The question is whether the pension assets test is the appropriate test for subsidised aged care services. The Henry Review argued that:

... charges for the costs of care should be set so they do not harm income adequacy in retirement and are consistent with pension means testing. ... Following the approach in the income support system, means testing should not be designed to force the drawdown of assets, but instead target the income from assets. (2010, p. 637)

The aim of the Age Pension assets test is to assess individuals' (potential) income from their assets and is designed so as not to erode the value of people's assets. When becoming eligible for an Age Pension, most people can look forward to another 15 to 20 years of independent living with no need for aged care services, so allowing people to retain their home and income earning assets makes sense. But, as people move towards the end of their lives (typically the time they require aged care) the logic of excluding particular assets (the home and accommodation bonds) from tests for public subsidies weakens considerably. A different approach to subsidising care and support for people who are disabled can also be justified on the grounds that people who acquire a disability often have had no or less opportunity to accumulate wealth to meet their costs of care (particularly if a disability is acquired early in life). Older people, on the other hand, in many cases will have accumulated assets over their lifetime.

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In principle, people in the same financial position, but different combinations of income and assets, should be treated the same way. But, as discussed earlier, the Age Pension income and assets tests are already in place (and not the subject of this inquiry), so from a pragmatic perspective, moving to a more comprehensive means test for subsidised aged care services can only be justified if it makes a considerable difference to the equity and sustainability of the aged care system.

**Box 7.8 Older Australians' capacity to pay for care and support**

Wealth projections suggest that by 2030 older Australians will own around 47 per cent of total household wealth, although they will only make up around 19 per cent of the population. This suggests that asking younger Australians to pay higher taxes to fund aged care, while also being required to save more to fund their own retirement, is inequitable. So what is the capacity of older Australians to pay for their care?

Data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey conducted in 2006 shows that the medium net worth of households headed by a person aged 65-75 years was \$443 000 and \$332 000 for households headed by a person aged 75 years plus. The principal residence makes up most of this wealth — the 65-75 years median household holds 79 per cent of their net worth as a principal residence increasing to 90 per cent for the median 75 years plus household (RBA 2009).

The HILDA data provides some insight into the distribution of household assets for older households. Using data from 2002, it was estimated that the bottom 10<sup>th</sup> percentile of households headed by a person aged 75 plus had \$17 200 in assets, those in the 30<sup>th</sup> percentile had \$145 400, those in the 70<sup>th</sup> percentile had \$380 600, while those in the 90<sup>th</sup> percentile had \$828 000 (in 2006 dollars). As the net worth of the median household had grown by almost 29 per cent from 2002 to 2006, these numbers are likely to be similarly higher.

The ABS Survey of Income and Housing in 2007-08 found that average (mean) weekly household income declined with age after retirement up until 80 years plus. In 2005-06, average weekly disposable income fell from \$516 for households headed by a person aged 65-69 years to \$433 for the 75-79 year households, but rose to \$454 for the 80 years plus households. This pattern remains the same even after adjusting for housing costs. It has, however, changed over time. In 1988-89, the oldest households had the lowest average weekly disposable income, while the 75-79 year households were slightly above the average for the 65-69 years households.

The average income data tends to overstate the capacity of the median household to pay as it includes the tail of the distribution — the high wealth and high income households. And capacity to pay, once people move towards the end of their lives, is better defined by their wealth rather than their income.

*Sources:* HILDA Release 7; RBA (2009); Heady, Warren and Wooden (2008); Bradbury and Gubhaju (2010).

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HILDA data shows that in 2006, 14 per cent of full pensioners had assets in excess of \$500 000, while 13 per cent had less than \$6000 (HILDA 2010). As such, a system that uses the pension test for determining co-contributions is likely to be considerably less equitable than one that applies a more comprehensive means test for subsidised aged care services. And, because of a limited aged care budget, there will be fewer resources to pay for care for those people with the least capacity to pay.

Noting that the majority of older Australians will continue to receive either a full or part pension looking out to around 2050 (table 7.7), the Commission considered three options:

- all people receiving a full or part Age Pension would receive the full rate of subsidy, with self-funded retirees receiving a lower rate of subsidy (option 1)
- people receiving a full Age Pension receive the full rate of subsidy, those on a part pension receive a lower rate, and self-funded retirees receive the lowest rate (option 2)
- an assets means test (includes the principal residence, accommodation bonds, and the Commission's proposed Australian Age Pensioners Savings Account scheme) with three levels of subsidy based on the level of assets. Those with assets below the median of \$350 000 receive the full subsidy (the Age Pension assets test also allows non-home owners assets of \$313 250 for a single pensioner and \$389 500 for a couple for full pension, as at March 2011). Those with assets below the 80<sup>th</sup> percentile of \$550 000 receive the mid rate of subsidy, while those with assets above the 80<sup>th</sup> percentile receive the lowest rate of subsidy (option 3).

Table 7.7 shows the shares of older Australians that would be eligible for the three different levels of government subsidy under the three eligibility rule options. This is an indicative calculation, but it demonstrates the lock-in of adopting the existing Age Pension means test as the basis for eligibility of different levels of aged care subsidies (option 1).

Options 2 and 3 start with a fairly similar share receiving the full rate of subsidy, but they diverge over time. It should be noted that, as those at the older end of the retirement age spectrum are more likely to have lower assets, the eligibility criteria in options 1 and 2 will understate the shares that will be eligible for full and mid level aged care subsidies.

Initial cost projections undertaken by the Commission show that using the Age Pension means test for aged care costs is the least sustainable option for taxpayers. Applying the assets means test, on the other hand, results in the percentage of older

Australians eligible for a full aged care subsidy declining from around 50 per cent in 2010 to around 15 per cent in 2050, with those on the lowest subsidy rate increasing from around 20 to 75 per cent.

**Table 7.7 Older Australians eligible for various subsidies under different eligibility criteria**

Rate of subsidy	Option 1	Option 2	Option 3
	Existing Age Pension means tests	Full and part Age Pension recipient criteria	Assets means test
	%	%	%
<b>2010</b>			
Full	83	55	50
Mid	0	28	30
Low	17	17	20
<b>2030</b>			
Full	77	39	23
Mid	0	38	22
Low	23	23	55
<b>2050</b>			
Full	76	36	15
Mid	0	40	10
Low	24	24	75

Source: Commission estimates, based on Treasury projections.

The Commission proposes the use of a comprehensive means test for determining care recipients' co-contributions. The comprehensive means test would involve a combined income and assets test. Participants' views on the proposed comprehensive means test for care varied (box 7.9).

For the income assessment, the Age Pension income test could be used — for ease of understanding by older people and for efficiency of administration. However, the assets test needs to overcome the Age Pension's exclusion of the principal residence and accommodation bonds. A further complexity of the current Age Pension assets test is that lump sums arising from the sale of a home, but invested in instruments other than housing or accommodation bonds of similar value, are not exempt assets. The Commission therefore proposes that care recipients be subject to an assets test on those assets exempt from the age pension assets test (such as the principal residence and accommodation bonds) and the income test on the interest deemed to accrue from assets included in the age pension assets test. Such an approach would retain the familiarity with, and efficiency of, a Centrelink pension assessment. It would not affect the person's ongoing eligibility for the Age Pension.

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### **Box 7.9 Participants' views vary on a comprehensive means test for care**

#### **The Benevolent Society:**

We also support the view that those with considerable wealth (e.g. in housing assets) should be expected to pay more of their aged care costs, with the proviso that they should be able to do so without having to sell their home at a time of crisis (and possibly unnecessarily if their health improves). (sub. DR805, p. 2)

#### **Older People Speak Out:**

...nothing more clearly shows the failure so far to understand this age group than the proposal that the very frail aged should sell or reverse mortgage their home in order to pay for nursing home care. These are the generations who suffered the Great Depression and the World War 2: they went without, and afterwards were determined at all costs to pay off their home for their old age, and to ensure they leave the home to their children so they would not have to suffer as they had done in their younger days. (sub. DR746, p. 2)

#### **Challenger Limited:**

It is reasonable to expect that those who have sufficient means make a contribution to the cost of their care. If the cost structures and co-payments for that care are determined on a rational and predictable basis that will provide a foundation for the provision of financial products designed to assist the aged to meet their co-payment obligations and give them more choice in relation to their care. (sub. DR785, p. 3)

#### **National Seniors Australia:**

NSA is not opposed outright to the Commission's proposal to include the family home in the comprehensive aged care means test. We note, however, that this is a very contentious issue, as evidenced by member responses to our survey on the overall direction of aged care reform proposed by the Commission. Two-thirds (67%) of respondents disagreed with the inclusion of the family home in the comprehensive means test, with more than one third (36%) strongly disagreeing with the proposal. This was the most negative response received to all the Commission's proposals and points to the very large task that the Commission will have in persuading the seniors' community of the proposal's merits. (sub. DR832, p. 20)

#### **DoHA:**

The Commission's reform proposals recognise the need to finance the increasing costs of care into the future, through a new proposed co-contribution regime that would include the family home in the means test for determining what consumers contribute towards the costs of their care in both community and residential settings. They also provide for the impact of this to be moderated through its proposed pension bond and home equity release scheme. This element is important in removing perverse incentives for consumers to pay higher accommodation bonds. However, it could also have a significant impact where there is a spouse or dependent also living in the home. (sub. DR694, p.6)

#### **Combined Pensioners and Super Association of NSW:**

CPSA questions the wisdom of including the family home in care co-contribution assessments when there is a large body of evidence that suggests access to community care prevents more expensive residential aged care and hospital care in the future. (sub. DR760, p. 12)



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### *Consistency between co-contributions in the community and residential care*

For there to be consistency between co-contributions for community and residential care, there needs to be a consistent test on an individual's capacity to pay. Many participants called for a move away from providers determining older Australians' ability to pay for community care costs and for contributions to be determined by Government (as for residential care). For example, Blue Care said:

The government should give strong consideration to operationalising means-testing and administration of client payments for community care (and possibly other care services) through the social welfare or Medicare system, rather than at the service interface. (sub. 254, p. 54)

Some participants noted the difficulties that providers have in determining care recipients' capacity to pay. Catholic Community Services, for example, said:

... service providers face challenges in gauging a client's 'actual' ability to pay. These challenges include clients who are asset rich but cash poor, those who refuse to contribute, those who refuse to disclose their financial situation and those who have many additional costs such as medication and allied health interventions. The current system requires case managers / coordinators to make a judgement call on whether to reduce or waive fees. ...The Australian Government has well-established systems for means-testing which is used to assess eligibility for pensions and other benefits. (sub. 256, p. 2)

And Catholic Health Australia pointed out that inconsistent means testing results in poor targeting:

Consistent with CHA's view that those that can afford to should contribute towards the cost of their care and support services, it will be necessary to introduce nationally consistent income testing for these services. This would make the provision of these services more affordable for the community, allow available public funds to be directed to those most in need, and would not impede further growth in the private market for these services. (sub, 271, p. 21)

The limited extent of means-testing for community care and poor targeting of support also increases the cost to taxpayers. DoHA expressed concern about what this could mean for demand for community care over time:

... the different means testing treatment of community and residential care will, over time, induce greater demand for community care, as recipients of that care are not required to bear as a large a portion of the cost as they would be required to bear if they were receiving residential care. (sub. 482, p. 61)

To facilitate greater consistency in the approach to means-testing and to determine co-contributions across community and residential settings, the Commission proposes that means-testing of care recipients' contributions to care costs in both settings should be undertaken by Centrelink and coordinated by the proposed the Gateway (chapter 9). This should not only improve equity, but also provide the

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scope for subsidised services to be better targeted to those with the greatest need. This proposal was generally supported by participants. The Benevolent Society, for example, said:

We support the simplification and standardisation of co-contributions payable by care recipients ... Co-contributions should be based on affordability and capacity to pay and be set at such a level that they do not negatively affect care recipients' social inclusion and ability to participate in the community. We support in principle the proposal that the assessment of user contributions should occur through the Gateway Agency. (sub. DR805, p. 2)

But consistency in co-contributions within community care and across community and residential care also requires consistent assessment and entitlements across all care settings. While residents currently in residential care are assessed against the ACFI and providers receive subsidies based on the assessed care needs, in community care each of the three community care packages only offer a single subsidy level. As discussed in chapter 9, the Commission is proposing a new comprehensive aged care funding instrument that would assess individuals' needs and consistently apply entitlements (based on need, and not on whether care is provided in the community or in residential care). A person who requires care and support would go through the single assessment process. The assessment would identify the person's care and support needs and link to this the government's set of scheduled fees (taking into account additional costs associated with location, special needs, etc.). Co-contributions would be set based on the person's capacity to pay.

The introduction of the comprehensive aged care funding instrument should overcome the inconsistencies in assessment of need and the single financial capacity test similarly overcome inconsistencies in co-contributions for care and support services across care settings (see chapter 9 for more detail).

For both ease of administration and consistency, the Commission proposes that the same scale of co-contributions should be applied across all care services (with those having the least financial capacity paying the lowest co-contribution). Currently, recipients are not required to disclose the value of their home for the purposes of either the Age Pension or for determining co-contributions for care services. The Human Services Portfolio of Medicare Australia indicated that achieving consistency in co-contributions across community and residential care, and ensuring that people with the same wealth are treated equally, would require significant changes to supporting infrastructure:

- Medicare would need to significantly expand its rules based system
- Centrelink would be faced with an increase in the volume of requests for income and assets tests for aged care (sub. DR804, p. 9).

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To propose a comprehensive means test (particularly for low levels of support) may seem disproportionate and, given administrative costs, inappropriate. However, the currently applied co-contribution arrangements are not appropriate because they are often arbitrary in nature, lacking any obvious rationale and relationship to a person's capacity to pay. The Commission considers that the proposed comprehensive aged care means test should apply across all Australian Government subsidised services (the Australian Aged Care System, see chapter 9). The co-contribution would apply to the total value of the care entitlement.

Under the Commission's proposed new arrangements, older Australians with less complex needs would be able to access community support services directly or via a referral or an entitlement from the Gateway. Some of the community services would receive a level of block funding from the Australian Government (such as care for the homeless), and many would receive funding support from other levels of government (chapter 9). Direct access would obviate the need for a Gateway assessment and Centrelink financial capacity test. Accordingly, the simplified means testing for low level services, as proposed in the draft report, is not required.

### *Easing the way*

Under the proposed comprehensive means test there will be older people who lack the income to meet their care and support costs. Some participants raised concerns about people on low incomes not being able to access services because of their costs. Full pensioners and low income older Australians receiving care in the community, for example, are unlikely to have sufficient income to pay for their care costs, despite their overall wealth, and this points to the need for financial products that allow the unlocking of equity in homes and deferred payments. The need for such options was acknowledged by Aged Care Association of Australia and Deloitte:

... domiciliary care provided in the family home obviously cannot be funded through the sale of that home, though there may be ways other than sale of unlocking the consumer's equity in his or her home. (sub. 285, p. 7)

Catholic Health Australia also said:

Copayment policies ... have to take into account that the lifetime savings of most Australians are in the form of home ownership. The illiquid nature of this asset can constrain payment options for individuals, with potentially adverse financial consequences if lack of flexibility does not allow choice of payment arrangements that suit personal financial circumstances and objectives. (sub. 217, p. 32)

As discussed in chapter 8, the Commission acknowledges a role for the Government is to provide a means by which older people can use their accumulated wealth to

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contribute to their aged care costs. Consequently the Commission is proposing the establishment of a Government-backed Australian Aged Care Home Credit scheme which would enable older Australians to draw down on the equity in their home to contribute to the costs of their aged care and support.

### *A lifetime stop-loss for 'out-of-pocket' care expenses*

On both equity and efficiency grounds, the Commission considers that while everyone with the capacity to pay should contribute to the cost of their care, older Australians should not be faced with having to pay for very high or catastrophic costs of care — there should be a limit to their out-of-pocket expenses irrespective of their financial circumstances.

Intensive care for extended periods of time is very expensive. Under a system of co-contributions, those with the highest care needs and a capacity to pay face the highest costs. The Commission proposes that, combined with new co-contribution arrangements, a lifetime stop-loss mechanism be put in place to protect individuals against very high out-of-pocket expenses for aged care, recognising that voluntary insurance arrangements to do this do not exist and are not really feasible (chapter 8).

There are a number of ways that such a limit could be implemented. It could cut in either after a certain period of time of paying care costs (for example, after paying the cost of intensive care for a number of years), or after an individual had made a specific level of financial payout.

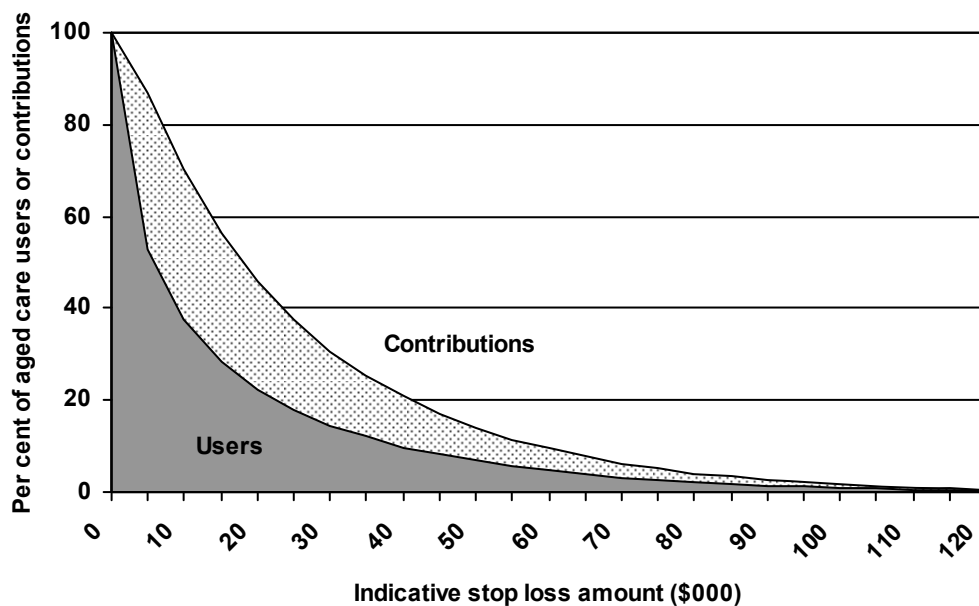
The United Kingdom recently announced a National Care Service which supports universal entitlement and protection from catastrophic costs of care. Commencing in 2014, anyone staying in residential care for more than two years would receive fully subsidised care after the second year (HM Government 2010).

Annual and lifetime limits should apply only to approved care services. Amounts above these limits would be a de facto insurance scheme as any very high out-of-pocket expenses for subsidised aged care services would be fully publicly funded. This suggests that limited liabilities should be based on a whole of life basis rather than an annual basis. In the Commission's view, the stop-loss should cut in at the same point for everyone.

Based on a costing analysis of the Commission's proposed arrangements, assuming co-contributions for care range from 0 to 25 per cent (see next section), a stop-loss of around \$60 000 would cover 10 per cent of private contributions (about 5 per cent of recipients) would need to be set at around \$60 000 (figure 7.1). That would mean that older Australians requiring close to the highest level of care and

who were paying the highest assumed co-contribution rate of 25 per cent of their care costs, would take around five years to reach the stop-loss limit. Assuming co-contributions for care ranging from 0 to 35 per cent, a stop-loss that covers around 11 per cent of private contributions (around 5 per cent of recipients) would need to be set at around \$70 000. Taxpayers would pay for all remaining care costs once a care recipient has reached the stop-loss limit (appendix E).

**Figure 7.1 Projected percentage of care recipients expected to reach indicative stop-loss amounts with a 25 per cent maximum co-contribution**



*Data source:* Commission estimates.

Any specified financial limit would need to be indexed. The Commission's proposed AACC should recommend on the most appropriate form and rate of indexation (chapter 15).

Some of the practicalities associated with a stop-loss arrangement include:

- when the clock starts ticking for the stop-loss would be linked to when people are assessed or start to receive services (this could be facilitated via the proposed Gateway and the comprehensive aged care funding instrument)
- proof of purchase of services (receipts from care recipients, electronic records)
- a record keeping system.

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### Box 7.10 A lifetime stop-loss limit – participants' views

#### Benevolent Society:

The proposed lifetime stop-loss limit has many attractions as a way of ensuring that care recipients and their families are not exposed to excessive costs. It is preferable to systems that require users to run down their savings until almost nothing is left. As such it is likely to attract wide community support. (sub. DR805, p. 3)

#### Peninsula Health:

Given the potential for lifetime costs to become very high, it is reasonable to propose a limit on the expenditure any one individual can be required to make via co-contributions for care. (sub. DR650, p. 6)

#### Royal District Nursing Service:

The introduction of a stop-loss is an important safety net. However, determining a single figure across Australia (e.g. \$65,000), does not represent the same financial impost for all Australians as the cost of living can vary significantly between states, and within states. (sub. DR546, p. 2)

#### The Salvation Army Aged Care Plus:

... supports the principle that care recipients should not be faced with having to pay for very high or catastrophic costs of care but that these costs should be 'risk pooled'. Therefore, a lifetime stop-loss mechanism is supported whereby the tax payer would pay for all remaining costs for an individual (excluding accommodation and everyday living expenses) who has reached the amount determined as the stoploss limit. (sub. DR567, p. 7)

A number of participants supported the lifetime stop-limit proposal (box 7.10). National Seniors Australia, for example, said:

... we welcome the proposal for a life-time stop-loss limit on co-contributions to care costs, as this should give older Australians greater 'peace of mind', knowing that they will not face crippling care costs as they age and can preserve much of their accumulated wealth. (sub. DR832, pp. 18-19)

As discussed in chapter 6, the lifetime risks of requiring aged care services and the potential costs of such care are not well understood. To make Australians more aware of these risks and the potential cost of aged care (so they can be better prepared financially), the Commission considers that there is merit in a public education campaign. Such a campaign could take place at the same time that the community is made aware of the proposed lifetime stop-loss for care costs. This information could also be made available via the Gateway.

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## **A new care co-contribution regime**

### *Consistent co-contributions*

As discussed above, to overcome the complexities and discontinuities between the levels of co-contributions made by care recipients across community care packages and residential care, the Commission is proposing a new single national co-contribution regime which would apply across all approved aged care services, irrespective of whether they are delivered in the community or in a residential aged care facility. Under such a regime, co-contributions would vary according to the price of the service and the person's financial capacity to pay.

As part of its analysis, the Commission prepared projections based on a range of co-contributions (appendix E). The guiding principles for the projections of the care co-contribution regime were that:

- co-contributions to care costs are consistent regardless of the care setting
- no one should pay more than the cost of their care
- those with limited means only make a small contribution, generally comparable with current arrangements.

In developing cost projections, the Commission looked at the impact of applying maximum care contributions of 25 and 35 per cent of care costs. For residential care, the co-contribution was assumed to begin at zero, while in community care the minimum payment (excluding hardship provisions) was assumed to be 5 per cent of care costs.

The co-contribution to care was assumed to be based on a comprehensive means test (as discussed above) covering a person's assets and income. The income deemed to accrue on assets subject to the Aged Pension means test was included as income for determining a person's care co-contributions, while all other assets were subject to the care asset test.

The Commission assumed that care recipients with an annual income below \$17 443 (excluding pension supplement) and relevant assets below \$39 000 (the minimum asset test threshold at March 2011) would pay the minimum co-contribution for their care setting (community care or residential care) towards their care costs. For every dollar in income or assets that a person has above the thresholds, they are assumed to make a larger co-contribution to their care costs, until they reach the maximum care co-contribution rate. As an example, the

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maximum co-contribution to care costs in the community would be paid by someone with an annual income of over \$40 000 when their relevant assets reached:

- \$441 000 if a maximum 25 per cent care co-contribution was assumed
- \$740 000 if a maximum 35 per cent care co-contribution was assumed.

The relevant asset thresholds for reaching the maximum care co-contribution if the same person was in residential care would be \$551 000 and \$851 000 for the 25 and 35 per cent maximum co-contributions respectively.

The Commission estimates that 66 per cent of community care recipients and 76 per cent of residential care recipients would pay a care co-contribution of 15 per cent or less in 2013. Further detail on the Commission's projections are provided in appendix E.

DoHA suggested that further work needed to be undertaken on the proposed new co-contributions, noting that:

While the proportion of care recipients making a significant contribution would increase from around 12-25 per cent to 70 per cent under these proposals, charges for residents on higher incomes would decrease due to the proposed stop-loss mechanism. For example, current arrangements allows for residents with very high incomes to pay up to \$50 000 per year towards their care costs, and potentially several hundreds of thousands of dollars over their full period of care, significantly higher than the Commission's indicative lifetime stop-loss limit of \$60 000. (sub. DR 694, p. 6)

The Commission agrees that further analysis on options for means testing care co-contributions is warranted. But, as acknowledged earlier, the evidence base for such analysis currently limits what can be done. Effort should be directed towards obtaining more robust data to support further analysis of the distributional impacts of the proposed different means tests. The expertise of government agencies and departments in implementing means tests should also be drawn on.

As discussed in chapter 6, the decision about the levels of co-contributions is one for the Government in balancing the relative proportion of care recipient contributions and taxpayer funding.

### **A body for determining costs of care and accommodation**

A major concern of participants to this inquiry was the appropriateness of indexation arrangements for determining the cost of care and accommodation on which government subsidies are based.

The Commission considered indexation arrangements as part of its 1999 inquiry into nursing home subsidies and found that, with other sources of income for



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providers largely tied, inadequate increases in subsidies after allowing for efficiency improvements would, in one way or another, compromise the delivery of quality care. While not putting forward a view on the most appropriate indexation methodology, it recommended that:

Basic subsidy rates should be adjusted annually according to indices which clearly reflect the changes in the average cost of the standardised input mix, less a discount to reflect changes in productivity. (PC 1999, p. 97)

This approach recognises the importance of both ensuring subsidies accurately reflect the cost pressures faced by the aged care industry and providing an incentive for providers to look for ways to improve their productivity.

There was widespread support among participants of this inquiry for the establishment of an independent body to determine the cost of care and annual indexation methodology, a role analogous to the proposed Independent Hospital Pricing Authority for the National Health and Hospitals Network (box 7.11).

**Box 7.11 Widespread support for an independent body to determine costs and appropriate indexation**

Aged Care Association Australia and Deloitte:

What is needed is an independent mechanism for calculating an appropriate economic cost of care & personal services and levels of hotel and accommodation services. The task of undertaking this cost assessment should be allocated to an independent Authority or Commission (ie consider the possibility that that function be undertaken by the new Hospital Pricing Authority) for the ongoing evaluation, calculation and administration of this cost mechanism. This can then serve to be the price setter, whereby Government as purchaser, can determine the level of services it will fund and to who it will fund into the aged care system. (sub. 285, p. 13)

Blue Care:

Establish an independent body to benchmark each year the true cost of care including regional variations and to estimate input cost increases and the required level of indexation of subsidies.

Adjust the accommodation supplement over time based on independent evidence as to building development costs, clinical and community norms regarding standards of accommodation and regional disparities. (sub. 254, p. 4)

Catholic Health Australia:

... because the fees and subsidies reflected in the current ACFI rates are historically based and indexed to minimum wage adjustments, they do not reflect contemporary care practices, standards or labour market conditions. The reforms, therefore, should provide for periodic independent reviews of the cost of care to inform the setting of care subsidies and fees, undertaken by a body such as the proposed Independent Hospital Pricing Authority. (sub. 217, p. 14)

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A transparent methodology was also seen as particularly important. Blue Care, for example said:

Implement a transparent method of estimating input cost increases that is relevant to the residential aged care and community care sectors and capable of being subjected to external scrutiny and review. (sub. 254, p. 3)

The Commission proposes that the AACC (chapter 15) would, as one of its functions, recommend the costs of delivering care (community and residential) and of providing a basic standard of accommodation for supported residents. Participants pointed to the importance of the AACC liaising with experts and providers when recommending the cost of delivering care. The Royal District Nursing Service said:

RDNS strongly advocates liaison with providers and expert clinicians when setting the price structure. If the set price does not reflect the true cost of quality service delivery for a customer base in different geographies with different service requirements, it may have the opposite effect to what is intended. Customers may not be faced with a diverse group of quality providers with interesting and exciting service offering — but a few providers offering the bare minimum. (sub. DR546, p. 1)

COTA Australia argued that the move to independently recommended prices should be one of the first and highest reform priorities:

We strongly endorse the move to fund on the basis of prices recommended by an independent agency and that these prices would be mandated for services attracting the government subsidy.... It is vital that moving to independently recommended pricing be one of the first and highest priority steps in implementation of the Final Report. Even if higher prices are phased in over a couple of years they need to be set as soon as possible. Without prices that truly reflect the cost of care the Commission's integrated blueprint will not have the confidence of consumers, providers or unions. (sub. DR656, p. 9)

Care recipients' co-contributions should be regularly reviewed by the Government based on transparent recommendations from the proposed AACC.

#### RECOMMENDATION 7.9

***The Australian Government should:***

- ***prescribe the scale of care recipients' co-contributions for approved aged care services which would be applied through the Australian Seniors Gateway Agency***

- 
- *set a comprehensive means test for care recipients' co-contributions for approved aged care services. This test should apply the Age Pension income test. The test should also apply an assets test to the relevant share of a person's assets which are excluded from the age pension means test (such as the principal residence, accommodation bonds and the proposed Australian Age Pensioners Savings Account).*

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

*The care recipients' co-contributions scale should be regularly reviewed by the Australian Government based on transparent recommendations from the Australian Aged Care Commission.*

RECOMMENDATION 7.10

*The Australian Government should set a lifetime stop-loss limit comprising the care recipients' co-contributions towards the cost of approved aged care services (excluding accommodation and everyday living expenses). Once the limit has been reached, no further care recipients' co-contributions would be required for those services.*

*With a stop-loss limit in place, the Australian Government should exclude aged care costs from the net medical expenses tax offset.*



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## 8 Options for broadening the funding base

### Key points

- Australians will have to pay more for the care of older Australians as our population ages. Finding the right balance between public funding and private funding is a sensitive and complex task. The burden of funding should be equitable and the mechanisms should be efficient in their design and application.
- There are a number of options for broadening the existing taxation and user contribution funding base for aged care — increased dedicated private savings (aged care saving accounts and quarantined superannuation contributions), equity release products and insurance (voluntary or compulsory).
- Increasing private savings dedicated to funding the private costs of aged care is not efficient. Some older people will save too much, others not enough. Private savings redistribute resources across a person's life, but do not allow pooling of the costs of aged care costs across the population.
- Many older Australians have built up assets over their working life that could be drawn on to pay for the more predictable and manageable costs of care. But equity release products can be complex and there is nervousness about current privately offered products. The Commission supports the introduction of a government-backed equity release scheme, under which money could be drawn down upon to cover aged care costs.
- Voluntary insurance is unlikely to work in anything but a very modest way because of problems on the supply and demand side of the insurance market. That said, with a lifetime stop-loss mechanism along the lines of that proposed by the Commission, there could be a role for private insurance to cover the more predictable and manageable costs of care.
- There are many similarities between the current tax-funded system supplemented by a lifetime stop-loss mechanism, and compulsory insurance — both involve risk pooling (to protect individuals from catastrophic costs), progressive mechanisms for raising funds and access to care based on need, rather than ability to pay. But there are significant design and transitional issues (and costs) with moving to a compulsory insurance model.
- Given the characteristics associated with aged care, the Commission supports the current pay-as-you-go tax financed system supplemented by higher co-contributions and a lifetime stop-loss mechanism, in preference to a compulsory pre-funded insurance scheme.

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The current funding arrangements for aged care are supported by two pillars — a dominant taxpayer funded pay-as-you-go subsidy pillar and a user pay pillar. Under these arrangements, taxpayers bear the full financial risk associated with the public subsidy, including rising unit costs and the effects of population ageing on overall care costs.

A number of analysts (including Ergas 2010; Fine and Chalmers 1998; Howe and Sargeant 1999; Myer Foundation 2002) and participants to this inquiry (Bethanie Group, sub. 407; Melbourne Citymission, sub. 173; Medibank Private, sub. 250; National Seniors Australia, sub. 411) suggested the need to consider a third funding pillar. For some, the case for an additional pillar rests on concerns about fiscal sustainability. Others contend that, with population ageing, marked intergenerational inequities can arise under the current system.

Options for broadening the funding base for aged care include:

- increased dedicated private savings (aged care savings accounts, quarantined higher superannuation contributions)
- drawing on housing equity (equity release products or income contingent loans)
- insurance — voluntary or compulsory.

This chapter looks at each of these options with a focus on the incentives they create and their implications for economic efficiency, equity (including intergenerational equity), simplicity and sustainability. The merits of these options will be influenced by the relative importance attached to each of these considerations. However, a complete assessment should also balance the merits of any new arrangements with those of the existing funding base.

Section 8.1 examines the use of savings accounts and superannuation. Section 8.2 looks at the use of home equity to help individuals contribute to their care costs, while section 8.3 examines the insurance option.

## **8.1 Saving accounts and superannuation**

Aged care saving accounts and the use of superannuation funds to cover the private costs of aged care were two ideas put to the inquiry to encourage individuals to save for their ‘later-life’ care costs (and, in turn, take some of the pressure off taxpayers). Alzheimer’s Australia NSW, for example, said:

... consideration should be given to creating a form of Healthy Ageing Savings Account (HASA) or similar mechanism to fund aged care. This account should be

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considered in addition to current Medicare levies and superannuation arrangements. (sub. 455, p. 5)

Mercy Health said:

A greater emphasis should be placed on increased superannuation contributions, both employer and personal contributions to better position people to support themselves and their health needs in their latter years. Even with greater superannuation contributions, there will be a significant percentage of people who will be unable to pay for the services that they require. (sub. 215, p. 8)

Accumulated savings represent a form of pre-funding for future aged care costs. As such, they provide a mechanism for lessening the future call on public funds. They also help address concerns about perceived intergenerational inequities by evening out the burden of paying for care into the future. But it is difficult for individuals to estimate the amount of savings required to meet their aged care costs. In particular, people who face catastrophic costs of care (arising from extended and intensive periods of care) would be unlikely to have saved enough to cover these costs, whereas people who save for care by making higher contributions to a quarantined account, but do not subsequently require aged care, will have forgone the benefits of higher consumption or other forms of saving. As Deeming and Keen point out, it is ‘socially inefficient’ for everyone to save for the possibility of needing long term care in older age:

Saving for long-term care is not an efficient option for individuals. Not everyone will need long-term care, therefore it would be unrealistic and socially inefficient for everyone to save to meet the average cost of needing care, let alone the maximum cost. (2001, p. 84)

Private savings, because they do not permit risk pooling, are unable to facilitate the redistribution of resources between individuals according to need (or provide protection from catastrophic costs). As Glendinning et al. argued:

Private savings approaches are not likely to provide equal resources for equal needs. They redistribute resources across the life cycle, but do not redistribute from those with lesser to those with greater needs for long-term care. They are more costly for women; as women face a higher risk of needing care, they need higher savings than men. Savings approaches would not be widely affordable and moreover, involve no pooling of risk. (2004, p. 4)

Barr also said:

Self-finance (i.e. financing long-term care out of personal savings of a long-term care savings account) is an inferior solution. Where someone is risk-averse the possibility of pooling risk is welfare-enhancing. (2010, p. 372)

As such, private savings are best suited to cover everyday living and accommodation costs and contribute to basic support and care costs that are more modest and predictable. The unpredictable and potentially catastrophic costs

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associated with intensive long term care (that have a relatively low probability) are better suited to some form of insurance or stop-loss arrangement.

Having individuals pay for some of the more predictable care costs from private savings could provide an incentive for the greater use of preventive and early intervention measures. International evidence on healthy ageing savings accounts suggests that these accounts can encourage individuals to be more conscious of the costs of their care and to take greater responsibility for their health (box 8.1). The Aged Care Association of Australia (ACAA) and Deloitte also argued that a private savings option could reduce concerns about moral hazard (or over-use):

... if consumers are using their own savings to finance care, moral hazard in care decisions may be reduced, which is likely to be especially important for domiciliary care. (sub. 285, p. 8)

#### **Box 8.1 Healthy Ageing Savings Accounts — international experience**

A review of international experience with HASAs suggests the following lessons:

- *Accounts encourage efficiency.* A case study of Discovery Health in South Africa found efficiency gains as members were more conscious of cost when paying from personal savings, since the marginal cost is explicit.
- *Accounts deliver better health outcomes* particularly if coupled with wellness programs (e.g. screening, health checks, vaccinations, lifestyle modification) and rewards (such as flyer points) as people take greater responsibility for their health.
- *Lower income groups take up accounts*, potentially more attracted to saving for their own needs rather than pooling risks through insurance. In the US, a third of accounts have been taken up by previously uninsured people and around 40 per cent of accounts were taken up by people with incomes below the median.
- *Incentivisation* is necessary to overcome moral hazard in relation to saving; in New Zealand a HASA product failed due to a lack of tax-deductibility.

*Source:* Access Economics (2009b).

Some participants suggested that dedicated aged care savings accounts would need to be additional to current superannuation. Because there are no restrictions on how superannuation income is spent, the concern was that older Australians might have an incentive to spend their retirement incomes on other less essential items and fall back on the public safety net to cover the cost of their care needs. In this context, Access Economics argued that:

This moral hazard underpins the need for a parallel, complementary private saving mechanism. (2009b, p. 123)



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Looking forward, while many Australians are likely to have larger superannuation and other asset balances when they retire (chapter 7), increases in average life expectancy will mean that the assets have to provide income for a longer period of time (box 8.2). In this context, the Henry Review said:

As the superannuation guarantee scheme matures, cohorts of older people should have larger assets balances available to them at retirement. However, these assets will need to provide an adequate stream of income over a person's retirement, the duration of which is uncertain for individuals. The expected increase in average life expectancy is likely to add to this risk. Further, the use of aged care services is particularly intensive for people aged 85 and upwards, once many have been in retirement for 20 years or more. (2010, p. 642)

**Box 8.2 Retirement — funds for around 20 years required**

Retirement and retirement expectations have changed dramatically over the past 100 years. When the Age Pension began in 1909, the maximum payment was 12 per cent of male average weekly earnings (10 shillings per week). Only half of all people born lived to age 65 years and of those who lived to 65, their life expectancy was another 11.3 years for men and 12.9 years for women. Because of strict means testing and other eligibility criteria, few received the pension — just 23 000 or 28 per cent of those aged 65 years or more.

Today, 87 per cent of men and 92 per cent of women live until age 65 and can expect to live for around a further 20 years (18.7 years for men and 21.8 years for women). The introduction of compulsory superannuation in 1992 ensures that everyone working as an employee will have something saved for their retirement. That said, more than three-quarters (77 per cent ) or 2.3 million older Australians currently receive either the Age Pension or Department of Veterans' Affairs Service Pension.

*Sources:* ABS (2010e); Harmer (2009); NATSEM (2009).

While quarantining part of an individual's superannuation funds for aged care would lessen the scope for early draw downs prior to needing to contribute to the costs of aged care, it would also constrain consumption choices. And, for those individuals who do not require care in old age, they are likely to leave behind larger bequests than they might otherwise have chosen. As ACAA and Deloitte put it:

This excess bequests distortion (and the associated reduction in life-time utility) is obviously especially large if the mandated savings level is set in line with average expected life time care costs while the distribution of those care costs is bimodal or in any event, highly skewed (so that many consumers will experience costs well below the mean, while some others will experience costs many times the median). (sub. 285, p. 8)

A compulsory aged care savings account is likely to be more distortionary than unrestricted superannuation as it can only be drawn on for aged care expenditure (or

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if unused, left as a bequest), while unrestricted superannuation can be used for any purpose once it is accessed.

Compulsory saving imposes a deadweight loss as it distorts decisions about which savings vehicles to use as well as between consumption and savings. In particular, younger people may be less able to invest in their preferred mode of savings (for example, owning their own home, which is a tax effective savings vehicle and offers social benefits).

As a compulsory savings mechanism already exists in the form of the superannuation levy, the administrative costs of expanding savings in this way would be minimal (although not necessarily the administration costs of quarantining them). Medibank Private noted that such an approach could be implemented with relative ease, but also noted the additional burden on the working population:

Advantages of this model include the relative ease of management if the scheme is aligned with current mandated superannuation contributions. However, this model relies on the working population who may feel they are already overburdened with taxes related to retirement and future needs. (sub. 250, p. 10)

Some participants suggested the need to provide subsidies or tax incentives to increase the attractiveness of making extra savings to cover the potential costs of aged care. However, such subsidies perform poorly on equity grounds as they offer the greatest benefit to those with the greatest capacity to save (being also those most likely to have the capacity to contribute to their own aged care in the future). And, without compulsion, subsidies for saving for aged care are unlikely to significantly increase overall savings for aged care costs. As Barr put it:

Many people realize that they need to save more for their old-age security and intend to do so — but somehow it never happens. (2010, p. 370)

The challenge is to provide people with incentives to save in their preferred savings vehicles to fund both their retirement and the predictable costs of their aged care. The more generous the safety net for aged care, the lower the incentive to save for these likely, but not certain, costs. But a reasonable safety net is required to ensure that all older people have access to an appropriate quantity and quality of care.

An alternative approach is to change people's attitudes towards funding their aged care. There is currently an incentive to save in assets, notably the home, that delivers a service as well as a store of value, especially if this asset is tax free. Under the Commission's proposed lifetime stop-loss limit, individuals will have greater certainty about the maximum cost of care and therefore a greater incentive to ensure adequate savings/income to cover the predictable costs of care (chapter 7). Also, in the vast majority of cases, older Australians have built up assets over their working life that could be drawn on to pay for their costs of care.

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The least distortionary approach would be for these assets to be available to contribute to the costs of aged care — especially if the draw down against the wealth of their share of their principal place of residence is structured so that their owner could continue to use the house, while drawing against it to pay for aged care costs (see below). A comprehensive means test for assessing an individual’s rate of aged care co-contributions, combined with a mechanism that would allow people receiving care to continue to use their house while they can do so, could form the platform for a change in attitude towards accepting responsibility for contributing to one’s own aged care costs.

## **8.2 Drawing on housing equity to pay for care costs**

Accessing housing equity is a contentious issue, yet most Australians recognise that the home is the main means of long term saving. From participants’ input into this inquiry, there seems to be a growing sentiment that many Australians could tap into the wealth they have tied up in their primary residence to pay for aged care costs. The Country Women’s Association of NSW, for example, said:

We are of the opinion that the thought that ‘the family home being sacred and having to be passed on’ is slowing changing. This is evidenced by the baby-boomer generation selling the family home, buying mobile homes and ‘seeing the country’. (sub. DR669, p. 3)

The Little Company of Mary Health Care, also said:

Given that approximately three-quarters of older people in Australia own their own home, this most important source of funding cannot be ignored. (sub. 289, p. 22)

Cam Ansell and Jim Toohey called for action to:

Further broaden the choices for residents to meet the costs of their accommodation and services beyond lump sum refundable deposits including the option to levy deceased estates for an agreed amount incurred in the provision of aged care. These agreed deductions, over and above any government subsidy, can include costs for the provision of extra nursing and personal care where the resident and/or the family feels that such care is necessary or desirable. (sub. 464, p. 8)

And the ACAA and Deloitte said:

Many elderly Australians have limited assets and income, and a substantial share of what assets they own involve the family home. While that home can be sold at the time of entry into residential care, it may not be so readily sold if only one member of a couple is going into care. Moreover, domiciliary care provided in the family home obviously cannot be funded through the sale of that home, though there may be ways other than sale of unlocking the consumer’s equity in his or her home. (sub. 285, p. 7)

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As discussed in chapter 12, just over 83 per cent of Australians aged 65 and over own or are buying their home. Looking forward, older cohorts are likely to have significantly more wealth in real terms. Kelly (2002), for example, estimated that the share of Australia's total family net wealth for those aged 65 and over is likely to increase from around 22 to 47 per cent between 2000 and 2030.

Equity in housing can be released by selling and moving into something less expensive, with the balance being used for other purposes (see chapter 7 for a discussion covering a proposal for an Australian Age Pensioners Savings Account to protect eligibility for the Age Pension). Alternatively, housing equity can be drawn down via an equity release scheme or an income contingent loan. Equity release schemes allow people to borrow against the equity in their home with no (or limited) repayments made until the home is transferred to another person. An income contingent loan<sup>1</sup> is broadly comparable to an equity release scheme and, as described by Bruce Chapman, works in the following way:

An individual entering a nursing home, for example, would be allowed to borrow funds using her/his home or other assets as collateral. A given sum of money provided by the government, say \$100 000, could be set aside and drawn down over time to cover the costs of nursing home care. At the end of the person's time spent at the nursing home, in most cases meaning the death of the individual, the remainder of the loan would be returned to the individual's estate, which has a debt equivalent to the original amount borrowed. This debt would be considered to be a debt of the estate. (2006, p. 2)

The advantage of schemes that draw on housing equity is that they allow people with housing assets to meet the costs of extra spending, including spending on aged care, without having to sell their home to finance it. These schemes can be an attractive option when a partner goes into residential care while the other remains in the home, or to fund care while remaining in the community.

For those older people with limited superannuation (including most of the current cohort of those aged 85 or older), access to housing equity could improve their capacity to contribute to the cost of their care and to purchase additional services. This would allow the government's funding of care to be greater for those with less capacity to pay (and/or reduce the tax burden on future generations), and provide more choice for older Australians. That said, the current market for equity release products is limited by the value (and expected changes in valuation) and condition of the homes of older people (an issue particularly relevant for many people living in rural and remote areas).

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<sup>1</sup> Australia's higher education contribution scheme provides an example of an income contingent loan arrangement.

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There are two broad ways to release equity:

- reverse mortgage — where the equity in a home is used as security to borrow money. The loan can be taken as a lump sum, a regular payment stream, a line of credit, or as a combination of these. No repayments are made on the money borrowed until the home is sold
- home reversion — where a proportion of the equity in the home is sold (usually up to a maximum of 50 per cent). A lump sum payment is received in exchange for a fixed proportion of the future value of the home. The proportion of the future value of the home belongs to the scheme provider, but is only paid to them when the home is sold (ASIC 2009).

Explaining the difference between the two products, Deloitte Access Economics for Homesafe Solutions said:

Reverse mortgages involve the accumulation of debt over the life of the contract whereas home reversion is debt-free. Under a reverse mortgage, longevity risk, interest rate risk and property value risk are borne by the homeowner, whereas under home reversion these risks are transferred to the provider. This is a crucial distinction since homeowners are generally less well placed to bear such risks compared with commercial providers who can diversify and lay off risks to investors through the capital market. (sub. DR600, pp. 6–7)

Both products are available in Australia, but generally only for people aged 60 years or over. Reverse mortgages are the most common product, while home reversion schemes are relatively new and only available in certain areas of Sydney and Melbourne (ASIC 2010). In commenting on the narrow spread of the home reversion product, Deloitte Access Economics for Homesafe Solutions said:

Since home reversion involves the sale of a share of the future sale proceeds of a home, providers naturally focus on locales expected to provide sustainable long-term capital growth. They also gravitate to houses in more desirable locations within those areas, and to cities rather than country towns. At present, Homesafe Solutions only offers its home reversion product in Greater Sydney and Greater Melbourne, for example. (sub. DR600, p. 15)

Equity release products can be complicated financial products and there is some nervousness about them amongst consumers. This may explain the low take up rates to date. As AMP Capital Investors said:

Reverse mortgages have been available in Australia for some time now, however their attractiveness for investors has been slow to develop. (sub. 342, p. 10)

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Medibank Private also said:

Many current private equity release schemes have not offered good terms to homeowners and there is an opportunity for the private sector to offer better product packages with government support. (sub. 250, p. 10)

A number of participants expressed concerns about the use of equity release products for aged care. The Financial Planning Association of Australia (FPA), for example, said:

While reverse mortgages or equity release products have the potential to significantly improve the quality of life of older people with few assets other than the family home, they have significant risks and are not suitable in all cases. Such loan products are very complex, are commonly very expensive, and the FPA is concerned that existing laws do not adequately protect consumers. (sub. 376, p. 5)

A recent FPA member survey highlighted a number of concerns about reverse mortgage products including:

- clients' ability to comprehend how the critical features and risks of the products may affect them in the future, particularly when conditions and circumstances change
- future uncertainties (interest rates, property values and longevity) affecting the suitability of the product
- beneficiary discontent
- high implementation costs for the product
- the long term, irreversible nature of the contract. (sub. 376, pp. 5–6)

Reverse mortgage products can expose home owners to financial risks, largely because of a number of 'unpredictable' factors including interest rates, real estate prices and life/independence expectancies (box 8.3). As Bridge et al. said:

Reverse mortgages can yield cash quickly but they are complicated and can expose vulnerable homeowners to potentially serious financial risks. These risks include: negative equity; rising interest rates; falling property values; and default conditions that could, for example, trigger immediate loan repayment and negate 'no negative equity' guarantees. (2010, p. 8)

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### Box 8.3    **The risks of equity release products**

The Australian Securities and Investments Commission (ASIC), an independent Australian Government agency responsible (among other things) for consumer protection in financial services, noted that while equity release products can provide benefits, they also have significant risks:

- they can be difficult to understand
- they can be relatively expensive compared to other types of loans with regular payments
- if certain terms and conditions are breached, the person may have to sell their home and replay the loan
- if property values don't increase as much as expected, or if they fall, the person might end up with less money than expected when selling their home
- circumstances and financial views can change as people age — if a person releases too much money early in retirement they may not have enough later on.

Because of compound interest and fees, and not making any repayments, the amount owed on a reverse mortgage can grow very quickly. What is owed can end up being more than the value of the home. Most reverse mortgages protect against negative equity by putting a limit on how much can be owed with a No Negative Equity Guarantee, but not all reverse mortgages offer this feature.

*Source:* ASIC (2009).

Reluctance to reduce the 'kids' inheritance can be a further barrier to the use of equity release products. The Council on the Ageing (COTA) Australia commented that the issue of 'estate beneficiaries' needs to be tackled directly:

It is also time that we directly confront the 'estate beneficiaries' issue and ask who wants to put their hand up publicly and say that they want to put part of their inheritance at a higher priority than the partial cost of care of their parent? Or that when parents do have means to contribute to their care (and only up to a maximum limit) they should not need to because their children would like to inherit the funds, when this will lead to taxpayers on lower incomes subsidising the inheritances of those much better off. (sub. DR565, p. 11)

A survey of 7000 Australians aged 50 years and over undertaken by the Australian Housing and Urban Research Institute (AHURI) suggested that concerns about leaving inheritances are becoming less evident. AHURI concluded that:

The attitudes of many men and women towards inheritance has shifted as to what previously would have been considered 'the right thing to do' in terms of traditional obligations and responsibilities to their children. Our data strongly suggest that many older people's attitudes have taken on more of those of their Baby Boomer children;

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that is ‘put yourself first’. The desire to bequeath assets to the next generation seems to be significantly diminishing. (2005, p. 13)

A Deloitte study commissioned by the Senior Australians Equity Release Association of Lenders (SEQUAL) found that as of December 2009, the market in Australia consisted of just under 39 000 reverse mortgages with total outstanding funding of \$2.7 billion and an average loan size of just under \$70 000. The number of reverse mortgages more than doubled between 2005 and 2009 (table 8.1).

**Table 8.1 Number of reverse mortgages, outstanding market size and average loan size, 2005-2009**

	2005	2006	2007	2008	2009
Number of reverse mortgages	16 584	27 898	33 741	37 530	38 788
Outstanding market size (\$ billions)	0.85	1.51	2.02	2.48	2.71
Average loan size (\$)	51 148	54 233	60 000	66 150	69 896

Source: SEQUAL (2010).

It is unclear, however, whether reverse mortgage products are being used to fund aged care or to fund other consumption (Access Economics 2010c). One provider indicated that it had clients using equity release products to fund aged care costs. Fortus said:

Our company has a client with a \$50,000 per annum income, but requires another \$50,000 per annum from Equity Release in order to have 24 hour care at home. Whilst this is an extreme example, the funding for Community Aged Care Packages (CACPs) has not kept up with inflation or demand, and more elderly want to receive special care in their home rather than an aged care facility. (sub. DR755, p. 2)

Internationally, the uptake of equity release products by older home-owners has been relatively low. The complexity of schemes, limited information and the failure of providers in the past, have been factors contributing to the hesitation of consumers to use these products (appendix D). According to the Organisation for Economic Cooperation and Development (OECD):

... in most countries, [reverse mortgages] are still scarcely used, including because they require a relatively high degree of household financial education. Even in the United States, where the reverse mortgage market has developed rapidly in recent years, it remains very small. (2005b, p. 51)



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## Is there a role for a ‘public equity release’ scheme?

There are a number of reasons why government involvement in equity release products might be justified to assist older Australians to contribute to their aged care costs.

- Information asymmetries — the evidence suggests that older Australians lack the information about how such schemes work and they have poor financial literacy. In the context of Debt Free Equity Release Products, Access Economics argued that information asymmetries arise due to the relative infancy of the market, which means that both consumers and investors have insufficient knowledge about the product and are unable to make informed decisions. Also, many consumers and investors may be unaware of the product.
- Older Australians may be vulnerable to exploitation and hence may need protection. Bridge et al. (2010) found that people typically make the decision to investigate or take out a reverse mortgage when they experience an unexpected change in their circumstances and/or an ongoing shortfall between their income and their expenses. As Access Economics (2010c, p. 31) said: ‘government should be mindful above all of the vulnerable circumstances of the older Australians’ who are most likely to consider such products.
- Equity release products can be costly to set up and this can be problematic if the amounts required for aged care are small (and not suited to the flexible drawing down of relatively small amounts against a line of credit).

The Australian Government could play a more active role by simply providing information about equity release products and educating older Australians about the role such products can play in paying for retirement activities and services. Deloitte Access Economics for Homesafe Solutions said:

To some extent, information gaps can be filled through advertising and product awareness campaigns. However, government-backed education programs would also help to boost financial literacy and consumer confidence in this new product. (sub. DR600, p. 10)

To a large extent, however, the Government is already active in providing information. For example, ASIC provides information to consumers about equity release products, alerting people to potential risks and providing scenarios for different circumstances (box 8.3).

A public scheme could play an important role in inspiring confidence in equity release products and stimulating market development, although it could also crowd out the further development of private schemes. But as Harper said, there are also problems around the supply of such products, particularly outside Sydney and Melbourne:

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People are rightly wary of a relatively new financial product, especially when they are older and naturally more cautious about their biggest asset. However, demand for the product is not the real problem. A debt-free equity release product is already on sale for homes in inner Sydney and Melbourne through a single private supplier in partnership with a regional bank.

The problem is supply. For the product to be available beyond Sydney and Melbourne, institutional investors need to recognise a new asset class, namely, pooled residential real estate. This is new territory for investors as much as for homeowners, and it is here there is a bellwether role for government, as the Productivity Commission rightly identifies. (2011)

Internationally, some governments have sought to increase the attractiveness of equity release products and/or have put in place public measures to defer the payment of aged care costs.

- The New Zealand Government has put in place an interest-free ‘Residential Care Loan Scheme’. Under the scheme, the government advances funds to facilities, on the care recipient’s behalf, for residential care services. The aim of the scheme is to assist older people who, because they own their home and have assets above the applicable asset threshold (and therefore are not eligible for a care subsidy), are obliged to pay for the cost of care services.
- In the United Kingdom, eligibility for public support for the cost of residing in a nursing home is subject to an asset test, which can take into account the value of a care recipient’s principal residence. For those individuals who meet the asset test, some local councils provide a scheme that allows them not to sell the home, but rather to move all or part of the nursing-home fees through a deferred-payment agreement. Interest is generally not paid on deferred payments over the period of the agreement and until a period after the death of the resident at which point the deferred amount must be reimbursed or the residence sold.
- Under the United States (US) Medicaid system, the value of a principal residence is generally excluded from the assets test, but can be subject to an estate recovery after the death of the resident (Colombo et al. 2011).

A government-backed (but not necessarily operated) equity release scheme may be more acceptable to some older people. The higher uptake of government-sponsored schemes, relative to private provider schemes, in the US suggests that the added security from government backing can help dispel nervousness about using the products (appendix D).

Such a scheme could take a charge over the equity in an older person’s home (up to a maximum amount, say 40 to 60 per cent) and draw against this to help finance their accommodation and care costs. To avoid gaming, any sale or transfer say

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within five years prior to entering a residential aged care service could be deemed as being included in the asset test at market value.

Alternatively, the Government could expand the existing Pension Loans Scheme to allow small regular sums of money to be drawn down to cover care costs. The Pension Loans Scheme is an equity release scheme offered by Centrelink that allows older Australians to draw an Age Pension or top-up their part pension using their home equity (box 8.4). The scheme is currently not available to people on the full rate Age Pension and only allows relatively small amounts (fortnightly payments) to be made available rather than one-off large payments.

**Box 8.4 Pension Loans Scheme — how it works**

People of Age Pension age (or their partners) who cannot get a pension because of their income or assets (but not both), or those who only receive a part pension, can access capital tied up in their assets under the Pension Loans Scheme. The Pension Loans Scheme is not available to people who are paid the maximum rate of pension.

The Pension Loans Scheme is a voluntary arrangement that provides support in the form of a loan, for a short time or for an indefinite period. It is paid in regular fortnightly instalments. Compound interest is charged on the balance of the loan and calculated on a fortnightly basis. The Pension Loans Scheme loan must be secured by real estate owned in Australia.

Features of the Pension Loans Scheme include:

- a No Negative Equity Guarantee (a guarantee that no matter how long the loan runs, the borrower can never owe more than the value of the security)
- minimum age 65 years or pension age if less
- capped at the maximum Age Pension plus pension supplement and rent assistance
- underwritten by the Australian Government
- available Australia-wide
- available as an income stream only
- interest rate fixed by the Minister for Families, Housing, Community Services and Indigenous Affairs.

An example of how it works: Tim has a property valued at \$210 000 which he offers as security for his loan. As he wants to be sure that he has the flexibility to move into a retirement village when the need arises, he nominates a guaranteed amount of \$85 000 for that purpose. His eligibility for payments under the Pension Loans Scheme is based on \$125 000, the value of his property less the guaranteed amount.

*Source:* Centrelink (2009).

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There were 710 Pensioner Loan Scheme loans outstanding as at 30 June 2010 (Medicare Australia, sub. DR804, p. 20).

An equity release scheme such as the Pension Loans Scheme that allows small withdrawals, so that payments accumulate over time, is less likely to be attractive to private operators. A small loan at the outset that grows over time is unlikely to be offered by the market without a large upfront fee.

In responding to the draft report, a number of participants supported the Commission's proposal for a government-backed equity release scheme (box 8.5). COTA Australia, for example, said:

We welcome the proposal for a government endorsed equity release scheme which we believe should be on a shared equity basis or a HECS-like loan recoverable from the estate, rather than a compounding interest loan. (sub. DR565, pp. 9-10)

And the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) said:

FaHCSIA's Money Management Branch is broadly supportive of a government-backed Equity Release Scheme, which could include an aged care equity release scheme as we can see advantages in terms of consumer protection and a tightly focused equity release goal. (sub. DR673, p. 1)

National Seniors Australia (NSA) suggested that the uptake of such a scheme would be sensitive to its design:

While not opposed to this recommendation, on the basis that it adds to consumer choice, we think that the take-up of the proposed Aged Care Equity Release Scheme is likely to remain limited unless it incorporates innovative design features that address the key drawbacks associated with the traditional models. (sub. DR832, p. 22)

Other participants, however, raised concerns. For example, the Orana Branch of the Combined Pensioners & Superannuants Association said:

The very thought that having worked very hard all our lives and paid off our homes, when we need a nursing home in our twilight years, we will have to take out a reverse mortgage, in other words having lived frugally, saved and reared families, paid our taxes and settled that mortgage debt we will be lumbered with another with extremely high interest rates until we and our spouses are dead. What a disgrace. (sub. DR671, p. 1)

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**Box 8.5 Support for a government backed equity release scheme****The Benevolent Society:**

The proposed government backed equity release scheme and relaxation of the pension assets test are supported. (sub. DR805, p. 4)

**The Australian Guardianship and Administrative Council:**

We give cautious support to the concept of a Government-run or backed equity release scheme provided it addressed all of the risks that currently attend to reverse mortgages. (sub. DR 663, p. 2)

**Medibank Private:**

Medibank is ... supportive of the recommendation that the Australian Government establish a government-backed Aged Care Equity Release scheme which would enable individuals to draw down on the equity in their home to contribute to the costs of their aged care so that people are able to access funds on better terms than those that are currently available in the market. (sub. DR819, p. 4)

**Law Institute of Victoria:**

An Aged Care Equity Release scheme would provide flexibility to care recipients who wish to retain the family home and make periodic payments. (sub. DR897, p. 6)

**ACAA:**

ACAA supports the proposal to establish a government-backed Aged Care Equity Release scheme which would enable individuals to draw down on the equity in their home to contribute to the costs of their aged care and support. (sub. DR777, p. 4)

**Pam Webster:**

The notion of broadening the funding base with the establishment of a government backed Aged Care Equity Release Scheme and the Australian Pensioners Bond scheme is excellent. (sub. DR617, p. 2)

**Deloitte & Retirement Village Association:**

The PC has recommended a government backed equity release scheme be introduced to enable care recipients to draw down on the equity in their home. We note that one of the key issues affecting the industry is access to capital and hence the development of a viable economic business model that attracts investment and delivers to market needs is vital. (sub. DR900, p. 1)

It was also pointed out the some older Australians will not have homes that are suitable for equity release (due to the low value of the home, its location, and purchasing arrangements within retirement village settings). Fortus, for example, said:

... with the increasing use of Retirement Villages, in most circumstances these facilities are of a leasehold nature, and are not considered as suitable security for Equity Release. (sub. DR755, p. 2)

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Deferred payments (a call on the estate) are an option in cases where equity release is not feasible. Some participants support this option above an equity release scheme. Michael Fine, for example, said:

The problems of equitable contribution also deserve attention through the taxation system — in particular through the levying of a modest estate duty following death, at the time property and other resources are being passed on through inheritance. Australia is the only advanced economy without such duties. The wisdom of attempting to introduce payments based on housing equity for aged care in their absence is dubious. (sub. DR592, p. 6)

Crowding out the private sector in the area of equity release was also raised as a concern. SEQUAL, for example, said:

The Australian Equity Release market is both efficient and ethical. Older Australians have access to well-designed products both in the form of Reverse Mortgages and Home Reversion Schemes. A degree of competition between major banks and non-bank specialist providers delivers a robust environment for consumer benefit. It is therefore not necessary for a Government-backed equity release scheme to be developed. (sub. DR820, p. 13)

Challenger also said:

If the government has reason to believe that there are deficiencies in the operation of existing reverse mortgage providers there would be wider social value in the government addressing those concerns than by establishing a government reverse mortgage provider. (sub. DR785, p. 8)

And Deloitte Access Economics for Homesafe Solutions argued that rather than recommending a government-backed scheme, the focus should be on removing the obstacles to the development of the private market in home reversion:

This submission welcomes the Commission’s focus on equity release, particularly home reversion, as a viable source of supplementary funding for aged care in Australia. Rather than recommending the establishment of a government-backed equity release scheme, however, this submission urges the Commission to recommend that government actively consider how best to remove obstacles to the development of the private market in home reversion. (sub. DR600, p. 17)

The Commission agrees that any equity release scheme should be focused on seeking to achieve benefits that are additional to those that would arise through private decisions (that is, avoid crowding out). However, if the Government requires care recipients with low income, but with assets, to contribute to their care costs, a vehicle is required that allows recipients to draw down small regular sums of money. Such a scheme is unlikely to be attractive to private providers and, if offered, is likely to involve very high set-up costs. SEQUAL acknowledged that ‘there may be a limited place for government operated schemes which fill the “gaps” that are less attractive to private providers’ (sub. DR820, p. 13). Deloitte Access Economics for Homesafe Solutions also said:

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There may be a case for a residual government-run equity release scheme, akin to the existing Pension Loans Scheme, but targeted to those whose homes are for whatever reason unsuitable for equity release through the private market. (sub. DR600, p. 6)

Any proposed government-backed equity release scheme would need careful design to ensure its acceptance in the community, drawing from the experience of private and government-backed reverse mortgage schemes and the Pension Loans Scheme.

Clarification was sought from participants on specific design features of any proposed scheme. For example, some participants expressed concern about the situation where partners, carers and siblings or dependent children share the same house as a person who needs to access care or move into residential care. COTA Australia, for example, argued for continued protection and flexibility in recovering any deferred contribution so that any dependents would not be required to move from the home in order for the contribution to be paid out of the home equity, noting:

In any scheme there should as now be protection for the partner, primary carer, cohabiting sibling or dependent child that ensures that person is not required to move from the home in order for the contribution to be paid out of the home equity. In such cases, the repayment should be required only once the dependent dies, moves to other accommodation, or is no longer a dependent. (sub. DR565, p. 10)

The Commission agrees that, in such situations, payment should only be required when the partner, carer or dependent child ceases to permanently live in the home or ceases to be a dependent.

The Commission's proposed government-backed scheme would be akin to a line of credit and could, therefore be titled an Aged Care Home Credit scheme. Some of the key features of the proposed scheme would include:

- eligible individuals accessing a government-backed line of credit secured against their principal residence (or their share, generally 50 per cent, where a couple is living in the home)
- flexibility in the rate at which the line of credit could be drawn on up to a specified limit (assessed at the time of the loan), provided it was applied to aged care services, including residential aged care accommodation charges
- relatively low upfront charges
- preferential interest charges (equivalent to the consumer price index), calculated on a daily basis and accrued on the loan outstanding (not the undrawn portion of the maximum amount)
- payment of the loan from the person's estate upon death (unless a partner, carer or child still lives in the house). In the latter situation, the outstanding balance of

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the line of credit would be repayable when the spouse, partner or dependent child ceases to permanently reside in that home or ceases to be a dependent

- once the loan amount is drawn down (together with interest charges), and reaches the maximum allowable amount, no further equity could be drawn, and no further interest charges would be applied — in effect a no negative equity guarantee, with a minimum guaranteed level of remaining equity
- access to funds through the scheme would not be treated as an income stream (therefore would not adversely affect any pension benefits) provided the funds were used for approved expenses and not accumulated
- design features to make it work with the existing and potential private market rather than as a competitor.

As an example, if a home was valued at \$800 000 and up to 50 per cent of a person's share of the equity in the home owned could be accessed, an amount of \$200 000 could be drawn on. The person could take out relatively small amounts (say \$250 per week) to pay for aged care and accommodation costs. The interest (at the CPI rate) would be calculated daily and would accrue on the loan outstanding. Once the \$200 000 limit was reached, that would remain the final nominal amount repayable.

In order to maintain equity with those people who do not own a principal residence, the Commission suggests that if the minimum asset threshold for a supported resident is set at \$X, a person should be able to borrow until their share of the equity in the home has fallen to \$X. For example, if a home owned by a couple was worth \$800 000, and one of them required aged care services they should be able to draw down their equity to \$X leaving the total equity in the home at \$400 000 + \$X. Once the home equity for the individual was drawn down to \$X, the interest rate should revert to zero so there would be no further loss in home equity.

It should also be noted that as assets are drawn down, an individual's co-contribution to care would fall — for example, a person may start paying a co-contribution of 25 per cent but as the home equity (share) falls towards \$X, the co-contribution would also fall.

A further concern raised by participants was the case where a part owner refused to sign a contract that would put the Government (or its agent) on the mortgage title deed. From the perspective of a reverse mortgage (or deferred payment) where the government takes security over a property, the title would be a tenancy in common. As such, the person requiring care could deal with their share with the government without the other person's permission. The government could facilitate the



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conversion of the interest to a tenancy in common and then offer the line of credit or deferred payment.

Conducting an information campaign to educate older Australians about the option of equity release will also be important to ensure the new arrangements benefit those whose circumstances make this an attractive option. FaHCSIA recommended that the National Information Centre for Retirement Investments Inc, an Australian Government program funded under the Financial Management Program — aimed at building financial resilience and wellbeing among those most at risk of financial and social exclusion and disadvantage — should have a role in communicating the existence and operation of the government-backed equity release scheme (sub. DR673). The Australian Seniors Gateway Agency (the Gateway) should also provide extensive information about any aged care equity release scheme with links to other relevant websites.

RECOMMENDATION 8.1

***The Australian Government should establish a Government-backed Australian Aged Care Home Credit scheme to assist older Australians to make a co-contribution to the costs of their aged care and support.***

- ***Under the scheme, eligible individuals would receive a Government-backed line of credit secured against their principal residence, or their share of that residence.***
- ***In establishing the line of credit, the Australian Seniors Gateway Agency would arrange a valuation of the principal residence and specify a minimum level of equity for the person's share of the home. The individual could draw progressively down to that minimum to fund their aged care costs. The drawdown on the line of credit would be subject to interest charged at the consumer price index. If the outstanding balance and accumulated interest reached the minimum limit set by the Australian Seniors Gateway Agency, the interest rate would fall to zero, and no further draw down would be permitted under the scheme.***
- ***The outstanding balance of the line of credit would become repayable upon the disposition of the former principal residence including upon the death of the individual, except where there is a protected person permanently residing in the former principal residence.***
- ***In the latter circumstances, the outstanding balance of the line of credit would be repayable when the protected person ceases to permanently reside in that former principal residence, or ceases to be a protected person. (Protected person is defined in the Aged Care Act 1997 and includes, for example, a partner, dependent child or a carer.)***

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### 8.3 Insurance for aged care

Aged or long term care insurance (LTCI) would cover care services not covered by Medicare or private health insurance. Such insurance would pool the risk of aged care costs across those participating in the scheme. As discussed in chapter 6, given the unpredictable nature of incurring very high aged care costs, there would be welfare gains from having a mechanism in place that pools these costs. A number of participants acknowledged the advantages of a pooled funding approach. Laurel Hixon, for example, said:

The need to focus on insurance options stems from the fact that certain aspects of aged care represent a textbook case of an insurable event ... Australia should be prepared to have in place strategies that anticipate the future demand for aged care and mechanisms to spread the financial risk of aged care over the *widest possible population and over time*. (sub, 328, p. 2) [emphasis in original]

While voluntary insurance would allow risk-averse individuals to insure against the possibility of high care costs, it is unlikely to work in anything but a very modest way because of problems on both the supply and demand side of the insurance market (box 8.6). As Barr put it:

There are potentially large welfare gains if people can buy insurance that covers the cost of long-term care. However, technical problems — largely information problems — face both the providers of insurance and potential buyers. These problems on both the supply and demand sides of the market suggest that the actuarial mechanism is not well suited to addressing risks associated with long-term care. (2010, p. 359)

Internationally, private insurance plays a relatively small role in financing aged care.

- In the US, where insurance is voluntary and privately provided, less than 10 per cent of the population aged 65 years and over are insured for aged care, despite tax incentives.
- In Germany, private insurance is available for high-income individuals and as supplemental coverage for all. Participation rates are less than 10 per cent.
- In France, 25 per cent of people over the age of 60 have private insurance.

Myopia in planning for the risk of dependency, failure to recognise the potential risks of needing care into the future, and the high cost of care are factors explaining the relatively small size of the private LTCI market in the above countries. Private providers, in seeking to extend the market have simplified insurance products (moving towards policies that provide fixed cash benefits) and introduced hybrid financial products, including combined life and long LTCI cover. In France, for example, around 150 000 individuals have LTCI coverage as part of their life insurance policy (Colombo et al. 2011).

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**Box 8.6 Voluntary insurance — problems on the supply and demand side of the market**

While voluntary insurance would allow risk-averse individuals to insure against the possibility of high care costs, problems on the supply and demand side of the market limit the extent and coverage of such insurance, including:

- a lack of knowledge about the risk of needing care and competing priorities for the premium payments (mortgages, childcare costs). Also difficulty in predicting care needs and framing an acceptable level of coverage
- affordability problems for consumers arising, in part, from the limited number of people likely to take out insurance which in turn increases the costs of premiums. Individuals also tend not to think about purchasing insurance until late in life, and the later in life the insurance is purchased the higher the premiums. The greater risks of requiring aged care for females — related to their morbidity and mortality profiles — means they will face higher premiums
- low incentives to insure because of existing safety net mechanisms and uncertainties about future age care policies
- the unpredictable nature of future care costs and life expectancy for any individual makes it difficult for insurers to calculate appropriate insurance premiums
- adverse selection problems — people with the worst health profiles and highest likely future care costs are most likely to buy insurance. If insurers are unable to set differential premiums, a common rate premium would discourage potential lower-risk purchasers. Identifying people more likely to claim aged care benefits involves more than assessing their health and future probability of becoming disabled as availability of a carer or preferences of individuals and their families towards using paid care can also determine whether a claim is made.

While insurers can counteract some of these problems (by requiring co-contributions or limiting what can be claimed) this further reduces the attractiveness of insurance.

*Sources:* Barr (2010); Colombo et al. (2011); Gleckman (2010); PC (2003).

It is often argued that governments could provide tax incentives to improve the attractiveness of private insurance. However, the merits of providing such incentives are frequently contested because incentives largely involve transfers from taxpayers to policy owners who would have purchased insurance anyway rather than inducing people who otherwise would not have purchased insurance to take out insurance. Further, where incentives are provided as tax deductions rather than rebates, they provide disproportionately large benefits to those with high taxable incomes. As Colombo et al. (writing in an OECD Health Policy Studies paper) recently said:

... in the context of voluntary pooling arrangements, public initiatives have generally had limited success in broadening access to private LTC coverage. But, some public

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initiatives seem to be less cost-effective than others. For instance, preferential tax treatment needs to be considered carefully in terms of its effectiveness to affect demand. More specifically, most of the fiscal cost of a tax measure can take the form of a ‘windfall’ to those relatively better-off individuals, who would have purchased the insurance even in the absence of the tax reduction. Alternatively, support towards the purchase of a private LTC insurance could be targeted to lower-income individuals thereby compensating for the regressiveness of risk-related premiums. (2011, p. 259)

Under a lifetime stop-loss taxpayer model where the Australian Government covered costs above a nominated cap, there could be a role for private insurance for the more predictable care costs as the government would be taking on the ‘long risk’ that individuals and insurers are less willing to accept. As the OECD noted, supplementary private insurance would be considerably more affordable for individuals:

Supplementary private insurance could play a stronger role in the future to cover private cost-sharing. Private insurance on top of a basic universal public insurance, for example to pay for the cost of accommodation in nursing homes, covers a risk that is easier to calculate and therefore to insure for the private insurance industry compared to full coverage of the risk of care needs in old age. And it is more affordable for private households. (2005, p. 14)

With a government funded lifetime stop-loss mechanism in place, insurance is really a form of pre-saving for the more predictable costs of aged care. Hence, insurance brings with it an added issue of prudential regulation to ensure that the insurance policy can be redeemed when it is needed, a long time into the future. While voluntary insurance may complement other forms of funding it is — for the reasons outlined in box 8.6 — unlikely to provide an adequate funding mechanism for a large share of the population. Nonetheless, the Commission considers that any unnecessary legislative restrictions on personal insurance being offered by the private sector should be removed.

An alternative approach which addresses these problems is compulsory insurance.

### **Compulsory insurance**

Compulsory care insurance can be provided publicly or privately, although it is usually discussed in terms of public provision and referred to as social insurance. Compulsory contributions under a social insurance scheme are typically collected via a levy on income and put into a designated (hypothecated) fund. In contrast, contributions under a private compulsory insurance arrangement would typically be collected as premiums related to an assessment of the underlying insured risk and placed in an insurance pool as reserves to meet subsequent claims.

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As with voluntary private insurance, compulsory insurance represents a pre-funded approach to funding the costs of aged care. By extending coverage, compulsory insurance provides a more effective risk pooling mechanism that, in principle, provides individuals with an assurance that funds would be available if needed.

Over the past decade or so, commentators and key stakeholder groups have suggested introducing compulsory insurance, usually in the form of social insurance, to broaden the funding base for aged care (box 8.7).

**Box 8.7 Past interest in compulsory care insurance**

Over the past decade or so, many commentators and stakeholders (including those representing providers, consumers and workforce groups) have listed compulsory insurance among the possible options for raising the level of funding for aged care through increased user contributions.

In the late 1990s, interest in social insurance was kindled following the public backlash against substantial increases in user contributions, and, in particular the proposal to introduce accommodation bonds in high care (Fine and Chalmers 1998; Howe 1999).

In 2002, the Myer Foundation suggested a pre-funded social insurance scheme, funded by a compulsory premium on national wages similar to the Medicare Levy, could be introduced to enable individuals to contribute more to the costs of their care when they can afford to. Although the 2004 *Review of Pricing Arrangements in Residential Aged Care* did not include a social insurance scheme among its recommendations, many participants to that review did raise this option, including 24 peak industry members of the National Aged Care Alliance (NACA 2003). Participants to the Senate Inquiry into Quality and Equity in Aged Care (SCARC 2005), including Aged and Community Services Australia on behalf of 10 other peak industry bodies, also proposed that the scope for a social insurance scheme to broaden the funding mix, such as that currently operating in Japan, should be investigated.

More recently, in recognition of the growing pressure on the taxation system, the Henry Review (2010, p. 641) recommended the Commission consider the ‘potential for insurance to play a role in helping to fund aged care as Australia’s population ages’.

Despite the seemingly significant level of in-principle interest, past reviews have been unable to determine whether a compulsory insurance scheme would represent a significant improvement over the existing arrangements.

Howe, for example, observed that:

Current aged care funding relies on only two ‘pillars’ — taxation revenue and user charges. Adding a pillar of social insurance would add a third pillar and so strengthen the whole of the funding arrangements. In particular, by providing a source of forward funded capital, social insurance would serve as a buffer against downturns in the wider

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business cycle for aged care investment, and in turn, marginally moderate the business cycle.

A social insurance approach to aged care funding in Australia is highly consistent with and would complement both the Medicare Levy and the Superannuation Guarantee that are already in place. Both have proved ‘painless and popular’ taxes with the community, and a social insurance scheme for aged care could be expected to gain similar acceptance. (2003, p. 8)

A number of participants to this inquiry also supported a compulsory insurance type scheme, many suggesting an increase in the Medicare Levy (box 8.8.).

**Box 8.8     Some participants supported the introduction of a Medicare type levy and compulsory insurance**

**Melbourne Citymission:**

The Government should examine introduction of an Aged Care Levy in the taxation system, as a social insurance levy similar in function to the Medicare Levy ... Australia currently has transparent mechanisms to help fund the public health system and citizens’ retirement. Why not introduce an Aged Services Levy in addition to the Medicare Levy? (sub. 173, p. 21 and p. 23)

**Baptcare:**

Baptcare agrees that many people may not have adequate superannuation for their needs in the long term or may choose to utilise their superannuation payout to live well for the period whilst they are fit and healthy. To combat this, we suggest the Government extend the Medicare levy to cover aged care costs. This could be applied to all taxpayers, with an additional impost on high-income earners who do not choose to take out private insurance for aged care costs, such as the longevity insurance products suggested by the Henry Review. (sub. 212, p. 30)

**Medibank Private:**

The benefits of this model [mandated social insurance] include the development of a sense of individual responsibility to fund aged care needs as well as the benefits of sharing costs and pooling risk at a population level. However this model requires that premiums be set at a high enough rate to ensure future sustainability of the scheme and is a long term strategy which relies on people in the transition phase having assets to draw on to support their ageing care needs. (sub. 250, p. 10)

**Blue Care:**

Blue Care **recommends** that the government considers introducing social insurance by an increment to the present Medicare levy ... to close the present residential aged care funding gap of some \$1 billion. We estimate that the required increment at around 0.15% to 0.2% (percentage points). In the longer term, the increment could be increased to meet the rising cost of care of the ageing population. (sub. 254, p. 16) [emphasis in original]

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A well-designed compulsory insurance scheme for aged care could offer several advantages:

- because compulsion means that risks are fully shared, individuals would be protected against catastrophic costs and there would be enforced savings for predictable costs
- spreading the costs of aged care across a wide range of individuals would address the adverse selection and information problems associated with voluntary insurance, which in turn helps improve affordability
- if contributions to the scheme are means tested and proportional to income (as with the Medicare levy), a broad cross-section of individuals would be covered under the scheme, with contributions from those on higher incomes effectively extending the benefits available to low income participants.

As Barr observed:

while compulsion makes politicians nervous, it has economic advantages, including:

- It recognises the evidence from behavioural economics that people do not always make decisions in their own self-interest.
- It avoids adverse selection, since good risks cannot opt out and bad risks cannot choose to buy inefficiently large amounts of cover.
- A system that is compulsory allows some redistribution; thus it is possible to charge a contribution to x per cent of earnings, respecting ability to pay. (2010, p. 317)

Another argument advanced in favour of a compulsory insurance scheme is that it can smooth intergenerational transfers. In this regard, younger generations may be more prepared to support older generations who have contributed to the cost of their own aged care costs. But as Ergas said:

... if incomes are rising, the welfare cost of reducing current consumption exceeds that of reducing future consumption. Moreover, the reduction in current consumption would be greater for the transition generation, as it would have to cover both the costs of care for current, unfunded, consumers and provision for its own care costs. Indeed, if the real rate of return is less than the 'biological rate of interest' (i.e. the sum of population growth and productivity growth), then a PAYG scheme is generally efficient.

The mere fact of moving to a funded scheme therefore need not increase welfare. Whether it does depends on its impact on efficient risk-allocation and service provision, and on its overall effect on savings. (2010).

In the case of aged care, the opportunity to smooth the higher costs associated with the bulge of the baby boomers has largely passed.

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It is also often argued that the hypothecation of funds provides greater protection from the vagaries of the government's budget process, as money can be more securely ring-fenced than through simply increasing taxation. In this context, Colombo et al. observed:

... there can be advantages in having 'dedicated' financing channels for LTC as in the case of social LTC insurance in Germany, Japan, Korea, Luxembourg and the Netherlands. It can ensure a reliable and predictable source of revenue streams, relative to non-earmarked taxation; it can also create a sense of entitlement for people, raising their willingness to pay for such an entitlement. (2011, p. 222)

But, hypothecation can also introduce rigidities in the way funds are allocated and it does not necessarily provide a guarantee about the level of specific funds available (Barr 2010). As Catholic Health Australia said:

It has been suggested an advantage of a dedicated social insurance scheme is that it would provide greater certainty of funding for aged care, but this has not necessarily been borne out in other countries. What tends to happen instead is that the funding debate moves to the adequacy of the levy to meet needs and the normal variables which affect cost and affordability such as eligibility, what services are in scope and the level of service. (sub. DR748, p. 12)

The appropriateness of hypothecation needs to be considered having regard to the specific characteristics and policy objectives of the service sector under consideration. While there are arguments for and against hypothecation of funding, this debate is secondary to the question of the appropriateness of having a social insurance scheme for aged care.

Advances in medical and assistive technologies over time as well as potential changes covering other variables have the capacity to alter the future cost profile for aged care in ways which are inherently hard to predict. If the contribution rate (premium) is set too high, there will be excessive savings (reserves) relative to the future costs of care while if set too low, additional funds would be required from general tax revenue (or higher premiums).

## **International examples of compulsory insurance**

A number of OECD countries — Germany, Japan, Korea, the Netherlands and Luxembourg — have adopted dedicated social insurance arrangements for long term care services (table 8.2). Common features of the arrangements include:

- separate funding channels for LTCI and health insurance, but with the same social insurance model
- mandatory participation for the whole population or a large section of the population (for example, in Japan everyone over 40 years of age)



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- predominantly financed through employment-based payroll contributions, but seniors can also be asked to pay contributions. A share of the cost is funded out of general taxation in most countries (Colombo et al. 2011).

Under Germany's insurance scheme, insurance premiums are means-tested and paid for through payroll tax. Around 90 per cent of the population is covered by the scheme, with the remainder opting for private insurance (high income earners, the self-employed and civil servants have the option to take out LTCI with a private provider). The government determines eligibility for aged care services and makes all capital investment for residential aged care facilities (Arntz et al. 2007). Eligible beneficiaries can opt for a cash payment (at a lower value), in-kind professional services, or a combination of the two.

Japan introduced an LTCI system in 2000. The scheme is funded by a combination of general tax revenue and income-related premiums (payroll tax) levied on those over the age of 40 years. Anyone over 65 years of age in need of care (eligibility for care is determined by the government) is granted access as are people aged 40-plus suffering from age-related disabilities such as stroke or Parkinson's Disease.

LTCI was introduced in Korea in 2008, covering people aged 65 years and over assessed as needing care and younger people with geriatric diseases. The working-aged population contributes around 5 per cent of wages to the National Health Insurance scheme, 4.78 per cent of which goes towards LTCI. The government pays subsidies equal to 20 per cent of contribution receipts and care recipients pay an out-of-pocket contribution of between 15 per cent of the cost for in-home services and 20 per cent for institutional services.

For details of the schemes in the Netherlands and Luxembourg see table 8.2.

A recent OECD Health Policy Studies paper (Colombo et al. 2011) observed that, as a share of GDP, long term care spending is around the OECD average of 1.5 per cent for those countries who have adopted LTCI models, apart from Korea (0.3 per cent) and the Netherlands (3.5 per cent).

Both the German and Japanese schemes have begun to face increasing cost pressures because contributions have been insufficient. In Germany, contributions were increased in July 2008 from 1.7 to 1.9 per cent of gross salary for people with children (of any age) and from 1.9 to 2.2 per cent of gross salary for people without children. Commenting on the pressures faced by these countries, Featherstone and Whitham said:

Both Germany and Japan ... are struggling to ensure long-term financial sustainability of these systems. In Japan, costs of care have escalated and, in 2005, they excluded hotel costs (care home accommodation as opposed to care home nursing costs) from the benefits package. Currently lowering the minimum age of contribution to 21 is under

consideration. The German system now only covers about half of the cost of institutional care, leaving some older people forced to pay out-of-pocket to cover their long term care. (2010, p. 29)

**Table 8.2 Universal long term care insurance (LTCI) schemes in selected OECD countries**

	<i>Introduced</i>	<i>Financing sources</i>	<i>Contributions</i>	<i>Eligibility</i>	<i>Benefits</i>
Germany	1995	Payroll and income-related contributions	1.95% payroll tax (additional premium of 0.25% for those with no children)  Paid by all working age and retired population  Approx 11% opt out and are obliged to buy private insurance	Needs based assessment regardless of age	In-kind or cash at user's choice
Japan	2000	General revenue (45%) Contributions (45%) Cost-sharing (10%)	Paid by over 40 year old population Individuals aged 40-64 years pay 0.9% of wages	65+ assessed as needing LTC 40+ with certain diseases	In-kind
Korea	2008	Tax (20%) Payroll contributions (45%) Cost-sharing (15-20%)	Paid by working-age population through contributions to health insurance. National Health Insurance contributions set at 5.08% of wages, 4.78% goes toward LTC	65+ assessed as needing LTC Younger people with geriatric diseases	In-kind or cash
Netherlands	1968	Payroll and income-related contributions Means-tested copayments	Contribution rate is based on income. Paid by working-age and retired population (all citizens over 15 years with taxable income)	Disabled assessed as needing LTC, regardless of age	In-kind (institution) Cash (home, personal budgets)
Luxembourg	1999	Taxation (about 45%) Contributions Special tax	Paid by working-age and retired population. Contribution set at 1.4% of income	Disabled assessed as needing LTC, regardless of age	In-kind and/or cash, at user's choice

Source: OECD (2010c).

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## Designing and implementing a compulsory insurance scheme

Moving to a compulsory insurance scheme would be a big change from the current aged care arrangements and would raise significant design and transitional issues.

In designing a compulsory scheme, policy makers would need to resolve a number of important questions.

- What costs should be covered — only care costs or also accommodation and everyday living expenses?
- Whether the scheme should be administered by the public or private sector, a single insurer or multiple insurers?
- If provided by the public sector:
  - would the contribution rate be based around a hypothecated levy with a flat rate or a progressive income-related rate?
  - would the contribution rate be imposed on the entire working-age population or only those above a certain age?
  - how would the scheme deal with non-taxpaying individuals or those not in the workforce?
  - what level should the contribution rate be set at, how would it be adjusted as expected future costs change and how would fund surpluses be distributed or shortfalls be funded?
- If provided by the private sector:
  - should the premiums to be paid be mandated by the Government or subject to conditions set by Government as with private health insurance?
  - should premiums be allowed to vary on the basis of risk?
  - what regulatory framework is needed for the operation of the insurance scheme and to manage contingent liabilities for government should an insurer fail, or if coverage falls short of expectations?
  - how would equity issues be addressed if premiums rather than a flat rate or income related rate was used?
  - what regulatory mechanism would be used to enforce compulsion and how should premiums be collected?

There may be significant operational and administrative efficiencies which can be achieved by having a single insurer. And, at least in principle, a single insurer would have a greater capacity to impose strong disciplines on service providers to encourage cost effectiveness and efficiency. In contrast, a multiple insurer arrangement offers scope for competition between insurers, which may promote

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greater efficiencies and a more dynamic market over time. A private insurance market would need to be highly regulated and government would need to subsidise insurance for those who could not afford to purchase cover.

In the Commission's view, whether the economies of scale and buying power of a single insurer would outweigh the potential dynamic efficiencies of multiple insurers is an empirical question, about which there is little evidence. More fundamentally, the regulatory regime required to underpin a compulsory private insurance system for aged care may well undermine the scope for efficiency gains, and it is highly likely that government would, in effect, become the insurer of last resort.

### **Similarities between a tax-funded scheme and compulsory insurance**

There are many similarities between the current aged care taxpayer funded system supplemented by a lifetime stop-loss mechanism and compulsory insurance — both involve risk pooling (to protect individuals from catastrophic costs) and can involve progressive mechanisms for raising funds. Access to care is based on need, rather than ability to pay.

Laurel Hixon suggested that the ability for governments to control costs may be more difficult under compulsory insurance than a taxpayer funded scheme.

General revenue funded programs have greater cost controls because they have to compete with other government spending priorities and these priorities are reviewed on a regular basis. In contrast, because of their 'entitlement' nature, it is more difficult to impose cost controls on social insurance programs. (sub. DR830, p. 4)

Further, as noted earlier, the introduction of a compulsory insurance scheme for aged care would also raise significant transitional issues. A key one relates to how to treat different age cohorts relative to the likely timing of prospective demands by their members for aged care services. For those who have already retired, or are nearing retirement, the magnitude of their accumulated contributions under any scheme is likely to be small relative to their potential drawdowns. Hence, the scope for compulsory insurance to handle the population bulge associated with the ageing of the baby boomers is arguably becoming limited. A number of participants agreed with this assessment while others considered that the option of compulsory insurance warranted further analysis (box 8.9). Michael Fine, for example said:

A social insurance model, such as that of the National Disability Insurance Scheme (NDIS) proposed in the Productivity Commission's *Disability Care and Support, Draft Inquiry Report (PC, 2011b)*, could be extremely successful as a form of user pays instrument that helps fund an expansion of services. It does so by spreading the risk amongst all potential users. The costs would not fall simply on the unfortunate enough to require assistance, but on all people who contribute. (sub. DR592, p. 6)

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## Box 8.9 Participants views on compulsory insurance

### Catholic Health Australia:

CHA agrees with the Commission's analysis which led it to reject voluntary insurance as an option for broadening the funding base for aged care.

CHA also shares the Commission's assessment that compulsory social insurance would not represent a significant improvement over a pay-as-you go tax financed system, supplemented by higher copayment for those who can afford to pay and a stop-loss mechanism to address the unpredictability of incurring very high aged care costs. A stop-loss mechanism would serve the same purpose as risk pooling in a social insurance arrangement without the overheads of managing an insurance scheme and the intergenerational transitional issues involved. (sub. DR748, p. 12)

### Medibank Private:

Medibank holds the view that a long-term compulsory insurance scheme targeted at funding the costs associated with aged care will not offer a significant improvement on the current funding model. (sub. DR819, p. 4)

### Anna Howe:

The Draft Report is correct in noting that the time has passed for introducing a standard contributory insurance scheme as it would not allow those who have already retired or are approaching retirement to accumulate sufficient funds to cover likely costs of aged care. The most effective option for handling the population bulge associated with the ageing of the baby boomers instead rests on drawing on the contributions that they have already made to superannuation and the subsequent earnings of their superannuation funds. These balances will peak at the time of retirement and there are strong grounds for recovering a small part of the substantial tax benefits on contributions and earnings that have added to these balances. (sub. DR856, p. 8)

### Combined Pensioners & Superannuants Association of NSW:

CPSA calls for an aged care insurance funding scheme to be established to move away from the user-pays funding model. An insurance scheme would avoid penalising aged care recipients for accessing care services, ensure that funding was spread evenly regardless of the care recipient's wealth, and safeguard funding adequacy over the long-term.

An insurance scheme, similar to Medicare, would raise revenue in accordance with capacity to pay as tax-payers contribute to the scheme in line with their income. In effect, this achieves the same principle as the Commission's recommendations pertaining to wealthier aged care recipients paying more for their care. The difference is that an insurance model spreads responsibility among both care recipients and non-care recipients, thus removing barriers to aged care access that may arise under a user-pays system. As the Commission points out, "access to care is based on need rather than ability to pay." CPSA considers aged care services, especially high care services, healthcare services should therefore be universally available. (sub. DR760, pp. 13–14)

### Christine Mifsurd:

I also support the concept of a **social insurance scheme** to provide for older age, though I acknowledge that this may not be politically feasible in the current climate. (sub. DR660, p. 2) [emphasis in original]

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A key difference between the aged care and disability sectors is that the probability of needing to receive care and support in old age is much higher than the probability of acquiring a non age-related disability. Older Australians needing aged care services have generally had the opportunity to purchase a home and to accumulate other wealth such as retirement savings, and therefore have the financial capacity to contribute to the costs of their care. Care co-contributions by older Australians, and ongoing responsibility for providing their own accommodation, achieve a measure of intergenerational equity. Also, as the baby boomers are moving into their retirement years, their scope to contribute to an insurance pool is limited.

After weighing up the pros and cons, the Commission does not consider that a compulsory insurance scheme, in the context of aged care, represents an improvement over the pay-as-you-go tax financed system supplemented by higher co-payments by those with the financial capacity to make them and a lifetime stop-loss mechanism (to achieve risk pooling) for the high costs of care.

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## 9 Care: Access, coverage and delivery

### Key points

- Older Australians find the current aged care system difficult to navigate. Care services are limited and community care packages are relatively inflexible.
- A single agency that is responsible for aged care information, needs assessments and care coordination would help older Australians and their families make informed choices. These services should be delivered through a network of regional centres.
- While most older Australians receive timely assessments of care needs and access to services, there are significant delays for some.
- A reformed, nationally consistent system of assessments is required.
  - It would build on the current approach of Aged Care Assessment Teams.
  - The resourcing of assessments would reflect the level of anticipated need.
  - Low intensity community support services would continue to be accessed directly, or through entitlements or referrals.
- A model of care and support based on flexible service entitlements which are tailored to people's needs, rather than on providers funded for approved places and packages, will significantly enhance the delivery of continuous care.
  - The care entitlements should comprise elements of personal and specialised care that meet the changing needs of individual older Australians, together with carer support services.
  - Consumers should have choice of providers, with initial care coordination and more intensive case management available where warranted and requested.
  - The role of publicly-funded care advocacy to assist individual care recipients will need to be expanded, as will restorative care and rehabilitation.
- There is a strong and increasing preference for ageing at home.
  - The removal of quantity restrictions on the supply of care will allow services to be delivered more widely in all types of accommodation.
  - A greater role is likely for the delivery of palliative and end-of-life care in people's own homes and in congregate care settings.
- Improvements to the interface between aged care and health are needed, with a greater focus on in-reach services.

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Participants to this inquiry argued that there are significant opportunities to improve the provision of publicly-subsidised care and support services, and that an expanded and more coherent focus is needed for aged care. Strengths and weaknesses of the current system are analysed in chapter 5. Many submissions said that the purpose of the aged care system should be to assist the physical, emotional and social wellbeing of the person, and provide opportunities for purposeful interaction with community and family. The Commission’s wellbeing framework developed in chapter 4 recognises both the importance of these objectives and that a publicly-funded system must also be sustainable.

In the Commission’s view, there is a need to develop an aged care system that better allows the principles of wellbeing to be reflected, particularly in the areas of information, needs assessment, and the provision of care and support. The new model would retain a strong emphasis on respecting individuals and their role in society, but it would also give them a degree of control and self determination (something that is not always possible under current arrangements).

This chapter sets out the main features of a new system, and discusses the Commission’s proposed reforms to:

- care access and coverage, including reforms to information, needs assessment and care coordination services (section 9.1)
- arrangements for improving care continuity and enhancing consumer choice (section 9.2)
- policy settings in a number of areas directly affecting care delivery, including accommodation, health and disability services (section 9.3).

Improvements in care quality resulting from implementation of the proposed reforms are discussed in chapter 10.

## **9.1 An aged care gateway: information, needs assessment and care coordination**

For many older Australians and their families, the first time they access the aged care system is to search for information about what services are available and those to which they might be entitled. Often this is at a time of significant stress. The Commission was told that the current aged care system is difficult to navigate. ‘Complex’, ‘confusing’, ‘fragmented’, ‘overwhelming’ and ‘uncertain’ were terms used to describe the current system. Also, that attempts to make the best decisions about care services are ‘time consuming’ and ‘bewildering’.



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To quote the daughter of two elderly parents who had worked in the community care sector for over 20 years:

Our family navigates the complex interfaces between the [Home and Community Care] HACC, Veterans' Health, Centrelink and Commonwealth community aged care support systems. While I would be considered a well informed consumer, this navigational act is at times overwhelming. (Dianne Beatty, sub. 413, p. 2)

National Seniors Australia (NSA) argued that:

The complex and myriad regulatory regime results in confusion for the consumer and stifles innovation. Also, there is little coordination between the structured components of the system and the informal support networks. This makes it difficult for older Australians to plan and take responsibility for their own care. (sub. 411, p. 18)

This section explores the 'front end' of the journey for older people who need formal care and support. There are three broad stages of this front end which, if reformed, could greatly help older Australians to retain control over their lives.

- The first stage requires information to be more readily available and easily understood. Information needs to be made available at both the community level and at a level that is specific to the needs of individual older people.
- The second entails the development of simpler and more accessible needs assessment processes. A single integrated assessment service would: help older people understand and make choices about their own care and support needs; determine their eligibility for subsidised services; inform them of their required co-contributions; and provide them with a set of care and support entitlements which they could take to approved providers.
- The third involves access to services from approved providers once the entitlements have been determined. Often these services can be contracted directly by the consumer or with the aid of an informal carer. But, where necessary, assistance may be required through the provision of low-level care coordination. In many cases, more intensive case management may also be needed.

## **Information services**

Independence and self-control is built on a strong foundation of being aware of one's own needs. Understanding what services are available, and their quality and cost, is also important. Information is critical to building this foundation (box 9.1).

There are significant challenges in providing effective information for older Australians. People turn to care and support services, in the main, when they are experiencing an increase in their frailty and, for some, a reduction in their cognitive

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capacity. Information is often sought in stressful circumstances, such as the loss of carer support or during recovery from an acute health episode. Information for these people, as for various disadvantaged groups, must be comprehensible and accessible. Many are not familiar with the internet but most have telephones. Importantly, partners, family and other informal carers who help them to navigate the system need to be able to clearly understand and explain the benefits and costs of the various care and support options.

**Box 9.1 Participant's views on information — accessible and useable?**

**ACH Group:**

In the new aged care older people and their families and advocates should be able to get information more easily — information should be independent, comprehensive, accessible by all in a diverse society, have many outlet mediums and backed up ways in which people can see how things work (e.g. resource centres). This information should enable older people to assess their own needs and to assist their access to services and supports. (sub. 111, p. 5)

**The Council on the Ageing (COTA) Australia:**

Work has already started on [improving information] with the allocation of \$36 million in new investment for the 'one stop shops' but there needs to be a greater sense of urgency around ensuring the information elements ... are pulled together in a way that facilitates individuals accessing the services they need. (sub. 337, p. 43)

**Older People's Reference Group:**

Unless people know what their choices are, how can they make good decisions? It should be much easier to understand what care programs are available in the community and in residential facilities. Less jargon, more accountability, more public information and more access points are needed. Local councils are well placed to provide details of options in their areas. General practitioners, and especially the proposed new primary health centres, are also suitable points of information. (sub. 25, p. 4)

**Health Care Consumers' Association of the ACT:**

Information and communication is essential ... We need information that helps with decision making; this means taking into account one's health status, hobbies and interests, community and family connections and financial means as well as lifestyle preferences. (sub. 326, p. 4)

Currently, information is provided on a broad range of topics and through a diverse range of sources. For example:

- there is an expanding number of organisations and sources of information that promote positive ageing — for example, information is provided by health insurers, retirement villages, care providers and superannuation funds. Peak ageing and aged care bodies such as COTA Australia, Alzheimer's Australia, NSA, Carers Australia and Palliative Care Australia also disseminate valuable

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information. This information is spread across the system and tends to be targeted to particular groups or individuals. They offer guidance on how older people can maintain or enhance their wellbeing

- government agencies also maintain positive ageing and service access websites, ranging from the Australian Government Department of Health and Ageing's (DoHA's) website, [www.agedcareaustralia.gov.au](http://www.agedcareaustralia.gov.au), to local government information services.

In the Commission's view, both healthy ageing and access to aged care services have equity and public good characteristics, and there is a case for public funding of an information platform that assists with both. On efficiency grounds, a streamlined approach to information provision reduces the search costs incurred by those seeking the information, and makes it easier to ensure the information is accurate and up to date. To achieve equity of access, investment is warranted in making the system user friendly.

#### *Features of a consolidated platform*

There is already a well developed network of government information portals and services in place. But there is a clear need for consolidation to ensure that such services (such as the current Commonwealth Respite and Carelink centres, the Agedcare Australia web-based information service, the [seniors.gov.au](http://seniors.gov.au) website, Home and Community Care (HACC) funded information services, and information provided by Aged Care Assessment Teams (ACATs)) all feed off, and are linked to, an overarching single information platform.

The information platform needs to be targeted at two main levels:

- broad community education about healthy ageing and Australia's support and care arrangements, to help people plan and prepare for their own (or their parents and friends) later aged care needs
- specific information that helps older people and their carers to find and choose the particular services that can meet their immediate and ongoing needs.

This would give consumers far more clarity about where to begin when looking for authoritative information.

However, a common single information platform does not imply a single means by which older Australians discover information about aged care and healthy ageing — the one set of information should be available through many outlets.

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The proposed information platform would provide both general information on the aged care system and information tailored to the individual. The platform would also be region-specific. Local information is needed on how to contact assessment services and on the availability, quality and cost of services delivered locally by approved providers. The nature of a proposed aged care access gateway that would provide this information is discussed further below.

## **Needs Assessment**

Accurate assessment of a person's care needs is a necessary precondition for the delivery of appropriate care. As Davis et al. state:

Frail, older people with multiple problems and co morbidities, particularly those not under the direct care of geriatric services, are at risk of adverse outcomes. Appropriate assessment is required to address the complexities of health needs. Hence, the cornerstone of contemporary care for older people is assessment. (2009, pp. 168–69)

The often vexed circumstances in which assessments take place (for example, immediately after a health event) also mean that assessment can be a critical transition point for older people.

The assessment process can also be fundamental in avoiding inappropriate access to services, thereby limiting the overall fiscal cost of providing government-subsidised services. Currently, government controls operate through a mix of eligibility criteria, quantity restrictions and price (chapter 2). The Commission's proposed model removes the constraints on the supply of aged care and support services, so that people assessed as needing services will have access to these services. In turn, this makes the assessment of needs and the coverage of the system (which defines the eligibility criteria, the services that are subsidised and their resourcing) critical to managing the fiscal cost of aged care.

### *Assessment issues*

The current assessment system's strengths include its multi-disciplinary approach and nation-wide coverage. However, as discussed in chapter 5 and in box 9.2, there are a number of significant problems with structures, outcomes and variability.

In light of these problems, there is a need for an improved national assessment process. This should result in more timely assessment and improved access to services. Greater consistency is also needed in assessments, resulting in similar outcomes irrespective of where people are located.

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## Box 9.2 Participant's views on assessments

COTA Australia stated:

Older people (and their families) often express frustration at having to go to separate services for information, screening, assessment and access to services. They have to make separate trips, separate phone calls and have to give the same information many times over. The current system of information and referral is under-resourced and quite fragmented, often resulting in people accessing the wrong services for their needs, and/or experiencing long delays that can be extremely detrimental. (sub. 337, p. 13)

DoHA identified the multiple and inconsistent assessment processes under the current system as an area of inefficiency:

There are ... significant issues of allocative efficiency in the current arrangements. For example, in (low intensity) community care, clients can face multiple and inconsistent assessment processes as they are referred to different organisations depending on their care requirements. In addition, service specific assessments may not be designed to identify other issues that the client (and their carer) may be experiencing therefore reducing the chances for appropriate and timely referrals within the system. (sub. 482, p. 50)

Others questioned the long waiting periods for assessment. For example, Just Better Care said:

In many areas throughout Sydney the waiting time for an ACAT assessment is six to nine months. The ACAT teams have been under-resourced for the past decade to deal with the growing numbers of older people they need to assess and the waiting times are unmanageable. (sub. 131, p. 1)

A further concern of providers was the number of inappropriate admissions to either low or high care through the ACAT assessment process. In this context, Mission Australia said:

Reforms are required to review the process of ACAT assessments for older people requiring formal care. Currently the ACAT assessments are not validated and the assessment may take just two hours. There is a feeling that the Department of Health and Ageing does not trust the assessment process of the residential aged care facilities. Residential aged care facilities conduct assessments over a four week period and as such are likely to be more accurate due to the longer assessment process yet must be validated. (sub. 117, p. 3)

Lack of consistency of needs assessments was also raised by many participants. For example, Aged Care Queensland Inc. said:

There is a perceived lack of consistency between Aged Care Assessment Teams (ACAT) across Queensland. Members advise that ACATs have different approaches to responding to referrals, managing waiting lists, interpreting ACAT guidelines and assessing clients. (sub. 199, p. 17).

A single (or joined-up) assessment process is likely to result in better outcomes for individuals and produce savings for the community. This process must be based on a common set of standardised and validated tools (or toolbox) for the assessment of aged care needs, and a mechanism to ensure that these are applied in a consistent manner by people with the appropriate skills.

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### *Assessment tools*

A national suite of standardised and validated assessment tools (see box 9.3 for one possible approach) should aim to achieve outcomes that:

- promote independence and build on an older person's strengths
- identify restorative options that accord with an individual's own aspirations
- identify when a more in-depth assessment is needed
- provide adequate follow up, with timing depending on the nature of the assessment
- use electronic records, attached to a more detailed e-health record, where possible
- support other aspects of care facilitation, such as identifying the need for a care coordinator to help with making appointments with care providers and helping choose an appropriate provider or providers, linking health and care providers and arranging transport.

This suite would be structured to enable a single initial assessment as a foundation, with various triggers that indicate the need for more complex assessments where required.

#### **Box 9.3 A possible new suite of assessment tools**

In considering the possible nature of a new suite of assessment tools, and in order to supplement its own analysis on this topic, the Commission contracted Applied Aged Care Solutions Pty Ltd (AACS) to provide an independent report on a new care and assessment model. The report is available on the Commission's website in appendix C of this report.

The approach proposed by AACS includes the following key elements:

- A system involving a central agency and hubs, which would provide a range of services including triage; information provision; management of needs identification; initial care planning including goal setting; actioning, coordination and monitoring of the care plan; and provision of independent advocacy for the clients.
- A layered funding model involving a base subsidy varying across low to very high levels of need; together with layered 'supplements' covering specialist areas (e.g. dementia/behaviour/mental health, health/nursing/continence, palliative care, rehabilitation) and 'care support' needs. The proposed supplements are aligned to the current specialist high care programs (CACPs, EACH, EACH-D) but the funding that would be allocated will only be directed at the 'marginal cost' in these areas over and above what is already taken account of in the base layer payment.

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### *Initial assessments*

The first of the tools in the national assessment suite would provide an initial assessment of an older person's core functions, such as their ability to undertake instrumental activities of daily living (IADLs) and activities of daily living (ADLs), their care setting and the level of informal carer support.

The initial assessment would be undertaken by or on behalf of the proposed Gateway and include the older person with the assistance of their carer, General Practitioner (GP) or other health care professional as appropriate. Initial requests for such an assessment could be made through a variety of means, including a form that could be filled out directly at a shopfront, online, by mail, or by phone.

Evidence suggests that, for both initial and later assessments, face to face contact is likely to yield more effective outcomes. Questions remain concerning the reliability of other alternatives, such as self assessment or assessment via the phone. In this context, the Peninsula Primary and Community Health Committee stated that telephone assessments:

... are not an effective means to determining, in conjunction with the community member, the best information or supports that would assist them to maintain and improve their functional capacity, independence, social connectedness and general health/wellbeing. (sub. DR 877, p. 2)

Similarly, North West Region CACP/EACH/ACAS Network stated:

Telephone assessment is a poor substitute for assessments conducted in a client's home. Home based assessments provide greater insight (in a shorter period of time) of the real circumstances of a person's abilities and living situations. (sub. DR 605, p. 3)

Royal District Nursing Service drew on experience both here and in New Zealand to argue that:

In many instances much extra information can be gleaned through observation of the client's physical environment, and physically checking their self-assessment of functional capacity. (sub. DR 546, p. 5)

While in the future the expanded use of alternatives should not be precluded, these approaches would need to be thoroughly trialled before being introduced more widely.

The initial assessment could also be an opportunity to assist an older person with advice on healthy ageing, falls prevention and care coordination. Preliminary care plans (including preventive and reablement measures), in consultation with the care recipient (and family), could be established. This would be an opportunity for the

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older person to express their preferences for how their assessed services should be delivered.

Under the Commission's proposed model (outlined in greater detail below), direct access to some low intensity community support services would be retained without the need for a gateway assessment (figure 9.4). This part of the system would draw largely on the best practice formats currently used under the HACC program.

### *Further assessment*

The initial assessment would also act as a screening tool for the Gateway to determine whether there is a need for a further, more comprehensive assessment. Regionally based multidisciplinary teams would undertake more complex assessments using a more sophisticated suite of assessment tools (including comprehensive medical assessments where appropriate (HealthCube, sub. 103)). The assessment would usually lead to determining a person's entitlement to personal care and specialised services. If not undertaken as part of the initial assessment, a person's financial capacity to make a co-contribution would also be assessed (discussed later in this chapter).

Periodic reassessment would continue to play an important role in matching care needs with service delivery. For someone whose initial assessment was as a consequence of hospitalisation, more detailed assessments should take place in their longer-term accommodation. Reassessments would be undertaken by residential and community care providers in many cases, as occurs under current arrangements. General oversight of reassessments would be conducted by the Gateway on a risk managed basis.

It is important that the audit of reassessments is comprehensive and robust. This is required to ensure accuracy of assessment and to minimise the scope for gaming the process. Should it be necessary, a charging regime for unwarranted reassessments may need to be introduced. This charge would apply to the person instigating the reassessment (such as a provider or consumer) if there was no material change in assessed condition.

Each reassessment, and the information it generates, would build on the electronic records of earlier assessments. This record would establish a case history of support and care as a basis for care coordination and, if required, case management. More detailed assessments would also include consideration of a wide range of supplementary care needs and supports, including those relating to: transport; oral health; higher level aids and equipment (discussed below); dementia care (including for those with younger onset dementia); specialist palliative and end-of-life care;



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and additional needs relating to diversity (including cultural and linguistic services — chapter 11).

### *Carer assessments*

The assessment process can play a critical role in leading to services which assist not only care recipients but also their carers. Several submissions discussed the importance of including carers at various stages in the assessment process. Carers Australia argued that:

... broad consideration should be given to the introduction of carer assessments in the aged care sector as an innovative approach to supporting carers in the aged care system... carer assessments would take into account the needs and opinions of carers regarding the support they require and would provide a clear process, with standards across the sector. This simple introduction could easily provide a tangible reflection of a conceptual change in the sector. (sub. 247, p. 16)

COTA Australia stated:

There should be separate carer assessments undertaken at both the basic and complex stages of a person's support and care assessment. This carer assessment needs to occur as soon as possible after the person they support and care for is assessed. If the person is in hospital the carer must not be assessed until the person returns home.

The carer assessment is the basis for a support and care plan for carer/s needs. The assessment identifies the carer's needs for training, support and respite.

Carer entitlements can apply whether or not the person they support and care for is actually receiving services but would need services if the carer was not there. This is important as a carer may need support when the person they are caring for has refused services. (sub. 337, p. 28)

Alzheimer's Australia WA said that:

... consideration of the needs and well-being of the caregiver are necessary components of a comprehensive dementia needs assessment. This approach is likely to facilitate and encourage more timely access by people living with dementia along their dementia journey to suitable services. (sub. 345, p. 10)

A consistent theme in submissions was that some form of comprehensive carer assessment can provide fuller information about both the care circumstances of older people and the broad range of their carer's needs.

Under the revised assessment arrangements proposed by the Commission, there would be several points at which carer assessments would take place:

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- through the Gateway as part of initial and more comprehensive assessments for older people receiving care, with detail being collected on current carer/s, and the nature of support they provide
  - via separate carer support centre assessments for the carer. This would involve assessing and providing for carer's needs in relation to dedicated services such as income support, advocacy, education and training, counselling and emergency respite
  - during any reassessment of care needs for the care recipient or the carer.

These arrangements would build on the foundation of several initiatives already underway, including the development of the revised Australian Community Care Needs Assessment and the Carer Eligibility and Needs Assessment.

Broader measures to support the role of carers, including the development of specialist carer support centres, are discussed in chapter 13.

### *The role of aids and equipment*

Many inquiry participants argued that aids and equipment can play a critical role in the care process. In specific cases, such as macular degeneration (Macular Degeneration Foundation, sub. DR709), participants argued that the early provision of low level aids was fundamental in preventing further decline. Anna Howe (sub. DR856, p. 4) also referred to a significant body of evidence from both Australia and the United States on the effectiveness of aids and equipment.

Several submissions called for a greater consideration within assessments of the role of assistive and enabling technologies. For example, Independent Living Centre NSW stated there was a need to explicitly recognise and integrate:

... the importance of assistive technology across the life domains of communication, self care and mobility and enabling selection of assistive technology that supports the individual needs of each older Australians and any carers or careworkers who support them. (sub. DR778, p. 1)

A recently released study by DoHA looked at the role of assistive technologies in helping older people. It found that:

... the most effective assistive technologies identified in the literature include...aids, devices and equipment to improve ease of living, safety and physical function, where they are provided early and are supported by training, maintenance and follow-up support. (2008, p. 6)

The proposed Gateway assessment process would consider the need (on cost-benefit grounds via a test for reasonableness) for higher level aids and equipment or other

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assistive and enabling technologies. This would use a schedule of higher levels aids and equipment, with entitlement to use but not ownership. This approach would supplement existing services delivered by a range of charitable and other organisations.

In providing for comprehensive care planning and case management supports, the Gateway would also provide the follow-up that has been identified as being essential if such technologies are to be effective.

### *Summing up*

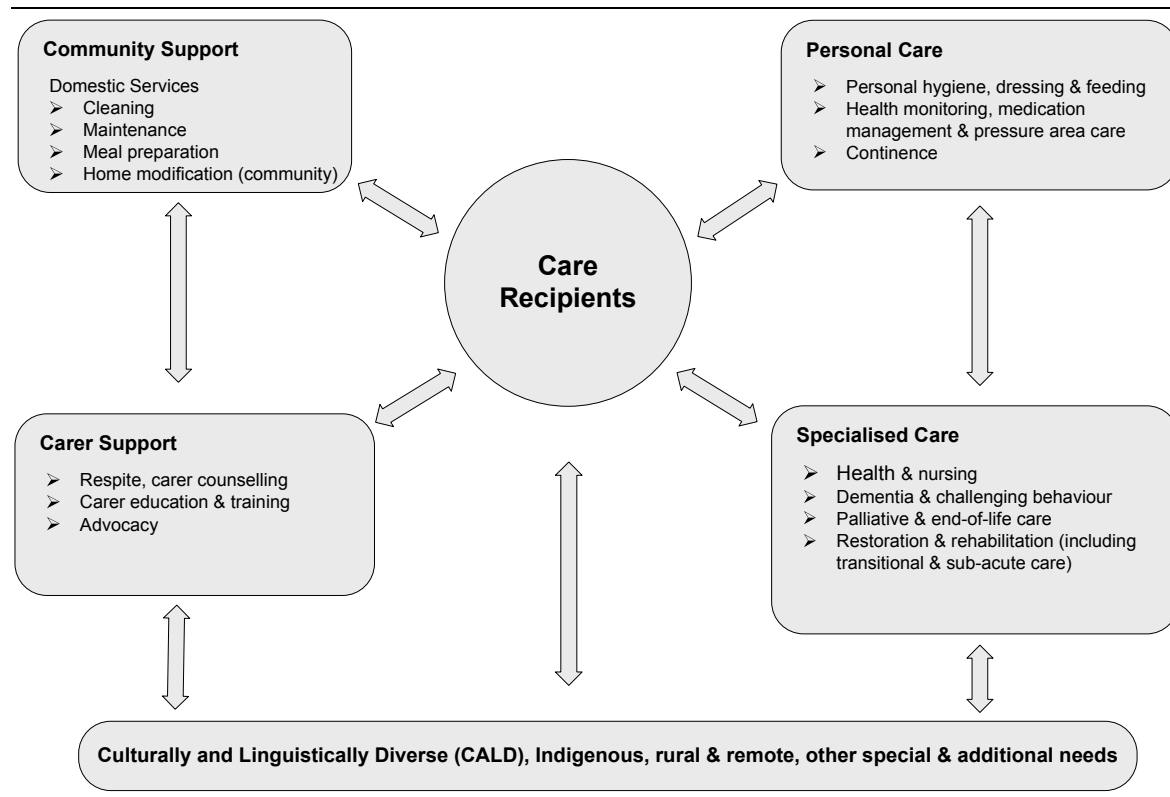
The main attributes of the Commission's broad proposed approach to needs assessment are shown in figure 9.1. An important feature is the translation of a needs assessment into a quantifiable entitlement to a range of care and support services.

There are several possible options for implementing this process, and one is outlined in a separate paper appended to this report at appendix C. The Commission is of the view that, put broadly, an integrated approach is required to determining the level of care service entitlements across both community and residential care (figure 9.1). In the Commission's view, the Gateway would draw on a range of services covering basic support, personal care, specialised care and carer support that best meet the assessed needs of the older person.

The main elements in this approach would be combined in various ways depending on assessed need. It is not necessarily the case, for example, that individuals would receive one element (for example, specialised care) only if they had also received another (for example, basic support) within their assessment. What is required is a combination of service elements that will best meet the person's current needs.

Further detail on this approach, and related proposed reforms to arrangements for accessing services, is provided in section 9.2.

**Figure 9.1 Aged Care and Support: key elements in an integrated approach**



## A single national care gateway

A number of organisations provided thoughtful and detailed proposals for reforming information, assessment and care coordination services. One key element in several of the proposals was the need for a single gateway or portal of some form, so that older people did not have to navigate between a complex array of possible entry points into the aged care system. The Commission notes that there is strong agreement as to the broad design of a new system.

One of the more comprehensive proposals was that offered by COTA Australia. In essence, it advocated a two-level system, the first being a multi-purpose gateway for promotion, information, screening and basic referrals, and a second specialist Care Assessment Service for more complex assessments (box 9.4). The Commission has drawn on this model for its proposed reforms.

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**Box 9.4 Information and Assessment – COTA Australia’s Gateway proposal**

COTA Australia argued the need for an aged care gateway, with a number of key services offered through this improved entry point.

**The Gateway**

The key initial functions performed by the Gateway would be to:

- undertake promotion of positive ageing and awareness of availability of support for older people
- provide people with information on relevant support and care services
- undertake basic screening and assessment to help direct people to the most appropriate services
- make direct referrals to basic support and care services and to more complex assessments for those with higher needs.

In COTA Australia’s view, the Gateway would be a valuable entry point for first time users of the aged care system, and be a point of continuing referral for individuals as they move into and out of the system across time.

**Care Assessment Service**

COTA Australia also proposed the establishment of a Care Assessment Service, drawing on features of ACATs, that would provide:

- a national specialist service, separate from health and aged care providers, that uses a standard set of assessment tools and processes
- comprehensive assessment prior to receiving more complex levels of support and care

COTA Australia argued that provision must be made for the assessment decisions made by the service to be appealed by users.

*Source: COTA Australia (sub. 337, pp. 12–15).*

Blake Dawson proposed a similar consolidated approach, which focused on the concept of what it called Senior Living Centres. They stated that:

We submit that the service that conducts professional assessments of the care and accommodation needs of older Australians should form the base for a broader service that also provides:

- (a) case management services, for those individuals who qualify for fully or partly funded services and their families and carers on an on-going basis;
- (b) information and advice for all older Australians and their families and carers who are considering senior living issues, options and services (irrespective of whether any qualify for fully or partially funded services);

- 
- (c) introduction and assistance with access to senior living social activities and networks;
  - (d) introduction and assistance with access to accommodation and care providers. (sub. 465, p. 40)

A further key feature of Blake Dawson's proposed approach was a greater local devolution of these service locations.

There have been several recent initiatives by the Australian Government and by the Council of Australian Governments (COAG) that relate to the concept of a gateway. They include the Government's recent reforms to aged care's front end (including the 'single number', 'front end' and aged care 'one-stop-shop' initiatives), the transfer of full responsibility for the Aged Care Assessment Program to the Australian Government in 2012-13 (COAG 2010b), and broader pursuit of the consolidation of service delivery.

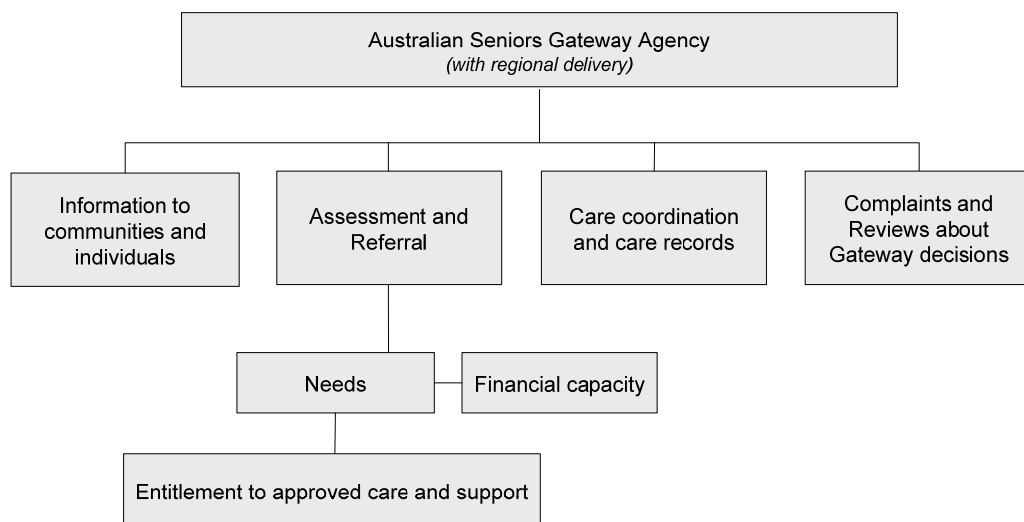
While these initiatives go some way towards a more unified approach, in the Commission's view there are good grounds for going further and introducing a comprehensive, centralised gateway which provides information, needs assessment and care coordination services. If adequately resourced and administered, the Gateway would ensure that processes for access are more streamlined and that the system is easier to navigate. It would be more efficient, by replacing a range of currently disparate elements in the system, including:

- many assessments for low level home-based services (currently undertaken by individual providers, whether they be local councils, charities, community organisations or others who are funded under the HACC program)
- higher level assessments (currently performed by ACATs) — and the overheads in each state and territory which administer ACATs
- the Commonwealth's Respite and Carelink Centres — which would be disbanded (with some elements reconfigured into new specialist carer support services)
- a number of websites maintained by various government agencies.

An integrated Gateway agency would require additional initial funding to further develop an electronic data base and other key infrastructure although there would also be a transfer of some resources from DoHA. There would also be longer run savings because duplication could be reduced, as set out above.

The agency would be separate from DoHA, with a separate Budget appropriation for its core services. It would take over all related operational activity from DoHA. The Commission’s proposal is shown in figure 9.2, and includes provision for the agency to arrange for assessments of financial capacity to make co-contributions (chapter 7).

Figure 9.2 **Australian Seniors Gateway Agency**



Many participants supported the proposed Gateway (box 9.5). Concerns, however, were expressed by some about the capacity of the Gateway and the potential for bottlenecks. Some thought that lower level services should be able to be accessed directly as well as through the Gateway.

*An emphasis on local service delivery*

Importantly the Australian Seniors Gateway Agency (the Gateway) proposed in recommendation 9.1 would deliver its services through a locally devolved network of Gateway centres. Each of these local centres would provide information, needs assessment and care coordination and draw heavily on local knowledge. While in many cases these would be directly administered by the agency, regional Gateway centres could be operated on a contract basis by other government or non-government agencies, should the Australian Government determine that this would be the most efficient and effective way to operate them. These regional centres could become the basis for the one-stop-shop outlets currently proposed by the Australian Government.

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### Box 9.5 The proposed Gateway: some participant's comments

#### The Repatriation Commission:

The establishment of the Australian Senior's Gateway Agency ... will address the call for a more seamless pathway from home into residential care. (sub. DR754, p. 5)

#### The Benevolent Society:

The matter of resourcing is critical. The proposed scope of the Gateway agency's role will require resources well beyond those currently provided to Carelink centres, if it is to offer anything other than basic call centre service. The information technology foundation of the Gateway will also be critical if it is to function well. Adequate resources will be needed to ensure service details are accurate and continually updated. (sub. DR805, p. 6)

#### MND Australia:

This agency will need to have formal links to disease specific and disability organisations for access to disease/disability specific information and support for people with chronic health issues, or with a disability, who are ageing. (sub. DR700, p. 2)

#### Catholic Health Australia:

The Commission notes that organisations such as Alzheimer's Australia also provide support, education and counselling for people with dementia and their families. Because of the more specialist nature of the support provided by such organisations, CHA considers that there is a continuing need for such activities to complement the Gateway's more generic information role, and not be supplanted by the Gateway Agency. (sub. DR748, p. 14)

#### Aged and Community Care Victoria:

ACCV supports the move to a Gateway concept provided there is adequate resourcing which can ensure local access, including in rural communities, as well as avoidance of delays in assessment ... It is essential that the Gateway does not end up with problems of capacity or bottlenecks. (sub. DR735, p. 7)

#### Multicultural Disability Advocacy Association of NSW:

How information is distributed and presented impacts on who receives and understands it. The establishment of a gateway agency must ensure that it actively engages multicultural communities and demonstrates best practice in multicultural marketing. (sub. DR816, p. 6)

#### Alzheimer's Australia:

The Gateway should have a networked approach with multiple entry points to accessing aged care. Individuals who need access to low-level services such as specialised support and counselling should be able to access them through the Gateway or by directly contacting NGO's like Alzheimer's Australia. The Gateway should be a source of information about social and clinical outcomes of care services to enable informed consumer choice. (sub. DR656, p. 7)

There are several options for defining regional areas for the purposes of locating Gateway centres. Given the importance of ensuring cohesion with the health sector, using similar regional definitions to those used for Medicare Locals (or Local Hospital Networks if appropriate) would appear worthy of further consideration. In this regard DoHA stated:



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The Government's National Health Reform agenda places a strong emphasis on Medicare Locals and Local Hospital Networks in achieving integration between primary care, acute care and aged care services at the local level. In developing the new front end to aged care, a key area of focus is how to best link aged care services with these new structures in providing referrals to health care services and creating clear hubs, linkages and transition points through which older people can access a range of health and aged care services. (sub. DR694, pp. 2–3)

The Australian General Practice Network supported the integration of any proposed Gateway with Medicare Locals (box 9.6), stating:

Should the Government take a policy decision to implement the PC's proposed Gateway Agency, Medicare Locals would be ideally placed to work closely with the Agency in determining service needs and the most appropriate service models, as informed by local context, service infrastructure, population and workforce profiles. (sub. DR877, p. 8)

Catholic Health Australia (CHA) cautioned that in some cases the boundaries between Medicare Locals and Local Hospital Networks are not well aligned. They nevertheless endorsed some general alignment between the Gateway and these broader health areas, stating that:

On balance ... the primary determinate for the delineation of regional Hub boundaries should be to achieve maximum congruence with the boundaries of Medicare Locals and Local Health Networks in order to increase the potential for better coordination and integration of health and aged care services. (sub. DR748, p. 5)

Should this alignment occur, it is important that there is ongoing communication between administrators in the Gateway and those involved in setting and administering these broader health initiatives.

In the case of CALD communities, however, the broad areas set in recent health initiatives may not be suitable. Many such communities have limited numbers of people spread across a geographically large area. In these cases, the Commission has given further consideration to the introduction of multicultural hubs for the purposes of accessing some care and support services (chapter 11).

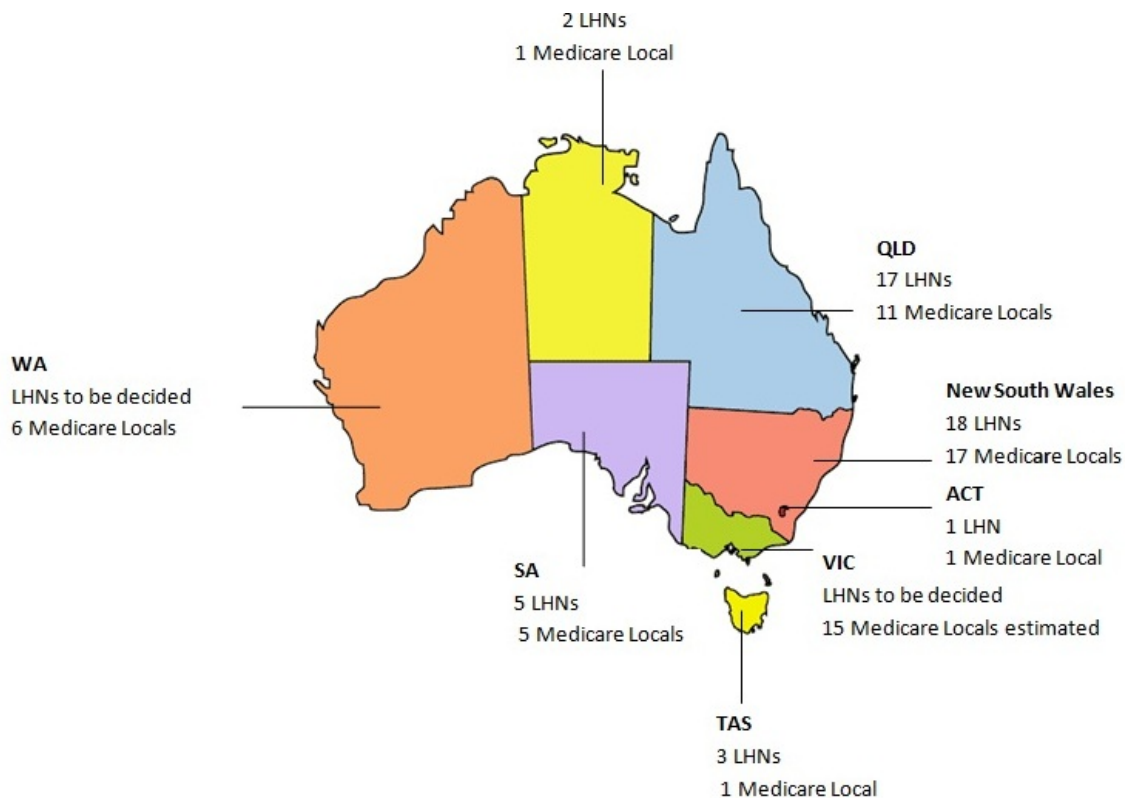
Regional definitions for the purposes of price setting and supported resident ratios are discussed in chapter 7.

**Box 9.6 Medicare Local and Local Hospital Network areas**

The Australian Government developed Medicare Local boundaries following consultations with state and territory governments and consideration of approximately 120 submissions from the health sector and the wider community. By December 2010, a total of 42 Medicare Local boundaries had been agreed across all states and territories with the exception of Victoria. At that time, the Commonwealth extended the time for the resolution of the boundaries with the Victorian Government. The first group of Medicare Locals and their associated branch offices will begin operating in mid 2011, with the remainder planned to start in mid 2012.

For Local Hospital Networks, 46 had been agreed by late 2010 across all states and territories except Victoria and Western Australia, including 41 geographically based networks and 5 state-wide networks, delivering highly specialised hospital services across some jurisdictions. The Commonwealth has also extended the time for the resolution of the boundaries with the Victorian Government. In Western Australia, Local Hospital Networks will not be established at this stage as Western Australia is currently not a signatory to the National Health and Hospitals Network Agreement. Local Hospital Network boundaries have been developed by state and territory governments through consultation with stakeholders and local communities.

The number of regions as agreed at 31 December 2010 are shown below:



Sources: Consumer’s Health Forum of Australia (2011); DoHA (2011j).

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### *Importance of flexible access*

The Commission recognises that many older Australians and their carers will wish to directly access their local councils and privately provided services and other government supported services such as those that enhance social engagement and inclusion, or primary and preventative health care, without the need to go through the proposed Gateway. Similarly, many organisations such as Alzheimer’s Australia, Carers Australia and others provide services which those in need would continue to access directly. For a large share of government-subsidised aged care and support services, however, the Gateway will be the new streamlined access point, while working in a close cooperative manner with these other service providers.

Gateway assessors would determine the care needs of older people and their flexible service entitlements (and inform them and providers of the price the Government has set for the services). For those entering residential facilities, this entitlement would replace the initial Aged Care Funding Instrument (ACFI) assessment currently undertaken by providers. The Gateway assessors would also arrange for an assessment of the consumer’s capacity to pay, with a more comprehensive financial capacity assessment undertaken by Centrelink as detailed in chapter 7.

In recommending the establishment of the Gateway, the Commission is keen to ensure that a ‘no wrong door’ approach is also maintained. That is, older people should be able to continue to access information and appropriate care and support, particularly at low levels of needs, through a variety of ways, in their local area. Further detail on directly accessing such services is provided in section 9.3.

#### RECOMMENDATION 9.1

***The Australian Government should establish an Australian Seniors Gateway Agency to provide information, needs assessment, care coordination and carer referral services. The Gateway would deliver services via a regional structure.***

- ***A platform within the Gateway would provide information on healthy ageing, social inclusion and participation, age-friendly accommodation, and information on the availability, quality and costs of care services from approved providers, and how to access those services.***
- ***Assessments of the needs of older people would be undertaken for their potential entitlement to approved care services. The level of assessment resourcing would vary according to anticipated need.***
- ***Assessments of financial capacity to make care co-contributions toward the cost of services would be undertaken by Centrelink on behalf of the Gateway.***

- *The assessment of the individual could lead to an entitlement to a set of aged care services which the older person and their carer may access from approved aged care providers of their choice.*
- *The assessment could lead to a referral or an entitlement to community support services and carer support services where such services form an essential part of a set of services to meet complex needs.*
- *Initial care coordination services would be provided, where appropriate and requested, as part of the Gateway. Further care coordination and case management, which may form part of the entitlement, would be provided in the community or in residential aged care facilities by an individual's approved provider of choice.*

*The Gateway would:*

- *have a separate Australian Government Budget appropriation for the entitlement-based services that it approves*
- *be a Prescribed Agency under the Financial Management and Accountability Act 1997.*

*The Gateway would operate via a network of regional centres to enhance local responsiveness, with operational regions defined with reference to those for Medicare Locals and/or Local Hospital Networks. These regional centres would offer the full range of information, needs assessment and care coordination services and their operation may be subcontracted to third party operators including other government agencies or non government or private entities.*

*Care coordination and case management by the Gateway and providers*

In relation to care coordination, the main functions to be performed by care planners were described in general terms in several submissions. For example, one participant emphasised the need for planners with local knowledge, stating:

They would know what services were available. They would have all the data about local operators at their finger tips and national figures for comparison. They would be in a position to give expert local support and advice. They would provide the glue to coordinate hospital, disability services, nursing home and community. (J.M. Wynne, sub 368, p. 48)

Care coordination services should be provided at a number of points within the reformed system. Care coordination in the form of a preliminary care plan should be available to older people upon entry into the system through the Gateway. More complex assessments should include identifying whether intensive case management services are needed.

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In the case of individuals receiving care in the community, these services could be provided by independent agents along similar lines to those case management services currently provided under the Community Options Program (box 9.7). Many community options providers could be well placed to offer such extended case management services. Case management would also continue to be provided in residential care facilities as part of the suite of services on offer by the residential care provider.

**Box 9.7      The Community Options Program**

The Community Options Program is a service funded under the Home and Community Care (HACC) Program. It provides individually tailored services to support people with complex needs wishing to remain at home in their local community.

There are a range of services offered in the program. They can include case management (coordination and monitoring of support); domestic assistance (support with household tasks); personal care (support with showering/medication); social support (support with shopping and accessing the broader community); transport to medical appointments and recreational activities; and respite.

*Source:* Footprints in Brisbane Inc. (2010).

*Care records*

Electronic records of an older person's needs assessment and service usage were considered by participants to be important for improving the quality of care of older Australians. For example, the Business Council of Australia said:

... the adoption of unique health identifiers and electronic sharing of health information — the current e-health measures — are fundamental to making the provision of health and aged care services seamless while improving quality and patient safety. (sub. 274, p. 11)

The Australian Medical Association also said:

The multidisciplinary nature of care that older people need — general practice, acute, emergency and sub-acute care — will be improved by the application of an electronic medical record. In particular, electronic discharge summaries and electronic medication management systems have the capacity to improve communication between health care professionals and across care settings, to improve continuity of care and reduce the potential for adverse events. (sub. 330, p. 11)

Other participants noted the scope for electronic records to remove inefficiencies. For example, UnitingCare Australia said:

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E-health monitoring and support and single health records would streamline processes and help reduce red tape and ultimately ensure a higher level of care through more accurate record keeping. (sub. 406, p. 13)

Some progress has already been made in developing and integrating electronic records in aged care. In this context the Commission notes recent announcements by DoHA of further progress in rolling out the electronic Aged Care Client Record (DoHA 2010b).

Further development and rollout of electronic records has been recommended by several recent reviews, most notably the National Health and Hospitals Reform Commission (NHHRC). In its final report, the NHHRC proposed:

- increased use of electronic clinical records in aged care homes, including capacity for electronic prescribing by attending medical practitioners, and providing a financial incentive for the electronic transfer of clinical data between services and settings (general practitioners, hospital and aged care) subject to patient consent
- that hospital discharges include timely provision of good information on a person's hospital care to the clinical staff of their aged care provider, subject to patient consent (2009, p. 23).

In the Commission's view, linked electronic records would avoid the need for older people to repeat the same basic information to multiple people. The initial questionnaire would provide the base information for any further assessments and should be attached to the record. There would be protocols for who could update the information as care needs changed. The relevant information, subject to agreement from the client, would be attached to an e-health record, as would any advanced care plan, and be made available to all approved and relevant health professionals and care providers.

### *Reablement services and the Gateway*

Several submissions responding to the Commission's draft report called for a greater focus on reablement. This included calls for a general strengthening of reablement approaches across aged care, and more specific calls to place reablement at the core of the Gateway assessment processes. For example, CHA stated that:

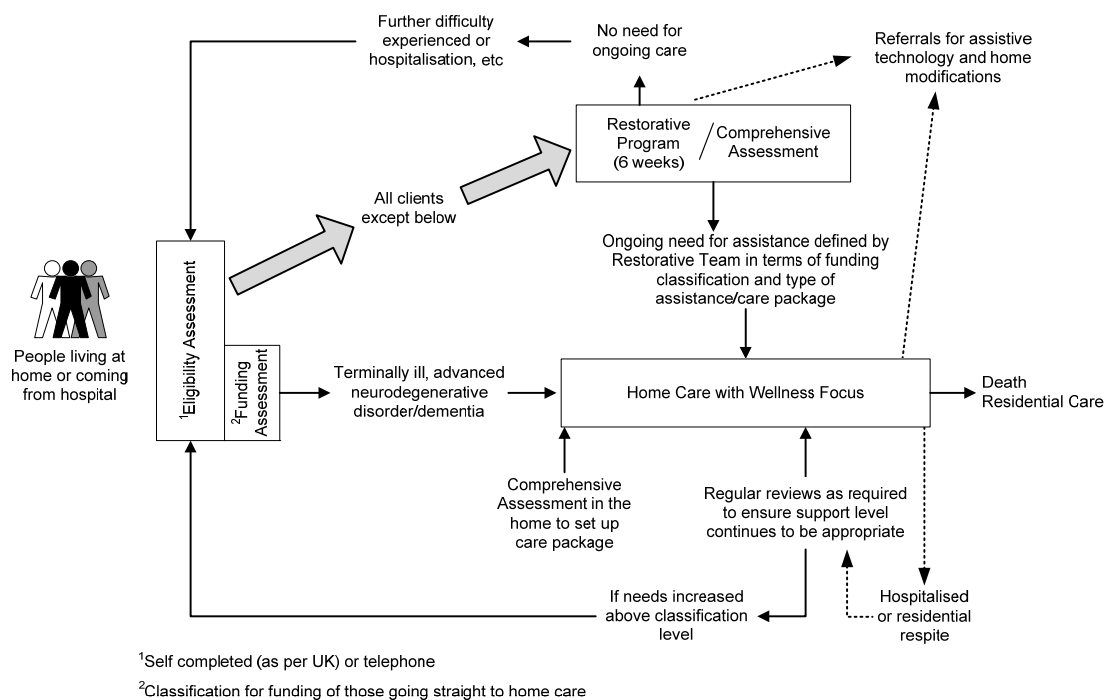
... consumer preferences should be tempered, without being directive, by the need to avoid dependency wherever possible and to promote and ensure a more active and effective early intervention and restorative approach. (sub. DR748, p. 13)

Gill Lewin supported a model:

... in which there are independence services as an integral part of the gateway. They would be basic entry level services available to everyone experiencing difficulties managing in the community who was not terminally ill or had an advanced degenerative disorder ... Eligible individuals who wished to receive the service would be referred after the initial eligibility assessment, the service would be limited to 6 weeks unless the care coordinator could support an extension on the basis that progress towards a client achieving their goals would be severely compromised. (sub. DR790, p. 6)

Further detail on this approach is shown in figure 9.3.

Figure 9.3 Possible design of an intensive reablement program



Source: Gill Lewin, pers. comm., 29 September 2010.

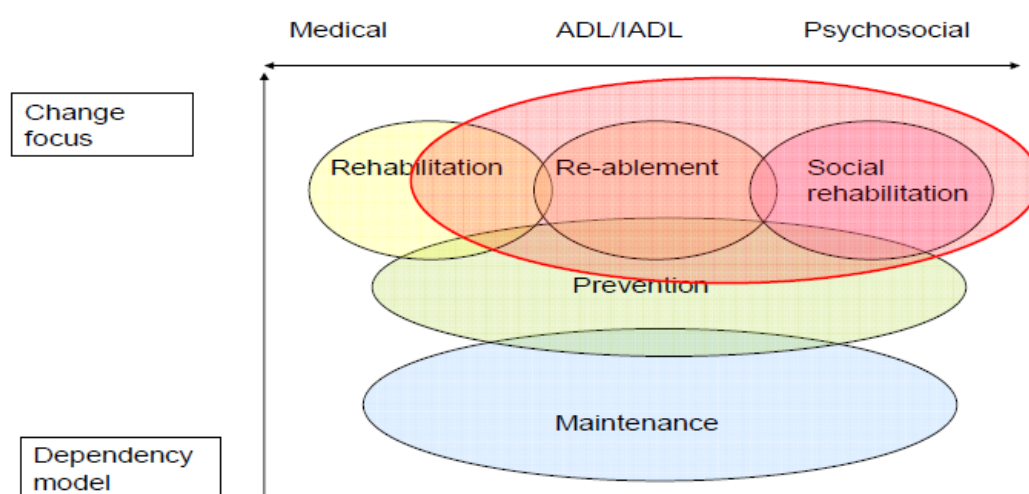
Examples of programs and therapies that might be provided as part of a more comprehensive reablement approach are outlined in Uniting Care Ageing NSW and ACT (2008, p.4). These include:

- Adequate support to re-learn or learn alternative methods to undertake a particular task (e.g. cooking classes)
- Physiotherapy to address an underlying issue that has led to restriction in mobility
- Connection and support to a range of capacity building options (e.g. local walking groups)

- The trial of different equipment (e.g., labour saving equipment such as new style cleaning gadgets)
- The provision of environmental modifications (e.g. grab bars and ramps), often facilitated by an occupational therapist
- Psychosocial education and support to assist individuals to cope and adopt strategies for the self-management of chronic illness
- Encouragement to participate in local health promoting activities and other activities to enhance health
- Health education about principles of healthy ageing, use of medications and illness/accident prevention strategies
- Reactivation and support to sustain social networks, via a short term process of social rehabilitation

While the service mix may vary, a key objective of reablement approaches is to move away from the delivery of care and support that encourages dependency (figure 9.4).

Figure 9.4 **A wellness/restorative approach and other approaches**



Source: Uniting Care Ageing NSW and ACT (2008, p. 4)

Greater emphasis on reablement is apparent in social service delivery in Australia and a number of other countries. In the United Kingdom, for example, recent guidance on adult social care released by the Department of Health emphasised the need for an intensive reablement phase (DOH 2010c). A major focus on reablement has also been apparent in New Zealand's Restorative Home Support Program, Western Australia's Home Independence Program and Victoria's HACC Active Service Model.



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The rollout of a strong reablement service within the proposed broader Gateway reforms would have several advantages. It would embed a proactive approach directly within the system, and ensure that earlier, time limited intervention is provided where it is needed and where it can add considerable value. In addition, it would integrate a reablement approach within the assessment process, so that those who most need such services would receive them. For the reasons outlined in chapter 7, the Commission considers that reablement services should be highly subsidised, if not provided to recipients free of charge.

The reablement service should be subject to periodic evaluation to assess its efficacy. These evaluations would focus on the extent to which the service delivers net benefits to the community.

RECOMMENDATION 9.2

*An intensive reablement service should be introduced to give greater focus on independence, rehabilitation and restorative care. Eligibility and entitlement for this service should be assessed by the Australian Seniors Gateway Agency.*

## **9.2 Improving care continuity and enhancing consumer choice**

Older Australians need a seamless range of services to assist them with ongoing care and support or rehabilitation if they become increasingly frail, lose the support of their partner or other carer, or suffer a significant health event. Services should be coordinated with their existing care services, with their primary health providers and with hospitals if they have had an episode of acute care.

Continuous care has for some time been a major goal of aged care planning and provision. The Organisation for Economic Co-operation and Development (OECD), for example, stressed the importance of continuous care in achieving better health outcomes and greater wellbeing for older people, particularly for those in the community (OECD 2005b, p. 11).

Providing for genuine continuity of care is not easy. The change in an older person's care needs is not always progressive. While many people's care needs do increase gradually, others may have episodic changes in need, followed by periods of rehabilitation and then a reduction in care need. There is also an increasingly diverse spectrum of care needs apparent among older Australians. As UnitingCare Ageing NSW & ACT put it:

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... in addition to ... variation (in the *level* of care required), there is also increasing variation in the *nature* of the care required, with a focus on wellness and prevention involving a move from care in its most conventional, narrow sense to a wider concept that includes a broad range of interventions that are neither therapeutic nor essentially assistive ... There is also variation in the *duration* for which care is required, also due to differences in the duration of various kinds of intervention ... Finally, and related to these, there is growing variation in the range of *settings* in which it is desirable to provide care. (sub. 369, p. 14)

Further, there are considerable differences in the types of care continuums required by older people depending on their health status (for example, older people who have suffered a stroke or who have dementia, as shown in table 9.1). A system that meets such diverse and changing needs requires flexibility, effective communication and an absence of gaps between care programs, personnel and contexts.

### **Recent reforms of note**

Recent reforms to aged care have, in part, been predicated on the need to provide greater care continuity. For example, COAG's National Health and Hospitals Network Agreement of 19 April 2010 announced considerable changes to arrangements for the funding and administration of aged care programs, including the transfer of funding responsibilities for HACC. It also stipulated that:

The Commonwealth and states share responsibility for providing continuity of care across health services, aged care and disability services to ensure smooth client transitions. (COAG 2010b, p. 49)

Many submissions to this inquiry commented favourably on the potential of these reforms to enhance the service continuum for older people. For example, the Aged Care Association Australia (sub. 291, p. 30) stated that the reforms 'will now provide the Commonwealth with the opportunity to integrate HACC, community care and residential care into a seamless service offering'. KinCare (sub. 324, p. 3) stated that 'COAG decisions to shift the funding and administration of Health and Aged Care services to the Australian Government open new opportunities for integrating and streamlining services'.

**Table 9.1 Interventions on a continuum-of-care for stroke and dementia patients**

<i>Type of intervention</i>	<i>Potential benefits in the case of:</i>	
	<i>Stroke</i>	<i>Dementia</i>
Prevention through risk management	Yes	No
Controlling severity of symptoms through drugs	Limited	Limited
Restoring functioning through drugs	Limited	No
Restoring functioning through physiotherapy	Yes	No
Occupational therapy to help patient to help themselves	Yes	No
Advice and help to enable patient to help themselves	Yes	Very limited
Advice and counselling to family carer	If necessary	Essential
Post-acute hospital care	Yes, where hospital treatment was required	Does not apply
Personal care service in own home	Yes, where symptoms severe but patient can remain at home	Yes when condition has become severe but patient can remain at home
Admission to long term residential care	In severe cases where rehabilitation unlikely and home care not possible	Yes unless family carer can provide extensive palliative care
End-of-life care	In severe cases only	Yes

Source: OECD (2005, p. 35).

## **Control of care subsidy and choice of provider**

Under current arrangements, public subsidies for aged care services are typically paid by the Australian Government directly to a limited number of service providers. In this supply-constrained system, many people who are assessed as in need of care have to join a queue and take a funded care ‘place’ when it becomes available.

The care that is provided is generally a ‘package’ (other than for HACC), and the extent to which this fits an individual’s care needs varies. This limited choice has led a number of analysts, as well as many participants to the inquiry, to call for reforms that provide subsidies to consumers rather than providers, as a means by which to promote a more consumer-directed approach to care.

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In a number of other areas of social policy there is a move away from traditional service-centred arrangements where providers and government officials decide what is best for care recipients towards giving people more choice and control. As discussed in chapter 4, older Australians generally value the opportunity to make choices about things that are important to them. At a time in their lives when they may be losing control over many aspects of their daily lives (because they require assistance with daily living activities), it is particularly important that they can exercise choice and maintain control over those aspects of their life where they can (see for example Langer and Rodin 1976). The importance of personal control was a key theme raised in submissions. A number of participants expressed frustration at not being able to influence care decisions under current arrangements (box 9.8).

**Box 9.8 Participants express frustration at their lack of control and choice**

Marjory Kobold:

I was very surprised, after working in aged care for 20 years and knowing how it all works, at how little I could influence 'the system' to effect changes to improve my father's care. (sub. 450, p. 2)

Dianne Beatty:

I, and others, regularly fail in our efforts to provide sensible answers to my father's reasonable questions about the reasons for the plethora of rules, individuals and agencies with whom we have to deal. ... they also are given little control or choice ... and don't understand service rules and rigidities which prevent them from choosing their most desired support. (sub. 413, p. 3)

Aged Care Crisis reported a comment it received:

Eating is one of the few pleasures left to some elderly folk and where are the inspectors at the vital times. Why should the residents be fed at 4pm so staff can go home and not cost extra in wages? Ask anyone if they eat their dinner at 4pm. (sub. 433, p. 37)

Tender Loving Cuisine:

Once we enter into our senior years we seem to lose the right to choose for ourselves. The elderly are often directed to certain goods and services usually provided by Government based care such as Home Care or Meals on Wheels. (sub. DR815, p. 2)

Law Institute of Victoria:

... the current residential aged care system offers consumers minimal choice, both in relation to the aged care facilities in which they live and in relation to the quality of their lives in residential care. (sub. DR897, p. 3)

Several participants argued that greater choice would be expected by consumers of aged care in the future, and that the system would need to respond to this expectation. CHA, for example, said:

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There is a need to change the current highly regulated arrangements for the provision of aged care services in response to the higher expectations of current and future generations for choice, responsiveness and flexibility in the way they use aged care services, including choice over what services they receive, which accredited provider delivers the services and where they are received. (sub. 1, p. 10)

A common point made was that a more consumer-directed approach to care would empower care recipients and informal care-givers. For example, the National Aged Care Alliance stated that there was a need for:

... funding for care and support services linked to each recipient so that the recipient and their family can determine how and where they receive their care and support, including the option to control how their funding entitlement is used. (sub. 88, p. 6)

Many participants also argued that a consumer-directed approach would introduce more flexibility into the system and result in more appropriate care for the individual. In this context, Pam Graudenz stated:

As the population of older persons increase ... the 'one size fits all' is not going to be appropriate. There will be a need for more personalised and individual responses to the requirement for care. (sub. 70, p. 1)

The Home Nursing Group noted:

In order to maintain their independence, older people require numerous different services in varying combinations at different times (e.g. home and garden maintenance, cleaning, meals, transport, medication checks/assistance, nursing care, etc.). This requires a flexible pool of funding available to buy different 'baskets' of care for different people at different times. It also needs to recognise that "caring for the carer" will often be very important to ensure there is no deterioration in the health status for either partner. (sub. 6, p. 1)

In submissions on the draft report, many participants commended the Commission on adopting a consumer choice approach.

However, there were a number of submissions that also highlighted the risks of moving to consumer directed care (CDC). Some argued that, on the basis of risks to frail and potentially vulnerable older people, a cautious approach was required, with an emphasis on a thorough assessment of a person's abilities to manage a care budget. In this regard, the National Foundation for Australian Women stated:

There should be some capacity in appropriate conditions for direct control methods to be allowed, subject to assessment of the suitability of the individual or the carer to manage such budgets efficiently. (sub. 95, p. 34)

Other participants argued that a range of supports is required to assist consumers in transitioning to a more choice-based system. For example, Carmel Laragy stated:

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My studies show that there needs to be information and support services available to inform choice and that adequate, but not overly intrusive review mechanisms are needed to ensure vulnerable people are not exploited or abused. Existing agencies need support to transition to individual service provision. Finally, more work is needed to understand how individual funding impacts on the workforce. (sub. DR818, p. 7)

Other submissions raised concerns about market power and attempts to gain greater market share by providers. For example, Anna Howe stated:

[Past findings suggest that] providers' interests in expanding greater choice of provider is driven in part by goals of increasing their share of service provision and funding, and that these interests may not always be the same as the interests of clients and their carers. (sub. 355, p. 3)

Other concerns raised included the scope for cost increases, the challenge of designing effective quality standards of care and whether entitlements for care would be appropriately spent.

Some participants focused on the limits of such an approach in regard to certain care levels or components of care. Several saw a greater opportunity to introduce choice for lower levels of basic support (such as community transport), but argued it would be inappropriate to provide greater choice at higher levels of personal and specialised care need due to the frail condition of people. Even for those higher levels, however, choice enables the older person to select a provider based on their cultural awareness, languages spoken, suitability of individual personal carers and timing of service delivery. Such choices enable older people to retain some control over their lives.

## **Assessment of issues**

The Commission considered a number of key issues around the possible benefits and risks of introducing greater consumer choice into aged care. As part of its consideration, it has paid particular regard to:

- international experience in providing greater consumer direction in aged care
- recent developments in enhancing choice in aged care and other sectors
- key design issues, including whether care entitlements would be provided in a CDC system via vouchers or cash
- possible supportive services to consumers in a CDC system (such as information, care advocacy and care planning)
- implications for the supply side, including the impacts on providers and on care infrastructure more generally, of a move to CDC.

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### Overseas reform experience

A number of OECD countries have sought to enhance choice in aged care by introducing consumer-directed initiatives (table 9.2). The experience in these countries has been previously discussed in PC (2008) and is also detailed in appendix D.

**Table 9.2 Personal budgets and consumer-directed employment of care assistants for eight OECD countries<sup>a</sup>**

<i>Country</i>	<i>Personal budgets and consumer-directed employment of care assistants</i>	<i>Payments to the person needing care who can spend it as she/he likes, but has to acquire sufficient care</i>
Austria		• Cash allowance for care
Germany		• Cash allowance for care
Luxembourg		• Cash allowance for care
Netherlands	• Personal budget for care and nursing	
Norway	• Care wage	
Sweden	• Carer's salary	• Attendance allowance
United Kingdom	• Direct payments	• Attendance allowance
United States	• Consumer-directed home care • Cash & counselling	

<sup>a</sup> Includes those countries that have experience with arrangements allowing users more choice and flexibility with regard to the way care is provided, and for which sufficient information was available.

Source: Lundsgaard (2005).

Some countries offer older people personal budgets which, in some instances, allow them to directly employ personal carers. Other countries have provided older people with personal budgets which they can spend as they like, as long as they acquire sufficient care.

Evaluations of such schemes (see, for example, Carlson et al. 2007 for the US; Miltenburg and Ramakers 1999 for the Netherlands; Witcher et al. 2000 for the UK) generally show that many participants report higher satisfaction with care arrangements and their lives more generally; and a reduced likelihood of unmet needs, care-related health problems and adverse events.

However, despite the well documented advantages, participation rates in CDC are typically lower than the traditional agency-directed alternatives (Lundsgaard 2005). While these low participation rates may raise questions about the broader applicability of such schemes, as the Commission has previously argued (PC 2008) it is important to understand that even a relatively small number of active consumers switching between alternative services can induce providers to improve

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services and encourage broader innovation and quality improvement (for example, by offering enabling or assistive technologies).

### *Recent developments in enhancing choice*

CDC has been used widely in Australia in other social service sectors, including disability and child care.

Enhanced choice through greater consumer involvement in the design and delivery of disability services has been a feature of services in this sector since the mid 1980s. The strengthened client focus in these services has sustained a range of consumer and/or family direct support programs over many years in a social policy area with a number of similarities to aged care. The disability services sectors in most states and territories now offer a variety of programs or trials designed to promote independence and choice (Laragy and Naughtin 2009).

Recent reforms of Australia's child care system have also enhanced consumer choice, and the sector now responds more freely to changes in demand instead of places being administratively allocated. Further, the range of eligible carers has widened to include grandparents, relatives, friends and nannies (FAO 2007).

Beyond these social policy areas, interest in improving consumer choice has been part of wider policy debates across other industries. In particular, from the mid 1990s, National Competition Policy reforms were partly directed at making Australia's infrastructure industries more responsive to changing consumer needs and preferences. For example, the removal of regulatory barriers and fixed pricing regimes in the electricity and telecommunications industries sharpened incentives that improved the quality of services and increased the uptake of new technologies (PC 2005c).

Greater consumer choice in aged care has also been proposed in the past, and there are some aspects of choice in the current system.

Previous reviews have supported the idea of linking subsidies in aged care directly to consumers. The Hogan residential aged care review (2004b), for example, discussed vouchers and cash entitlements as a means of enhancing consumer choice. The final report of the NHHRC also recommended that subsidies be more directly linked to people rather than places in aged care (NHHRC 2009, p. 22).

At present, there are more limited forms in which consumer choice applies in aged care. For example, the introduction of community care packages such as CACP, EACH and EACH-D allowed a limited number of older people to choose to be cared for at home rather than enter residential care. More recently, the Government announced the roll out of consumer-directed packaged care and consumer-directed



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respite care programs (box 9.9). These latter programs are focused on community care programs and have only limited applicability to residential care (focussed as they are mainly on respite). In announcing the rollout, the Government stated that an evaluation will be undertaken to explore the potential for implementing the CDC model more broadly across Australian Government community care programs (DoHA 2010f).

**Box 9.9      The current consumer-directed care trial**

In May 2010, the Australian Government commenced an application process for the funding of a limited number of consumer-directed care (CDC) packages and respite packages. Successful applicants for the packages were subsequently announced in mid 2010, with places initially allocated for a two year period (2010-11 and 2011-12).

A total of 500 (non-ongoing) CDC places were provided under the Innovative Pool Program as part of the trial. These align roughly with the community aged care programs that the Australian Government funds (CACP, EACH and EACH-D). A further 200 consumer-directed respite care places were also allocated in the first round with a focus on respite care provided under the National Respite for Carers Program.

The model adopted for the CDC packages is an individual budget based on a needs assessment and administered on the care recipient's behalf by an approved provider for an agreed percentage of the allocated budget. An individual budget will: be allocated to the care recipient; be based on a care recipient's needs as assessed by the packaged care provider and agreed with the care recipient; follow the care recipient's assessment by an ACAT, which determines eligibility for a specific level of packaged care (e.g. CACP); be held and administered by the packaged care provider for an amount agreed with the care recipient from the total budget; and be set for a one year period.

*Sources:* DoHA (2010f; 2010i).

*Design considerations*

There are several main design options through which a consumer-directed approach might be introduced into aged care. These include:

- an assessed person having an aged care entitlement and choosing from a range of approved providers to provide one or more of their services (perhaps with the assistance of an advocate or care coordinator funded by the Government)
- a voucher system where individuals choose an approved provider and negotiate a package of care that addresses their care needs
- a cash out option where people can take part or all of their assessed entitlement as cash and then purchase various services directly.

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As international experience shows, the design features of any consumer-directed approach are critical to uptake, quality of service, consumer protection and effectiveness.

### *Cashing out an entitlement?*

Of the three broad approaches, the Commission has most concerns about a *fully* ‘cashed out’ system, where individuals receive a subsidy via ‘cash’ and can determine to expend it in full in any way they see fit. Concerns include the possibility that individuals would underestimate the amount of their entitlement they would need to spend on care; and possible abuse of the funds by carers and relatives. A full cash out option in aged care would, in the Commission’s view, be unlikely to be taken up by a majority of consumers initially.

However, under the revised arrangements, some small cashed out element for incidental expenses or some specific elements of care may warrant further consideration. For example, in responding to the draft report, a number of participants identified respite services as a particular area where the expanded use of an entitlement in cash form may be appropriate. Alzheimer’s Australia suggested:

Conducting a trial of a cash option for both care and respite which could be modelled on the Commission’s proposals for the disability sector. (sub. DR656, p. 6)

COTA Australia stated:

... we are now proposing that carers should have the option to cash out their entitlement to respite and use the money to purchase services from a greater variety of people. We know many carers identify respite as a key service but then don’t use it and we think the ability to cash it out and source their own service would increase the take up. (sub. DR565, p. 5)

This could be of particular use for people with dementia and their carers, but would also have a broader applicability.

Further consideration of more flexible arrangements for respite, possibly through cashing out and/or via an approach which widened the range of people who could be registered to provide respite, would appear to have merit. One option would be to conduct an expanded trial of these and other possible variations for some respite services and to assess feedback from participants prior to their general introduction.

Any expanded introduction of CDC would also need to have flexible arrangements in place so that consumers could choose to entrust their care to a single provider. This would ensure that older people who did not want to be directly involved in

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organising their services from several sources could take their entitlement to a single approved provider and receive their approved services.

Monitoring of quality of service would be a further vital consumer safeguard. The nature of this function is described in more detail in chapters 10 and 15.

RECOMMENDATION 9.3

***A trial of more flexible arrangements for respite care, such as cashing out for respite services and extending the range of registered individuals who can be approved to provide respite, should be conducted as part of a broader introduction of an entitlement based approach to care services.***

*The role of support services (information, care advocacy and planning)*

The provision of relevant, current and accurate information will be critical in supporting greater consumer choice. Older people will require information on available services, alternative providers, quality outcomes and sources of further assistance. The reforms to information provision proposed by the Commission will assist in providing an accessible set of regionally-based information with which to inform choice.

Nevertheless, consumers may also require additional assistance to navigate the system and to plan their care needs. There are two different responses required. One is the provision of care coordination and/or case management services, as discussed earlier, and the second is the provision of care advocates who represent the interests of the consumer.

In relation to care or consumer advocacy, much advocacy for the care recipient is undertaken by informal carers and family members. Nevertheless, there is a need for a more formal system of advocates independent of carers and family members.

The Aged-Care Rights Service stated:

An advocate is someone who stands beside a person and works solely on their behalf and at their direction. An advocate listens to their concerns, provides information and speaks on behalf of the person if that is what they want. Before taking any action, the advocate always seeks the person's permission. (sub. 322, p. 1)

A number of submissions called for a system that built on existing publicly funded programs, such as the National Aged Care Advocacy Program, but with greater funding of these functions and wider availability.

The Commission acknowledges the importance of care advocacy functions in a system with greater choice, particularly in relation to vulnerable consumers. A

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balance would need to be struck in the proposed system between the need for adequate consumer support and the cost of any expanded publicly funded system of provision for advocacy. Nevertheless, this would appear to be a necessary precondition of any adequately regulated system involving greater consumer direction. Further detail on the proposed advocacy arrangements is provided in chapter 15.

### **The Commission's model of care and support in greater detail**

The Commission's reformed model of care and support services seeks to provide greater continuity of care and empower older people to exercise greater choice. To achieve this, it is particularly necessary to move away from the current rigidly defined and discrete care packages (CACP, EACH and EACH-D). While the various main community and residential care programs are the result of considerable innovation historically, and have in many respects performed well in meeting the needs of clients, problems remain in terms of service gaps and inconsistencies of funding levels and eligibility criteria (chapter 5).

A large number of submissions commented on the adverse effects these gaps have on care continuity and choice. For example, Blake Dawson stated:

Our clients commonly raise concerns that the current distinction between low care CACPs and the high care EACH and EACH-D packages do not provide for a seamless transition from one kind of care services to the next for older Australians. (sub. 465, p. 28)

Hal Kendig called for reforms to remove service gaps, stating that a key priority:

... is to develop a single, integrated care funding program after review of HACC services, Commonwealth packages and carer support, and the care component of current residential care programs. The aim would be to overcome the fragmentation, gaps, and inconsistencies of current programs that have evolved in an incremental, opportunistic way. A single, integrated care and carer support funding program would increase the capacity to deliver flexible, effective support in whatever ways are most appropriate for communities and individuals. (sub. 431, p. 6)

Many other submissions made similar observations about the need for a single, integrated and flexible system of care provision that applies equally in community and residential settings.

The reforms to assessment processes and to broader eligibility and funding arrangements outlined in this report will go some way towards improving consistency across programs. However, the Commission's view is that these should be accompanied by a move away from a focus on discrete care 'packages' to an emphasis on a more unified, seamless approach.

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Such an approach does not preclude the development of more multi layered levels of service entitlements for community care (to recognise short term fluctuations in actual hours of care required) but they would need to be closely aligned to the assessed needs of care recipients as described in this report. The current approach leaves too many gaps and discontinuities as a person moves from low level needs to more complex care requirements.

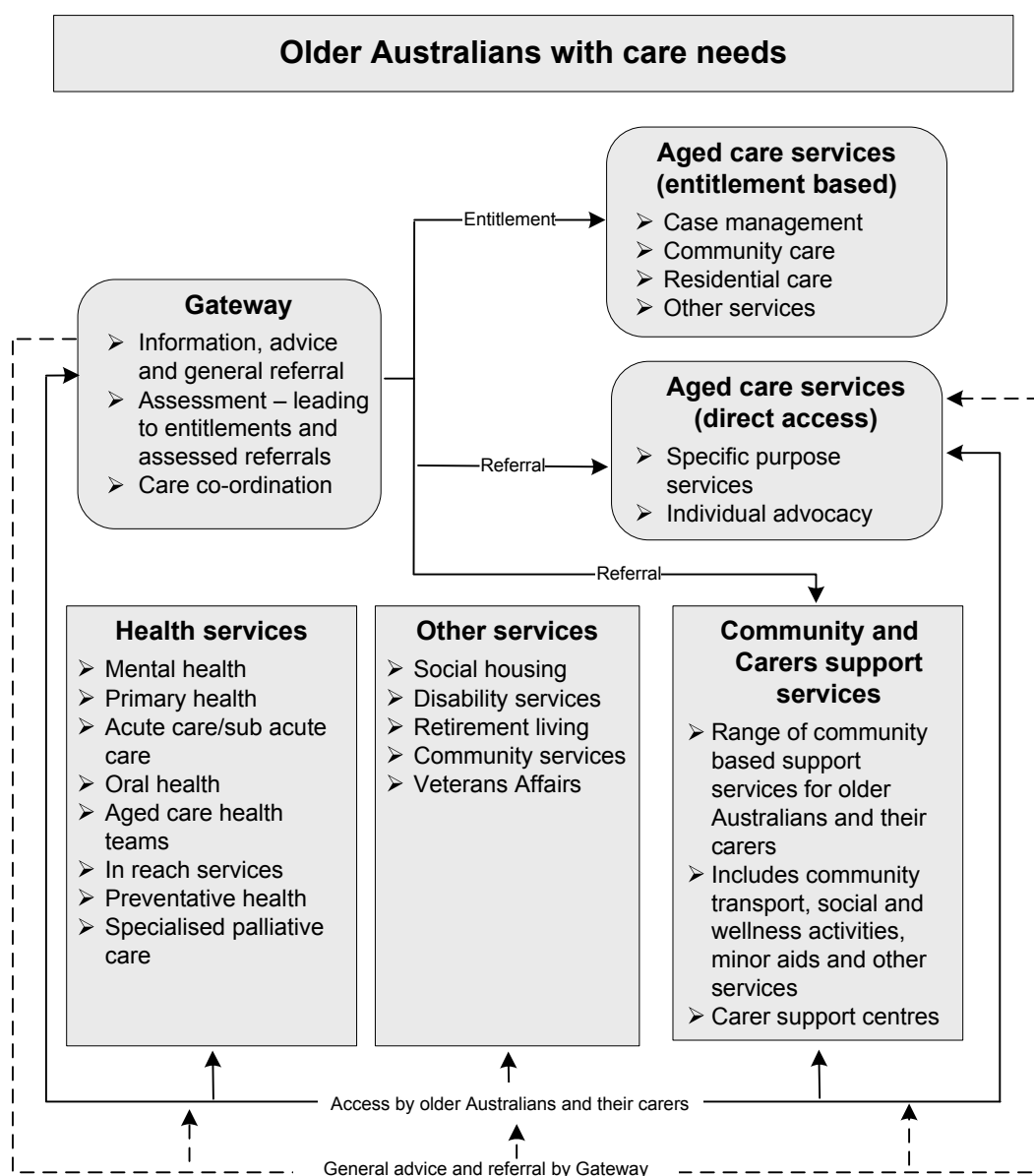
### *Revised arrangements for accessing services*

Under the Commission's proposed system, there would be a distinction between Australian Government subsidised aged care services (the Australian Aged Care System) and community and carers support services (figure 9.6).

The Gateway would be the access point for the majority, but not all, of the formal care services (figure 9.5). These would be accessed largely on an entitlement basis and targeted to people with more complex care needs.

In making an assessment of entitlements, the Gateway would take into account the services that the older person already has access to, including informal care services. The entitlement provided to consumers as part of the Gateway assessment process should include a detailed statement of the care assessment, the care objectives, the type and intensity of services to meet those objectives, the total value of the entitlement, and the period of the entitlement. The value of the entitlement could be expressed as being at a particular level of entitlement with a set price point, together with any supplements. The value of the care entitlement would be paid for through a care co-contribution and a subsidy. An assessment of a person's capacity to pay would be made to determine their rate of co-contribution which would be applied to all entitlement services up to a lifetime (indexed) stop-loss level, beyond which no co-contribution would be required. Drawing on current arrangements, care entitlements across both residential and community settings would be based on a comprehensive aged care funding instrument.

**Figure 9.5 Access pathways for services for older Australians and their carers**



There would be a limited range of specific purpose services that will be directly accessible by older Australians and their carers or via a referral or an entitlement from the Gateway (box 9.10). While some of these services, such as individual advocacy and care for the homeless in dedicated facilities, would receive a level of block funding from the Australian Government, and many would receive funding support from other levels of government, many would also be partly funded by co-contributions.

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**Box 9.10 Services covered under the different categories**

*Aged Care Services only accessible through the Gateway assessment and entitlement process would include the following*

- Personal and domestic care provided for older people who are no longer able to undertake some of the activities of daily living, and are unable to access these services through other arrangements. This includes feeding and routine medication, showering and dressing and light domestic activities such as cleaning.
- Health and nursing care provided to address health issues such as wound management, medication management, and preventive health care.
- Case management services, provided to those people who need assistance in planning and managing the services required to meet their age related needs. Case management, as defined by Case Management Australia, is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes.
- Reablement services, provided to improve the capacity of the person to undertake activities of daily living, such as through occupational therapy and physiotherapy support to allow greater independence and can include assessing client's needs with the aim of lessening dependence on long term supports.
- Major aids and appliances required to enable a person to function. These would include respirators and oxygen, but not include mobility aids.
- Planned respite, including both day and residential care services that can be offered in the home or at a respite centre to provide carers with a break from their caring responsibilities.
- Palliative and end-of-life care.
- Home modification services provided to enable a person to stay in their own home where their home is assessed as otherwise meeting their foreseeable needs. This would include the installation of ramps and hand rails but not major renovations.
- Residential aged care services provided (with the exception of home modification and planned community respite) in a residential aged care facility.

*Aged Care Services which can be accessed through the Gateway or directly*

- Specific needs services that provide integrated aged services for particular client groups who would otherwise find it difficult to access appropriate aged care services. This includes specific services for homeless older people and Indigenous flexible care services. Gateway assessment will be needed for care beyond 12 weeks.

(Continued on next page)

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**Box 9.10 (continued)**

- Transitional care services, which are time limited services available to people after an acute episode to restore the person's capacity to function in the community. The assessment will be made by the service and provided to the Gateway, with the person referred to the Gateway if they continue to have care needs beyond the period of transitional care.
- Individual care advocacy services providing independent representation to protect people's rights and to seek redress within the aged care system.

*Community Support Services which can be accessed directly or by the Gateway providing an entitlement or general referral would include:*

- Information and general advocacy services providing systemic and local information on the Gateway, Aged Care System, aged care providers and on community support services. Such services may be provided by local community organisations or community service agencies that cater to specific groups in the community such as CALD, GLBTI and Disability specific groups, support groups for people living with dementia, HIV and mental illness, and carers.
- Social activity programs that provide social engagements for older Australians in community settings.
- Wellness programs which aim to improve the health of older Australians such as exercise programs, dietary and lifestyle advice sessions.
- Day therapy programs which are centre based programs targeted to address needs of older people for specific types of activity involving allied health workers.
- Community transport which provides transport for older Australians to medical and other health related appointments, for shopping and conducting business activities and for social activities.
- Meals delivery including home delivered meals for short term needs eg arising from a return from hospital or rehabilitation, or longer term needs due to the loss of capacity or carer. While initially this service would be directly accessible, people receiving home delivered service for greater than 12 weeks would be referred to the Gateway for an assessment.
- Home maintenance services which allow a person to remain safely in their home by undertaking minor repairs and maintenance that the person can no longer undertake themselves, or assistance with organising such services.

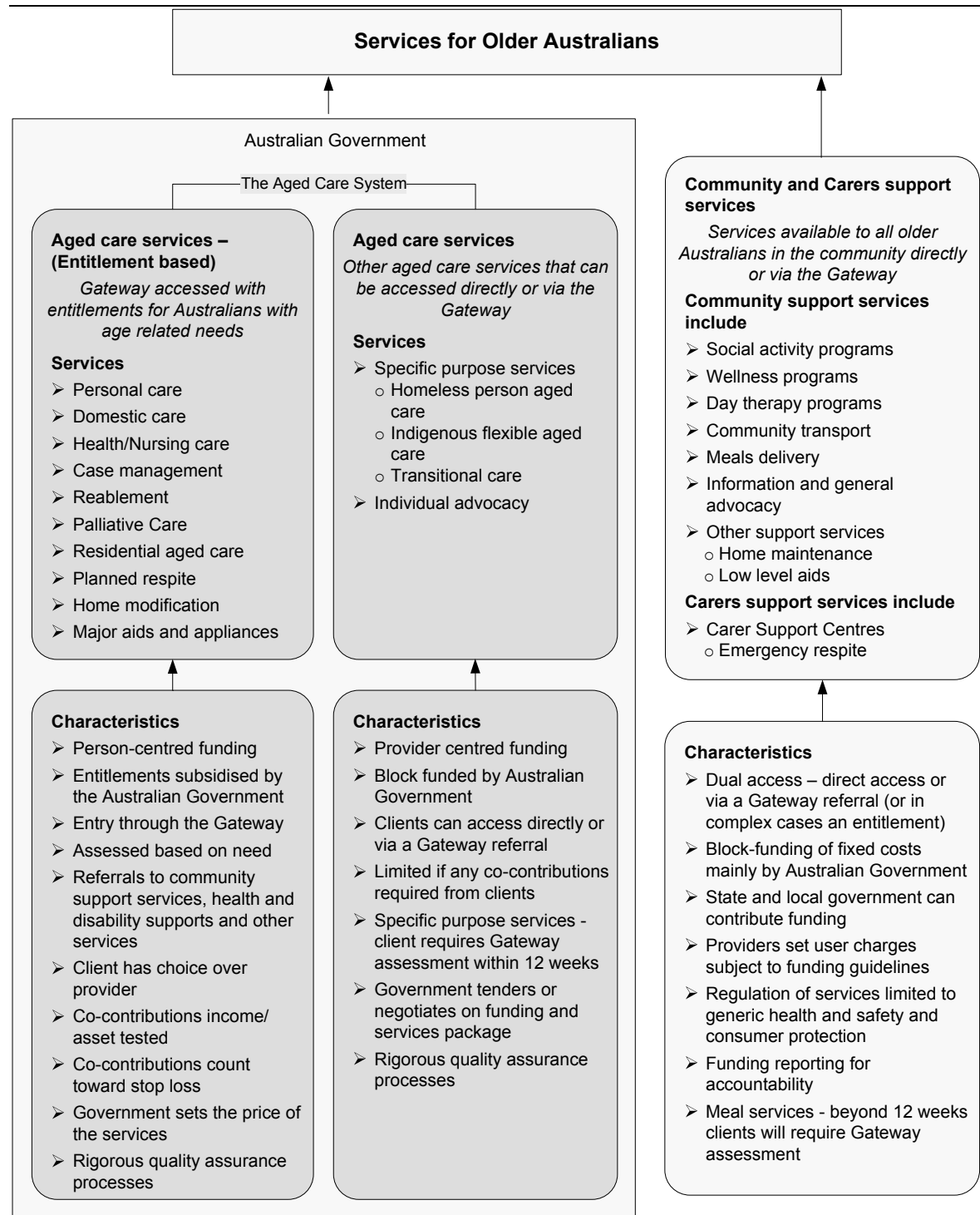
*Carer Support Services which can be accessed through the Gateway or directly include:*

- Carer Support Centres providing services such as carer counselling, training and education and peer support and emergency or unplanned respite.
- Additional carer supports that are provided through other community service providers and support groups, including Carers Associations.



Older Australians with less complex needs would also be able to access community support services (such as social activities, community transport, home delivered meals) either directly or the Gateway could offer general advice and referral (figure 9.6).

Figure 9.6 The structure of the wider system of support for older



**Characteristics**

- Person-centred funding
- Entitlements subsidised by the Australian Government
- Entry through the Gateway
- Assessed based on need
- Referrals to community support services, health and disability supports and other services
- Client has choice over provider
- Co-contributions income/asset tested
- Co-contributions count toward stop loss
- Government sets the price of the services
- Rigorous quality assurance processes

**Characteristics**

- Provider centred funding
- Block funded by Australian Government
- Clients can access directly or via a Gateway referral
- Limited if any co-contributions required from clients
- Specific purpose services - client requires Gateway assessment within 12 weeks
- Government tenders or negotiates on funding and services package
- Rigorous quality assurance processes

**Characteristics**

- Dual access – direct access or via a Gateway referral (or in complex cases an entitlement)
- Block-funding of fixed costs mainly by Australian Government
- State and local government can contribute funding
- Providers set user charges subject to funding guidelines
- Regulation of services limited to generic health and safety and consumer protection
- Funding reporting for accountability
- Meal services - beyond 12 weeks clients will require Gateway assessment

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If the Gateway assessed that one or more of these services were an essential part of aged care services to meet complex needs, it could include them in the entitlement that could be taken to community support service providers.

These services would receive some block funding from the Australian Government (with many being existing HACC services), but would also receive entitlement funding, funding from state and territory and local governments, user charges and public donations. Carer support services would be similarly funded and accessible directly or via an entitlement from the Gateway. User charges for community and carers support services would not count toward the aged care lifetime stop-loss provision.

An important element in the proposed scheme would be that older people would be able to seek a review of their assessment if not satisfied or at any time seek a reassessment of their needs which could result in changes to their level of entitlement. Sometimes, such a reassessment could lead to a lessening of services where a person's needs have reduced such as after a period of reablement. In residential aged care facilities more ongoing reassessment will be undertaken by providers subject to appropriate validation and audit oversight.

#### *Arrangements for special needs clients and rural and remote areas*

There are some older Australians who find it difficult to access suitable services (such as homeless people and some Indigenous people) and for whom special purpose service models are required. For such client groups a service provider centred approach is more suitable. These services would be available directly to the older person but with the aid of the service provider. People receiving these services would require a Gateway assessment within three months of the commencement of the service. As the capacity to make co-contributions for the clients of these groups is likely to be minimal, there would be no co-contribution for this three month period. Beyond this, clients would be subject to the same co-contribution tests as other older Australians.

Where it is not financially viable for providers to establish services because of uncertainty and volatility in client numbers, the Australian Government will need to provide a base level of block funding to ensure that services are available, such as in smaller regional communities. This would apply to the aged care component of *regional or remotely based* multi purpose services. There are numerous models but generally they combine or co-locate health and aged services in small communities. The Commission is more supportive of the models which are driven by aged care than by the public health system. Aged care clients could access these services but

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would require a Gateway assessment upon entry and would be required to pay co-contributions as assessed.

Where the operating costs of service delivery for some special needs clients or in particular locations (such as rural and remote areas) are significantly higher, a subsidy supplement may be appropriate. Such supplements, where deemed necessary by Government to ensure sustainable access to services, should be set at a level which covers the efficient supply of services by providers.

RECOMMENDATION 9.4

***The Australian Government should replace the current system of discrete care packages across community and residential care with a single integrated, and flexible, system of care entitlements (the Aged Care System). The System would have the following features:***

- ***it would cover services including residential care, community care (domestic, personal, nursing), reablement, planned respite, home modification, palliative care, high level aids and equipment, and care coordination***
- ***the Australian Government should approve a schedule of aged care services to be provided to individuals on an entitlement basis, according to the Gateway's assessment of their need. Individuals should be given an option to choose an approved provider or providers***
- ***the entitlement provided to consumers as part of the Gateway assessment process should include a detailed statement of the care assessment, the care objectives, the type and intensity of services to meet those objectives, the total value of the entitlement, and the period of the entitlement. In addition the consumer would receive a statement of their co-contribution obligation***
- ***the Australian Government would set the scheduled price of approved services based on a transparent recommendation by the Australian Aged Care Commission***
- ***the Australian Government should fund an expanded system of aged care individual advocacy by initially expanding funding and access to advocacy under the National Aged Care Advocacy Program.***

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*The Australian Government should also support a range of community support services which would be directly accessible by older Australians and their carers and through the Gateway. Such community support services would include funding from the Australian Government (including, for example, block funding for infrastructure and overheads) as well as user charges and financial and in-kind support from state, territory and local governments and the community. For some community services, where a person requires long term support, an assessment from the Gateway may be required.*

### **9.3 Associated reforms**

There are several further reforms that, in the Commission's view, are essential to secure a more continuous care system. These include:

- delivery of care across different forms of accommodation
- improvements to the interface between the aged care and the health and disability systems.

#### **Delivery of care across different forms of accommodation**

Home and community care services play a major role in allowing older Australians to remain living in their own accommodation (ACG 2007, p. 14). Sandra Hills, CEO of Benetas, stated:

If there is a lack of adequate care services available or people don't have their own social supports then the reality is that people often have no option but to move into residential care. (Aged Care INsite 2010, p. xx)

The provision of such care is a policy goal widely endorsed by the sector (NACA 2009, p. 4). Similarly, the sector is of the view that such care should be generally available to those in need of it, regardless of their type of housing:

Where older Australians require support or care, they will: have access to services in their own communities and homes ... [so that] Most people will receive care and support in their own homes, whether that is a 'family home' of long standing, or a retirement village, community or publicly owned housing, or a private dwelling chosen by people as their own later life housing option. (NACA 2009, p. 5)

However, some inquiry participants highlighted barriers which prevent care being delivered in certain types of accommodation: a situation which prevents some Australians wishing to age in their homes from doing so.

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Lend Lease Primelife (sub. 76, p. 6) noted that the highly regulated supply of subsidised care packages means that retirement village residents do not get the same access to care services as those in residential care homes. Referring to this problem, CHA (sub. 1, p. 3) noted that reforms are needed to ensure ‘... access for all in need of care regardless of ... where they live’ and suggested the solution lay in:

Aligning care fees and subsidies for people receiving care in their own home with those applying in residential care for people with similar care needs in order to allow fair and equitable choice.

ECH, Eldercare and Resthaven (sub. 100, p. 4) also argued for the need to align care fees and funding across residential and community care such that they are not linked to accommodation, and that the funding be portable across residential and community care to enable two-way movement between the client’s preferred housing location.

National Disability Services (sub. 102, p. 7) drew attention to policy barriers to appropriate support that can distort older Australian’s choice of accommodation. It referred to research (NDS 2009) that identified a range of barriers, such as community aged care packages not being available to group home residents and the variable access to services for people living in different accommodation types.

Barriers such as these limit the ability of some older Australians requiring care from continuing to live in their current housing. This situation is inequitable and, to the extent that it forces them to move into residential aged care (or hospitals) where care delivery costs are higher, it is also inefficient and costly.

Where possible, access to care services should be neutral with regard to the type of accommodation in order to not distort the accommodation choice of older Australians or the efficient delivery of care.

The Commission proposes an orderly phasing out of supply restrictions over a period of five years (chapters 7 and 17). The primary aim of this reform is for older Australian’s who have assessed entitlements to care services to be able to choose between competing approved providers.

A second benefit of the reform is that it would allow care services to be delivered widely in all types of accommodation, subject to appropriate co-contributions. Where care delivery would be significantly more costly because of the attributes of the accommodation and its location, it would be reasonable to limit its provision. In the case of community care, for example, subsidised costs would be subject to a maximum limit (broadly equivalent to a current EACH-D package), with any care beyond that (such as 24 hour home nursing) being the responsibility of the client if they wish to remain in the community.

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*As proposed in chapter 7, the Australian Government should remove quantity restrictions on care services. This would allow services to be delivered widely in the accommodation of choice of the clients.*

## **Improvements to the interface between aged care and health**

A large number of participants highlighted problems with the interface between the aged care and health care systems. This was seen as a key factor in preventing older Australians from receiving appropriate and seamless care. For example, in its submission, COTA Australia noted:

... the interfaces between aged support and care and the health system often work poorly and sometimes to the severe detriment of older people (sub. 337, p. 41).

Many submissions argued that the lack of coordination between health and aged care leads to inappropriate or avoidable care and admissions to hospital. For example, Blake Dawson (sub. 465, p. 23) stated that poor coordination leads to inefficiency because of overlapping and duplicated services and gaps in service provision, resulting in older Australians not receiving services they need.

United Care Ageing (NSW) stated:

... the administrative and bureaucratic structures within which these services are provided differ, and the degree to which they are coordinated is very uneven. The result is that interventions that could be efficiently carried out in an aged care setting — for instance, for rehabilitation — are often carried out at what seems to be far higher cost in the health system (sub. 369, p. 17).

HammondCare also noted:

The inefficiency and cost of moving residents between residential aged care and the providers of sub-acute services is significant (sub. 168, p. 2).

In the case of medication management, the Aged Care Association of Australia noted:

... the inefficient systems used to administer medications result in aged care staff, GPs and pharmacists spending considerable time and effort on prescription writing, (including chasing new prescriptions when the current ones expire), owing prescriptions and double handling of excessive paperwork. Clearly this is an area for potential and significant productivity improvement for all three stakeholder groups. (sub. 291, p. 25)

There is considerable scope to increase the efficiency of these interacting systems through the use of information technology, such as the e-Health initiative (including e-prescriptions and e-transactions), that allows information to be shared and

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accessed in an efficient but safe way. The introduction of aged care electronic records was advocated earlier in this chapter.

Some inquiry participants argued that providers are constrained from introducing technology because they cannot access the capital and recurrent funding to do so. Manor Court Werribee Aged Care Ltd, for example, noted:

We are reliably informed that the Aged Care sector has one of the lowest levels of investment in IT & technology, of any of the industry sectors in the country. Why is this the case? The answer is pretty simple.

- The providers cannot find the capital cost for the investment
- The providers can't find the recurrent funding to implement systems, and train staff. (sub. DR529, p. 4)

The Commission's proposed reforms will increase the level of funding for aged care providers (e.g. increase the level of government subsidies on the basis of the real cost of providing services) which should, in turn, provide greater incentives to increase the uptake of technology in the sector.

Participants argued that it has been increasingly difficult to find general practitioners who are willing to visit residential facilities and make home visits to community care recipients. ACAA stated:

It is generally recognised that securing sufficient GPs to visit aged care residents is problematic in many parts of the country.

There are a variety of problems ranging from small client numbers, poor remuneration, lack of consultation facilities, lack of GP confidence in treating the very old and lack of coordination of consultation times. (sub. 291, p. 23)

These issues are discussed in further detail in chapter 10.

### *Recent and further possible reforms*

In 2009, the NHHRC proposed reforms to the hospital system that will have the effect of increasing the demand for aged care resources. These reforms, which were subsequently agreed to by COAG (2010b), aim to reduce the extent to which hospitals provide care to older people that could be provided more appropriately in individuals' homes and residential aged care centres. Elements of the reform agenda include:

- facilitating greater access to primary health care providers and geriatricians for residents of aged care homes (NHHRC 2009, p. 23, recommendation 52)

- strengthening access to specialist palliative care services for all relevant patients across a range of settings, with a special emphasis on people living in residential aged care (NHHRC 2009, p. 23, recommendation 55).

The benefits of improved coordination between the sectors are likely to be significant. For example, HammondCare stated that an acute hospital bed in NSW costed \$1223 per day compared with a HammondCare sub-acute hospital bed between \$650 and \$900 and an aged care bed around \$160 — a substantial difference as illustrated in table 9.3.

**Table 9.3 Acute care and aged care access and cost**

	<i>Hospitals and primary care</i>	<i>Aged care</i>
Access to entry	Relatively easy	Relatively difficult
Cost to government	Higher cost (uncapped)	Lower cost (capped)
Cost to private health insurers	Private health insurance coverage	No private health insurance
Services offered	Accident and emergency Acute care Sub acute care Other primary health care	Residential care Community care

*Source:* HammondCare (sub. 168, p. 3).

In addition to direct cost savings to the health budget, other benefits include:

- improved wellbeing of residents not having to move frequently between residential and acute care (and benefits to partners and others)
- an increased capacity for residential facilities to deliver higher level services, with attendant benefits to staff from higher skill sets and a wider scope of practice
- synergies for other residents from the proximate delivery of sub acute services
- an additional revenue stream to residential providers, diversifying their risks.

The use of electronic medical records, improved discharge statements from hospitals and the transfer of advanced care plans would improve the coordination of care between the two sectors.

Improved coordination will go some way to increasing the scope for sub acute services to be provided in residential settings. The proposals outlined in this report, which increase the flexibility of the aged care sector, reduce the burdens of regulation, encourage innovation, and establish a sustainable funding regime, will also assist to build momentum in this direction.



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A further reform that would, in the Commission’s view, have merit in this context is the expanded use of multi-disciplinary teams (so-called in-reach teams) that are able to provide services to residential aged care facilities. Several submissions discussed positive outcomes from the use of these teams, which are generally run out of state and territory administered hospital emergency departments. For example, VincentCare stated:

... we have found a particular pilot program which has now received ongoing funding, to be of benefit. “In-Reach” covering inner Melbourne and “Out-Reach” covering outer metropolitan region is a program which provides a specialised medical advice service which has assisted facilities by minimising the transfer of residents into hospital ... The In-Reach/Out-Reach model has eradicated previous issues such as residents being discharged without a phone call to the facility, being returned without transfer information and requiring the facility to spend considerable time chasing up relevant information on behalf of the resident. (sub. 258, p. 21)

General Practice Victoria stated that:

The (In-Reach) service ... has been positively received by nursing homes, GPs and hospitals. (sub. 235, p. 5)

The use of such teams has been trialled in limited form in Victoria (box 9.11) and internationally has also been used in Canada and the UK (see, for example, Sczepura et al. 2008).

The Commission believes there are significant benefits in the expansion of in-reach services and the development of regionally based multi-disciplinary aged care health teams. Such teams would better utilise the professional health workforce, create a more responsive health service and develop professional expertise in the area of care for older people. They could provide not only services to older people in residential care facilities, but also to those living in the community. Expansion of these approaches should be actively undertaken by all levels of government where evaluations prove that the net benefits are as significant as initial indications appear. The design of such programs should ensure that they do not substitute for the ongoing responsibilities of residential and community care providers.

RECOMMENDATION 9.5

***The Australian, state and territory governments should promote the expanded use of in-reach services to residential aged care facilities and the development of regionally or locally-based visiting multi-disciplinary health care teams (including from oral and mental health disciplines and dementia care specialists as appropriate).***

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### Box 9.11 **Clinical in-reach pilots in Victoria**

The residential aged care clinical in-reach pilots were developed as part of the Victorian Department of Human Service's Winter Demand Strategy 2008. The aim of the in-reach pilots was to reduce the need for transfer of aged care residents to an emergency department if safe and appropriate care could be provided in their own home.

Each health service was given the flexibility to develop a program that accommodated existing strengths and capabilities and built on an existing service to utilise resources already available in the health service. Wide ranging, positive feedback from health services led to the extension of the pilots to run all year round and nine metropolitan and three regional health services were running the pilots in mid 2009.

An external evaluation of the pilots was completed in mid 2009. The evaluation found that the in-reach pilots met their main objective of assisting to avoid unnecessary travel of older patients to a hospital facility, were well regarded, accessible and met referrer (Residential Aged Care Services, General Practitioners and Ambulance Victoria) and hospital requirements.

*Sources:* DHS (2009); Larkins et al. (2009).

### *The role of sub-acute and transitional care*

Further key areas where the interface between health and aged care can be improved are sub-acute and transitional care.

Sub-acute care involves the delivery of a wide range of services (such as high level palliative care, pain and wound management), and this may be increasingly feasible in many residential facilities and in the community. In supporting the increased delivery of these services in residential care, Wayne Belcher coined the term aged care hospital:

An aged care hospital service is generally more intensive than traditional nursing home (high care) but less than acute (hospital) care. It requires frequent (daily to weekly) recurrent patient assessment and review of the clinical course and treatment plan for a limited (several days to several months) time period, until the condition is stabilised or a predetermined treatment course is completed. (sub. DR759, p. 24)

KinCare argued that community delivery of such services was also increasingly feasible. It stated:

There should be an expectation that an increasing range of health services will be provided in the community and appropriate funding mechanisms to achieve this. Aged care services should become an alternative to services presently only funded in hospitals. Community care can become an alternative to hospital infrastructure in some circumstances in the same way it has become a strong alternative to residential aged care for many clients. (sub. DR896, p. 1)

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As discussed above, sub-acute care provided in residential aged care facilities and the community may, in many cases, be far less costly than the equivalent service provided in a hospital setting.

Transitional care assists older people, following an acute care episode, with treatment in the home or like environment. Examples of low intensity therapy services provided via transitional care include: physiotherapy; occupational therapy; dietetics; podiatry; speech therapy; counselling; and social work. Personal care services may include assistance with showering, dressing, eating and eating aids, managing incontinence, transport to appointments, moving, walking, and communication (DoHA 2009i).

The Commission's proposed reforms in this and other chapters would considerably enhance the flexibility of care delivery in residential, community and other age friendly settings. In particular, they may allow improved access for consumers to flexible aged care services, including sub-acute and transitional services that are better integrated with local health services. They will also assist providers in delivering a more flexible range of such service offerings, and diversify their client and revenue bases.

To further assist this process, the fees paid to approved service providers for delivering sub-acute services should be sufficient to encourage their provision. These fees should be cost reflective, and should as a general rule be set at lower levels than those for an equivalent service provided in a hospital setting.

RECOMMENDATION 9.6

***The Australian Government should set scheduled fees for the delivery of certain sub-acute services that are delivered in a residential aged care facility. These fees should be cost reflective and, in general, lower than the scheduled fee for the equivalent service provided in a hospital.***

## **Interface with the disability sector**

Concurrent with this inquiry, the Commission is undertaking an inquiry into disability care and support. That inquiry is scheduled to deliver its final report to the Australian Government in July 2011.

The Commission received several submissions advocating an integrated system covering both disability and aged care. For example, Pam Webster wrote:

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Should Australia have an ‘aged care system’ as currently conceived, or could a broader conception of care and disability policy be more appropriate, with the needs of the aged being one part of this continuum?

I believe the two Inquiries need to work together and look carefully at the benefits of developing an integrated system that will meet the needs of all Australians no matter when, at what age or how they develop the need for care and support (sub. 178, p. 1).

While both the aged care and disability sectors provide support for people with disability, there are significant variations in the philosophies and goals in each sector, the services that people use and their aspirations. Further, while the probability of acquiring a disability is low, this is not the case for aged care. Many people who live long enough can expect to require some level of assistance. The majority of those who use aged care services have had previous employment, have owned a home and are now retired. Many people with a disability aspire to joining, or rejoining, the workforce.

The Commission is particularly aware that many more people with disabilities are living longer, whilst many young people acquire disabilities previously associated with ageing.

*Irrespective of the funding source or assessment arrangements, all people with a disability and all older people needing care and support should receive services appropriate to their needs, on a fair and equitable basis.*

People with disabilities should receive services from providers best skilled to meet their needs, however funded. So, for example, a person with a severe long term disability, such as multiple sclerosis, may be best served by specialist disability service providers to the end-of-life. On the other hand, people who experience younger onset of disabilities normally associated with ageing, such as severe dementia, might be best served by providers skilled in the support of older Australians.

### *Interface with the proposed NDIS*

The Commission’s current inquiry into disability care and support has, in its draft report, proposed the establishment of a national disability insurance scheme (NDIS) for eligible individuals. Arrangements should be in place in the NDIS (and broader disability care system for non eligible individuals) and aged care system such that individuals receive an adequate level of care and support.

Many people who acquired their disability earlier in life are concerned that, as they age, they may fall between the cracks of two systems. They want to preserve the continuity of their support arrangements and the adequacy of funding. For example,

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many people want the capacity to stay in their own homes (say a group home), to stay with the support workers they like and to use the service providers that best meets their needs, regardless of the system that accredits these providers.

The Australian Government has already committed to funding the disability support needs of such people under the National Health and Hospital Network Agreement (NHHNA) (COAG 2010b). It has agreed to funding specialist disability services provided under the National Disability Agreement for people aged 65 years and over (50 years and over for Indigenous Australians). Meeting this agreement is already factored into the Australian Government's budget commitments, and so lies outside consideration of funding for the NDIS.

That nevertheless leaves the practical issue of achieving continuity of care as people with disabilities age. The Commission proposes that, upon reaching the pension age or 50 years of age for Indigenous people (and at any time thereafter), the person with the disability could elect to stay with the NDIS or move to the aged care system.

- If a person elected to move to the aged care system, then they would be governed by all of the support arrangements of that system, including its processes (such as assessment and case management approaches).
- If a person elected to stay with the NDIS service arrangements, their support arrangements would continue as before, including any arrangements with disability support organisations, their group accommodation, their local area coordinator, or their use of self-directed funding. The NDIS approach to assessment would be used to determine their entitlements
- If a person over the pension age required long term residential aged care then they would move into the aged care system to receive that support, regardless of the age at which they acquired their disability.

For younger people with disabilities should they require access to aged care services then their costs of aged care and accommodation will be met by the disability care system (including where eligible, the NDIS).

#### *Further supporting arrangements*

These proposed interface arrangements would be supported by a number of other key measures.

For individuals requiring *aids and appliances* in the aged care system, and as outlined above, major aids and appliances may be funded by an entitlement for use. Low levels aids would continue to be available through community support

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agencies or purchased from the market. Disability specific agencies could continue to supply aids and equipment in both circumstances together with other community or private agencies.

In regard to *price setting*, the Australian Aged Care Commission (AACC) will recommend to the Government a schedule of prices for aged care subsidies and for the supported resident accommodation payment. The AACC and the NDIS price setting agency would maintain close links to not only share analysis, but ensure consistency of prices for similar services.

While the *assessment tools* and methods will vary between the NDIS and aged care systems, the two agencies responsible for assessment in either system would sign a Memorandum of Understanding and exchange information. The regulatory agencies in both aged care and the NDIS would also agree to ensure consistency in approach, and to discuss standards. There would be data exchange between the agencies and systems. An approved provider in the NDIS would have an almost automatic status as an approved provider in aged care (and vice versa) via mutual recognition.

Some young people with disabilities will be using aged care services. So long as they meet the criteria for NDIS funding, the NDIS would pay the full cost of their “aged care services”. If a person was not eligible for NDIS supports, the person could receive aged care services once assessed by the Gateway agency, being regarded as a person with an age related condition. If receiving services under the aged care system, the person would be liable to a means test under the aged care co-contribution regime.

#### RECOMMENDATION 9.7

***The Commission notes that the Australian Government has agreed to assume funding responsibilities for specialist disability services delivered under the National Disability Agreement for people over the age threshold.***

***In that context, the Australian Government should ensure that:***

- ***a person with a disability eligible for and being supported within the disability care system prior to reaching the aged threshold should be able to be continue to be supported by services best able to meet their needs including through the disability care system***
- ***such a person may at any time after reaching the age threshold elect to be supported through the aged care system and be subject to that system’s arrangements and shall be deemed to have done so upon permanent entry into a residential aged care facility.***

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## 10 Quality of care and support

### Key points

- Defining and measuring the quality of care and support is not straightforward. Quality is multidimensional and it can be difficult to observe because of its personalised nature — quality is in the ‘eye of the beholder’. Common themes among definitions of quality care include effectiveness, safety, efficiency and the experience of care recipients.
- Inferences about the quality of care are typically drawn from three sources: the structural aspects of care (such as the size and amenity of rooms, staff ratios, skills mix and qualifications); the ‘process’ of delivering care (including mechanisms to protect residents and care planning); and the outcomes from the care (such as the prevalence of falls and pain management).
- The three main complementary approaches to monitoring and ensuring quality care include: standard setting and monitoring; raising commitment to quality improvement; increasing consumer information and competition.
- Under the Commission’s proposals for care entitlements, and the relaxation of supply constraints, care recipients will play a more active role in influencing the quality of their care. Also, the proposed improved funding arrangements, regulatory oversight and upgraded complaints handling processes will assist in delivering higher quality care.
- To ensure high quality care is provided, the quality assurance framework needs to go beyond regulated care standards and monitoring. Easy to understand information about how providers compare on outcomes is needed, as is more information on what high quality looks like (reflecting best practice) and care recipients’ experiences with aged care services.
- Making available easy to understand comparable information on the quality of care and support services would not only help care recipients and their families make decisions about care options, but by making outcomes more transparent, it would also drive continuous improvement and provide stronger incentives for providers to deliver quality services.
- With aged care providers increasingly caring for people with complex and chronic conditions, access to general practitioners, geriatricians and specialist health teams (such as palliative and behavioural management specialists) will be increasingly important if quality care outcomes are to be achieved. This points to the importance of getting the incentives right to encourage the involvement of multi-disciplinary health care services in aged care.

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Australians want older people to have access to safe and high quality aged care. A key reason for the extensive regulation of aged care is to ensure quality care and to provide consumer protection for those considered among the most frail and vulnerable in the community.

Looking forward, measures aimed at ensuring the quality of aged care are likely to become increasingly important as community care services assume a greater role (where monitoring of quality can be trickier, particularly where it involves care for older people with cognitive impairments). The affluent baby boomers will also demand higher quality services that are tailored to meet their needs and preferences.

The personal experiences of older Australians and their carers suggest that the quality of care provided within Australia's aged care system varies. While the community is often concerned when they read and see media reports about poor quality care being provided to older Australians, it seems that everyone has a personal story and experience. Some participants to this inquiry were clearly satisfied with the quality of care provided, while for others the quality of care fell far short of their expectations. Many nurses working in aged care expressed concern to the Commission about the quality of care provided in residential care facilities. On the other hand, providers generally rated the quality of aged care highly and commented on the dedication and care shown by carers working in this industry (box 10.1).

This chapter begins by looking at what quality of care means and how it can be evaluated or measured (section 10.1). The current arrangements for ensuring quality in the aged care sector are then briefly described (section 10.2) before concerns about the effectiveness of the current quality framework are discussed (section 10.3). Section 10.4 looks at the role of information in improving the quality of aged care services. Finally, the chapter looks at the importance for older Australians of having access to healthcare services for quality care outcomes, including access to general practitioners (GPs), palliative and end-of-life care and mental health care (section 10.5).



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### **Box 10.1 Some participants praised the quality of care received while others were critical**

George Sadler:

My observation is that the level of care on the average is basic care. However, I believe that no patient's needs are deliberately overlooked. (sub. DR517, p. 3)

Christine Drake:

... Residents needs for feeding, showering and dressing, toileting, teeth cleaning are being at best marginalised or totally overlooked as overworked carers strive to meet the tasks demanded by nursing home proprietors. (sub. DR490, p. 1)

National Seniors Australia:

NSA acknowledges that many aged care services, both residential and community care, provide excellent and quality care and meet the standards and other requirements for their residents and clients. (sub. DR832, p. 7)

Lorraine Andrew, a registered nurse currently working in aged care:

... we have a duty of care to our residents, yet sadly the current staff levels in most aged care homes I have worked in, impact markedly on the quality of resident care that is (is not) at the end of the day actually delivered. (sub. DR851, p. 2)

Maree Bernoth, relaying what the family of one resident, said:

... although we had a number of fantastic people working there, with a real spirit of care, there were also people in there who had English as a second language; they had trouble communicating effectively with the people. We had people [carers] who were completely unskilled ... not knowing how to lift them [the residents] and people were being hurt. People who were nil by mouth, an ex-digger, was fed by someone! Even with a sign there: Nil by Mouth. (sub. 253, p. 4)

Maree Bernoth commenting in her own right:

If our aim is quality care, then we are far from that goal. There are not enough carers and there is not enough staff with clinical expertise to support the care staff in prioritising their work and ensuring that care is appropriate to the needs of the residents and provided in a timely way. (sub. 253, p. 11)

Yun-Hee Jeon:

My substantial experience as a nurse and researcher in aged care over the past 20 years indicates that the capacity of nurses in Australia, in particular those working in residential and community aged care, to deliver high quality care is falling. (sub. DR593, p. 1)

Tabulam and Templer Homes for the Aged Inc:

... I remain totally amazed at the exceptional care delivered by many undervalued, under-remunerated and overworked staff at all levels of the Aged Care spectrum. The love, care, dedication, loyalty and perseverance of so many carers is what continues to make caring for the aged in our RACF's such a joy despite all the frustrations. (sub. DR535, p. 2)

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## 10.1 Defining and measuring quality of care and support

Defining and measuring the quality of care and support is not straightforward. Quality is multidimensional and is defined differently by different people and organisations. As the Aged Care Standards and Accreditation Agency (ACSAA) said:

Quality in healthcare is seen from many different perspectives — service users and professional groups (staff and management), informal carers and other interested groups but also from the organisational and systems level. Assessing performance against standards therefore provides an assessment (with varying degrees of objectivity) against a range of expectations concerning the quality of service outcomes. (sub. DR763, p. 4)

Because of the highly varied and personalised nature of quality of care there are dimensions of quality that can be difficult to assess (our perception of quality varies and can relate to positive and negative incidents). As a recent European Paper on Quality Management and Assurance in Long Term Care (LTC) put it:

Quality can be defined — for instance in terms of colour, hardness or density — as a particular feature or modality of a good. But quality cannot be evaluated for itself. It is always evaluated regarding the finality/ies the considered good is expected to fulfil ...

Care is effective, when it is able to produce the expected effect; it is efficient when it is produced faultlessly, free of malpractice; and it is optimal, when the provided solution corresponds to the state of the art. (Nies et al. 2010, p. 7)

Deficiencies in care quality can reflect inter-related problems. For example, a high prevalence of pressure ulcers, malnutrition and dehydration can be indicators that care workers are unable to devote sufficient time to care recipients or that care workers are not adequately qualified, motivated or trained. This can reflect poor management, insufficient dollars being spent on staffing or an inadequate underlying level of funding for care.

Coordination of care services, access to services that align with the care needs of recipients and access to specialised services (such as GPs and other health services) can also be extremely important in achieving quality of care.

Some of the many definitions of quality used in LTC and health systems are presented in box 10.2. While definitions of quality care vary, there are some common themes — including effectiveness, safety, efficiency and the experience of care recipients.

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## Box 10.2 Varying definitions of quality of care

The United Kingdom's Department of Health's framework for adult social care defines quality as a composite of four factors:

- *effectiveness* — *getting it right the first time* (achieving the best possible outcomes for individuals in their circumstances)
- *experience* — *a positive experience of care and support* (people are treated with dignity and respect, and are involved in their care)
- *safety* — *protecting vulnerable people* (protecting people from avoidable harm, ensuring risk and choice are balanced appropriately)
- *efficiency* — *ensuring value for money*.

In the context of health care, the World Health Organization (WHO) identifies six dimensions of quality — *effective, efficient, accessible, acceptable/patient-centred, equitable, safe*.

The Organisation for Economic Cooperation and Development (OECD) Health Care Quality Indicators project focuses on effectiveness, safety and patient-centeredness.

Australia's national health performance framework developed by the National Health Performance Committee for the delivery of quality health care uses the criteria:

- *effective* — care, intervention or action achieves the desired outcome
- *appropriate* — care, intervention or action provided is relevant to the client's needs and based on established standards
- *efficient* — achieves results with most cost effective use of resources
- *responsive* — service provides respect for persons and is client orientated, including respect for dignity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks and choice of provider
- *accessible* — ability of people to obtain care at the right place and right time irrespective of income, physical location and cultural background
- *safety* — the avoidance or reduction to acceptable limits of actual or potential harm from care management or the environment in which health care is delivered
- *continuous* — ability to provide uninterrupted, coordinated care or services across programs, practitioners, organisations and levels over time
- *capable* — an individual's or service's capacity to provide a health service based on skills and knowledge
- *sustainable* — system's or organisation's capacity to provide infrastructure such as workforce, facilities and equipment, and to be innovative and respond to emerging needs (research, monitoring).

Sources: DOH (2010c), National Health Performance Committee (2004); OECD (2009c); WHO (2006).

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Donadbedian (1992), in providing a framework for assessing quality of care, suggested that information from which inferences could be drawn should be based on a three component approach:

- *structure* — the setting in which care occurs. It covers buildings, equipment, the number and qualifications of personnel and organisational structure (such as such as the size and amenity of rooms, staff ratios, skills mix, staff qualifications)
- *process* — the organisation of care or the way care is delivered. It includes residents privacy and rights, requirements for care and the compilation of clinical records
- *outcomes* — the effects of the care on care recipients. Indicators could include prevalence of falls, pressure ulcers, pain management, nutrition and hydration.

Reflecting the various dimensions of quality, three complementary approaches have been adopted by OECD countries to monitor and ensure quality of LTC:

- standard setting and monitoring by agencies such as regulators and purchasers
- raising provider and professional commitment to quality improvement
- increasing consumer information and market competition (OECD 2005b).

## **10.2 Current measures to ensure quality of care**

As discussed in chapter 4, there are strong arguments for governments to play a role in overseeing the quality of aged care and ensuring providers adhere to community expectations about the standard of care provided. Providers of aged care services are caring for some of the most frail and vulnerable people in our society. Government action to protect these older Australians is warranted because:

- often important decisions about care are made at short notice and in times of intense stress (such as at the time of an adverse health event) which means they do not have sufficient opportunity to objectively assess their options. Older Australians and their families also may not have the information or expertise to accurately judge the quality of aged care services (services could be judged on the appearance of the facility when the skills and attitudes of staff may be a better indicator of quality) and providers can have less of an incentive to compete on quality (particular when there are supply constraints)
- some older people may not have the cognitive ability to make informed rational decisions that serve their best interests and may have a limited ability or confidence to express any inadequacy in the services they receive

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- care is often delivered in private settings, such as people’s homes, where inadequacies are less likely to be detected by others
  - there can be a power imbalance between providers and older people requiring care because they rely on uninterrupted provision of care and support.

There can be very high costs (risk of physical and mental harm and poor outcomes, including death) if quality care is not provided. Participants acknowledged a role for government in protecting vulnerable older people. United Voice — NSW (LHMU), for example, said:

United Voice members agree with the Commission that ‘regulatory oversight is essential to protect older Australians’. ... A continuing strong role for government should be a fundamental principle of any reform process. Government involvement is essential in protecting aged care consumers from the risk of low quality or unsafe services. (sub. DR845, p. 10)

The remainder of this section provides a brief overview of the current arrangements for ensuring quality of care for older Australians including: the provider approval process; building certification requirements for residential care; care standards and the accreditation system; other measures to protect care recipients; complaints processes and advocacy services. Further detail is provided in chapter 15 and appendix F.

### *Approved provider status is required*

Service providers of aged care services are required to seek approved provider status before they can receive Australian Government subsidies for providing the services. This requirement aims to ensure that service providers are legitimate enterprises and they have the capacity to deliver aged care services.

A provider’s approval can be for residential care, community care and flexible care.

Approved Providers of Australian Government funded aged care must comply with the legislative obligations set out in the *Aged Care Act 1997* and the *Aged Care Principles 1997* relating to the quality of care they provide, the rights of the people they provide care to, accountability for the care they provide and the basic suitability of their key personnel. Failure to meet any of the responsibilities set out in the Act can lead to the imposition of sanctions and the revoking of Approved Provider status (appendix F).

There is also a *Charter of Rights and Responsibilities for Community Care* for older people receiving Australian Government community care packages. Providers of

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these services are required to appraise their performance against program standards and complete a Quality Report at least once during a three year cycle.

### *Measures to ensure building quality standards*

Internationally, the setting of standards for the quality of buildings and the housing environment is widely considered a prerequisite for progress in improving the quality of care (OECD 2005b). Certification is about the building quality of aged care facilities and is based on the principle of continuous improvement. To be able to receive Government funding, all aged care facilities must meet specified building standards (certification), including fire safety and privacy and space targets.

An agreed ten-year plan, introduced in 1999, provides aged care facilities with a clear framework for improving safety, privacy and space standards. Facilities built since 1999 are required to meet a higher standard (chapters 12 and 15). The requirements of the 1999 Certification Assessment Instrument do not override the building and fire safety regulations within each state and territory. Through the Building Code of Australia, the state and territory building regulations set the minimum community standard for safety, health and amenity of buildings (DoHA, 2010n).

### *Care standards*

Care standards are aimed at providing guidance to service providers about good quality care and management and accountability. Most OECD countries have attempted to maintain and develop the quality of LTC by setting minimum requirements on providers as preconditions of licensing or contracting decisions. The setting of standards can provide some guidance to care recipients and their families about what to expect from care services. It also provides them with a basis to complain when they consider standards are not being met (OECD 2005b).

Aged care facilities must be accredited to receive Australian Government funding. The accreditation process assesses the performance of facilities against 44 indicators and associated expected outcomes covering four Accreditation Standards (management systems, staffing and organisational development; health and personal care; residential lifestyle; physical environment and safe systems — appendix F, table F.1).

An independent agency, the ACSAA manages the accreditation of residential aged care facilities in accordance with the Accreditation Grant Principles 1999. The ACSAA undertakes visits to facilities to assess their performance against the

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Accreditation Standards. The assessment may include accreditation site audits, support contacts or review audits. Support contacts and review audits may be announced or unannounced. Facilities found to be non-compliant with the Accreditation Standards are placed on a timetable for improvement, providing them with an opportunity to correct the non-compliance. Information about a facility's accreditation status, including copies of the most recent accreditation and review audit reports, are published on the Agency's website.

Governance issues around accreditation arrangements (including overlapping responsibilities between ACSAA and Department of Health and Ageing (DoHA)) and options for reforms in this area are discussed in chapter 15.

Up until recently, the quality of HACC services and community aged care packages were subject to a range of different quality standards across jurisdictions. From 1 March 2011, a set of Community Care Common Standards were implemented by most jurisdictions. Under this framework, there are 18 indicators and associated expected outcomes covering three standards (effective management; appropriate access and service delivery; and service user rights and responsibilities — appendix F, table F.6).

#### *Other measures to protect residential care recipients' safety*

Residential aged care facilities must report incidents or allegations of sexual assault or serious physical assault. Police check arrangements are also in place to prevent unsuitable people from working in aged care services. Police checks apply to all staff and contractors who have access to care recipients and to volunteers who have unsupervised access to care recipients. Chapter 15 examines in more detail the regulations aimed at ensuring the safety of care recipients.

#### *Complaints processes*

There is an Aged Care Complaints Investigation Scheme (CIS). The CIS is a free service that allows members of the community to submit open, anonymous or confidential concerns/complaints about the quality of care and/or the services being delivered to a care recipient in a residential or community care setting. The CIS has the power to conduct investigations and issue Notices of Required Action where an Approved Provider of aged care is found to be in breach of its responsibilities under the Act. It is available to anyone who wishes to provide information or raise a complaint or concern about an Australian Government-subsidised aged care service. The CIS was reviewed in 2009-10 by Merrilyn Walton (chapter 15).

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There is also an Office of the Aged Care Commissioner (OACC) which has been established independently of DoHA. The Aged Care Commissioner (the ACC) is able to review decisions and examine complaints about CIS processes and examine the conduct of the Office of Aged Care Quality and Compliance (AOCQC) audits and assessors. The ACC may only make recommendations (generally to the Secretary of DoHA) when examining complaints. Governance issues relating to complaints handling and options for improvement are discussed in more detail in chapter 15 and appendix F.

### *Advocacy and support services*

The Australian Government funds aged care advocacy services in each state and territory under the National Aged Care Advocacy Program. Advocacy services provide independent advocacy and information to recipients or potential recipients (or their representatives) of aged care. The services also perform an educative role for aged care recipients and Approved Providers on the rights and responsibilities of care recipients. The Commonwealth Ombudsman stressed the importance of aged care consumer advocacy services:

Older Australians seeking to access aged care, regardless of their funds, may be vulnerable to persuasion from others that they do not need to expend their funds on solicitors, financial advisors or other independent sources of advice. Moreover they may be frail and have physical difficulty accessing their funds without negotiating with family members, friends or others. ... Easily accessible independent advocacy and advice services would seem of vital importance in a field which involves the living arrangements of an inherently vulnerable sector of the community. (sub. DR786, pp. 1-2)

There is also a Community Visitors Scheme which provides one-on-one volunteer visitors to residents of Australian Government subsidised aged care facilities who are socially or culturally isolated and whose quality of life would be improved by friendship and companionship. The scheme is available to any resident who is identified by a facility as at risk of isolation or loneliness, whether for social or cultural reasons, or because of disability.

## **10.3 How effective is the current quality framework?**

As discussed in chapter 5, one of the strengths of the Australian aged care system is the accreditation and quality assurance framework. DoHA described Australia's quality framework as being one of the most comprehensive in the world:



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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. (sub. 482, p. 31)

An evaluation of the impact of accreditation on the quality of care and quality of life of residents in Australian Government-subsidised residential care homes (DoHA 2007, known as the Campbell Report) found that aged care managers and staff considered accreditation to be the major driver of quality improvement in the sector. The introduction of accreditation was found to:

- remove under-performing homes from the sector
- set a minimum standard for quality
- raise the standards of quality across the sector
- establish a degree of consistency across the sector
- develop a focus on continuous quality improvement and resident-focused care.

The Campbell report concluded that:

... accreditation, together with the regulatory framework in which it is embedded, is an appropriate way to improve quality in residential aged care and has achieved an overall improvement in residents' quality of care and quality of life. (DoHA 2007, p. v)

In 2000, 63.5 per cent of homes were assessed as meeting all outcomes at their last site audit. The figure is now over 90 per cent (DoHA 2010n).

A number of inquiry participants agreed that accreditation had improved quality in the aged care sector over the last decade or so (see, for example, ECH, Eldercare, Resthaven, sub. 453; Wesley Mission Victoria, sub. 311). But, as discussed in chapter 5, many participants were also of the view that there were limitations to what the minimum standards could achieve and that the accreditation process was too focused on process rather than outcomes.

### **The role and limitations of minimum standards**

The setting of minimum standards and the flexibility around some of the standards was a concern expressed by some participants. Citing the example of staffing and skill-mix, the Combined Pensioners and Superannuants Association of NSW said:

... some standards lack clear guidelines, making them easy to flout. Staffing and skill-mix is a good example. The current standard for human resources requires a facility to have 'appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with [the aged care] standards and the residential care service's philosophy and objectives'. This is very vague and it is unclear how assessors are able

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to make an accurate judgement about a facility's success in meeting this standard. (sub. DR760, p. 15)

Valerie and John Braithwaite also argued that the lack of variation in scores, represented by over 90 per cent compliance, tells care recipients and their families very little about the quality of care:

Our experience of observing the issuance of 98 per cent compliance outcomes in Australia is that high scores should be interpreted as evidence of 'soft' accreditation assessment rather than of high standards. The other problem with ridiculously high scores is that they make the transparency reforms of a decade ago meaningless. Going to the website to inform a choice of nursing home is a meaningless activity because the website almost always tells you that everything is wonderful in every respect at every nursing home in your locality! (sub. DR679, p. 2)

Participants also criticised the accreditation process's focus on monitoring compliance rather than quality improvement. Wesley Mission Victoria, for example, said:

The current accreditation process focuses on monitoring compliance rather than operating as a quality improvement process. The status of being either compliant or non-compliant largely ignores quality of life outcomes for residents. The focus on compliance/non-compliance has led to a reactive approach to change, associated with the fear of what will happen if we are found to be non-compliant. Operating within such a system means that it has been hard to engender a culture of continuous improvement. (sub. 311, p. 4)

Similarly, Mercy Health said:

The present aged care standards are focused more on the achievement of minimum standards than on the idea of continuous quality improvement. ... Best practice accreditation systems focus on quality improvement to find the underlying causes of errors or system failures so that their future incidence can be reduced. (sub. 215, p. 9)

The ACSAA agreed that 'standards alone do not provide incentives for providers to improve quality above the minimum'. In addition, it argued that there are a range of variables which influence care outcomes for residents that are not directly related to the standards, such as strategic business decisions made by facility managers, the workforce and revenue streams (sub. DR763, p. 4).

Recognising this, Hogan recommended that the ACSAA develop a star rating system where the basis of the system was the relative performance of aged care facilities as a means of encouraging providers to provide care above the minimum standards:

The current accreditation process may encourage some providers to aim only for the minimum standard required to maintain accreditation and access to Government funding. A star rating system would reinforce commitment to continuous improvement.

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Further, as the industry moves to more flexibility in management and pricing, consumers would have greater assurance of transparency to determine the choices available. (2004b, p. 245)

One of the roles of the ACSAA is also to help industry improve service quality by identifying best practice, providing information and supplying education and training services. Initiatives of the Agency in this regard include:

- Better Practice Awards. These are presented for better practice in programs run by a residential aged care facility that benefit the lives of the residents. Achievers receive a certificate and a better practice profile on the Agency's website.
- Seminars and a Quality Education on the Standards (QUEST) program delivered by quality assessors in aged care homes to improve stakeholders' understanding of the standards and accreditation, with a focus on continuous improvement.

The Campbell Report noted the tensions inherent in a regulatory scheme that has the dual objectives of stimulating continuous quality improvement and assuring compliance with minimum standards:

... the notion of standards implies clear-cut criteria and fixed definitions of quality, whereas the notion of continuous quality improvement implies a continual process of self-examination and a never-ending search for improvement without a fixed destination. (DoHA 2007, p. 33)

The Report concluded that accreditation was capable of achieving both continuous quality improvement and assuring compliance with minimum standards, but that there was limited capacity for measuring quality to encourage quality improvement:

While there was evidence that accreditation *promotes* continuous quality improvement, its capacity to effectively *measure* quality in order to stimulate quality improvement is limited. The measurement of continuous improvement is embedded in each of the Standards. However, the non-prescriptive nature of both the Standards and the accreditation process means that improvement in quality is based on the individual focus of the home and is not necessarily consistent within the same home over time, or between homes across the sector. (DoHA 2007, p. xiii)

The Aged Care Accreditation Standards and the accreditation process for residential care facilities has been under review. A Technical Reference Group established to review the standards has developed a draft set of standards. According to DoHA, in revising the Standards, there is an increased focus on the resident and encouraging the provision of resident-centred care, reducing duplication across the standards and encouraging continuous quality improvement.

Quality improvement could be further enhanced by establishing stronger links on the best available evidence into effective practices and processes and the standards

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of care. In residential care, the Encouraging Best Practice in Residential Aged Care program supports the uptake of existing evidence-based guidelines by funding organisations to translate evidence into practice (DoHA 2010n). Care recipients should also know what high quality services are able to achieve (based on good evidence).

## **Does the accreditation process present a true picture?**

Participants questioned how true a picture is provided by the accreditation process. The Combined Pensioners and Superannuants Association of NSW said:

... facilities have ample time to 'prepare' for accreditation. It is well known that facilities put their best foot forward when accreditation is due because they receive three months' notice of the site audit. This may point to why so often poor care is uncovered in facilities shortly after an accreditation visit where 44 of the 44 standards were passed.

... the Agency generally only visits facilities during business hours. CPSA often hears of facilities that put on skeleton staff at night and weekends. This can lead to residents waiting until Monday for treatment if their health declines over a weekend either because management was not present to make a decision about the resident's care or the resident's decline was not picked up by overworked staff. (sub. DR760, pp. 16-17)

Jody Kerrins suggested that only the best staff are rostered on for accreditation visits:

When aged care facilities are coming up for Accreditation, often approved providers ensure that the 'best' staff are rostered on duty, on those days only, even when it may not be the normal rostered shift of the staff member. Example: Some staff asked 'not to come in' on the days the Accreditors are in the facility. (sub. DR523, p. 1)

Some participants called for more unannounced visits as a way of getting a better picture of the care provided on a day-to-day basis. Donna Moses, for example, said:

... there should be more unannounced visits to ACFs by Accreditation Surveyors that would to some degree balance out the frantic pre-Accreditation chaos that takes place in all ACFs and hospitals prior to the 3 day visit, all aimed at glossing over or distracting from any deficiencies in management or operation. (sub. DR545, p. 2)

ACSAA also acknowledged the importance of unannounced visits for ensuring high quality care:

Although sometimes criticised, unannounced visits have a number of benefits. They help organisations to focus on providing safe, high quality care at all times; affirm the expectation of continuous compliance with the standards; enhance the credibility of the accreditation process by ensuring that an organisation's performance is observed under normal circumstances; address public concerns that the accreditation body receives an

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accurate reflection of the quality and safety of care; and provide an assurance the provider is continuing to meet relevant standards. (sub. 354, p. 5)

The Australian Government requires that each facility receives at least one unannounced visit each year and ACSAA uses a risk management approach to determine which facilities receive unannounced visits.

Anna Howe (sub. 355) suggested that reducing the frequency of full site audits from three years to every 4–5 years would free up resources for ACSAA to undertake more frequent unannounced visits. Her analysis of sanctions from 1999 to 2008 showed that non-compliance is rarely identified at site audit visits and mostly identified during unannounced visits. Along similar lines, ACSAA noted that of the all the facilities identified as failing to meet at least one expected outcome in 2008-09, around 36 per cent were identified from unannounced support contacts (ACSAA sub. DR763).

While both targeted and random unannounced visits should be part of the visits program of a regulator, the Commission has previously argued that the focus should be on targeted visits (PC 2009a). Targeted unannounced visits should be made to those facilities that meet certain risk profile parameters.

The Commission is also recommending that a Community Visits Program<sup>1</sup>, similar to that operating in other residential care settings (for example, disability and children's services), be developed for aged care (chapter 15). Under such programs the community visitors have specific legal powers to make unannounced visits to facilities, talk privately with residents or employees, inspect operational documents and report on the adequacy of services provided. They support the quality provision of services in a number of ways:

- they can draw issues to the attention of service providers
- when serious issues are detected, they can instigate further investigations
- their annual reports provide information to consumers about ongoing issues with certain providers and to government about broader industry challenges and trends in service delivery (PC 2011).

### **A focus on process rather than outcomes**

A common theme among participants was that the quality framework, and the accreditation process in particular, is very much about ticking the boxes, looking at

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<sup>1</sup> This program is different from the Community Visitors Scheme mentioned earlier which provides volunteer visitors to residents who are socially or culturally isolated.

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processes and paperwork and is not sufficiently focused on outcomes for care recipients (box 10.3). Wesley Mission Victoria, for example, said:

There is a fundamental tension between standards focused on the services that are delivered and the outcomes that people want and value in relation to their own lives. The Aged Care Standards which underpin the accreditation process relate to what is delivered, rather than what the result of that delivery is in terms of impact on individuals' sense of their own well-being. It cannot be assumed that just because an organisation is providing a service to established and measurable standards, that this means that all people always get the care and support that they want, or in a way that they want. (sub. 311, p. 5)

National Seniors Australia (NSA), also said:

Anecdotal evidence from NSA members suggests that even those providers who are fully compliant are not necessarily meeting the expectations of consumers and their families for 'high standards of care'. The focus of the regulatory framework needs to be targeted to improving quality of life and quality of care for consumers. In relation to quality of care, it should be noted that quality indicators are often developed from a provider perspective and focus on the process of care delivery rather than from the consumer's perspective. (sub. 411, p. 17)

Engaging with users of aged care services to gain insights into their experiences with aged care services is a crucial element in any quality assurance process and for ensuring that people are receiving the expected quality of care and support (particularly as moving between aged care providers is difficult, especially for those in residential care).

ACSAA acknowledged that 'the level of resident engagement in the accreditation process is currently limited to confidential interviews conducted with residents and their representatives during visits by assessors from the Accreditation Agency', but that the Agency has recently begun talking to consumer groups about ways to gather information about resident experience on an ongoing basis and thinking about how users of the services might become part of assessment teams (sub. 354, p. 10).

A further concern of participants was that the paperwork requirements of the accreditation process takes staff time away from care recipients (Aged Care Crisis, sub. 433; Baptist Village Baxter sub. 170). Helping Hand Aged Care (sub. 196) estimated that in a twelve month period more than 1000 hours (the equivalent of 28 full time weeks) were spent by the organisation to facilitate visits from regulatory bodies, primarily the ACSAA.

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### Box 10.3 Accreditation — participants said it was more about process and paper than care

Northside Community Forum Inc:

There must be stringent quality control checks for all aged care. Too often the 'checks' are arbitrary, tokenistic and fail to see the *quality* aspects of care that make such a difference to a resident's life. (sub. DR683, p.6)

Maree Bernoth:

It is not about care given, it is about having systems in place and on paper. It is irrelevant whether or not those systems are functioning because the real, tangible outcomes are not looked at, that is, the actual care delivered (or not) in the bathrooms and the bedrooms. (sub. 253, p. 23)

The Quality Aged Care Action Group Inc, Blue Mountain Branch:

Many hours are spent updating forms for the visit at the cost of care hours. (sub. DR834, p. 4)

Cheryl Young:

Accreditation seems to be a process of looking at paperwork only and not looking at the resident and the actual resident outcome as far as actual physical outcomes for that particular resident. (trans, p. 105)

... I do believe that it could be improved, but it has to get its focus off the paper-based systems and the risk management to the Nth degree on so many small issues and start actually looking at the residents, their care, their needs and whether they're happy. You can tell when you walk into a facility whether the residents are happy, and that's what they should be looking at, not whether I've got thumbtacks on my pin boards, which was what I got picked up on last time. You know, I hadn't risk managed my thumbtacks. (trans., pp. 110-111)

Aged Care Crisis:

The current accreditation system does not adequately measure the delivery of care to frail Australians in our aged-care homes. The Agency concentrates on processes rather than on measurable adverse events. These often remain hidden.

Measurable levels of real care (performance) such as bedsores and weight loss are not recorded nor reported publicly. Instead the Agency refers to 'indicators' and looks at whether processes are in place to prevent and treat these failures in care. Their success in doing so is neither evaluated nor reported. While these processes are important for improvement they are not the measures of performance which inform regulators, citizens or researchers. (sub. 433 , p. 8)

According to ACSAA, however, many of the costs that providers attribute to accreditation are costs associated with conducting a good quality management system:

... it has been reported that accreditation requires a provider to have a complaints management system and that this is therefore a cost of accreditation. The Accreditation Agency's perspective is that such a system is fundamental to the conduct of a residential aged care facility and is a cost of supporting the delivery of services. Similar

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comments have been reported concerning care plans and other documentation that is critical to the management of services to residents. (sub. 354, p. 7)

ACSAA (sub. 354) also said that questionnaire's filled out by residential aged care facilities following visits from the Agency suggest that site visits are not as onerous as some claim them to be. Based on 4000 feedback forms, responses to the question 'staff were able to continue work' in 2009-10 showed satisfaction rates of 98 per cent (for unannounced visits) and 95 per cent (for announced visits).

Any quality assurance system should be about cost effectively assessing compliance, keeping in mind that the objective of assessing compliance is to protect those most vulnerable in our community. Too much emphasis on process and documentation adds to costs, and can detract from care quality, without adequate benefits to the wellbeing of care recipients.

Excessive reporting was also cited by some as an impediment to attracting and retaining staff who are attracted into the industry by the opportunity to provide care, not to undertake clerical tasks (chapter 14). As discussed in chapter 15, the current regulatory system should be reviewed to identify where unnecessary regulatory burdens could be removed without compromising quality and safety — indeed leading to improved quality and safety. In February 2011, ACSAA announced a project to determine what documents are created exclusively for the purpose of accreditation and to develop a strategy to stop the practice (ACSAA sub. DR763).

Stronger competitive pressures should provide an incentive for providers to find more cost effective ways to meet the requirements of the compliance framework. This in turn could mean better care for recipients (less staff diversions away from meeting care needs) and a more attractive work environment for staff.

The increased use of electronic records should also offer scope to significantly reduce the burden of documentation (and improve the quality of care of older Australians), but requires that regulatory authorities and providers accept and embrace the technology. As discussed in chapter 9, DoHA has made recent announcements about further progressing the roll out of the electronic Aged Care Client Record (DoHA 2010b).

### **Accountability and transparency — the missing pieces in the quality assurance framework?**

A number of participants argued that under current arrangements there is little accountability and transparency about how care dollars are spent and as a result



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taxpayers have no guarantees that public monies are achieving the best quality of care outcomes. Aged Care Crisis, for example, said:

Aged-care providers receive billions of dollars of taxpayer funding. There should be full disclosure as to how that money is being spent. As well as providing increased transparency for consumers, such disclosure would undoubtedly encourage improvement in residential aged-care services. (sub. DR433, p. 7)

A former carer who for two and a half years had visited her husband in a residential care facility also said:

Taxpayers have a right to know how their money is distributed and the earmarking of government money for specific purposes such as nursing care and resources is the only just outcome acceptable. (Margaret Zanghi, sub. DR638, p. 2)

Improving quality is an important part of ensuring the best use of taxpayers' money.

United Voice — NSW (LHMU) said that the move away from the CAM/SAM funding arrangements (where each assessed level of care had assigned a standard number of care hours) has 'left providers free to choose how they spend their funding' (sub. DR845, p. 14). Nurses spoke about it not being uncommon for there not to be a registered nurse in facilities:

At my current workplace, which is classified as a low level with ageing in place facility, comprising 60 beds, and at time of writing housed 40 high level care residents, there is often no registered nurse on site and at times not even an enrolled nurse. It is difficult to persuade management to provide an extra 'supernumerary' staff member related to budgetary constraints. (Lorraine Andrew, sub. DR851, p. 2)

Others spoke about the absence of any link between accreditation and the Aged Care Funding Instrument (ACFI) funding provided to facilities. Cheryl Young, for example, said:

I think there's a complete separation of accreditation, ACFI funding and what really is required in each facility for the kind of acuity of the residents that they have in that facility. I don't think there's a lot of marrying up between the two. (trans. p. 105)

In addition, Tabulam and Templer Homes for the Aged Inc said:

The current ACSAA processes do not provide any kind of reliable way to adequately provide an appropriate staff mix or a ratio to provide for all the assessed care needs of a resident in accordance with ACFI. The assessors who conduct an audit or support visit rely heavily on 3 verifications – staff comments, resident/relative comments and a cursory glance at a roster, which may or may not be truly reflective. They have no way of knowing what the ACFI ratings are for the whole facility, individual areas or individuals. Therefore there is no correlation drawn between the care needs and the funding. The staff and resident/relative input is equally subjective and relies on the information from the proprietors. (sub. DR535, p.1)

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Several participants suggested that accountability for providing good quality care has been shifted to the nursing and personal care workers. Vince Watson, for example, said:

I have interviewed confidently several staff members with some 10 years each of service. They are adamant that they do not have sufficient trained staff, with hours being cut at all times. (sub. DR757, p. 1)

The Commission heard repeatedly from nurses who said that they were unable to provide the level of care to residents that they would like to provide (or that was required) because of inadequate staffing levels and an inappropriate mix of skills (box 10.4). A former informal carer also said:

One RN explained to me her sense of frustration and abandonment in her attempt to deliver care to the residents. She felt the heavy weight of responsibility for medical decisions for a large number of people, when in a different environment i.e. a public hospital, she would have the back up of doctors and specialists. (Margaret Zanghi, sub. DR638, p. 2).

The Australian Nursing Federation also reported that over a quarter of aged care nurses responding to a Queensland survey stated that they did not believe that there were enough qualified staff to meet client needs. And a more recent study of aged care nurses in NSW found that:

... just under three quarters of respondents did not support a model of care whereby registered nurses fulfil the role of care facilitator/planner only with all direct care tasks, including medication administration, delegated to unlicensed workers. (sub. 94, p. 3).

Several nurses also provided anecdotal evidence to the Commission of residents' symptoms being ignored or poorly treated because personal care workers did not have the appropriate skills (box 10.4) — chapter 14 looks at the issue of care worker qualifications.

The Australian Nursing Federation argued that it is:

... critical there are minimum staffing levels in all aged care facilities, 24 hour registered nurse coverage wherever there is one or more high care residents; and for each facility employing nurses that a full time director of nursing (or classification equivalent) is employed. It is also critical that national benchmarks of care are developed that are directly linked to relevant skill mix of staff required to deliver appropriate care. (sub. 327, p. 7)

As discussed in chapter 14, aged care services are labour intensive, and as such, access to an adequate and appropriately trained workforce is essential to ensure that quality and safe care can be delivered when required. But under current arrangements, providers in seeking to minimise costs, have an incentive (particularly in an environment of high occupancy rates) to employ a high

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proportion of lower qualified (and therefore less expensive) care workers. A high proportion of lower qualified workers means that nurses working in aged care facilities can experience excessive workloads where they spend a large proportion of their time on administrative tasks (as they are effectively managers) rather than on caring. This, in turn, can drive nurses away from aged care to acute care settings.

**Box 10.4 Some comments from nurses about the adequacy of staff levels and skill mix**

Erica Kurec (a registered nurse with over 20 years of aged care experience):

Chronic conditions such as arthritis, respiratory disease, multiple sclerosis, Parkinson's - not to mention dementia: time is needed to approach these people to prepare them for daily living activities as resistance is the usual response to a hurried manner and, when a carer has eight or nine people to feed and shower and dress by a reasonable hour or when determined by resident preference, it's nearly impossible. We have to remember, too, that facilities accommodate large numbers of residents and, if there is a ratio that's more than one to six, planned care outcomes are compromised. (trans. p. 352)

Deborah Knapp spoke about times when she was the only registered nurse on a shift looking after 192 residents:

... we usually have three RNs in the afternoon shift, and there will be one of us ... they still make you work just one to 192 people, which is a heck of a load when you've got the staff, and you've got any other problems that can arise. You have to also deal with doctors, of course, and families and issues. (trans. p. 359)

Cheryl Young:

There seems to be a lack of understanding of the acuity of the residents that we now have in aged care. They really do require quite highly-skilled nursing or at least the supervision of a highly skilled nurse and at the moment that is really quite impossible when you have things like ratios of one registered nurse to, say, 60 residents during a day shift. It is just impossible to look after 60 people and to see how they all are and you're relying on your enrolled nurses and your PCAs to actually give you feedback and I don't think they are really qualified to be able to do that.

I have seen many instances where enrolled nurses and PCAs have totally ignored quite serious symptoms in somebody because they simply do not know what those symptoms relate to and when the RN finally gets to see them, it's either too late or it's a well-established infection or a pressure sore or something is already well established. It's not the fault of the enrolled nurse or the PCA, it is the fault of the system which is not giving us any kind of guidance as to how many registered nurses should be in any one facility at any time. (trans. p. 106)

United Voice — NSW (LHMU) (sub. DR845) called for the Commission to investigate the link between staff time and quality outcomes for residents and for the outcomes of the investigation to be incorporated into the transparent pricing mechanism of the proposed Australian Aged Care Commission (AACC).

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There is some evidence to show that more hours of care delivered by registered nurses in residential care facilities is related to better resident outcomes. For example, Horn et al. (2005), found that care delivered by RNs in residential care facilities was related to better outcomes for care recipients, including fewer pressure sores, fewer hospitalisations, lower incidence of urinary tract infections, less weight loss and less deterioration in care recipients ability to perform activities of daily living.

While there are superficial attractions to mandatory staffing ratios, there are also downsides. An across-the-board staffing ratio is a fairly ‘blunt’ instrument for ensuring quality care because of the heterogeneous and ever changing care needs of aged care recipients — in the Commission’s view it is unlikely to be an efficient way to improve the quality of care. Because the basis for deciding on staffing levels and skills mix should be the care needs of residents, it is important that these can be adjusted as the profile of care recipients changes (because of improvements/deteriorations in functionality and adverse events, etc). Imposing mandated staffing ratios could also eliminate incentives for providers to invest in innovative models of care, or adopt new technologies that could assist care recipients (chapter 14).

That said, there could be a more direct link between the funding provided for the complex health care needs of recipients and how much providers allocate to health care funding (primarily wages for nurses) over a period of time (say over a six or twelve month period). As discussed in chapter 7, the Commission is proposing that the AACC would undertake a public benchmarking study to determine the prices associated with entitlements to care services. The benchmarking study would take into account the appropriate staffing requirements in the delivery of service entitlements (chapter 14).

A key piece of information for care recipients and their families when trying to make an assessment about the quality of care (and staff satisfaction, which can influence the quality of care) is the facility’s/provider’s staff and skill mix for the profile of care recipients (the complex care component of ACFI provides some indication of the dollars allocated to individuals for ‘health’ care).

Such information would help empower consumers and enable them to make more informed choices about what services best suit their needs. It would also provide an incentive for providers to compete more on quality of service. With care recipients increasingly consisting of people with complex care needs (particularly in residential care), information about the skill mix will become increasingly important for determining whether providers have a workforce that is equipped to meet these care needs (and for ensuring quality clinical care). The Commission suggests

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facilities should be required to publish staff qualifications and skills together with a profile of care recipients.

## **10.4 Building the evidence on quality of care**

Under the Commission’s proposed entitlement approach to care and the relaxing of supply constraints, care recipients will play an increasingly important role in driving improvements in the quality of care because they will generally have the choice to take their entitlement elsewhere if they are not happy with the quality of care. The Commission heard on many occasions that, under the current arrangements, care recipients (particularly those receiving care in the community) are often not prepared to withdraw from services that do not meet their expectations because it can mean that they have a long wait before gaining access to a similar service by another provider. KinCare argued that the Commission’s proposed approach would force providers to be more responsive to care recipients needs:

The model of increased choice proposed by the Productivity Commission will reduce the current challenges with complaints as providers will be forced to be more responsive to consumers, and consumers will know that they have the option of changing provider at any time. Exercising this right will always be simpler in community care than residential care, so some additional protections may continue to be needed in residential care. (sub. DR578, p. 11)

The Commission also believes that the proposed improved funding arrangements and consequential improvements to workforce conditions will assist in promoting higher quality care, as will better regulation and regulatory oversight, together with upgraded complaint handling processes (chapters 7, 14 and 15). But there is also considerable scope to improve the quality of services and the experience of care recipients by collecting and publishing user friendly data about how well care services are performing relative to the care dollars spent and the profile of the care recipients.

### **Some information is available, but not very user friendly**

Currently, approved providers are required to demonstrate effective quality assurance as part of accreditation. However, the publicly available information simply tells care recipients and their families whether providers comply with the accreditation standards. ACSAA makes its decisions public along with a copy of the assessor’s full report but the format is not very user friendly. Information about complaints made is also available. But, as the information provided in box 10.5 shows, the performance information currently available does little to support informed choice.

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### Box 10.5 What do current indicators tell us about quality of care?

At 30 June 2010, 92 per cent of residential aged care services were accredited for at least three year and 99.5 per cent of services were compliant with the privacy and space and fire safety requirements.

During 2009-10:

- the Agency identified 186 facilities as being non-compliant with one or more of the 44 expected outcomes of the Accreditation Standards (at 30 June 2010, 2779 homes were accredited)
- of 60 review audits conducted, 58 decisions were made
  - 19 homes were the subject of a decision not to revoke or vary the period of accreditation
  - 38 homes were the subject of a decision to vary accreditation
  - one home was subject to a decision to revoke accreditation
- DoHA issued Notices of Decision to Impose Sanctions to seven approved providers and 134 Notices of Non-Compliance against aged care services in relation to quality of care, and an additional 16 Notices of Non-Compliance against approved providers in relation to prudential matters
- DoHA received notification of 1488 alleged reportable assaults — 1232 were recorded as alleged unreasonable use of force, 239 as alleged unlawful sexual contact, and 17 as both
- there were 745 notifications of unexplained absences of care recipients.

In 2009-10, 618 community aged care organisations providing CACP, EACH, EACH-D and NRCP services were reviewed. The proportion of the reviews for which an outcome 1 (effective processes and systems in place) was achieved was 78.7 per cent.

The CIS received 13 166 contacts during 2009-10:

- just over 61 per cent (8 055 cases) were considered 'in-scope' (relating to an Approved Provider's responsibilities under the Act) and were investigated. The other 39 per cent of cases were either 'out-of-scope' or were resolved with additional information
- almost 97 per cent of 'in-scope' cases related to care and services provided in residential care facilities while the remaining 3 per cent related to community care services
- 931 breaches (11.5 per cent of finalised in-scope cases or 5.8 breaches per 1000 residents) were identified nationally as a result of an investigation.

The number of in-scope cases increased from 7496 in 2007-08 to 8055 in 2009-10 (an increase of around 7.5 per cent).

Source: DoHA (2010n).

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A similar assessment was made by the Australian National Audit Office (ANAO):

Currently, the Accreditation Agency and DoHA largely report performance on an activity basis, such as the number of homes visited as part of the accreditation process and the numbers of Approved Providers on whom sanctions were imposed. By its nature, and in isolation, activity-based reporting limits the extent to which stakeholders can develop an appreciation of regulatory performance and its contribution to improvements in the quality of outcomes. (2011, p. 24)

The Victorian Government also said:

The lack of available public and ‘user friendly’ information regarding the relative quality and/or suitability of the services delivered by providers further exacerbates the difficulty consumers have in choosing a provider. (sub. 420, p. 13)

For care recipients to make sensible choices between providers they need to be informed. Participants pointed to the additional information about quality of care and outcomes available in both the United Kingdom (UK) and the United States (US) that helps older people and their families compare care services (box 10.6). Cam Ansell, for example, said:

To enhance competition and provide valuable information to consumers, consideration should be given to the introduction of a star rating system for aged care accommodation and non-care services. An independent rating system for residential aged care has been successfully implemented in the UK. (Grant Thornton Australia 2011, p. 7)

Until recently, in the UK the Care Quality Commission (CQC) assessed providers of social care services and awarded them a star rating. The CQC and the Social Care Institute for Excellence are now developing a new ‘excellence’ rating which is to be closely linked to best practice standards. The ratings will be subject to an application from the provider, putting the onus on the provider to meet the standards (box 10.6). In the US, information is collected from nursing homes and collated into reports with results at the facility level.

Other participants suggested that information about aged care services could be provided on a website similar to the ‘My Schools’ website. Kerry Williams, for example, said:

Create a ‘my Schools’ website for aged care placements that ranks and provides information about breach’s etc. These facilities end up being peoples homes and it is unfair to move frail aged people surely if more information is readily available providers will be more willing to up their game. (sub. DR501, p. 1)

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### Box 10.6 **Report of information on care: United States and United Kingdom**

In the United States (US) there is a comprehensive system of assessment used within nursing homes and information is collected on a number of clinical care areas and then collated into meaningful data for interpretation. The data generated by the Minimum Data Set/Resident Assessment Instrument is used for quality monitoring. Integral to the process is the use of Quality Indicators (QIs)/ Quality Measures (QMs) and threshold of care. The thresholds are a form of benchmarking providing targets of excellence and poor care. The Center for Health Systems Research and Analysis produces quarterly reports which provide information on facility results with some risk adjustments for resident mix characteristics. According to Courtney et al., the use of QIs is pivotal to improving care and care outcomes:

There is no doubt that, at least in the United States, QIs are proving to be very meaningful tools to improve the care delivered to residents. ... One all-inclusive measure of quality may never be found. However, quality indicators such as those derived from MDS data can serve as a reasonable first step in determining what level of quality exists in a facility. (2007, p. 584)

The US is also developing a Personal Experience Outcomes iNtegrated Interview and Evaluation System as a way of measuring and using personal experience outcomes for people receiving long term care services in the community.

Until recently in the United Kingdom (UK) the Care Quality Commission (CQC) assessed providers of social care services and awarded a star rating. According to the Department of Health, the star ratings (later replaced with quality ratings) were useful in terms of supporting informed choice on the part of users, carers and their families, and assisting commissioners in judging the overall quality of the local care market. The CQC and the Social Care Institute for Excellence are currently developing a new 'excellence' rating for care homes. The excellence rating is to be subject to an application from the provider, not a routine assessment, putting the onus on the provider to meet the standards. The ratings are to be closely linked to the content of best practice standards.

The UK's Department of Health recently launched *Transparency in Outcomes: A Framework for Adult Social Care* — a consultation on a new strategic approach to quality and outcomes in social care. The strategy has three interdependent themes: the outcomes which services achieve for people; the quality of services which underpin those outcomes; and the transparency of the system which allows for public accountability as the safeguard.

The CQC also actively seeks consumer views in assessing the quality of care in both residential aged care and community aged care.

*Sources:* Mor et al. (2003), Courtney et al. (2007), Zimmerman et al. (1995). [www.chsra.wisc.edu](http://www.chsra.wisc.edu), DOH (2010c), (CQC 2011a, b).



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And National Seniors Australia said:

NSA believes that provider performance against standards must be publicly reported to ensure transparency, to drive continuous improvement in quality and efficiency, and to help consumers make informed choices. There should be regular reviews at key points in the implementation of agreed reforms, to ensure that key learnings and unintended consequences are taken into account. The outcomes of these reviews also need to be publicly reported to give the community confidence that their needs remain central to the reform process (sub. 832, p. 9)

United Voice NSW (LHMU) called for the Commission to recommend a publicly available indicator of quality available through the proposed Gateway (sub. DR845).

The National Health and Hospitals Reform Commission's final report also recommended that aged care providers be required to make standardised information on service quality and quality of life publicly available on [agedcareaustralia.gov.au](http://agedcareaustralia.gov.au) to enable older people and their families to compare aged care providers (NHHRC 2009).

### **Information — a driver of better care outcomes and care recipient experiences?**

There is very little comparative analysis and reporting of outcomes achieved by aged care providers. By collecting and publishing information on quality performance measures, care recipients would have better information on which to make choices about care and impose, as a consequence, a discipline on providers to deliver better quality care. As well, providers would be better positioned to benchmark their performance, understand variations in performance and identify best practice. As Courtney et al. said:

To evaluate and improve care delivery, it is ... important to compare resident and facility characteristics and outcomes, making it possible to identify other facilities that achieve better outcomes with similar residents. These types of comparisons encourage clinicians to question previously accepted practices, stimulate them to design and implement better ways of caring for residents, and subsequently improve outcomes (2007, p. 583)

The OECD also argues that better information can create a climate of competition for quality:

There is also the case for making information on the quality of care and the prevalence of adverse outcomes more open and accessible to the public on a regular basis. Publicly available information on quality assessment at the level of the provider could lead to improved consumer protection and create a climate of competition for quality, in particular when combined with greater choice on the part of consumers. (2005b, p. 5)

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And the CQC suggested that greater transparency can encourage a stronger culture of safety:

Things sometimes go wrong when people receive care. It is crucial that organisations report their mistakes and near misses (called ‘incidents’). This is so that they can learn and put things right, which creates a culture of improvement in safety, rather than one of blame. Reporting rates vary from organisation to organisation, but places with few (or no) reported incidents are not necessarily safer. A higher level of reporting can reflect a stronger culture of safety, with a greater potential to learn from incidents and prevent the same things happening again. (2010b, p. 77)

The Victorian Government called for a change in ‘culture’ with a focus on transparency and learning from mistakes underpinned by data:

Fundamental to any such transformation would be a change in culture and a system that encourages transparency and learning from adverse events and system errors to promote sector wide quality improvement. An increased focus on effective clinical governance would be required to drive such change, underpinned by robust data and systems. (sub. 420, pp. 32-3)

Collecting and publishing data on quality indicators can provide insights into areas where things are done well and shed light on areas where there is scope for improvement. This in turn can help create a culture where a focus on continuous improvement comes to the fore, particularly where there are best practice quality indicators against which performance is benchmarked.

Quality of care indicators and the use of benchmarking have become an important vehicle for improving health care quality and compliance with guidelines for best practice care (Werner and Asch 2007). Quality of care outcome measures, however, are to some extent easier to operationalise for health care than for aged care services. As Pratt said:

Most people feel that outcomes-based measurement is a superior method, but they also recognize the difficulty of using it in a field as complex as long term care. (2010, p. 241)

The ultimate objective of aged care is the ‘wellbeing’ or quality of life of the care recipient and, as such, clinical outcomes are only part of what aged care services are about. Nies et al., commenting on outcome measures, said their use in LTC is ‘less prevalent and more tentative’ and:

... this has to do with the objectives of LTC: while quality of care may be the predominant objective in acute health care, in LTC it is a prerequisite for achieving quality of life as the more relevant paradigm. (2010, p. 13)

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The Commission was told by some older Australians that ‘what’ care is delivered is just one factor — ‘who’ delivers the care and ‘how’ the care is delivered are just as important. The family and friends of care recipients also value that their loved ones are treated with respect and dignity. In this context, Reinhard et al. said:

The quality of a long-term services and supports system depends equally on the quality of the care it delivers and on the quality of life that its beneficiaries experience. Therefore, the system must attend to people’s social and emotional needs, not just their needs for help with medical tasks or activities of daily living. In all instances, the delivery of services and support should be free from abuse, neglect, and unsafe or unhealthy practices. (2010, p. 50)

This points to the importance of any assessment of quality of care also taking into account what care recipients and their carers have to say about their care experiences. As a UK paper titled *High Quality Care For All*, said:

Quality of care includes quality of *caring*. This means how personal care is – the compassion, dignity and respect with which patients are treated. It can only be improved by analysing and understanding patient satisfaction with their own experiences. (DOH 2008, p. 53)

That said, outcome measures are also consistent with the Commission’s proposed person-centred approach to care. The UK’s Department of Health, in setting out a framework for adult social care, said:

Outcomes are crucial — they are what should drive all effective services. Social care needs to focus on outcomes because a truly personalised approach means placing the outcomes that matter to people at its heart. Embedding outcomes throughout the social care system will help all levels to think about what the individual needs, and design services to meet those needs. (2010c, p. 7)

And, as noted by the Victorian Government, clinical outcomes will become increasingly important in aged care given the changing profile of care recipients:

While the traditional focus of clinical governance work has been on acute services, improving clinical governance in aged care is equally important, where increasing age, co-morbid conditions and dementia can significantly increase the vulnerability of older people to clinical harm. (sub. 420, p. 34)

However, the evidence about the effectiveness of comparative analysis and the reporting of care quality (largely in the context of health care), is mixed. Some studies suggest no effects or only marginal effects while others have found that publicly reporting information on performance is highly effective in improving the quality of care (Fung et al. 2008; Shekelle et al. 2008; Hibbard 2008). For example, Fung et al., in a systematic review of 45 studies, found that public reporting of hospital performance seemed to stimulate hospitals to make efforts to improve quality but had only a moderate impact on consumers’ selection of a health plan.

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Setting up and maintaining a dataset and making data available is also not without costs and these need to be weighed up against the potential improvements offered by any new data performance indicators. ACSAA supported the reporting of key indicators, suggesting that many providers already collect such information:

The introduction of a system whereby approved providers report key data to the Accreditation Agency has the potential to reshape the current visit-centric processes that are set out in the regulations. Such reporting could include corporate information and clinical and lifestyle indicators that would inform Accreditation Agency's case management. It is understood that most approved providers already collect such information for their own purposes. (sub. 354, p. 7)

An increased focus on performance or outcomes could also mean that fewer resources would need to be devoted to monitoring of compliance with process. As the United Kingdom Department of Health said:

... by describing the ends, not quantifying the means, we can meet our commitment to significantly reduce the burdens placed on local services. (2010c, p. 7)

#### *But what about perverse incentives?*

Increased emphasis on publishing performance outcomes may improve quality of care, but it could also create perverse incentives for providers. As Raleigh and Foot warn:

While public reporting of information on performance may drive improvement, it can also have powerful unintended consequences. Quality measures, especially when they are used in performance assessment, or form part of high-profile national policy, or are made publicly available, or have incentives and sanctions attached can have unintended and damaging consequences. (2010, p. 11)

Providers could focus only on areas that are subject to measurement (maximising the performance of what is measured). There can also a bias to measures that are quantifiable, leaving out qualitative measures for which it is often harder to collect meaningful information.

Providers could also seek to 'game' the system, that is, find ways to achieve performance levels without actually improving the quality of care for care recipients. One provider, for example, suggested that the incidence of falls could be lowered by minimising the opportunities for people to move around facilities by themselves (for example, using a wheelchair rather than allowing the resident to walk). Such an approach would work against the objectives of maintaining care recipients independence, minimising functional decline and improving quality of life. This would be a form of moral hazard.

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Providers could also select those care recipients who would best demonstrate measured improvements, so that the risk of performing poorly against particular outcome measures is minimised. This is a form of adverse selection.

Performance measures should seek to not only cover the important aspects of quality but also provide a holistic picture about quality of care and support (so that if there is gaming involving targeting a few measures, this would be reflected in other measures). Deciding how many indicators should be put in place to get a balanced picture about quality needs careful thought. Too few indicators could distort care priorities and also mean there are unmeasured aspects of care, but this needs to be balanced against the costs of collecting data on a wider range of indicators (Raleigh and Foot 2010). In addition, a deluge of measures might be difficult to comprehend.

The success of using indicators to encourage improvements in quality and outcomes will be dependent on getting the incentives right. As such, the range of indicators and their effectiveness should also be reviewed over time.

#### *What indicators provide insights on quality?*

As discussed above, there is no single measure that can capture the quality of care. But as the wellbeing or quality of life of older Australians is the key reason for putting in place a quality assurance framework, outcome measures for those receiving care would seem to be a crucial feature of any performance framework for aged care. Experts in the field also argue that an outcome-based approach which places priority on resident satisfaction is the key to improving LTC systems (Colombo et al. 2011).

Concerns about the levels and skill mix of staff relative to care recipient profiles, and the importance of this information for care recipients and their families when making choices about care options, also points to the need for published information on inputs as well as outcomes.

Both qualitative and quantitative indicators could be used to obtain an overall or balanced insight into the quality of care being provided.

- Qualitative indicators, such as the experiences of people who use the services, can give rich information about quality (a number of participants spoke about the importance of outcome measures which place priority on care recipient satisfaction, see for example, Quality Aged Care Action Group, Blue Mountains, sub. DR834; NSA sub. 411), but typically the information collected is difficult to aggregate, standardise and compare. ACSAA (sub. 354) acknowledged the importance of more consumer engagement in the making of assessments about

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quality of care and indicated that it had recently talked to consumer groups about how they might gather better information on resident experiences (see also chapter 15).

- Quantitative indicators are easier to aggregate, and standardise but they can be misleading and misinterpreted. Such indicators may emphasise particular features of care quality simply because they are measurable.

The National Health Performance Committee (2004), in establishing the performance framework for health, set out a list of criteria for indicators which suggested that they should:

- *be worth measuring* (the indicators should represent an important and salient aspect of the performance of the system)
- *be measurable for diverse populations*
- *be understood by people who need to act*
- *galvanise action* (the indicators should be of such a nature that action can be taken at the national, state, local or community level, by individuals, organised groups and public and private agencies)
- *be relevant to policy and practice*
- *reflect results of actions when measured over time*
- *be feasible to collect and report*
- *comply with national processes of data definitions.*

The Commission considers that performance measures developed for aged care services should be aligned (as much as possible) with the principles of the aged care system (chapter 4) and aligned with information collected on health care performance.

### ***Building on what is already available***

Some work has already begun on developing aged care quality indicators in Australia.

- The Victorian Government has developed quality indicators for public sector residential aged care facilities and developed standardised, evidence-based care processes for key clinical risk areas via its *Strengthening Care Outcomes for Residents with Evidence* initiative (sub. 420, box 10.7).
- Courtney et al. (2007) developed (in consultation with aged care clinicians and managers) and trialled a Clinical Care Indicators (CCI) Tool for residential care.

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The tool covers four care domains (resident health, personal care, resident lifestyle, care environment) and has 21-item Clinical Indicators (including, for example, indicators such as pressure ulcer rates, infections, pain management, hydration status, falls, depression).

- The Campbell Report (DoHA 2007) developed a draft suite of quality indicators.
- The AIHW (2008d) developed a set of performance indicators across the health and aged care system following agreement on the need for such indicators at the Australian Health Minister's conference of 29 February 2008.
- The Steering Committee for the Review of Government Service Provision (SCRGSP 2010b) also publishes performance data including (amongst other indicators) indicators on selected adverse events in residential care and hospitalisation for falls in residential aged care facilities.

The existing aged care data collections (both in Australia and overseas) and insights from pilot testing should form the basis for developing any national standardised quality and outcomes dataset for aged care services.

#### **Box 10.7 Strengthening Care Outcomes for Residents with Evidence**

'SCORE': Strengthening Care Outcomes for Residents with Evidence is an initiative commissioned to support Victorian Health Services operating aged care homes to provide high quality care to residents. SCORE has a focus on managing some key areas of risk for residents and seeks to develop and implement evidence based standardised care processes. The Australian Centre for Evidence Based Aged Care is engaged to develop and implement phase one of SCORE.

In the scoping and development of standardised care processes, the categories of clinical risks identified through SCORE included abuse, constipation, delirium, diabetes management, pain, depression, palliative care, falls, infections, medication management, oral and dental hygiene, skin integrity, functional decline, sleep management, hydration and nutrition, swallowing disorders, incontinence and unmet needs behaviours.

The following 10 areas of risk were prioritised and draft evidence based standardised care processes developed for each risk: alternatives to physical restraint, unplanned weight loss, responding to a choking episode, oral and dental hygiene, polypharmacy, response to a hypoglycaemic episode, depression, delirium, constipation, dehydration.

Phase two has commenced and will involve the broader development and implementation of the care processes and tools across public service residential care facilities in Victoria.

Source: <http://www.health.vic.gov.au/agedcare/services/score.htm>.

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### *Where does that leave us?*

The Commission considers that a stronger emphasis on publicly reported performance information would help care recipients make more informed choices over services and improve transparency around how care dollars are spent. This will be particularly important in the context of the Commission's proposed entitlement system, which confers more control and choice of aged care services in the hands of older Australians.

In chapter 15, the Commission recommends that the ACSAA be made a statutory agency within the proposed AACC (recommendation 15.1). Accordingly, the responsibility in implementing change to quality accreditation would lie with the AACC.

The Commission recommends that the quality assurance framework for aged care, and the accreditation role of the AACC be expanded to include collecting, collating and disseminating quality performance indicators. The indicators should make up a new Quality and Outcomes Data Set and should be aligned with the objectives of the aged care system (and where appropriate with health care indicators) and determined in consultation with care recipients, aged care providers, health professionals and peak bodies. Lessons from the development of other countries LTC quality frameworks should also be drawn on in developing the Data Set.

As discussed in chapter 16, the Commission is proposing that the AACC also play a central role in the collection of national data sets on aged care and facilitating the links to data within Medicare. Accordingly, the AACC should build on any relevant data currently available and make publicly available for research, evaluation and analysis the results from the Quality and Outcomes Data Set.

#### RECOMMENDATION 10.1

***The quality assurance framework for aged care should be expanded to include published quality indicators at the service provider level to help care recipients and their families make informed choices about care and to enhance transparency and accountability about funds spent on care. The Australian Aged Care Commission should develop a Quality and Outcomes Data Set for use by care recipients and bring together evidence on best practice care, with the information openly accessible via the Gateway.***



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## 10.5 Access to health care and what it means for quality care

A number of inquiry participants expressed concern that older Australians in aged care facilities (and in some cases those living in the community) are not always able to access appropriate medical care and that this affects the quality of care they receive. Mercy Health, for example, said:

Nurses working in the aged care sector are generalist. Given the increasing acuity, residential aged care facilities require improved access to specialist services ... Residential services should be seen as a true extension of the broader health network, not simply a 'storage place' for the frail elderly without any ongoing support. (sub. DR781, pp. 2-3)

Good partnerships between health and aged care and a skilled aged care workforce are vital for high quality care and for avoiding unnecessary hospital admissions (Australians aged 65 years or over account for around 50 per cent of all patient days in public hospitals, AIHW 2009a). A recent OECD paper said:

The links between health and long-term care are significant. There is potentially scope for efficiency gains by managing the interactions. (Colombo et al. 2011, p. 35)

With residents entering residential care later and with more complex care needs, interactions with the health care system will become increasingly important. As DoHA put it:

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. (sub. 482, p. 59)

The trend of rising acuity of care recipients points to the need for a more skilled health workforce. DoHA also said:

... 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. (sub. 482, p. 59)

But there seems to be a disconnect because, as discussed in chapter 14 and earlier in this chapter, changes in the composition of the aged care workforce have seen the proportion of both registered nurses and enrolled nurses employed in aged care facilities decline in recent years, while the level of acuity has risen.

Given this trend, there will be an increased need for care recipients to have access to specialised nursing expertise and specialist health teams to provide clinical leadership and care management (particularly in areas such as palliative and end-of-

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life care and in the area of behavioural management skills). Reinhard et al. is of the view that:

High-performing systems must integrate long-term services and supports with health-related services such as clinician services and physical therapy, as well as with social supports such as transportation. In addition, the systems should avoid unnecessary transitions between settings — for example, from a nursing home to a hospital — and ensure the smooth coordination of necessary transitions, such as from a hospital to home. (2010, p. 50)

But integrating aged care services with health care is not without its challenges. As a recent paper from the OECD noted:

Long-term care systems operate in close link with health care. However, it can be hard for the user to navigate the health and care crossroad, care continuum is not always guaranteed, and providers face inefficiencies and cost-shifting incentives. (Colombo et al. 2011, p. 307)

### **Access to medical and allied health professionals**

Access to medical and allied health professionals is essential for quality of care for older people. According to the AIHW (2007a) for older Australians, the average number of visits to a general practitioner (GPs) is more than double that of people less than 65 years of age and the highest number of visits is for people aged 85 years and over. As the Australian Medical Association (AMA) said:

In the same way that medical practitioners are an integral part of the hospital workforce, medical practitioners and other health practitioners comprising the GP-led team are an integral part of the aged care workforce, particularly in residential aged care. They are central (not peripheral) to the provision of quality care to older people across all care settings. (sub. DR653, p. 1)

Concerns about the quality of care for older Australians being threatened because of inadequate access to GPs and allied health professionals in residential aged care facilities, and in older people's homes, were raised by many participants. Many said that at a time in life when their care needs were highest, access to a GP was the most difficult. Timely access to a GP can prevent deterioration in the health and wellbeing of older people and a move to a more expensive care setting.

The Consumers Health Forum of Australia presented results from a Survey of Access to General Practice Services in Residential Aged Care (2010) which showed that:

- more than 70 per cent of surveyed consumers had entered aged care homes in circumstances where health practitioners had declined to continue to provide services to them

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- 68 per cent of respondents reported difficulty accessing primary health care services and 15 per cent of respondents experienced difficulties in accessing health services such that it compromised their care
  - 63 per cent of aged care facilities in cities and 80 per cent of aged care facilities in regional areas regarded accessing health services as an ongoing struggle
  - 75 per cent of aged care facilities reported difficulty in accessing GP services, including locum services, with the result that residents were transferred to hospital emergency departments (sub. DR584, p. 5).

The AMA reported a number of obstacles confronting GPs who wished to provide medical services in residential settings, including ‘inadequate’ subsidies through the Medical Benefits Schedule (MBS) for GP services, particularly in complex cases where there is significant non face-to-face time involved in providing medical care:

It is well known that Medicare rebates are inadequate to cover the costs of providing medical care to residents in aged care homes, and do not reimburse the non face-to-face time required to provide that care. This is a significant deterrent to providing care, particularly for younger doctors who do not find providing medical services to aged care attractive in the current environment. (sub. DR653, p. 4)

The AMA also noted that inadequately equipped clinical treatment areas are a barrier to providing medical services in some aged care facilities, and that the use of agency staff who are not familiar with residents can compromise the quality and continuity of care (box 10.8). In an AMA survey of 750 GPs in 2008, 15 per cent of GPs said that they intended to reduce the number of visits to residential aged care facilities over the next two years and 7 per cent reported they would stop visiting altogether if the current barriers to the delivery of medical care were not addressed (sub. 330, p. 5).

The AMA also acknowledged that ‘caring for older people in their homes is an expensive proposition for many private medical practitioners’ (sub. DR653, p. 2). The *Bettering the Evaluation and Care of Health* report found that there had been 690 000 fewer home visits nationally by GPs in 2009-10 compared with 10 years earlier. And, like visits to residential care facilities, home visits are declining because they are time consuming, remuneration is relatively poor and there are concerns about personal safety (Joyce and Pitterman 2008).

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### Box 10.8 **Obstacles to providing medical services in residential settings**

According to the AMA, there are a number of obstacles to providing medical services in residential settings, such as:

- a lack of access to registered nurses with whom to coordinate care
- an increasing use by residential aged care facilities of agency staff who are not familiar with residents, which compromises continuity of care
- poor access to properly equipped clinical treatment rooms, which limits the medical treatment that can be provided in that setting
- an absence of information technology infrastructure to facilitate access to electronic patient records and medication management, including software appropriate to the needs of GP's
- a strong financial disincentive for the doctor to leave their surgery, with all its attendant costs, to provide services in residential aged care
- a growing tendency to build residential aged care facilities in the outer growth corridors or 'urban fringe' of metropolitan areas which further adds to the time spent by doctors away from their surgeries.

*Source:* AMA (sub. 330).

The Australian Government has attempted to increase access to GP services for older people in residential aged care settings through the GP Aged Care Access Initiative as part of the Practice Incentives Program (PIP). Under this initiative, GPs affiliated with a PIP practice are paid an incentive payment (up to a maximum of \$3000 per annum) depending on the number of specific MBS-itemised services delivered in these settings. Initial analysis indicates that the number of qualifying services has increased at a faster rate than comparable services (ANAO 2010). DoHA considers that this initiative has been:

... effective in increasing GP service delivery to residents of RACFs, noting that this is an assessment relatively soon after payment implementation. (ANAO 2010, p. 163)

But, despite the initiative, the AMA continues to argue that the Medicare payment for GPs to provide care in residential care facilities is inadequate. The AMA also argues that, in the absence of an aged care accreditation standard to arrange medical care for residents, there is no incentive for facilities to facilitate GP visits.

Aged care providers have an inherent responsibility to guarantee residents access to ongoing medical care and supervision. Yet there is no aged care accreditation standard which requires aged care providers to arrange medical care for their residents. In the absence of such a standard, there is no process for monitoring whether residents are

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receiving medical care, and there is no incentive for providers of residential aged care to facilitate attendance by GP's. (sub. 330, pp. 5-6)

The Commission's proposed Quality and Outcomes Data Set (which would include clinical care indicators) would address this concern and make more transparent the clinical care outcomes from the services provided.

That said, older Australians living in residential care should be able to access publicly-funded health services (including primary health services) in the same way as they would if they were living in the community. Also, if people cannot receive GP services they may end up in the emergency department of a hospital calling on resources in limited supply (and potentially limiting the ability of these departments to deal with other cases).

But, if GPs are to deliver services in residential care and home settings, there must be adequate incentives to provide such services, that is, Medicare rebates must be sufficient to cover the cost to GPs (taking into account the alternative use of the GPs time) of providing this care. The AMA said that:

Medicare rebates for medical services in residential aged care need to reflect the complexity and amount of clinically relevant non-face to face time in providing medical care to residents. Medicare Benefits Schedule items must reflect innovations that exist in other areas of the MBS by expanding the scope of tasks practice nurses can perform on behalf of doctors in the residential aged care setting. (sub. 330, p. 8)

The Commission considers that the MBS fee for residential care and community visits should be independently reviewed and (if appropriate) adjustments made so that the payment is adequate to cover the costs of providing the service. It may also be appropriate to review whether a residential facility could receive direct funding to provide medical (including GP) services as a block to its residents rather than individual residents contracting separately. There are likely to be economies from a doctor (or several doctors) specialising in the provision of medical care in one or more residential facilities.

There is also the costs associated with GP support services which currently are incurred by aged care providers, including for example, visiting rooms, dedicated equipment and IT support. The National Health and Hospital Reform Commission (NHHRC) recommended that funding be provided for use by residential aged care providers to make arrangements with primary health care providers and geriatricians to provide visiting sessional and oncall medical care to residents of aged care homes. The AMA was supportive of such an approach, stating that:

Dedicated funding from Government would allow aged care providers to enter into arrangements with local doctors to provide ongoing medical services to residents. Payments under these arrangements would offset the lost business costs that medical

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practitioners incur while they are not providing services in their surgeries and would be over and above the MBS fee for service payments which would continue to be claimed for each medical service provided to a resident in a residential aged care facility. (sub. 330, pp. 6-7)

The Commission suggests that the costs to providers of supporting GPs, geriatricians, and other specialist teams (such as palliative care specialists) be taken into account by the proposed AACC when recommending the costs of delivering care.

More extensive exposure to geriatric and aged care clinical practices in the core teaching of medical, nursing and allied health students may also encourage medical practitioners and other professions into the aged care field, which in turn could enhance the quality of care for older Australians (chapter 14). The AMA supported the development of teaching residential care facilities:

The provision of appropriate and accredited clinical training places in residential aged care would add to the overall breadth and depth of medical training and improve the quality of care of residents. It would encourage younger doctors to visit residential aged care, and educate the next generation of doctors about caring for the aged as part of routine medical practice. (sub. 330, p. 8)

Several aged care providers advised that they had formed strategic alliances with GPs and GP clinics to ensure that their services are available in a timely manner. Some GP practices are also making extensive use of practice nurses to deliver health care, including to older people. There has also been the development of gerontological nurse practitioners who service a number of aged care facilities efficiently and effectively. But there are limited positions available in aged care largely because under current arrangements the funding does not appear adequate to cover such positions. There would seem to be opportunities for industry networking groups to play a useful role in disseminating the lessons from such initiatives to inform other providers considering forming similar alliances.

Access to allied health professionals is also constrained by government subsidy restrictions. The Australian General Practice Network (AGPN) reports:

Access to allied health professionals for residents in RACFs is also, anecdotally, inconsistent and commonly limited and suboptimal ... AGPN members have also noted significant gaps in services, particularly allied health services, to support resident rehabilitation following a major health event, which may have prompted admission to the facility or require hospitalisation. (sub. 295, p. 5)

Under Medicare, Australians with chronic diseases are only entitled to five subsidised visits to allied health practitioners each year. However, as outlined by the Dieticians Association of Australia:

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People with a chronic disease often require multiple visits with a number of allied health service providers to achieve improved health outcomes and better management of their chronic condition/s. (sub. 371, p. 5)

However, the Australian Government is supporting an expanded Aged Care Access Initiative to improve access to allied health professionals for aged care residents:

Reports from GPNs [General Practice Networks] implementing the allied health components of the ACAI model suggest this initiative is working effectively to provide better access to timely allied health services for RACF residents ... Both GPNs and facilities have commented that without ACAI programs these services would not have been provided. (AGPN, sub. 295, p. 7)

The Commission strongly supports improving the means by which older Australians are able to more effectively access services by allied health practitioners.

RECOMMENDATION 10.2

*The Medicare rebate for medical services provided by general practitioners visiting residential aged care facilities and people in their homes should be independently reviewed to ensure that it covers the cost of providing the service.*

### **Promoting team-based care**

As outlined by the Commission in *Australia's Health Workforce* (PC 2005a), there is a much greater need for multi-disciplinary team-based care to meet the demands from an ageing population for the treatment of chronic conditions. Initiatives such as the Hospital Admission Risk Program in Victoria aim:

... to maximise collaboration across multiple levels of the health system, including hospitals, community providers, clinical health professionals, general practices, ambulance services, consumers, carers and research bodies, in order to achieve effective and sustainable change in health service delivery. (DHS 2006, p. 2)

While the AMA considered that:

The delivery of medical care to older people outside of the doctor's surgery, including models of care where the doctor delegates tasks to practice and/or specialised nurses, and/or other health practitioners within a team based model of care, will have an immediate impact on improving access to medical care. (sub. 330, p. 2)

Chapter 9 supports the development of collaborative team-based health and care services as an efficient model to deliver appropriate care for older Australians. The development of regionally or locally-based multi-disciplinary aged care health teams has the potential to increase the attractiveness of aged care to health professionals because of the peer support and professional development

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opportunities. It is likely to lead to a more holistic approach to client care and innovative practice development.

On the specific issue of care coordination, the Commission is proposing that this function be undertaken as part of the proposed Gateway and that case management be an approved service entitlement, when required.

## **Palliative and end-of-life care**

A key area of concern raised by participants in the context of quality of care was palliative and end-of-life care (box 10.9). While palliative and end-of-life care should be core business for aged care services — around 50 000 older Australians approach death or die each year in residential aged care facilities — many participants claimed that the end-of-life care needs of older Australians are not being well met under the current arrangements for community and residential aged care (box 10.10).

It is usually the preference of older people to die in familiar surrounds (in their own homes or in the facility they are living in), so they can be cared for by people they know rather than having to move to unfamiliar surroundings such as a casualty or hospital ward. But it was argued that there are limited options for this when it comes to receiving specialist care. Palliative Care NSW and Palliative Care Advisor's Group NSW, for example, said:

According to the literature, patients and families commonly express the wish to have their palliative care at home and wherever possible to die at home. The lack of available, appropriate and timely services often means patients and carers cannot achieve this goal. (sub. 445, p. 1)

While it was acknowledged that some aged care facilities provide excellent palliative and end-of-life care, the general view from many participants was that it was poorly provided in many residential facilities. Eastern Palliative Care Association said that while palliative care was 'core business' for aged care facilities, often staff were not equipped with the appropriate skills:

... we find that the quality of direct care staff in aged care facilities fluctuates, some facilities have excellent proactive well trained and competent care staff, other facilities employ care staff that have absolutely no understanding of the palliative approach and the specialist nursing care required for good palliative care for these residents. It is our view that a sound understanding of the palliative approach would be 'core business' and imperative in the aged care sector. (sub. DR570, p. 4)



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### Box 10.9 Defining palliative and end-of-life care

**Palliative care** — is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten nor postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patients illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if required
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

**End-of-life (terminal) care** — is a form of palliative care that is appropriate when the resident is in his or her final days or weeks of life. End-of-life care requires that the care recipient's decisions are reviewed more frequently and that the goals of care are more sharply focused on the resident's physical, emotional and spiritual comfort needs, and support for the family.

Sources: NHMRC (2006); PCA (2008).

Palliative Care Australia said:

Access to, and the quality of, palliative care is diverse and inconsistent in residential aged care. Some aged care facilities enjoy ready access to primary care physicians well skilled in palliative care and to specialist palliative care physicians. Some facilities, particularly high care facilities, have systems in place to limit hospitalisations by providing care in-place. (sub. 77, p. 8)

Too often, older Australians are transferred to acute care hospitals for pain management and to die, due to insufficient expertise being available in the residential or home environment. Palliative Care Australia said:

An expansion of aged care services for older people with chronic conditions will need to be complemented by an expansion of the capacity and competence of primary health

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care services to provide generalist palliative care for people living in the community and in aged care homes, supported by increased collaboration and networking with expanded specialist palliative care services. (sub. 77, p. 4)

A key area of concern is the lack of knowledge and skill among the aged care workforce in the area of palliative and end-of-life care (box 10.10). For example, Eastern Palliative Care, said:

One of the cornerstones of excellent palliative care provision is ‘impeccable assessment’. This cannot be fulfilled, nor should it be expected to be fulfilled by a PCW [Palliative Care Worker]. ... As a specialist palliative care organisation, our experience is that there are multiple issues that arise in facilities due to a lack of Registered Nurses. We find that there is often poor identification and assessment of pain and other symptoms. (sub. DR570, pp. 2-3)

And a family carer said:

Speaking from personal experience, (as a relative of a person who was in an ACF due to the need for palliative care) I acknowledge the dedication of carers. However, I am very concerned about the skill and available time for staff to provide this extremely complex and important end-of-life care. The fact that I was able to advocate on my relative’s behalf was good for him however I am really concerned about all the other residents who don’t have someone with the skills and knowledge to do this for them. (Jan Coad, sub. 54, pp. 1-2)

In the Commission’s view, there is a strong case for a greater role for residential and community care providers to deliver excellent palliative and end-of-life care. Not only is this likely to be less expensive than equivalent services delivered in a hospital, but more appropriate care can be provided in a home-like environment that best meets the desires of the dying. As the UK’s Care Quality Commission (CQC) said:

Where money may be shifted from one part of the system to another, the transformation of services may sometimes be cost neutral, rather than reducing costs. However, if such service transformation results in improved outcomes for those using the services and a greater sense of empowerment and quality of life, then this certainly represents far greater value for money for all involved. (2010b, p. 49)

Palliative Care Australia states that the current ACFI subsidy for palliative care is around one-third of the amount that specialist palliative care services receive (sub. 77). Participants suggested expanding the ACFI to cover palliative care. Warrigal Care said:

Expand the ACFI to include a hospital bed funding level to allow acute aged care residents to transfer to aged care facilities with their health service needs being met at the aged care home and a phased and diminishing level to return to the person’s ACFI rate. (sub. 279, p. 2)

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### **Box 10.10 Participants comments about palliative and end-of-life care available to older Australians**

Roger Hunt:

Possibly more deaths will occur in RACFs than in any other setting in the foreseeable future. There are several impediments, however, to the provision of palliative care in RACFs:

- The number of available nursing hours falls well short of that required for labour-intensive terminal care.
- GP workforce shortages, the corporatisation of practices, the relatively poor remuneration of RACF consultations, and the lack of support systems (IT, limited medication imprests, lack of treatment rooms and equipment etc) results in many residents being poorly serviced.
- The knowledge and skills of nurses, carers and GPs for palliative and terminal care is suboptimal.
- Medical specialists usually do not attend RACFs, and specialist palliative services are less likely to be involved in the care of cancer patients who die in RACFs compared to cancer patients who die in other settings.
- The availability of allied health care services (social work, physiotherapy, occupational therapy etc) is also quite limited. (sub. 12, p. 1)

Australian General Practice Network said:

... despite a plethora of effective programs there remains limitations in the knowledge of aged care staff about working within a palliative approach, associated with a somewhat adhoc approach to who receives education in this approach. There also remains limitations in the confidence and competence of some GPs to provide palliative care, which may be frustrated by limited access to advice and support from a palliative care specialist. These limitations can negatively impact the quality of care and end-of-life experience of patients. (sub. 295, p. 9)

Eastern Palliative Care:

So from our perspective, one of the things that impacts on our ability to provide good quality palliative care in aged care facilities is a lack of qualified RN division 1s who are able to administer medication when required. (K. Draper, trans. p. 384)

Palliative Care Australia:

... ensure that primary care services offer a team-based range of services including general practice, allied health and nursing supports, with referral pathways to and from specialist services, to ... meet the needs of people at the end of life. (sub. 77, p. 14)

Hal Kendig:

We need to identify best practice on appropriate palliative care for providing comfort, dignity and support in line with the preferences of older people and their family through to the end of life. (sub. 431, p. 14)

Older Australians should have access to specialist palliative care irrespective of their care setting. It can lead to a more efficient use of services (including reducing the strain on public hospitals) and result in better care outcomes for older Australians. Payments for palliative and end-of-life care services should be aligned

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with those provided in other health care settings to ensure that those people receiving palliative care in residential facilities do not receive a lower standard of palliative care than someone in an alternative setting.

But good quality palliative and end-of-life care services can only be provided in residential and community aged care settings if staff are adequately trained and resourced. Given that palliative and end-of-life care is 'core' aged care business, it should be a basic competency of aged care worker training.

Specialist palliative care services could also complement the care provided by residential care staff and GPs (as is done in hospitals). The Australian Healthcare & Hospitals Association supports:

... the need for better access to specialist palliative care services and would like to see more emphasis placed on up-skilling a range of health professionals at all levels in palliative and end-of-life care. (sub. DR732, p. 2)

There is a National Palliative Care Strategy 2010 (Australian Government 2010i) in place (box 10.11), guidelines for a Palliative Approach in Residential Aged Care (endorsed by the National Health and Medical Research Council in 2005), and also guidelines for a palliative approach for aged care in a community setting which are soon to be released. At a minimum, best practice guidelines for palliative care should be used by providers of aged care to improve routine care. Funding for Palliative Care Australia should be such that it is able to educate and provide advice to providers about applying the best practice guidelines. Palliative Care Australia also recommended a formal link between the standards for providing quality palliative care and the Residential Aged Care Accreditation Standards.

One participant suggested that residential care facilities should have a specialised nurse to lead the delivery of palliative and end-of-life care in their facility. The specialist nurse would be educated in workshops and seminars provided by specialist palliative care services to improve knowledge and skills in palliative care (Roger Hunt, sub. 12).

Another model is for outreach teams to provide a pro-active service by visiting residential aged care facilities on a regular basis to provide advice, supervision and training. Indeed, the two models could reinforce each other, with the specialist nurse being supported, when required, by an outreach team.

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### Box 10.11 National Palliative Care Strategy 2010

Supporting Australians to Live Well at the End of Life (the National Palliative Care Strategy 2010) — was developed following extensive consultation and research. The goal areas identified included:

- awareness and understanding
  - to significantly improve the appreciation of dying and death as a normal part of the life continuum.
  - to enhance community and professional awareness of the scope of, and benefits of timely and appropriate access to, palliative care services.
- appropriateness and effectiveness
  - appropriate and effective palliative care is available to all Australians based on need.
- leadership and governance
  - to support the collaborative, proactive, effective governance of national palliative care
  - strategies, resources and approaches
- capacity and capability.
- to build and enhance the capacity of all relevant sectors in health and human services to provide quality palliative care.

*Source:* Australian Government (2010i)

In the draft report, the Commission proposed case mix funding payments for palliative care, the objective being that funding for palliative care across care settings should be such that equivalent levels of care could be provided. However, a number of participants expressed concern about such a model for palliative care (HammondCare Group, sub. DR666; Australian Healthcare & Hospitals Association, sub. DR732; Palliative Care Australia, sub. DR731). Palliative Care Australia, for example, said:

PCA is concerned at the appropriateness of a case mix funding model for palliative care. Inherent in palliative care is a multidisciplinary team approach, with different team members providing different care and different intensity of care at different times, fully dependent on the needs of the patient and their family/loved ones. Potentially the funding flexibility needed to properly deliver palliative care could be met through a mix of block funding and case mix, but further evidence would need to be gathered on the ability of a case mix model to truly meet patient and family needs, and for it to be adequate across both residential and community settings. (sub. DR731, pp. 3-4)

HammondCare Group suggested having a specific program and funding mechanism for palliative care (covering palliative care provided in the community, residential care and hospitals), as a way of creating policy indifference between residential,

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home or hospital stay (sub. DR666). This is one approach for achieving neutral outcomes across settings. Another would be to have the proposed AACC consult with the Independent Hospital Pricing Authority when making recommendations on the cost of care to ensure that palliative care across care settings is funded such that equivalent levels of care can be provided.

### *Advance care planning*

Palliative Care Australia defines advance care planning as a process to help people formulate and communicate their preferences regarding care during future incapacity. Advance care planning gives the person the opportunity to determine the likely scenarios coming towards the end of their life, including the treatment they receive and the way they would like to be cared for. This is consistent with a personalised approach to care as it is about shifting control to the individual and letting them have a say about how they want their care needs met (PCA 2008).

Advance care planning was identified by a number of participants as an important component of effective palliative and end-of-life care, not only in terms of better outcomes for care recipients and their families, but also in terms of savings for the health budget. Respecting Patient Choices, ‘Making Health Choices’ Steering Committee said:

We would suggest that advance care planning is a key component of consumer choice and patient centred care, and that its inclusion in the reform of the aged care system will help to improve the provision of high quality care and provide protection for this vulnerable population. (sub. DR803, p. 2)

The Victorian Healthcare Association (VHA) also said:

The VHA believes that a greater focus on advance care planning, respecting patient choices and appropriate clinical governance has the potential to improve lifestyle and care provision for ageing Australians. A shift from the current clinically driven model to a person centred approach that respects quality of life and wellbeing should be the ultimate aim of the service system. (sub. DR668, p. 4)

And Roger Hunt:

Satisfaction with care is improved when residents are given the opportunity to express their wishes about their management, and clinicians show a willingness to respect their wishes. The Respecting Patient Choices Program (RPCP) offers an established model for advance care planning that can be successfully implemented in RACFs. Most residents who make an AD declare a wish to remain in the RACF for palliative care at the end of their lives. This will help to reduce pressure on hospitals. It is incumbent on the providers of care to ensure these residents get their palliative needs met in the setting of their choice (sub. 12, p. 2)

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A Respecting Patient Choices Program conducted in 17 residential care facilities during 2004-05 found that residents that were introduced to the programs had an 18 per cent likelihood of being admitted to hospital with a mean length of stay of 6.9 days. In contrast, those residents not introduced to the program had a 46 per cent likelihood of admission to hospital with a mean length of stay of 15.3 days prior to death.

Bill Silvester (Respecting Patient Choice Program), giving evidence at the Commission's Melbourne Hearings, said:

It is crazy that we have a system whereby we're doing things for patients which cost a lot of money and which use a lot of resources and which the patient never even wanted, if people had only bothered to find out. (trans. p. 440)

Given that advance care plans can result in a 'win-win' situation, there is a case for assisting care recipients, their families and health professionals and care workers to be better informed about advance care planning and the common law rights of people to make decisions about their medical treatment (including the right to decline treatment). But, as acknowledged by the AMA, death is not something we like to talk about:

Having a conversation about how a person wishes to be cared for at his or her end of life is a difficult social issue. Our health care system must give older people the opportunity to die a proper and dignified death. Our community needs to be educated about the reality of death and dying. (sub. 330, p. 10)

The Commission suggests that funding should be made available for community awareness education (which could be linked to better informing Australians about the probability of needing care, chapters 7 and 16) about the importance of talking about dying and advance care directives. Health professionals and aged care providers also need to be appropriately trained to talk to care recipients about end-of-life issues and assist them to put in place advance care directives. The AMA's Position Statement on the Role of the Medical Practitioner in Advance Care Planning endorses the key role of the doctor in providing guidance, advice and in discussing treatment issues related to incapacitating conditions and/or future health care options with patients, as part of the therapeutic relationship (sub. 330).

As discussed in chapter 15, in 2009 Australia's Health Ministers endorsed the development of nationally consistent best practice guidelines for the use and application of advance care directives and a draft National Framework for Advance Care Directives has been produced.

The effective communication of advance care plans between health care sectors (for example, from hospital to residential aged care facilities and vice versa) is vital if patients' treatment preferences and end-of-life care wishes are to be known and

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respected. Advance care plans should be included in the proposed electronic records.

RECOMMENDATION 10.3

*The Australian Government should ensure that residential and community care providers receive appropriate payments for delivering palliative and end-of-life care. These payments should form part of the assessed entitlement determined by the Gateway assessment process. The appropriate payment for palliative and end-of-life care should be determined by the Government on the transparent advice of the Australian Aged Care Commission and in consultation with the National Hospital Pricing Authority.*

RECOMMENDATION 10.4

*Providers of aged care services should have staff trained to be able to discuss and put in place advance care directives.*

*Funding should be made available for community awareness education about advance care planning.*

*Advance care directives should be included in the proposed electronic records.*

## **Mental health care for older Australians**

With predictions of an increase in the number of people with dementia in Australia (chapter 3), and relatively few specialist psychogeriatric aged care homes and high dependency units, the expectation is that there will be many more older people with mental illnesses in years to come that will require management in generic settings. Also, the specialist nature of care provided will require different staff selection criteria, skills mix and support for staff than in mainstream residential aged care facilities. Care recipients with severe behavioural needs and/or comorbid psychiatric disorders often require specialist mental health services.

High rates of depression among older people living in residential aged care facilities was also raised as an area of particular concern. Although the exact rates of depression and anxiety are not known, research conducted by beyondblue indicates that between 10-15 per cent of older people living in the community experience depression and approximately 10 per cent experience anxiety (beyondblue sub. 216). Rates of depression among older people living in residential aged care, however, are much higher. A recent Australian study indicated that between 34-41 per cent of aged care residents experience depression (Snowdon and Fleming 2008). There was also some evidence to suggest that diagnosis and treatment of people



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with mental health disorders in residential care facilities often fails to occur. The Royal Australian and NZ College of Psychiatrists, for example, said that older Australians are less likely than younger adults to be referred for specialist mental health treatment (sub. 73).

Like other areas of health care, residents of aged care facilities should have access to appropriate mental health care services. Ensuring that residents have appropriate treatment would not only improve the quality of their lives, but may also reduce the need for more expensive treatment (including hospitalisation). Hospitals are also not always safe places for people with dementia. For example, in acute care settings, care recipients may not be identified as having dementia and therefore not be treated appropriately.

It was suggested by beyondblue that introducing and supporting consistent and standardised training for residential and community aged care staff was needed to facilitate improved detection and management of depression among older people in these settings. The Victorian Government also said:

Prevention, early intervention, recovery and social inclusion lie at the heart of the new agenda. For older people this includes reducing isolation and increasing social inclusion as a means of preventing depression and anxiety. It includes ensuring that there are a range of service options, and preference is given to the least restrictive care and treatment option. It also includes ensuring that mainstream aged care services have capacity to identify emerging or escalating mental health problems and ensure that the right care and treatment is accessed at the right time. (sub, 420, p. 20)

A greater focus on reporting care recipients' experiences with care services and outcome indicators will also provide an incentive for providers to ensure staff are adequately trained to diagnose and seek appropriate treatment for mental health concerns of care recipients. Stronger partnerships with specialist mental health teams are also likely to be encouraged as providers will have an incentive to prevent mental health problems from escalating.

## **Summing up**

There can be benefits to care recipients, staff and providers from developing stronger links between health care and aged care services. More integrated care can also lead to a more efficient use of services and funds devoted to care (by helping people to stay in the community longer, reducing both transfers to hospitals and multiple assessments).

However, for there to be better integration of services, the incentives for medical professions and multidisciplinary teams will need to be such that, when the health

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needs of older Australians are greater than what aged care providers can manage, additional health resources can be accessed.

Outcome indicators that are aligned between health and aged care services should also shed light on what services are achieving in the different sectors and provide an evidence base for further quality improvements. Outcome indicators that capture the interface could also promote shared accountability.

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# 11 Catering for diversity

## Key Points

- The Australian population is diverse and this is reflected in the needs and preferences of older people who require aged care services.
- A number of special needs groups are defined in the *Aged Care Act 1997* and associated principles for the planning and allocation of aged care places.
- An expected outcome of the quality and accreditation standards is that providers meet the needs and preferences of care recipients with special needs.
  - Not all special needs groups require additional services or higher levels of funding but many require services to be respectful of, and responsive to, their needs.
  - Concerns were raised about some mainstream aged care services discriminating against individuals with special needs because the higher costs associated with delivering appropriate care to them are inadequately funded.
- The aged care system should cater for diversity in all client groups by ensuring access to services for all older Australians that are delivered in an appropriate manner, to the extent feasible.
- Staff need the skills to deliver appropriate care to individuals with special needs. Training for aged care workers caring for these groups is likely to result in better outcomes for care recipients.
- Language and culturally relevant consultation services need to be extended so that older Australians from culturally and linguistically diverse backgrounds can make more informed decisions about their aged care and more effectively communicate so that their care needs are better understood and matched to their preferences.
- Providers of Indigenous services and services in rural and remote areas should be actively supported to ensure sustainable, responsive and culturally secure services.
- Block funding for certain specialised services (such as to the homeless) should occur where there is a demonstrated need to do so based on a detailed consideration of specific service needs and concerns about timely and appropriate access, and where such funding is cost effective.

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This chapter evaluates how well aged care services are being delivered in ways that meet the needs and preferences of clients with special and/or additional needs. It also looks at how these needs might be better met in a reformed aged care system.

The chapter begins by providing an overview of the diversity in the demand for aged care services and sets out some principles for responding to this diversity (section 11.1). Other sections explore issues relating to specific groups, including the socially disadvantaged (section 11.2), culturally and linguistically diverse people (section 11.3), gay, lesbian, bisexual, transgender and intersex people (section 11.4), veterans (section 11.5), Indigenous people (section 11.6), and people living in rural and remote areas (section 11.7).

Some older Australians may have quite complex aged care requirements as a result of multiple special needs, such as a socially disadvantaged older person from a non-English speaking background, living in rural Australia.

## **11.1 Diversity in demand for aged care services**

Aged care services are delivered in a variety of locations to a diverse population of older Australians from very different social and cultural backgrounds. The needs and preferences of some older Australians can be very different to those of mainstream care recipients and these should be catered for in the provision of aged care services. Diversity in this context relates to the non-health attributes of particular groups of older people which can affect the delivery of appropriate aged care services. However, some groups may also have higher prevalence rates of certain chronic health conditions as a result of their social and cultural background. Over the next 40 years, there is likely to be increasing diversity within successive cohorts of older Australians (chapter 3).

Some aged care services specifically cater for the needs of certain groups — for example, services designed to assist older Australians from specific cultural or linguistic groups or older Indigenous Australians in rural and remote communities.

### **Current approaches to catering for diversity**

The current aged care policy framework is designed to deliver services which meet the identified needs of individuals and the community. The primary mechanism for facilitating access to aged care services for older Australians who have special and/or additional needs is through the allocation of aged care places to organisations that focus on providing care to these groups. The *Aged Care Act 1997* (the Act) and

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its associated principles define a number of ‘special needs’ groups that are taken into account in the planning, allocation and transfer of aged care services (box 11.1).

**Box 11.1 Special needs groups recognised in the aged care system**

The Act recognises that some people have special needs that should be taken into account in the allocation and provision of aged care services. Specifically, the Act specifies the following special needs groups:

- people from Aboriginal and Torres Strait Islander communities
- people from non-English speaking backgrounds (NESB)
- people who live in rural and remote areas
- people who are financially and socially disadvantaged
- people of any kind (if any) who are specified in the Allocation Principles.

Under the Act, the current and future capacity of providers to service the needs of special needs clients is taken into account in the allocation and transfer process (of places) and in the determination of grant recipients (either for capital, advocacy, community visitors and/or unforeseen circumstances).

The Allocation Principles 1997 identify the following groups of people as having special needs:

- veterans — people who have seen active service in the Australian Armed Forces and their widows
- homeless — people who are homeless or at risk of becoming homeless
- care leavers — people brought up in care away from their family as state wards or raised in Children’s Homes, orphanages or other institutions, or in foster care.

*Sources: Aged Care Act 1997 and Allocation Principles 1997.*

The accreditation process is also designed to ensure that the delivery of aged care services respects the diversity of care recipients. The aged care accreditation standards for residential aged care require providers to deliver services which take into account and meet the diverse needs of clients. Item 3.8 in the accreditation standards for residential aged care covers ‘spiritual and cultural life’, and has the expected outcome that ‘Individual interests, customs, beliefs and cultural and ethnical backgrounds are valued and fostered’. Community Care Common Standards have been developed which include an expected outcome relating to appropriate assessments that consider cultural and linguistic diversity (appendix F).

The capacity of a provider to cater for special needs is also considered in the determination of grant applications.

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There are other groups with needs that differ in certain ways but who are not specifically identified in legislation. They include:

- people with a disability who cannot live independently in the community
- ageing people with a physical and/or mental disability
- older gay, lesbian, bisexual, transgender and intersex people
- older refugees.

While the Australian Government acknowledges the importance of providing appropriate care services to older Australians with diverse needs, some participants raised concerns about the adequacy of funding in catering for diverse needs and maintained that regulations can restrict the ability of providers to respond to the requests of some groups.

The benefits arising from being recognised as having ‘special needs’ status along with the capacity and commitment of aged care providers to effectively meet the needs of special needs groups were questioned (for example, Jo Harrison, sub. 190; Repatriation Committee, sub. 366). A number of participants argued that service providers should be required to report on how they meet the needs and preferences of clients with special needs, as such requirements are not clearly outlined in the current accreditation standards (for example, National Health, Aged & Community Care Forum, sub. 241). A review of the accreditation standards for residential aged care services is being undertaken and some submissions to that review have argued for greater clarity of requirements in the standards (chapter 15).

Services that cater for particular needs can be highly desirable to clients in these target groups, and they are often willing to travel significant distances to access the services. However, it is often not practical or efficient to have specialist providers in every geographical area. As such, it is important that mainstream aged care providers have the capacity to provide appropriate aged care services to the increasingly diverse population of older Australians. A number of submissions to this inquiry suggested that many current mainstream aged care services may not be sensitive to, nor adequately cater for, the needs of clients with special needs (for example, Alzheimer’s Australia, sub. 79; Matrix Guild (Victoria) and Coalition of Activist Lesbians, sub. 397; The Aged-care Rights Service, sub. 322).

### **Better meeting diverse needs**

As stated in the objectives outlined in chapter 4, the aged care system should seek to ensure that all older Australians needing care and support have access to person-centred services that treat them with dignity and respect.

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To achieve these objectives, the funding and delivery of aged care for groups with diverse needs should:

- ensure access to services — reducing barriers to access for those groups that age earlier than others, such as Indigenous Australians and the homeless, or those who may have challenging behaviours
- support specialised models of care — ensuring providers have the flexibility to meet the preferences of groups that require different aged care services because of cultural, religious or other values
- encourage service providers to tailor services to meet particular sets of needs and to create culturally responsive services (through, for example, training packages to provide workers with specialised skills and understanding) and to ensure that policies and practices reflect such needs
- acknowledge the higher costs of service delivery or difficulties in accessing capital for some services catering for some clients with diverse needs.

Catering for diversity in the provision of aged care services will require more attention to ensure appropriate principles are embedded in the legislation, policies and delivery of aged care services.

The reforms proposed in this report should deliver greater equity in access to aged care services for special needs groups over time because approved providers will be less constrained in the number and types of services they can offer. Specialist providers will be able to expand their operations to cater for care recipients who seek out their services. There will also be a greater intensity of competition between providers, which should drive improved service delivery, including for those with diverse needs.

However, there is a risk that a more market responsive system will not deliver services to particular groups who require more costly services unless they are adequately funded.

While regulations covering service provision (including the accreditation process) should increase access for groups that might not otherwise be served, they can result in cross-subsidisation where these services are more expensive to deliver but no additional funding is provided. This can distort providers' incentives to accept clients with additional needs and is inequitable for other care recipients, especially where they are required to meet a larger share of their own costs of care or to cross-subsidise other care recipients. Alternative funding and/or service delivery arrangements, such as targeted supplements, the use of competitive tendering or block funding, could be used to increase access to services for people from diverse backgrounds.

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In addition, extra funding may be necessary if specific services are required for the delivery of appropriate aged care services (for example, language services for older people from non-English speaking backgrounds). Further, a strengthening of quality accreditation systems would facilitate improved provision of appropriate services.

RECOMMENDATION 11.1

*The Australian Government should ensure the accreditation standards for residential and community care are sufficient and robust enough to deliver services which cater to the needs and rights of people from diverse backgrounds including culturally and linguistically diverse, Indigenous and sexually diverse communities.*

## 11.2 Socially disadvantaged people

There are number of older Australians who are socially disadvantaged, or who have been at some point in their lives. In the context of aged care, social disadvantage may result in access difficulties or even exclusion from services. Such marginalisation — either through one or a combination of homelessness, incarceration, disability or long term illness, and alcohol and other drug dependence — can have an adverse impact on the wellbeing of these people.

A number of submissions said there was excessive demand for services specialising in supporting socially disadvantaged care recipients because mainstream providers are reluctant to take on these older people as they may have challenging behaviours and/or care needs which are not adequately funded.

Many socially disadvantaged people age faster than the mainstream population and, as such, may require aged care services at an earlier age. In addition, they are less likely to have an informal carer available to provide assistance, which increases the demands on formal care services.

While the Act defines people who are socially disadvantaged as a special needs group, there is no clear definition of their characteristics and needs. McAllister (2004) has attempted to overcome this lack of clarity by elucidating the characteristics of the socially disadvantaged:

... [T]hose who have an inability to relate effectively and appropriately with others, who lack an informal support network, who have a tendency for self isolation and who display challenging behaviours. They are described as having a long-standing history of social estrangement including estrangement from family and friends and they have limited social and informal supports. Social estrangement relates to the person's social and interpersonal skills where they can be belligerent, uncompromising, unrelenting,



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contentious and unappreciative. Challenging behaviours can include intrusiveness, verbal and physical hostility. The characteristics defined here limit a person's ability to access, or maintain access to, services. (p. 100)

VincentCare Victoria (sub. DR633) considers the defining characteristics of social disadvantage to be isolation, exclusion and lack of connection. These characteristics manifest themselves in various ways throughout this diverse population.

The Commission recognises that moving to a more competitive aged care system may limit opportunities for the socially disadvantaged to access appropriate care services, although funding which matches service delivery costs will overcome one of the major barriers to the provision of care. Initiatives targeting social inclusion as part of the provision of aged care services are also warranted, and are important in ensuring that the socially disadvantaged are able to contribute to society, where possible, and feel relevant and valued for their contributions.

There are a number of types of social disadvantage which can be relevant to the provision of aged care services. Homeless people and care leavers are specifically identified in the Allocation Principles 1997. Submissions indicate that there is an emerging cohort of ageing people with a disability who may be homeless (or at risk of becoming homeless) and/or care leavers.

According to the Alliance of Forgotten Australians (sub. 486), many care leavers will require additional social support services (such as counselling and supported independent living arrangements) above that delivered by the mainstream aged care system. Having recently recognised care leavers as a special needs group (box 11.1), the Australian Government is in the early stages of improving aged care services for this group (DoHA 2010). A National Education Package has been developed for service providers with information and tools to deliver quality aged care services in a way that is appropriate and responsive to their needs. This package will consist of a general information awareness campaign and a targeted care management package for assessors, care managers and care workers (Healthcare Management Advisors 2010).

Some providers have specialised facilities dedicated to those who have experienced homelessness. These providers indicate that funding under the Aged Care Funding Instrument (ACFI) does not fully reflect the costs of service provision to them. Wintringham stated:

The primary difficulty in providing services to the homeless is that it is extremely difficult to make such services financially viable. As such it acts as a disincentive to aged care providers who may be considering providing services to the elderly homeless.

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Neither the DoHA [Department of Health and Ageing] Capital or Recurrent funding models are suitable for the elderly homeless. (sub. 195, p. 8)

In the context of those experiencing homelessness, there would appear to be a substantial unmet demand for aged care services. According to VincentCare Victoria:

The Department of [Health and] Ageing identifies that there are currently 2000 residential aged care places for homeless people and the census data identifies that there are more than 18,000 homeless people over 55 years old. (sub. 258, p.8)

The Australian Government recognises that additional funding is required to deliver aged care services to older Australians in residential settings who have experienced homelessness. The 2011-12 Budget expanded the residential aged care viability supplement to include facilities that specialise in caring for those who have experienced homelessness (Australian Government 2011d). However, this is only a temporary measure and does not address the additional costs associated with providing community care services to the homeless nor the wider issue of funding to provide additional services, such as counselling or outreach to those who continue to experience homelessness.

Southern Cross Care (Victoria) said in relation to older people with a mental illness:

While the introduction of the Aged Care Funding Instrument (ACFI) has generally been positive, capacity to meet the needs of clients with mental illness or dementia has decreased. (sub. 266, p. 7)

Similarly, the Psychogeriatric Care Expert Reference Group stated:

Current funding does not capture people whose behaviour is considered too difficult for mainstream aged care homes. The Behavioural Supplement under the Aged Care Funding Instrument (ACFI) was not developed with the expectation that aged care homes would be providing care to people with extreme behavioural disorders... In addition, funding under the ACFI does not reflect the need to engage, train and develop staff with special skills sets, including the need to employ Mental Health Nurses, nor does it reflect the higher staff ratios required to care for those with behavioural/mental health needs. (sub. 299, p. 3)

Carers Victoria indicated that there may also be an emerging issue with ageing refugees:

Even though the needs [of refugees] are high, there are barriers to elderly refugees and their carers accessing services. New arrivals to Australia may have limited knowledge of services which can assist them... More established and larger refugee communities may still face similar difficulties in accessing aged services, where language and culture remain alien and where the refugee experience may resonate throughout life and generations. (sub. 292, p, 19)

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VincentCare Victoria concisely summarised the funding conundrum for the provision of aged care services to socially disadvantaged older people, both in mainstream and specialised services:

The ACFI is a funding instrument that measures key care needs, however it does not incorporate these holistic needs of a person. (sub. DR633, p. 13)

Many socially disadvantaged people may require higher than average levels of assistance with behavioural issues but may not require significant assistance with activities of daily living nor have complex care needs. In addition, individuals who are socially disadvantaged are also generally financially disadvantaged. This restricts the capacity of service providers to derive supplementary income from bonds and extra service charges.

Due to the additional care needs related to social disadvantage, mainstream providers may be reluctant to take on clients who are disruptive to others, especially where there is insufficient funding for these individuals. While some providers specialise in caring for older people from socially disadvantaged backgrounds, they generally require additional funding (including from state health budgets) to deliver quality care.

In recognition that some components of the ACFI and care supplements may be set too low, the Commission considers that a full and public benchmarking study of the pricing of care and support services (in both residential and community settings) for socially disadvantaged clients should be undertaken by the proposed Australian Aged Care Commission (AACC — chapter 15) in consultation with service providers and other stakeholders. The AACC would then transparently recommend an appropriate price to the Government as proposed for the pricing of other care services. The issue of assistance to access capital for services specifically dedicated to disadvantaged, high needs clients (such as homeless people or people at risk of becoming homeless) will need to be examined by the Australian Government in order to ensure an integrated approach to the resourcing of these services.

The Commission considers that in some cases some amount of block funding may be an appropriate mechanism to support and encourage innovative service models for delivering residential and community aged care services to the socially disadvantaged, particularly where these individuals are unlikely to be cared for in the mainstream system. Marginal funding could be added to reflect actual service usage.

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### 11.3 Older Australians from culturally and linguistically diverse backgrounds

As discussed in chapter 3, Australia's population of older people from culturally and linguistically diverse (CALD) backgrounds is expected to increase by over 40 per cent between 2011 and 2026, in line with the overall increase in the older population.

By 2026, it is projected that one in four Australians aged 80 and over will be from a CALD background (Gibson et al. 2001). In the context of this report, cultural and linguistic diversity includes both people who are not proficient in English and also those who are proficient in English but come from a non-English speaking background. While people whose main language at home is European will still be the largest group, those who speak Middle Eastern and Asian languages are expected to become increasingly important (Gibson et al. 2001).

The cultural and linguistic diversity of many older Australians is an important consideration in the delivery of appropriate aged care services. Compared to other older Australians, this diversity may be reflected in:

- attitudes to the elderly, expectations of family care giving, roles of women and support groups, and beliefs about health and disability
- beliefs, practices, religions, behaviours and preferences which can affect the propensity to use formal care services
- English language proficiency, which can affect access to information and services, communication of needs and participation in the wider community.

As a result, the use of aged care services by older Australians from CALD backgrounds is different than for many other older Australians. They are relatively underrepresented in residential settings but overrepresented in formal community care services where they are supported by family and cultural groups (AIHW 2007a). However, there is some variation in usage patterns across locations depending of the level and mix of community support and the engagement of individuals with these services.

Some CALD communities in certain locations are well served by dedicated aged care providers (generally not-for-profit organisations arising from the respective community) that tailor services to particular groups, such as the Italian, Greek, Spanish, Dutch and Jewish communities. The standard of care provided by these organisations is generally high and, not surprisingly, these services are usually in great demand.

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Submissions highlighted the difficulties that some CALD seniors have in accessing timely aged care services, particularly packaged community care. For example, North West Region CACP/ EACH/D /ACAS Forum (Melbourne) said:

... currently the availability of culturally appropriate aged care services is much less than the demand. For example, in the Northern region, there are only 16 Chinese specific CACP packages, but there is a waiting list for 22 eligible clients. The waiting time is estimated to be over 2 years. A similar situation exists for Italian clients in the Northern and Western regions as the number of clients on the CACP and EACH waiting list doubles the number of packages allocated on an ongoing basis. (sub. 133, p. 6)

The Commission considers that the broader reform package proposed in this report, particularly the relaxation of supply constraints on community and residential aged care services over time, will provide opportunities for the emergence of new services specialising in delivering care to specific CALD communities (subject to them becoming approved providers) and allow existing services providers to expand their range of services and geographical footprint, wherever there is a demand that they can meet. Where a particular CALD population is not large enough to sustain a stand-alone aged care service, these communities may consider partnering with an existing aged care provider to develop appropriate CALD services while sharing operational experience and some costs (for example, administrative overheads and capital costs).

That said, most older Australians from CALD backgrounds access aged care services through the mainstream system. Under the current accreditation standards, mainstream providers are expected to deliver culturally appropriate aged care services to clients. However, some participants to this inquiry said that parts of the mainstream aged care system have difficulty delivering care that meets the needs and preferences of CALD clients. The main issues raised include:

- availability of suitable language and interpretation services as aids in accessing information, undertaking needs assessments and service delivery
- cultural appropriateness of assessment services and service delivery.

### *Language and interpretation services*

Older Australians from CALD backgrounds may not be proficient in English and may require assistance navigating and understanding the aged care system. In addition, many older Australians whose native tongue is not English, revert back to their first language as a result of the ageing process. This reversion can pose several challenges to governments and providers in delivering appropriate aged care services.

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In this context, Multicultural Access Projects (Metro North Region) stated:

Language and communication issues are the most frequently raised barriers for people from CALD backgrounds to access community support structures and services. The provision of language support services, such as face-to-face and telephone interpreting services is vital for effective service provision. (sub. 379, p. 5)

As Independent Living Centre's Multicultural Aged Care Service (WA) said:

Many older people from CALD communities are unfamiliar with the aged care system, with some cultural norms dictating that care is provided by family within the home and with little outside support. As such, there is a need for improved dissemination of information about aged care options to older people from different CALD communities, in a language and context that is appropriate to them. (sub. 139, p. 4)

This view was shared by the Aged Care Association of Victoria:

A critical success factor for navigating the new system is that CALD consumers must be provided appropriate information in a form which they can access, especially through the ethnic media, and in a language they can understand. (sub. DR739, p.4)

Older Australians from CALD backgrounds may also be less aware of information about preventative and early intervention measures. Multicultural Access Projects, for example, said:

... older people from CALD backgrounds are at greater risk for health consequences resulting from physical inactivity due to higher rates of sedentary behaviour (National Ageing Research Institute, 2008). This may be a result of both a lack of knowledge and a lack of opportunities to participate in programs specifically designed for older people.

'I did not know that I can still exercise even though I have difficulties to move around, and that exercise can help me improve my condition' Comment from a Spanish lady in an information event, 31 March 2010. (sub. 379, p. 8)

DoHA provides some language support for older Australians from CALD backgrounds and their carers. Information about the aged care system and aged care programs is translated in a limited number of languages and is available online and through information outlets (such as Respite and Carelink Centres and DoHA funded information services). There is also a telephone translation service and DoHA funds two programs specifically designed to assist in the delivery of culturally appropriate care to CALD groups — Partners in Culturally Appropriate Care (PICAC) and the Community Partners Program (CPP) (box 11.2) (DoHA 2009d).

The CPP helps older people from CALD backgrounds to access and discuss information about aged care services in certain languages other than English. However, the program is targeted towards the dominant language groups in each

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geographical area. As a result, it does not provide assistance in all languages and may not be available in all locations.

**Box 11.2 Assisting providers to meet the needs of CALD clients**

The Australian Government administers two programs to assist the delivery of culturally appropriate care to older people from CALD backgrounds:

- Community Partners Program (CPP)
- Partners in Culturally Appropriate Care Program (PICAC).

Both programs were developed to assist older people from CALD backgrounds access care services, and improve the capacity of aged care services to respond to the differing needs of older people from culturally and linguistically diverse communities.

The CPP promotes and facilitates increased access by CALD communities to aged care service providers and support services. A number of state-wide projects link CALD communities with aged care providers to improve use of aged care places by older people from these communities.

PICAC coordinators work to improve the partnership between aged care providers, CALD communities and DoHA. PICAC program outputs may include:

- identifying specific barriers to accessing care services for older Australians from CALD communities
- providing culturally appropriate training to care staff, including the dissemination of information and resources about best practice
- providing support for the development of new services, including ethno-specific and multicultural aged care services
- providing information to policy makers about important CALD issues.

*Source:* DoHA (2009d).

Some state and territory governments also invest heavily in language services for Australians from non-English speaking backgrounds. While these services provide older Australians and their carers with information, they may not assist them to understand the complexities of the aged care system (which can confuse even English speaking older people and their carers) nor shape consumers expectations about the range and nature of standards of care.

Other Australian Government agencies with a significant consumer focus, such as Centrelink and Medicare, provide a wide range of information and advice services in languages other than English. For example, Centrelink provides language and interpreting services in 226 languages through external contractors and provides on-site interpreters in areas where demand for certain languages is high. Centrelink also

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employs multi-lingual staff who are paid a Community Language Allowance if they use these language skills in the course of their employment (Centrelink 2010).

The proposed Australian Seniors Gateway Agency (the Gateway) could leverage off existing language and translation services provided by the Department of Human Services (Centrelink, Medicare, Family Assistance Office). This could provide economies of scale in delivering comprehensive information in languages other than English. An integrated service could also reduce complexity for consumers, especially given that the Commission proposes Centrelink undertake financial assessments for aged care services (chapter 9).

Older Australians from CALD backgrounds and their carers also report that many mainstream providers have difficulty finding care staff that can communicate effectively with the care recipient. Poor communication can negatively affect the health and wellbeing of the older person receiving care (Baptcare, sub. 212; Multicultural Access Projects, sub. 379). This can range from not being able to communicate their pain, continence management or even hydration needs, to not understanding the advice given by nurses and carers.

Where required, language and interpretation services may significantly increase the costs of delivering appropriate aged care services to CALD clients, especially in mainstream services which do not employ bi-lingual staff. Aged and Community Services Australia illustrated that interpreter services can add significantly to service costs:

... as at May 2007, the Telephone Interpreter Service (TIS costings via personal communication) provides on-site translator/interpreter services during business hours at a rate of \$141 for the first 90 minute block plus an additional \$46 for each subsequent 30 minute block. These rates increase to \$225 and \$74 respectively outside of business hours. These are substantial costs considering the (highest) day rate per person in residential aged care was funded at around \$175/day in 2007 (Government contribution plus client contribution) and make the provision of such services 'cost prohibitive'. Some ACSA members have estimated the cost of providing the listed components at between three and five per cent of total budget, with community care estimated to bear the largest expense. (sub. 181, pp. 38–39)

In order to attract staff with relevant language skills or promote the development of bi-lingual skills within staff, providers could consider a language allowance (along the lines of that provided by Centrelink) if these skills are used in the course of employment. Another option may be to engage bi-lingual family and friends, particularly for assessment and planning, as part of a communication strategy for understanding the needs and preferences of a CALD person in care where access to formal translation services is limited (Multicultural Access Projects, sub. 379).



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General information resources in languages other than English about aged care services and their availability should be developed centrally to ensure consistency, and be available from a variety of different sources — for example, in print, on the web and by phone.

The Commission proposes the establishment of multi-lingual hubs within the Gateway. These hubs would provide a pool of bi-lingual, culturally competent staff to provide information, advice, initial assessments and basic care coordination for people from different cultures and who have difficulties communicating in English.

More specific information about local services in languages other than English could be developed by regional Gateway hubs. For example, mainstream facilities may require assistance in the translation of key documents and the development of communication resources, such as cue cards for day to day communication. To facilitate this, regional Gateway hubs would have specialist bi-lingual staff who could offer translation services, where necessary.

Subject to logistics and viability, bi-lingual staff in Gateway hubs could also undertake initial assessments of client needs (chapter 9). Ideally, comprehensive assessments would be undertaken in the home of the older person by a bi-lingual assessor but the Commission recognises that this may not be possible in all situations, particularly in some rural and remote locations where the population of a specific CALD group may be low. The Gateway hub should be resourced to provide translation services to assist in more comprehensive assessments where appropriate bi-lingual assessors are not available locally.

Alternatively, there may be a role for ethno-specific aged care providers in the local area or community groups to assist in the provision of language and translation services where this capacity exists.

To ensure uniform access to appropriate language services, consideration should be given to expanding (and funding) the role of bi-lingual Gateway staff to allow providers, particularly mainstream providers, to access their services in care delivery, when required. Alternatively, the costs of providing language services as part of the delivery of care services should be considered in the pricing of care services as a separate supplement.

### *Supporting cultural relevance*

Many older Australians from CALD backgrounds have different beliefs, practices, behaviours and preferences to older Australians from non-CALD backgrounds.

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These cultural factors need to be taken into account in both the assessment process and the delivery of care services.

A number of submissions commented on the importance of providing culturally appropriate services, in addition to language services, to older Australians from CALD backgrounds. Multicultural Access Projects, for example, said:

Older people from CALD backgrounds have reported to service providers that they are more likely to use a service that specifically targets their communities, and has workers and/or volunteers who speak their languages and understand their cultural needs. This is particularly important for older people who do not speak English well, although cultural awareness and understanding is extremely important for older people from CALD backgrounds who also speak English well. (sub. 379, p. 4)

Multicultural Access Projects also suggested a partnership approach with culturally specific and multicultural services would secure better outcomes for care recipients:

There are many culturally sensitive and competent practices which specialist services can implement to improve service delivery including identifying and involving other cultural specific and multicultural services early in the service delivery process. These partner organisations can then share their cultural and language knowledge and expertise as well as their connections with local community groups. Such a partnership approach will result in better outcomes for the target group as well as building capacity in the partner services. (sub. 379, p. 7)

Some providers specialising in the provision of aged care services to particular CALD groups outlined a number of aspects which contribute to culturally appropriate services, including:

- food consistent with cultural identity — often with imported ingredients
- an appropriate physical environment — décor, room orientation, cleaning and laundry services
- social activities — religious services, cultural TV, CALD community group interaction (DutchCare and Fronditha Care, sub. DR811).

While some of these services may be marginally more costly to deliver, these costs are generally related to everyday living expenses and accommodation. By contrast, language and translation services are essential in undertaking care activities and should be included in the prices set for care services.

Social activities and associated transport are important in keeping older Australians from CALD backgrounds connected with their community. As the Migrant Information Centre (Eastern Melbourne) explains:

It is our experience, and also indicated in the HACC service usage data, that CALD seniors utilise social support and planned activity groups offered through the HACC

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program at a higher level than their Australian counterparts. In particular there is a preference for ethno-specific or multicultural services of this type. (sub. 154, p. 1)

Targeted social activities by specific cultural providers, which promote social inclusion, are one of the strengths of the current aged care system. Such activities will be increasingly required to meet the growing demand for aged care services by the rapidly growing older population. These service providers could also offer culturally appropriate activities for older people from these backgrounds who reside in some of the mainstream care facilities which have little capacity to provide such services.

Access to transport — whether it is public or community-based — is also important for promoting social inclusion. The Migrant Information Centre (Eastern Melbourne) considers that:

Transport services should be more available and more flexible to travel across boundaries. With smaller CALD communities it is often necessary to travel further distance to a preferred ethno-specific group which is not available in the local area. (sub. 154, p. 1)

Culturally specific aged care and community services, including transport, for older Australians from CALD backgrounds should be supported to ensure links between older people and their communities are maintained.

## **11.4 Gay, lesbian, bi-sexual, transgender and intersex people**

The recognition of sexual preference and gender identity as an aspect of diversity has been relatively recent and this has important implications for the provision of aged care services for the current cohort. Many older gay, lesbian, bisexual, transgender and intersex (GLBTI or sexually diverse) people<sup>1</sup> have experienced considerable discrimination over the course of their lives and this may continue in aged care where their sexuality and/or gender identity are not recognised or supported in the delivery of aged care services. As outlined by the GLBTI Retirement Association Incorporated:

The literature of GLBT ageing discusses the impact of historical experiences of discrimination against GLBTI people. GLBTI people who are currently accessing aged

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<sup>1</sup> GLBTI (gay, lesbian, bisexual, transgender and intersex) or sexually diverse is used as a general term to include people who are not exclusively heterosexual in identity, attraction and/or behaviour. There is much debate on terminology for this group and other terms are also used including gay, LGBTI (lesbian, gay, bisexual, transgender, intersex), queer, sexual minority groups, sexual and gender diverse (adapted from GLBTI Retirement Association, sub. DR720).

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care services have lived in an era where there was a real threat of losing their job, family and friends, and risking imprisonment and ‘medical cures’ if they disclosed their sexual identity (Barrett 2008) ...

McNair and Harrison (2002) found that major concerns for older GLBTI people were not about their health per se, but rather about institutionalised discrimination pertaining to sexual and gender identity. Concerns were also raised about how homophobic attitudes of institutionalised aged care facilities would impact on the quality of care delivered and the fear that this could result in elder abuse. (sub. 57, pp. 4–5)

Although there are no comprehensive projections of the number and distribution of older GLBTI people, a large increase in the demand for aged care services is anticipated by this group consistent with the ageing of the overall population (GRAI and Curtin Health Innovation Research Institute 2010; Harrison and Irlam 2010).

Consistent with the objectives of the Act, and care delivered to other diverse groups and the mainstream population, the provision of aged care services should be respectful and sensitive to the needs and preferences of older people, irrespective of whether they explicitly identify as being sexually diverse. However, the Commission received several submissions claiming that some GLBTI seniors face difficulty in having their needs and preferences recognised and that many face discrimination in service delivery. For example, Jo Harrison said:

There is a growing body of evidence regarding the extent to which GLBTI elders are experiencing discrimination, or fear of discrimination, within an industry which remains unaware and uneducated as to their special needs and unique concerns. (sub. 190, p. 4)

The GLBTI Retirement Association indicated:

To date, clients’ sexual orientation or gender identity remains largely invisible to service providers: an invisibility that impacts negatively on these clients’ wellbeing, and is extremely relevant to the standard of care made available to this cohort. (sub. 57, p. 2)

Submissions also indicated that seniors from sexually diverse backgrounds would like greater recognition of their sexuality and gender identity, and more appropriate services in the aged care system through: a safe and inclusive environment; recognition and inclusion of partners in consultation and decision making; and ambience. In particular, they would like greater recognition of partners and the role of the GLBTI community, who may be more important to them than their biological family (GLBTI Retirement Association, sub. DR720).

The Australian Government has recognised that some parts of the mainstream aged care system could be more sensitive towards the preferences and needs of GLBTI people. DoHA has recently developed a pilot training initiative to increase

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awareness among aged care workers in NSW about GLBTI issues and about delivering appropriate care to GLBTI seniors (Plibersek 2010). This initiative will be delivered in partnership with ACON (formerly the AIDS Council of NSW and currently Australia's largest community-based GLBT and HIV/AIDS organisation) and Aged and Community Services NSW and ACT. It is envisaged that the:

... program will be evaluated; with a view to a more broad application of this training should it be successful. (ACON 2010, p. 1)

In terms of service delivery, the National LGBT Health Alliance considers:

Some [LGBTI] organisations have the capacity to directly deliver care services and projects for LGBTI seniors. Other organisations would wish to partner with mainstream aged care organisations, combining their expertise and connection to LGBTI community with the expertise in aged care delivery of mainstream services. (sub. 138, p. 7)

Indeed, Care Connect was recently allocated 32 community care packages to partially service the ageing GLBTI community in South-East Queensland — the first specific allocation of services to the GLBTI population (Stoyles 2011). The Commission believes that its proposal to remove constraints on the supply of aged care places will create significant opportunities for specialist GLBTI service providers to emerge, either as stand-alone operations or in partnership with existing aged care providers.

At a broader level, several submissions argued for the development of a national GLBTI aged care plan or strategy (ACON, sub. DR764; AIDS Council of South Australia, sub. DR571; Jo Harrison, sub. DR710; National LGBT Health Alliance, sub. 138). In the Commission's view, consideration of the development of a specific GLBTI strategy is warranted given the anticipated increase in demand for aged care services by this group and the limited recognition of their needs and preferences in the current policy framework, delivery of services and accreditation processes.

Initiatives that increase the awareness of GLBTI issues within the aged care industry, such as training for aged care workers, are important in creating an environment in which sexual diversity is respected and catered for. There should be further initiatives between DoHA and peak bodies to help create an aged care system that can better cater for and respond to the needs and preferences of GLBTI older people. Service providers have an obligation to ensure both policies and practices acknowledge these needs and respond appropriately.

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## 11.5 Veterans

Veterans are classified as a special needs group under the Act. In terms of the provision of appropriate aged care services, the Repatriation Commission states:

Veterans have specific social and cultural issues, which include:

- personal hardships as a result of war service that can affect veterans and their dependants physically and psychologically
- critical shared experiences outside those of the general community
- identifying themselves as a distinct cultural group with distinct needs (e.g. commemoration of fallen comrades, observance of special days such as ANZAC day and Remembrance day, provision by government of healthcare and compensation for war caused illnesses/injuries). (sub. 366, p. 3)

There are different definitions of a veteran in the context of aged care services. The Act defines a veteran as ‘a veteran of the Australian or allied defence force; or a spouse or widow/er of a person mentioned above’.

The Department of Veterans’ Affairs (DVA) has a much narrower definition of a veteran as someone who holds a DVA health entitlement card and/or a DVA pension card, or is a war widow/widower or dependent holding such cards (National Health, Aged and Community Care Forum, sub. 241). The Repatriation Commission is responsible for determining the eligibility of veterans for services and which treatments and services should be made available for eligible veterans, with the DVA administering these policies.

Eligible veterans receive subsidised and high quality health and community aged care services through the specific entitlement scheme funded and administered by DVA (box 11.3). All veterans access residential aged care services through the mainstream system and are also entitled to access mainstream community aged care services.

Eligible veterans and war widows/widowers represent around 16 per cent of aged care residents but only a small proportion of residential care facilities have a majority of DVA clients as residents. As such, most residential aged care facilities have a small proportion (generally between 10-20 per cent) of DVA clients (Repatriation Commission, sub. 366).

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### Box 11.3 Specific service programs available to eligible veterans

There are a number of community care programs designed to meet the care and support needs of eligible veterans. These programs are not available to non-eligible veterans.

- *Veterans' Home Care* — assists eligible veterans and war widows/widowers with low level care needs to remain in their homes for longer. It provides a wide range of home care services designed to maintain their optimal health, wellbeing and independence. Services include domestic assistance, personal care, safety-related home and garden maintenance and respite care.
- *Community Nursing Program* — provides services in a person's home to restore health following illness, allow a person to maintain the best level of independence, and/or allow for a dignified death.
- *Rehabilitation Appliances Program* — provides appliances for self-help and rehabilitation purposes, and surgical aids for home requirements. The aim of the program is to restore or maintain independence and to minimise disability or dysfunction. The types of appliances available under this program include: mobility aids, such as handrails in bathrooms and near steps, and medical aids, such as continence products.
- *HomeFront* — assists in the provision of minor home modifications and appliances to reduce the risk of falls and similar hazards.
- *Coordinated Veterans' Care* — planned and coordinated access to community-based support for eligible Veterans who have one or more chronic conditions, complex care needs and are at risk of hospitalisation.

Sources: Repatriation Commission (sub. 366); DVA (2011).

In terms of ensuring that aged care providers are aware of the needs of veterans, DVA conducts:

... a well-subscribed national series of seminars for residential aged care, community care and hospital providers, on what constitutes the special needs of veterans and war widows(ers), and how these might be addressed with the assistance of established Repatriation benefits and services. (Repatriation Commission, sub. 366, p. 3)

DVA currently has a comprehensive information and assessment process for eligible clients, similar to the Gateway proposed by the Commission, which coordinates the integrated delivery of health and community care services. Some submissions representing DVA clients indicated that eligible veterans are at risk of becoming 'lost' in the Gateway if the DVA information and assessment processes are merged with that agency.

The Commission considers that integrated health and basic community support entitlements for eligible veterans should be handled by DVA up to the point where

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veterans require formal aged care services (that is, Community Aged Care Packages, Extended Aged Care at Home (EACH), EACH-Dementia and residential care under current arrangements). At this point, veterans should be assessed through the Gateway in the same way as all other older Australians requiring these aged care services.

Service providers said that there was scope to standardise and streamline the contractual and reporting processes, including quality assurance frameworks, for similar services which are currently administered separately by DVA and DoHA (ACSA, sub. DR730; KinCare, sub. DR578; Repatriation Commission, sub. DR754; Royal District Nursing Service, sub. DR546).

A number of issues concerning aged care services for DVA veterans were raised in submissions. Many of the issues overlap and are related to DVA's 'arms length' involvement in mainstream care services that it provides funding for but does not administer or regulate. These issues include:

- the transition from community to residential aged care
- accreditation processes — including standard setting and evaluation
- DVA's role and accountability in relation to mainstream aged care services.

Eligible veterans receive different levels of care and support depending on their needs. Veterans access the majority of community care services through DVA, but can access mainstream services or a combination of both. Residential care is only delivered through mainstream aged care programs. As DVA veterans are treated differently in terms of their health and home support needs through community care, it is often confronting when they make the transition to residential care, where they are treated the same as other residents. As explained by the National Health, Aged and Community Care Forum:

For veterans and war widows/ers who have had their health and community care needs met by DVA while living in their own home, often for many decades, this changes significantly on moving to residential aged care. This division of responsibility between DVA and DoHA is complex and difficult to understand for elderly veteran members and their families. Some members of the veteran community report that their experience of this transition of care can be disjointed and confusing, thereby adding greater complexity for elderly members of the veteran community in the transition process. (sub. 241, p. 4)

Similar experiences have been reported in cases where a DVA veteran decides to take a mainstream community care package (CACP, EACH or EACH-D) and they are no longer eligible for some services offered by DVA. For example, the North West Region — CACP / EACH/D / ACAS Forum (Melbourne) noted:



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Veterans' community clients are disadvantaged in regards to accessing normally eligible services via DVA if they are receiving care under an EACH or EACH-D package. (sub. 133, p. 7)

The Repatriation Commission (sub. 366) acknowledges that the transition arrangements between DVA and mainstream services are less than ideal and can be disjointed and confusing for clients. DVA has responded to issues surrounding aids, appliances and allied health care by introducing flexibility and discretion in allowing high care clients in residential facilities to continue to use the equipment or service until it is no longer needed.

Other concerns arise from the perceived loss of 'special needs' status compared to the volume and quality of services previously received in the community and/or a lack of understanding about DVA's role in the aged care system. The Commission considers that there should be greater clarity over what is provided under a mainstream entitlement to allow DVA and individual care recipients to determine whether additional services are required.

Many DVA veterans and their families are also concerned about the role that DVA has in making mainstream aged care services accountable. However, the aged care accreditation standards, determined by DoHA, do not explicitly outline how the needs and preferences of veterans (and other special needs groups) should be taken into account when delivering appropriate aged care services. DVA is not responsible for mainstream aged care service provision and the investigation of complaints relating to the provision of aged care services is undertaken by DoHA through the Office of Aged Care Quality and Compliance.

## **11.6 Aboriginal and Torres Strait Islander people**

Indigenous people who identify as Aboriginal or as Torres Strait Islanders have a number of social and cultural attributes which need to be taken into account in delivering aged care services. The challenges in providing services to this group are compounded by their heterogeneous nature — there are around 200 different skin groups or language groups across Australia (Wayne Herdy, sub. 18). In addition, there are marked differences in attitudes, cultural identification and needs, between Indigenous people living in many urban centres and those living in rural and remote locations. Like other special needs groups, a 'one size fits all' approach is not appropriate.

The Australian Government acknowledges the lower life expectancy of Indigenous people in the planning and allocation process by including Indigenous people aged 50–69 years, compared to the general population where planning is based on those

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aged 70 years and over (chapter 2). In the Commission's proposed aged care system, the Australian Government would continue to have responsibility for providing aged care services to Indigenous Australians aged between 50 and 64 years (and everyone of pension age and over). As part of the aged care system, Indigenous care recipients would be required to co-contribute to the costs of their care, where they have the means to do so.

The lower age service eligibility for Indigenous Australians is consistent with the Australian Government's health reforms (see the National Health and Hospitals Network Agreement — COAG 2010b). However, the Commission considers that the age limit for Indigenous Australians should be reviewed if evidence becomes available which suggests that the current age limit is no longer appropriate.

Many Indigenous Australians have different attitudes towards the elderly and the roles of family in giving care compared to non-Indigenous Australians. Culturally important issues in the delivery of aged care services to Indigenous people include:

- not wanting to leave their (often very remote) community to receive care services
- the communal nature of many Indigenous cultures, which can act as a disincentive for individuals to participate in the formal delivery of aged care services as workers
- some Indigenous people prefer intimate personal contact to be delivered by people of the same skin group and gender. This may increase care costs, especially where there is a relatively small service.

Many aged care services for older Indigenous Australians are delivered through the mainstream aged care system and there are specific initiatives within mainstream programs to increase both the awareness of and access to culturally appropriate services. For example, the Home and Community Care (HACC) Program has a special advisory body, the National Aboriginal and Torres Strait Islander HACC Forum, which provides leadership and input on policy and planning to the national HACC program on Indigenous matters. There are currently around 300 Indigenous-specific HACC services (Office of Indigenous Policy Coordination, sub. DR915). Irrespective of the future of HACC and community services, an Aboriginal and Torres Strait Islander aged care forum should be maintained to provide advice on the adequacy of the care and support system and any changes that are implemented.

Specific information and services for Indigenous carers is available through Commonwealth Respite and Carelink Centres. The National Respite for Carers Program has providers that tailor services to the needs of Indigenous clients.

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In addition, the Australian Government provides flexible and culturally appropriate aged care services to Indigenous Australians through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (which is not funded under or required to comply with the Act). There are currently around 200 aged care services directly funded by the Australian Government that are Indigenous specific and/or located in remote areas. Around 70 of these have a residential care component and 30 come under the Flexible Aged Care Program (ACSA, sub. 181).

Unlike mainstream programs, this program allows providers to deliver a mix of residential and community care services depending on the needs of the clients. These programs meet the preferences of older Indigenous people by allowing them to stay in their community and connect with younger generations and the Commission's reforms will enable this initiative to be adopted throughout the aged care system.

In relation to the current flexible care services, consultations indicated that they can be difficult to establish. ACSA explained that these services are vulnerable because 'they are small and located in remote areas where staff are hard to attract and retain' (sub. 181, p. 37).

Research has highlighted the importance of appropriate and extensive consultation in the implementation of successful Indigenous aged care programs (Bin-Sallik and Ranzijn 2001). The Consumers' Health Forum of Australia also noted that:

Rural consumers stressed that programs for older indigenous people must involve known and trusted community members in their development and involve local indigenous workers in their implementation. (sub. 287, p. 4)

The provision of aged care services into Indigenous communities can increase the stability of these communities. Steve Begg explained that aged care:

... is a really important component to Indigenous communities, particularly because it prolongs the life of the elders, and if it does that the influence that the elders have on the community in terms of stability, in terms of community development, in terms of law and governance plays a much stronger role. If the elders are no longer in community because they've gone away because they're ill, or they pass away, then the influence and the impact they can have is severely restricted... (transcript, p. 648)

Issues surrounding access to, and the provision of, culturally appropriate aged care services to Indigenous Australians include:

- attracting and retaining Indigenous workers to provide culturally appropriate services
- use of culturally appropriate assessment tools
- support to develop service capacity appropriate to meet their specific needs.

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These elements are critical to the establishment of culturally secure services where Aboriginal and Torres Strait Islander people know that they and their culture are respected and where they feel safe. This is irrespective of whether the service is mainstream or delivered by a specialist provider.

### *Attracting and retaining Indigenous workers*

The use of local Indigenous workers is important in providing culturally appropriate care to older Indigenous people as they can have a better understanding of the needs and preferences of older community members. As noted by General Practice South (Tasmania), Indigenous workers who are part of the local community have a wider range of responsibilities within that community:

Aboriginal aged care workers are different from non-Aboriginal because they are part of the community and therefore they're looking after their aunts and uncles, not just 'clients' that they can forget about when they knock off at the end of the day. (sub. 278, p. 26)

There are several important issues relating to recruiting and training Indigenous workers. For example, the South Australian Government considered that:

There is a need for significant investment in training to develop capacity of community workers to provide high quality service, and to support unpaid carers. (sub. 336, p. 16)

Aged care service providers indicate that it can be difficult to attract and retain Indigenous aged care workers (Frontier Services, sub. 323; Latrobe Community Health Service, sub. 220). In addition, as highlighted by the Queensland Aged and Disability Association, there are restrictions on who can provide care:

... Aboriginal and Torres Strait Islander communities are limited to who can provide care to the elders, as they require family members who they consider trustworthy to enter into the consumer's home, because of a concern for their safety and a sense of vulnerability. Due to local Aboriginal Lore it is often difficult for staff members from the community to provide care for certain members of the consumer group. An example of this is that a daughter in law is not to speak to her father-in-law; therefore due to communication issues she cannot provide appropriate care. (sub. 207, p. 10)

To develop capacity within Indigenous communities to provide aged care services, the Aboriginal and Torres Strait Islander Ageing Committee of the Australian Association of Gerontology argued that:

A systematic and regular, adequately funded training program, appropriate for the needs of Aboriginal and Torres Strait Islander workers' learning styles, is urgently needed. Networking; on-the-job training; targeted training, specifically designed consistent with local/appropriate cultural elements; apprenticeship; and work experience have all worked well. Basic caring skills can be documented, observed and

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accredited: this offers a good pathway into the formal education system and flexibility for career progression. (sub. 83, attachment 1, p. 3)

While there are important issues facing the broader aged care workforce (chapter 14), there are significant issues in respect of training Indigenous staff. For many Indigenous people located in remote locations, travelling to distant training locations for extended periods is neither feasible nor acceptable, particularly given their family and community responsibilities. There is need to deliver training locally, including with the enhanced use of technology. The lack of housing in communities for staff and trainers is a recognised problem which creates a barrier to developing and meeting workforce needs within Indigenous communities.

An innovative program has been developed between Frontier Services, Tennant Creek Hospital and the Bachelor Institute of Indigenous Tertiary Education to give local people the opportunity to undertake Registered Nurse training (Frontier Services, sub. 323). Cooperative partnerships of this nature, and also at the vocational education and training level, are extremely important in developing the skills required and should be actively supported.

Frontier Services argued that the introduction of criminal history checks for aged care workers has affected the capacity of providers to employ Indigenous people in service delivery due to relatively high levels of interaction with the criminal justice system:

Whilst Frontier Services recognises and supports the reasons behind such checks, we also appreciate that many potential employees are excluded from employment in areas of high demand because there is no right of appeal when excluded from employment for an offence that does not impact on a person's ability to provide competent levels of care for local, older people ... Very often the offences of Aboriginal people are related to domestic issues and would not impact on their ability to provide care to older members of their communities.

In many of the communities in which we work, the majority of residents are precluded from working in aged care because of criminal history issues. (sub. 323, p. 13)

In order to address current and prospective workforce shortages and offer more Indigenous people opportunities to work in aged care, consideration should be given to allowing approved and established service providers some flexibility in employing Indigenous people who they and the local community deem to be appropriate.

### *Use of culturally appropriate assessment tools*

Some tools and methods used in aged care assessments, and to diagnose ageing related diseases in the mainstream population, do not work well for Indigenous

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people because they are not culturally and linguistically appropriate. The development and use of culturally appropriate assessment tools increases the potential to accurately identify morbidities in target populations and ensure that proper care is delivered.

For example, the Kimberly Indigenous Cognitive Assessment (KICA) tool has been developed and validated as an appropriate cognitive screening tool for older Indigenous Australians living in rural and remote areas. This tool has identified that the prevalence of dementia among Indigenous Australians is substantially higher than among non-Indigenous Australians (Australian Association of Gerontology, sub. 83, attachment 1).

Funding has been provided by DoHA to validate KICA in the Northern Territory and a variation of this tool is proposed to be developed for use in urban areas (Alzheimer's Australia 2007). Evidence provided to the public hearings indicated that there are a variety of tools being developed in different locations around Australia (Steve Begg, transcript, p. 650). Sufficient resources should be devoted to developing culturally appropriate assessment tools to reduce the incidence of misdiagnosis.

#### *Support to develop service capacity*

During the consultation process, a number of providers indicated that Indigenous, rural and remote service providers would benefit from an ongoing support program which actively assisted them to develop and operate their services as efficiently as possible.

The Commission notes that the Australian Government allocated \$42.6 million over five years for the Remote and Indigenous Support Services initiative in the 2007-08 Budget (Australian Government 2007d). This initiative was intended to actively support these services by:

- improving the physical infrastructure of Aboriginal and remote aged care services
- more effectively developing and supporting care, management and organisational capacity, including day-to-day management, financial, governance and locum services
- developing a more sophisticated and shared understanding of service delivery models and quality frameworks in Aboriginal and remote aged care (ACSA, sub. 327).

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However, ACSA notes:

... the implementation of the program has been delayed by 3 years. In addition, the proactive supportive and capacity-building emphasis of the program has been watered down. Early this year [DoHA] released a tender to establish a panel of people/organizations who could provide support services on an ad hoc basis. (sub. 327, p. 37)

The Commission considers that providers delivering services in rural and remote locations and to all Indigenous people should be actively supported before remedial intervention is required. Such support requires flexible, long term funding models that are aimed at ensuring the sustainability of service delivery and the building of capacity to enable local people to be engaged in the management and staffing of such services over time. The use of partial or full block funding models can allow infrastructure to be developed and staff retained where service use is variable.

## **11.7 Older Australians living in rural and remote locations**

Rural and remote areas generally do not have the population density or demand to sustain many types of aged care services that are available in urban areas. As such, the Commission's proposed reforms to increase choice may have limited applicability in rural and remote areas where there are relatively small target populations and it is generally only feasible for one or two service providers to operate. Where there are unavoidable and significant variations in occupancy, alternative funding models, such as supplementary block funding and capital grants in addition to mainstream funding, may be required to ensure the ongoing availability of aged care services in these locations.

Submissions and consultations indicate that there are significant challenges in delivering services in rural and remote areas, including:

- the relatively high cost of establishing and delivering services
- difficulties in attracting, retaining and professionally developing suitably qualified staff
- the limited availability of medical practitioners and allied health professionals to support the provision of aged care services.

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### *Costs of service provision*

One of the key issues for providers servicing rural and remote areas is the relatively high cost of establishing and operating an aged care service compared to similar services in metropolitan and other regional locations. Despite relatively lower land costs, it is generally more expensive to build in rural and remote areas due to higher transport costs for construction materials and the sourcing of specialised construction skills.

The ongoing, non-staff costs of delivering aged care services can be considerably higher for rural and remote providers due to the costs associated with:

- transport of food and the cost of other basic services, such as power, water, fuel and communications
- fluctuations in occupancy rates (particularly for smaller, more isolated facilities) and the need to provide stable employment for staff
- costs associated with travel to clients in the delivery of community care.

In addition, older Australians in rural and remote communities may not have high levels of income and assets from which aged care providers can draw additional payments, such as significant accommodation bonds or extra service fees (National Rural Health Alliance, sub. 277).

The Australian Government recognises these higher costs and provides a ‘viability’ supplement reflecting the remoteness of the service, the number of occupied places and the proportion of special needs clients.

However, a number of submissions noted the increasing difficulty that smaller rural and remote aged care services have in remaining viable even with the viability supplement. For example, Presbyterian National Aged Care Network maintained:

It is particularly challenging to run smaller aged care facilities or community care services in a financially viable fashion. A number of Presbyterian aged care services are smaller services, some of them in rural areas. In many cases, the smaller urban services are being shut to allow development of new buildings with more beds. This option is not present in rural areas. We acknowledge the government does provide a viability supplement for small rural residential and community care services which certainly makes a difference. However, the reality is many smaller services struggle to break even, even though they are vital components of their local economies as well as their communities. (sub. 110, p. 9)

Similarly, Aged Care Queensland contended:

Queensland is one of the most decentralised states, making the provision of sustainable aged and community care services in rural and remote locations a real challenge.



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Financial viability is one of the biggest challenges for these providers as often they are faced with higher costs that are not adequately compensated by the current viability supplement. (sub. 199, p. 11)

Many aged care services in rural and remote locations, particularly residential services, are cross-subsidised from other activities (either in urban centres and/or community care and/or income from other sources including philanthropy).

To ensure that the aged care system operates efficiently, services delivered in rural and remote areas should be funded at a level which has regard to the additional costs incurred in supplying the services — this ensures that funding is sustainable and predictable to provide adequate incentives for providers to invest. The Commission considers that the AACC would be the appropriate body to undertake an independent study to recommend to Government the appropriate subsidies (including supplements) for providing sustainable aged care services in rural and remote locations (chapter 15).

Alternative funding mechanisms may be warranted in circumstances where the ACFI and supplementary funding does not cover the costs of service provision. These funding mechanisms could be used for targeted development programs, such as building accommodation for staff or staff education and training (see below).

### *Staffing difficulties*

Staffing is another important issue for the delivery of quality aged care services in rural and remote communities. Providers often report an inability to attract, retain and professionally develop suitably qualified staff. Staffing difficulties can be significantly more expensive to resolve in rural and remote locations compared to urban and regional centres due to:

- higher staff remuneration and other costs associated with temporary workers
- the higher costs of travel and staff back-fill associated with employees undertaking the required level of professional development
- difficulty finding suitable and affordable accommodation.

Regarding higher staff costs, Frontier Services explained:

... Other additional staffing costs not factored into the current viability funding are those related to the need to use agency staff. In remote Australia, agency staff are not able to fill a position day by day or week by week. They provide staffing over usually a minimum of a four week period and need to have covered, in addition to wages, travel costs and accommodation for that period. Short term accommodation is expensive and often very difficult to obtain, particularly in regions where our services compete for accommodation with the mining companies well able to meet the inflated market rates

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... It should be noted that there is no government funding to meet these costs. They are not covered in viability or indexation funding. (sub. 323, p. 12)

Southern Cross Care (WA) also raised the issue of staff accommodation:

... most public sector staff in remote locations are provided with housing or housing subsidies ... Aged care providers receive no realistic supplementation to take account of the real cost of operating in remote locations and are compelled to draw from reserves, should there be any, to remain competitive for staff. In Broome, in order to attract staff SCC invested \$400,000 of its own resources to convert premises to staff accommodation. (sub. 432, p. 8)

A further difficulty is providing competitive remuneration for similar work where there is a dedicated health or multi-purpose service in close proximity which pays public sector rates (chapter 14).

The National Rural Health Alliance outlined the impact on registered nurses who work in rural and remote locations, and health professionals in general, of the National Registration and Accreditation Scheme:

Special consideration should be provided for rural and remote aged care staff for career development ... Continuing professional development requirements, now more clearly defined under the National Registration and Accreditation Scheme, will also impose particular challenges for health professionals in rural and remote areas. Local training opportunities and the availability of suitably qualified locums or back-up staff to maintain service provision levels during training sessions are in short supply in rural Australia. (sub. 277, p. 15)

The National Rural Health Alliance (sub. DR887) also proposed the development and expansion of e-learning and distance education programs to support staff development locally. More broadly, Community Based Support South (sub. 275) indicated that the best way to attract and retain a suitably qualified workforce would be to train locals to provide services as these workers generally have a greater attachment to the local area and, as a result, are less likely to move away in the short to medium term.

In the Commission's view, initiatives such as the development of regionally based aged care providers as Registered Training Organisations, partnerships with education institutions and the Aged Care Channel, which develop the skills of aged care workers in rural and remote locations, should be encouraged and supported as they are important in the creation of a sustainable aged care workforce in these areas. As there are generally only one or two providers in rural and remote areas, these providers should be funded to deliver accredited training and education courses, including covering the costs of travel and replacement workers where staff need to travel for training purposes.

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In addition, some rural and remote aged care services may have difficulty attracting and retaining quality managers, particularly if there are limited opportunities for professional development and career progression. As noted in chapter 14, good management is a characteristic of quality aged care services, and this is an important issue in rural and remote areas. Developing networks of rural and remote aged care services offers a way to develop and share management expertise, while building on the experience of the local community.

Developing local capacity can have additional benefits for the community as a whole.

Effective aged care services sustain the local community through jobs and business as well as through the care of older people. Better support for these services, including encouraging their utilisation, assists in maintaining the fabric of a community through the retention of a greater number of older people for a longer time and in better health. (National Rural Health Alliance, sub. DR887, p. 6)

### *Access to health services*

In rural and remote locations, most older Australians and service providers have more difficulty accessing health services than their counterparts in metropolitan and regional Australia. The National Rural Health Alliance highlighted the extent of difficulties that older Australians face both in community and in residential settings:

Rural, regional and remote areas face serious shortages of doctors, dentists, medical specialists and allied health professionals, all of whom are needed for effective aged care. (sub. 277, p. 15)

The disparity in access to health services in rural and remote areas has been highlighted previously by the Commission in *Australia's Health Workforce* (PC 2005a). Despite a number of initiatives to improve medical and allied health services in rural and remote areas in response to that report, access to doctors and other health professionals is still relatively low compared to urban areas. However, as the Commission noted in *Australia's Health Workforce*, the proportion of nurses to other professional health practitioners has remained at a relatively high level and is comparable to urban centres (see also DoHA 2008a). The Commission considers that in rural and remote areas, team-based, multidisciplinary health service models are an important mechanism to attract and retain the services of health professionals.

The Australian Government has responded to the problems of accessing health and aged care services in many rural and remote areas through the Multi-Purpose Services (MPS) program. There were 129 Multi-Purpose Services in June 2010 with 3120 aged care places (DoHA 2010n). These services co-locate health (including

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acute) and aged care services in one place and provide economies of scale and scope which enable services to be provided that would otherwise not be feasible. In addition, MPS are able to offer health professionals a peer support environment and greater opportunities to undertake professional development.

The Commission notes recent initiatives by the Australian Government to fund capital development and expand these services to locations with a catchment of 6000 people (previously limited to catchments with less than 4000 people) as they are essential to ensuring these communities can access health and aged care services (Australian Government 2010f).

Notwithstanding these developments, Aged and Community Services Australia (ACSA) highlighted that:

The MPS program has not undergone a national evaluation since its inception in the 1990s so it is difficult to determine whether the purported strengths of the model have been fully realised. (sub. 327, p. 35)

Indeed, some participants were critical of the MPS program. For example, Baptistcare and the Shire of Brookton states:

There are many country communities in WA where the State Health Department continue to operate small hospitals whose viability is augmented by operating small numbers of aged care beds. While receiving Federal funding for the aged care beds these hospitals are not subject to the Aged Care Standards and Accreditation Agency audit and accrediting process that mainstream aged care providers are. Residents are often actually in a hospital environment rather than a more home like aged care environment. Health Department staff have acknowledged the challenges of matching the care standards of an RACF [residential aged care facility] in a hospital environment. (sub. DR922, p. 3)

The Commission agrees that a public and transparent evaluation of the underlying policy and operation of the MPS program should be undertaken to determine which types of MPS services are more effective in service delivery. In this regard, the Commission notes the diversity of approaches ranging from cooperative relationships between aged care and health care providers to public hospitals where aged care beds are provided in spare wards.

ACSA has proposed a number of alternatives to the MPS program, such as an integrated service which:

... would have the support and wellbeing of the older person as its primary focus and may offer a range of community and health services as adjuncts... It would be important to ensure that these services do not simply run a state health agenda... (sub. DR730, p. 30)

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Successful partnerships have formed between local governments and aged care service providers to ensure access to health and aged care services in areas where even a small hospital is not sustainable. In addition to initiatives in Tasmania, the development of a co-located service between the Shire of Brookton and Baptistcare has been an example of such co-operation (box 11.4).

**Box 11.4 Brookton Community Health Services and Aged Care Model**

The Shire of Brookton is 140 kilometres south east of Perth. Several years ago it took the decision to significantly restructure its health services. At the time its health services were centred around a small hospital which was augmented by operating a small number of aged care beds.

The Shire's decision was to close the Brookton Hospital and provide a community health service centre called Saddleback co-located with a residential aged care facility called Kalkarni (32 high care and 11 low care beds operated by Baptistcare). Saddleback delivers a variety of health services, including general practitioner medicine, physiotherapy, podiatry, nursing, and HACC services (operated by the Brookton Community Services Group). This decision created a health and aged care 'campus' for the community.

Although the management of services is structurally separated, the co-location of these services has resulted in benefits through:

- shared buildings with functional separation but sharing of some resources, such as a training room and overnight accommodation for staff
- direct provision of health services to Kalkarni
- combined building management.

In terms of outcomes, the co-location of these services has led to:

- maintenance of quality and accessibility to health services, compared to when the Brookton Hospital was operating
- reduced costs of providing health services
- an increased number of aged care beds
- enhanced operational viability of the Kalkarni aged care facility.

Baptistcare considers that the Brookton community health services and aged care model is replicable and offers significant opportunity to improve the efficiency and effectiveness of the health and aged care services in many country locations.

*Source:* Baptistcare and the Shire of Brookton (sub. DR922).

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As part of the National Health and Hospitals Reform agenda, there is merit in evaluating the opportunities for co-locating aged care services with integrated health and community services models in smaller communities. Irrespective of the details of the model adopted, the aged care component needs to be operated in a manner that is consistent with contemporary aged care standards and practices, and undergoes the same quality assurance process as other aged care services. The aged care service elements should not be subsumed into a general health regime as the objectives for, and the aspirations of, older clients may be different.

RECOMMENDATION 11.2

*The Australian Seniors Gateway Agency should cater for diversity by:*

- *ensuring all older people have access to appropriate information and assessment services*
- *facilitating access for people with language and cultural needs through the development of specific hubs for older people from diverse backgrounds that have limited English skills and require access to bi-lingual staff*
- *ensuring that diagnostic tools are culturally appropriate for the assessment of care needs.*

RECOMMENDATION 11.3

*The Australian Aged Care Commission, in transparently recommending the scheduled set of prices for care services, should take into account costs associated with catering for diversity, including:*

- *providing ongoing and comprehensive language services for clients from non-English speaking backgrounds*
- *ensuring staff undertake appropriate professional development activities to increase their capacity to deliver care with dignity and respect to all older people.*

RECOMMENDATION 11.4

*The Australian Government should ensure that rural and remote, and Indigenous aged care services be actively supported before remedial intervention is required. This support would include but not be limited to:*

- *the construction, replacement and maintenance of appropriate building stock*
- *meeting quality standards for service delivery*
- *clinical and managerial staff development, including locally delivered programs and enhanced use of technology assisted training*

- 
- *applying funding models that ensure service sustainability and support the development of service capabilities at a local level.*

RECOMMENDATION 11.5

*The Australian Government should partially or fully block fund services where there is a demonstrated need to do so based on detailed consideration of specific service needs and concerns about timely and appropriate access. Such services might include:*

- *dedicated aged care services for homeless older Australians*
- *Indigenous specific, flexible aged care services.*

*Direct access to these services would be available immediately but care recipients would be required to undergo an Australian Seniors Gateway Agency assessment within three months of entering such care services and, where appropriate, pay relevant co-contributions.*





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## 12 Age-friendly housing and retirement villages

### Key points

- Age-friendly housing and neighbourhoods can have a positive effect on the health and quality of life of older Australians. The development of age-friendly communities is receiving attention at Australian, state, territory and local government levels. A national approach could assist in spreading best practice.
- Universal design standards are increasingly being applied to new private and social housing. Although there are significant benefits from applying these standards, and voluntary adoption should be encouraged, the higher costs mean that mandating their application for all new dwellings is not warranted at this stage.
- Most state and territory governments do not have clearly articulated policies for providing home maintenance and modification (HMM) services, or clear connections to the wider goals of ageing policy. A better evidence base to identify the benefits and costs of HMM and a more systematic approach to assessing the need, and providing support, for HMM assistance for the elderly is required.
- Some building standards for residential modifications are inappropriate for the requirements of people over 60 years of age, and impose unnecessary costs and/or ineffective outcomes. New standards which address the needs of older people are required.
- Stamp duty and the assets test for eligibility for the Age Pension create disincentives for older Australians to sell their dwellings and move to more appropriate housing.
- Older Australians who rent tend to have less security of tenure and less wealth than home owners, and are more likely to enter residential care. The provision of affordable housing which facilitates both independent living and the delivery of home-based care for older Australians who have insecure tenure is thus a priority. Governments are playing a major role in meeting this need, but evidence suggests more support for housing and rental assistance will be needed to meet significant demand pressures.
- Legislation at state and territory level is inhibiting investment in retirement villages. Nationally consistent regulation appears warranted. However, aligning the regulation of retirement living options with that of aged care is not appropriate.

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The literature on ageing and aged care highlights the significant effect of housing and social inclusion on the health and wellbeing of older Australians (AIHW 2009a; Holt-Lunstad et al. 2010). It also highlights the overwhelming preference of people to age in their own homes and communities (The Benevolent Society 2008). Both views were widely held among participants. For example:

... the most important or crucial element to a Senior Australian maintaining their health, lifestyle and connection to their community is their housing choice. (Masonic Homes Limited, sub. 124, p. 7)

The preference for the majority of people is to continue to live in their own homes and receive care in this environment. (Boandik Lodge Incorporated, sub. 99, p. 1)

I think it is important for older people to live in their own house for as long as possible. (Don Baker, sub. DR812, p. 1)

Many submissions also referred to the reductions in health and aged care costs when people are able to age in their own homes and communities and so defer the time of their life at which they enter residential care (AARP 2008; ECH, Eldercare and Resthaven, sub. 100). These benefits can be substantial:

Analysis of IRT's [Illawarra Retirement Trust] customers showed that on average, seniors living in a purpose built residential community require access to both Residential Aged Care (RAC) and Community Services (CS), later in life when compared with their community peers. When accessing RAC the difference is four years, whilst for those accessing CS the difference is two years. (IRT, sub. 356, p. 13)

The vast majority of Australians aged 65 and over (around 83 per cent) own or are buying their home, while about 14 per cent are renting (table 12.1).

This chapter examines factors affecting older Australians' access to 'age-friendly' housing and communities (sections 12.1 and 12.2 respectively). It also examines the availability and affordability of rental accommodation suitable for older Australians (section 12.3) and whether the current regulation of retirement living options is appropriate for the future (section 12.4). Finally, the chapter examines how some regulations affecting residential aged care buildings are being changed (section 12.5).

**Table 12.1 Housing tenure/landlord type for those 65 and over<sup>a</sup>, 2007-08**

<i>Tenure or landlord type</i>	<i>Number and proportion of households</i>	
	'000	%
Owner without a mortgage	1 332.5	77.9
Owner with a mortgage	92.7	5.4
Renter		
State/territory housing authority	108.6	6.3
Private landlord	114.2	6.7
Other landlord type	20.2	1.1
Total renters	241.0	14.1
Other tenure type <sup>b</sup>	45.0	2.6
All households	1 711.2	100.0

<sup>a</sup> Includes usual residents of private dwellings in urban and rural areas of Australia (excluding very remote areas), covering about 97 per cent of the people living in Australia. Private dwellings are houses, flats, home units, caravans, garages, tents and other structures that were used as places of residence at the time of interview. Long-stay caravan parks are also included. Residents of non-private dwellings (which include hotels, boarding schools, boarding houses and institutions) are excluded. <sup>b</sup> 'Other' forms of tenure including living rent free with other family members, and group households. This is more common with advancing age, reflecting in part moves to live with younger family members precipitated by increasing frailty and care needs.

Source: ABS (2009a).

## 12.1 Improving choice of age-friendly housing

Australia's ageing population, and older people's strong preference to stay in their own homes as long as possible, will increase the need for housing that supports independent living, and associated home-based care.

Submissions raised various issues that affect older Australians' ability to remain living in their home of choice. Prominent among these were:

- housing design which better meets the requirements of older Australians
- availability of home maintenance and modification services
- barriers to moving to a more appropriate form of housing
- access to care services across all types of housing (dealt with in chapter 9).

### Housing design

In recognition of the growing number and proportion of older Australians, with the attendant growth in age-related frailty and disability, some participants proposed the development of building regulations which required accessibility features or that dwellings be built which could be easily adapted to achieve accessibility. This led to

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a call for mandated universal design standards to be embodied in the Building Code of Australia (BCA). For example, Physical Disability Australia Ltd argued that:

... new, national legislation be enacted to ensure that all new homes are at a minimum accessible from the street and are built to accommodate future adaption and provision for people who may have mobility impairments. (sub. 96, p. 17)

This view echoes that of aged care organisations more generally, which have called for reform along the lines of ‘mandatory adaptable, accessible and sustainable design standards for all housing’ (NACA 2009, p. 6).

There is limited regulation to deliver accessible, visitable or adaptable private dwellings (box 12.1). The *Commonwealth Disability Discrimination Act 1992* prohibits discrimination against people with a disability, including discrimination in access to public premises. Public premises under the Act include buildings to which the public has access, but not private premises such as private housing. Similarly, while there are disability access provisions in the BCA, they do not apply to Class 1 (detached homes, terrace houses, row houses) and Class 2 buildings (apartments).

**Box 12.1 Definition of accessible, visitable and adaptable dwellings**

*Accessible dwellings* allow full access and use for all occupants and visitors.

*Visitable dwellings* allow everyone (including wheelchair users or the vision impaired) to visit with dignity, including overnight, and for an occupant with a disability to reside temporarily. They would be expected, therefore, to have a no-step entry, wide doors and a wheelchair friendly toilet on the ground floor.

*Adaptable dwellings* should be visitable, but with additional provisions that enable the dwelling to be altered without major structural works and at a much lower cost to make it fully accessible and useable in the future.

*Source:* VCEC (2005, p. 117).

Mandated universal design standards to deliver accessible, visitable and adaptable private dwellings would improve independence and social inclusion for some older Australians and enhance their ability to age in their homes. Such standards would also substantially lower the cost of retrofitting those dwellings to achieve these goals (Quinn and Judd 2010; Queensland Shelter, sub. DR779, p. 4). However, the issue is whether the additional costs, if incurred for all new dwellings, would be outweighed by these benefits.

Mandated universal design standards in the BCA would increase the cost of all new housing. A 1999 study estimated that in New South Wales (NSW) the initial cost to make a townhouse compliant with AS 4299 class C (a standard specifying certain

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minimum levels of accessibility) is 0.5–1.0 per cent of the total cost, and to build an adaptable single dwelling or townhouse could add between 1.0–3.6 per cent to the total cost (Hill PDA 1999). More recent analysis shows the cost of including 12 ‘critical’ design elements of AS 4299 in typical project homes adds 1–2 per cent to the initial cost (Landcom 2008). For mid-rise dwellings, the cost could initially add 0.3–8.0 per cent to total costs (VCEC 2005).

While all new housing would incur these costs, only a proportion of those dwellings would deliver benefits to older Australians who occupied (or visited) them (although there would also be benefits for younger people with a disability).

In assessing the relative merits of this issue, the Commission notes that much is already being done in this space. Of particular relevance are the Liveable Housing Design Guidelines (box 12.2), launched in July 2010 by the then Parliamentary Secretary for Disabilities and Children’s Services, the Hon. Bill Shorten MP (Physical Disability Council of NSW, sub. DR807).

### **Box 12.2 Liveable Housing Design guidelines**

The guidelines describe a number of core easy living elements that aim to make a home safer and more responsive to the changing needs of its occupants.

Universal housing design is housing that meets the needs of all people at various stages of their lives, including people with a disability and senior Australians. Enabling key living spaces and features to be more easily and cost effectively adapted to meet changing needs and abilities, means safer, more suitable housing. It can help increase social inclusion, improve health outcomes, and allow greater independence and increased opportunities for anyone experiencing disability.

Three levels of performance are detailed in the guidelines.

The first level, Silver, comprises six core Universal Housing Design elements and is intended to apply to all new homes. The second level, Gold, contains enhanced and additional universal design elements for new home construction. The Gold level elements are also eventually intended to apply to all new social and affordable homes that receive government assistance or funding for construction. The third and highest level, Platinum, is intended to be more of an aspirational set of guidelines for people wishing to design houses with optimum accessibility features in mind.

These voluntary performance levels can be applied to all new detached and semi-detached houses, terraces and townhouses and to new apartment dwellings.

*Source:* FaHCSIA (2010b).

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These guidelines were developed as an outcome of the National Dialogue on Universal Housing Design. The dialogue brought together the housing industry, the disability and community sectors, and governments. The housing industry has embraced these guidelines and developed a plan which includes an aspirational target of having all new homes meet the guidelines by 2020. The Commission supports this initiative.

Queensland Action for Universal Housing Design (sub. DR640), however, noted that little has been done since this initiative. It and Anglicare Australia (sub. DR836) supported mandatory universal design for new or refurbished housing to address this lack of action.

The findings of an Australian Housing and Urban Research Institute (AHURI) study (Judd et al. 2010) suggest why this might be so. The study estimated the costs and benefits of visitable, adaptable and universal design and found visitable design was the only option with a benefit–cost ratio greater than 1.0 (where greater than 1.0 indicates benefits in excess of costs). The other options were found to have benefit–cost ratios of around 0.29, indicating costs far in excess of benefits.

Queensland Action for Universal Housing Design (sub. DR640) and Queensland Shelter (sub. DR779) sought mandatory minimum universal design standards and, to support their case, referred to a Victorian Regulatory Impact Statement (RIS) on the regulation of access features similar to the Liveable Housing Design’s silver standard (DPCD 2010a). That RIS estimated annual quantifiable costs of the features would be \$30.8 million and annual quantifiable benefits would be \$5.4 million. But, after taking into account unquantified benefits, the RIS concluded that overall benefits would outweigh the costs (DPCD 2010a). The RIS was based on an estimate of the average added cost at design stage of about 0.2 per cent of the housing cost. The Housing Industry of Australia has estimated these features would more likely add 1.35 per cent (nearly seven times those used for the RIS) to the cost (Queensland Action for Universal Housing Design, sub. DR640). The significant difference in cost estimates and reliance on unquantified benefits suggests the conclusions of the Victorian study are sensitive to the assumptions it used.

Further, there is evidence that the general housing market is responding to current and prospective demand from an ageing Australia and is incorporating accessibility and adaptability features in new housing targeted at this cohort. Landcom, a major NSW property developer, for example, aims:

... to influence the design of mainstream housing so that a greater proportion of new homes built will be suitable for older people to live in for a longer period of time. We aim to include a proportion of universal housing in each of our projects wherever appropriate. (Landcom 2008, p. 5)

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The Benevolent Society's planned accommodation complex in Bondi (an adaptation of the 'Apartments for Life' developed by the Humanitas Foundation in Holland) is another example of this (sub. DR805; ACIL Tasman 2009).

More specifically, the retirement village industry — which houses about 5.3 per cent of those aged 65 and over and is projected to house more than 7.5 per cent of this group by 2025 (RVA, sub. 424) — is generally geared to providing housing appropriate for older people. Australian Unity (sub. DR751) noted that retirement village units are typically being built to meet universal housing design guidelines, including larger bathrooms with grab rails and wheelchair accessibility. Similarly, Robert Harvie (sub. DR566, p. 2) noted, 'Many of the newer retirement villages have adopted the wider hall, doors, bathrooms etc'. This focus on age appropriate features is particularly so where villages target the older old cohort and offer supported living (rather than resort-style living) arrangements (Blue Care, sub. 254).

Australian Homecare Services (sub. DR509) also observed that innovative, independent, non-institutional, congregate living options for older people are emerging as alternatives to retirement communities, independent living options and serviced apartments.

New social housing is also substantially embracing design standards aimed at delivering age-friendly housing. The Australian Government's Social Housing Initiative, announced in February 2009, is providing funds to state and territory governments for the construction of up to 19 300 new social housing dwellings by 2011-12. Over 5300 of these dwellings are targeting older Australians, and in stage 2 of the initiative, some 16 500 dwellings will be constructed, with 99 per cent of these to comply with universal design principles (FaHCSIA, pers. comm., 9 August 2010). The Commission endorses this emphasis, particularly given the relatively high proportion of older Australians who are social housing tenants (in 2009, 102 000 or 29 per cent of all public housing tenants were over 65 years of age (OPAHA 2009)).

In assessing the benefits compared to the costs, these developments suggest that, from the perspective of older Australians alone, mandatory application of universal design standards for all new housing is not warranted given the community-wide costs. Nevertheless, voluntary adoption should continue to be encouraged.

### **Home maintenance and modification**

At present, home maintenance and modification (HMM) services are mostly provided under the Home and Community Care (HACC) program (table 2.2), and

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aim to assist people to conduct their everyday living activities and remain independent.

HMM services (box 12.3) are available to home owners, mortgagees or private renters who are ageing, have a disability, or care for someone at home who is ageing or has a disability. Access to these services is especially important where alternative age-friendly housing or residential aged care are less likely to be available — such as in rural and remote areas.

**Box 12.3 The definition of home maintenance and modification services**

Home maintenance and modification (HMM) services are defined as ‘services that are designed to modify or maintain the dwellings of older people in order to enhance their safety, independence, identity and lifestyle’.

The four main service types identified are: structural modifications, non-structural modifications, repairs and improvements, and maintenance.

Structural modifications involve changes to the fabric of the home (for example, widening doorways and passages and remodelling kitchens or bathrooms). Non-structural modifications are mainly concerned with installation or alteration of fittings and fixtures (for example, grab rails and ramps), but can include assistive/enabling technology such as Telecare and Telehealth monitoring devices. Repairs and improvements involve mending damaged or unserviceable elements of the home and surrounds, including steps, paths, floor coverings, roofs, lighting, and associated minor upgrading. Maintenance is work required on a recurrent basis to sustain the functioning and amenity of the home and surrounds, such as replacing smoke alarm batteries and garden maintenance.

HMM services are categorised as either direct, involving actual service provision, or indirect, involving such services as information, advice, referral, assessment, brokerage, project management and financing.

*Sources:* AHURI (2008); Carers NSW (sub. 211); Sundale Garden Village (sub. 269).

Under the Commission’s proposals, HMM services for older Australians may be accessed via an assessment by the Australian Seniors Gateway Agency (chapter 9), or directly though other paths by which existing HMM services are currently accessed (such as those in box 12.5).

HMM services can be instrumental in allowing people to continue to live in their homes and communities for longer. For example, Bridge found:

... maintenance and modification interventions have been shown to be effective in decreasing accidents and injury with a reported seven-fold reduction in reported morbidity ... Further, lack of access to appropriate housing costs taxpayers and government especially if institutionalisation results ... . (2005, p. 6)



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More recently, Molineux et al. (2010) concluded:

HMM services play a role in ensuring that older people and people who have a disability are safe in their home and surrounding environment, have access to the wider community and can remain in their home with as much independence as possible. This in turn can result in positive impacts on health and well-being for the individual and their carers. Furthermore, these can all have benefits for the community and local, state and federal governments. (p. 18)

Inquiry participants expressed similar views (box 12.4).

**Box 12.4 Participants' views on the benefits of HMM services**

Tech4Life:

... simple home modifications can be the difference between safe and independent living for older people, or institutional care. (sub. 273, p. 1)

The Physical Disability Council of NSW:

Home modification and maintenance schemes provide affordable, cost effective modifications and maintenance work for people within the HACC target group for people living in their own home or in private rental accommodation. These services allow people to live safely and independently in their own homes and reduce the need for premature admission to residential care facilities. (sub. 261, p. 6)

The Aged Care Association of Australia noted that home modification programs, as part of a general community care service:

... support older people to retain their independence at home, help to prevent the need for more expensive services (such as hospital or residential aged care), and help people return home more quickly after a stay in hospital. (sub. 291, p. 18)

The Home Modification Information Clearinghouse reinforced these views, citing research by Carnemolla & Bridge (2011) which found that timely, appropriately prescribed and installed home modifications:

1. Facilitate ageing in place;
2. Maintain a sense of independence;
3. Reduce hazards in the home environment; and
4. Act as a substitution for assisted care services, thus reducing the need for care.

Therefore, the economic benefits of ... home modifications could include:

1. Reduced length of stay in hospital (timely discharge)
2. Reduced risk of and/or deferred admission to residential care
3. Reduced risk of injury to clients, carers and careworkers
4. Reduced, or even negated, need for ongoing care assistance. (sub. DR793, pp. 7–8)

Comhouse Co-operative Ltd (sub. DR522) submitted research from the United Kingdom (Croucher and Lawson 2011) which provided similar evidence of the significant net benefits derived from HMM services.

In the context of home modifications, some participants highlighted the growing role for assistive technologies which help older people remain independent and safe in their homes. Samarinda Aged Services, for example, noted:

Existing technologies can provide many benefits in monitoring people within their homes via the web. This can reduce some of the need for contact but more importantly provide a constant coverage of care through monitoring various appropriate indicators. (sub. 90, p. 1)

while Perth Home Care and the Medical Technology Association of Australia noted:

Technologies which enable people to remain at home longer are becoming less a fiction and more a reality. Ageing-in-place supported by smart technologies offers the potential for substantial savings in residential aged care and in reduced admissions to hospitals, by providing early alerts to changing health patterns and by minimising falls and other accidents in the home. (Perth Home Care, sub. 398, p. 8)

There has been a large amount of research, and a large number of Australian pilot programs that demonstrate the effectiveness of technology to support ageing in place. (Medical Technology Association of Australia, sub. DR567, p. 5)

As an indication of the scale of HMM services delivered under home and community care (HACC), in 2008-09 around 122 500 clients aged 65 or older received home maintenance services and about 30 000 received home modification services (table 12.2).

**Table 12.2 HACC clients, assistance type by age group, 2008-09<sup>a</sup>**

<i>Assistance type</i>	<i>0–64</i>	<i>65–69</i>	<i>70 and over</i>	<i>Total</i>
	Number of clients			
Home maintenance	19 479	10 991	111 543	142 041
Home modifications	4 611	2 629	27 430	34 670
	Percentage of age group receiving assistance			
Home maintenance	9.8	16.2	18.5	16.5
Home modifications	2.3	3.7	4.4	4.0

<sup>a</sup> These numbers are indicative only because: the data does not cover all services (for example, some clients can opt out of having their data reported); not all HACC agencies required to report do so, and service levels may thus be higher than stated; and, in Victoria, home modification is recorded as part of property maintenance (home maintenance).

Source: DoHA (2009c).

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The 2008-09 data also highlights significant variations in HMM services delivered in the states and territories. The proportion of HACC clients of all ages receiving home maintenance services across the jurisdictions was between 7.4–21.7 per cent (national average 16.5 per cent). For home modification services, this proportion was between 0.2–7.4 per cent (national average 4.0 per cent). The average number of hours of home maintenance that clients received for that year ranged from 5.4–13.9 hours (national average 8.3 hours), and the average cost of home modifications per client ranged from \$181–\$3319 (national average \$529).<sup>1</sup>

Molineux et al. (2010), in a report for the Western Australian Government, ascribe these variations as likely being due to differences in state or territory policies and programs, costing of services, and a lack of coordination of local service providers. Similarly, AHURI found:

Under the HACC program the priority given to various service types can differ considerably from state to state, as have the organisational arrangements for service provision. One consequence has been that HACC-funded HMM services differ markedly from state to state both in their level of provision and the service structure. (2008, p. 2)

Participants also identified a number of problems with the provision of HMM services. Foremost among these were lengthy wait time to be assessed for these services or to have those services provided once approved (COTA Australia, sub. 337; Motor Neurone Disease Australia Inc, sub. 147; The North West Region—CACP/EACH/D/ACAS Forum, sub. 133; Rosemary West, sub. 94).

Delays in assessment were associated with inadequate levels of funding for assessment teams and shortages of assessment staff, such as occupational therapists in metropolitan and regional NSW (NSW HMMS State Council, sub. 268; Occupational Therapy Australia, sub. 203). Delays in services being provided were associated with a shortage of funds and a lack of service providers in some areas (NSW HMMS State Council, sub. 268).

Inadequate funding and workforce shortages are general problems for the whole industry, and are discussed in chapters 7 and 14 respectively.

Although delays in assessment or service delivery are of concern, a comprehensive review of HMM services published in 2008 suggests they are not the norm:

Most of the consumers who were interviewed reported that HMM organisations responded in a timely way to service requests, and that delays were experienced only

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<sup>1</sup> HMM services are also provided under community care packages. In 2008-09, around 12 per cent of the 61 000 care package clients received these services.

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with major modifications. According to the consumers interviewed, delays were more the exception than the rule. (AHURI 2008, p. 139)

Accessibility to HMM services also has an affordability dimension. The NSW HMMS State Council raised concerns about the equity and sustainability of HACC HMM services under existing co-contribution arrangements:

Currently, each HMMS sets their own Fees Policy in accordance with the National HACC Program Guidelines and Client contributions are collected from Clients on their ability to pay. Assessing a Client's ability to make a contribution is based on information provided by the Client. In essence it is an honesty system which is fraught with difficulty for the Service Provider and creates an inequitable subsidised payment system from one local planning area to another for the consumers.

To ensure a sustainable system and one which is based on equity of access by all Australians a clearly defined assessment system of income and assets needs to be implemented by the Government for all HACC Services. (sub. 268, p. 4)

Section 7.3 discusses how co-contributions (including those for HMM services) might be best assessed in the context of the Commission's proposed approach to financing aged care and support services generally.

While HMM services provided under HACC and community care packages constitute the bulk of HMM services provided for older Australians, there is some delivery under other programs (box 12.5).

Occupational Therapy Australia noted that access to home modifications for residents of state run public housing was a particular problem. It argued 'Public housing must be considered as a special case and urgent attention must be paid to streamlining and resourcing home modifications processes for older public housing tenants' (sub. DR849, p. 2).

In a report on HMM programs, researchers from the AHURI network noted that these services lie at the intersection of health, community care and housing policies for older Australians, but found:

- while individual programs and organisations have clearly articulated objectives and policies, there is no overarching policy framework for HMM service provision at the national level or in most states
- there are limited integration and coordination mechanisms and processes to ensure that HMM organisations and programs operate as an integrated service system
- planning and development of HMM services is hampered by an absence of integrated HMM information systems (AHURI 2008, p. 55).

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### Box 12.5 The main non-HACC HMM programs

The Department of Veterans' Affairs (DVA) provides HMM programs across the country for veterans and their families. Entitlement to HMM services under these programs is subject to DVA assessment and funded under the DVA budget.

State and territory housing authorities provide HMM services for social housing tenants. They may also provide loans to older people wishing to undertake home modifications. State and territory community health centres and hospitals also support HMM services in the context of hospital discharge programs, falls prevention programs and programs supporting older people with chronic illnesses in the community.

In addition, some states have unique HMM or HMM-related services or programs. The following four are of particular interest.

- The Queensland Government's Home Assist Secure program, which funds a network of services providing home maintenance, repair and non-structural modifications to 50 000 consumers annually across the state.
- Also in Queensland, the Smart Housing and Home Access initiatives provide information on access and building issues for home-building professionals, developers, real estate agents and consumers.
- The Victorian Government funds the building advisory service (Archicentre) of the Victorian Chapter of the Royal Institute of Architects to provide free home inspections to older people and people with disabilities, including recommendations on maintenance, repairs and modifications.
- The NSW State Government supports a State Council to provide coordination and advocacy for HMM providers and supports a Research and Resource Centre at the University of Sydney (the Home Modification Information Clearinghouse).

Some home modification services are also available under state and territory aids and equipment programs.

*Sources:* AHURI (2008); Medical Technology Association of Australia (sub. 187); Repatriation Commission (sub. 366).

The AHURI (2008) report concluded that a coordinated and integrated policy approach to the provision of HMM services in Australia is needed in order to improve their effectiveness in achieving health, community care and housing outcomes in later life.

The AHURI report proposed a national program with a set of objectives for housing, health and community care outcomes, linked to a national strategy for housing older people and a whole-of-government ageing policy. This approach would involve a lead agency in each of the Australian, state and territory governments, and a collaborative approach to policy and service provision between the two levels of government. Aged and Community Services Australia (ACSA)

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and the Council on the Ageing (COTA) Australia, via their Older Persons Affordable Housing Alliance, support such a national program (OPAHA 2009).

Within each jurisdiction a network of local and regional HMM organisations similar to those operating in NSW and Queensland (box 12.5) would be responsible for providing HMM services locally, linked to wider advice, information and referral services.

The report also proposed a national approach to benchmarks for the levels of services to be provided, terms of eligibility and user charges, and the development of professional and technical expertise. These new national arrangements would build on existing services and aim to incorporate the best features of schemes such as the Victorian Archicentre Home Renovations Service, the NSW Research and Resource Centre, and the Queensland Smart Housing and Home Access initiatives (AHURI 2008).

The Commission sees merit in an integrated national approach for aged care HMM programs and the various other HMM programs along the lines suggested above. The Australian Government's assumption of responsibility for HACC funding (except in Western Australia and Victoria) should facilitate developing such a national approach (COAG 2011)

In response to the Commission's proposed national policy approach, the Australian Federation of Totally and Permanently Incapacitated Ex Servicemen and Women Ltd (the TPI Federation) (sub. DR682) drew attention to the DVA's HMM system, which already has national benchmarks for levels of service and terms of eligibility. The experience of that system could thus inform the development of a broader national policy approach. Also, in response to the Commission's proposal, the Australian Services Union (sub. DR581) noted that any process to establish a national approach should take account of the role of local government as a key provider and funder of HMM services through the HACC program. This, it noted, is especially important for rural and remote areas, where local government plays an almost exclusive role in providing HMM services.

The Commission acknowledges that any new arrangements should build on existing schemes and aim to incorporate their best features.

#### RECOMMENDATION 12.1

***The Australian, state and territory governments should develop a coordinated and integrated national policy approach to the provision of home maintenance and modification services, with a nominated lead agency in each jurisdiction.***

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***To support this national approach, all governments should develop benchmarks for the levels of services to be provided, terms of eligibility and co-contributions, and the development of professional and technical expertise.***

AHURI (2008) research suggests that the evidence available to inform decisions on the efficiency and effectiveness of HMM services is inadequate:

The literature on Australian HMM policies and services is extremely sparse ... Current service arrangements have a history of some two decades, but no systematic research evidence base to underpin policy development has emerged during this time. ... Apart from a handful of highly focused studies, there is also no literature on the outcomes or cost-effectiveness of HMM provision in Australia. (p. 1)

Hal Kendig argued that further research was needed to improve the cost effectiveness of resources expended on aged care. This could include research into:

How can aids and equipment be most effectively accessed, provided, used and funded — to maximise cost effectiveness? (This should cover the spectrum of aids from low to high tech and include home modifications). (sub. 431, p. 15)

A 2010 report on HACC HMM services for the Western Australian Government came to a similar conclusion:

Research should be commissioned to further examine the effectiveness of HACC provided home modification and home maintenance services, and their economic outcomes. (Molineux et al., 2010, p. 36)

In view of the above, the Commission considers that the Australian Government should consider funding research to provide the evidence needed to inform decisions on the appropriate level and mix of HMM programs and services provided to older people. Moreover, this funding should be provided as a matter of priority. Marshalling existing research capabilities (such as the AHURI network and the NSW Home Modification Information Clearinghouse) would facilitate an early start on addressing this fundamental deficiency.

Chapter 16 also discusses this issue in the broader context of the proposed Australian Aged Care Commission facilitating more research and evaluation to inform aged care policy through providing a data (and research) information clearinghouse.

### ***Problems with the standards on which home modifications are based***

A problem with home modifications is the difficulty (and cost) of getting approval where standards under the BCA are inappropriate or do not address individual needs. In such cases, approval to deviate from the BCA might require:

- 
- engaging an accredited building assessor to seek ‘deem to satisfy’ provisions under the BCA
  - lodging a development application for the variation
  - two site inspections by council through the course of building the modification.

Inappropriate standards for home modifications arise because the only Australian Standard for residential housing designed to meet the needs of people with a disability is the Adaptable Housing Standard AS 4299, which calls up AS 1428 (the Australian Standard for design for access and mobility, which provides design requirements for buildings encompassing the specific needs of people with disabilities). However, AS 1428 requirements were not developed for older people or intended for private dwellings. The requirements within AS 1428 are derived from assumptions about the average dimensions of the 18–60 population and public access requirements. AS 1428 requirements are not linked to an evidence base of the capabilities of older Australians. Thus, an older person who, for example, is taller, shorter or uses a mobility device that has a footprint outside the A80/A90 wheelchair template could be further disadvantaged in their own home under this approach (HMInfo Clearinghouse, pers. comm., 14 October 2010).

Resolving this problem requires that the building standards designed to address the needs of people with a disability or age-related functional limitations be revisited with a view to making them appropriate for residential housing and be developed on the basis of a robust evidence base of the:

- dimensions and capabilities of the 60 years and over population
- dimensions and capabilities of contemporary disability aids (such as mobility devices).

New standards along these lines would provide individuals, who sought to build or modify a residential dwelling to cater for their access needs, with a more cost-effective solution than is currently available. These standards would also help guide occupational therapists in assessing what modifications are required to meet the needs of individuals within their home environment (NSW HMMS State Council, sub. DR646).

The National Presbyterian Aged Care Network (sub. DR547) and the Victorian Committee for Aboriginal Aged Care & Disability (sub. DR575) supported developing standards more relevant to older people. National Seniors Australia Knox Branch (sub. DR580), though, thought these standards were already catered for in the Universal Design Codes, and there would be value in recognising these in national standards. Masonic Homes (sub. DR721) felt standards would be too constraining and supported instead the development of guidelines.



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It would be sensible for any new standards to be reviewed within three years of their introduction and thereafter to be subject to regular review to ensure their continued relevance and practicality.

RECOMMENDATION 12.2

***The Australian Government should develop building design standards for residential housing that meet the access and mobility needs of older people.***

While reform along these lines would address the problem of inappropriate standards, it would not address the problem where modifying dwellings to new standards would be impractical and excessively expensive. In these circumstances, some compromise on a case-by-case basis is needed to achieve an affordable solution that meets an individual's needs (and leaves them better off) even though it does not meet deemed-to-comply standards.

In the United Kingdom, where this situation arose on a sheltered housing project run by Pennine housing, the underlying issue was identified as the legal liability arising where modifications varied from building standards. In that instance, the issue was tackled by all concerned parties (for example, builder, designer, certifier and building owner) agreeing to share liability (HMInfo Clearinghouse, pers. comm., 10 November 2010).

### **Barriers to moving to more appropriate housing**

As people age and their needs change, their homes may become unsuited to sustaining their independence. For home owners, one option is to sell and move to housing better suited to the delivery of the support and care they need.

However, major regulatory (and associated financial) disincentives face older Australians who wish to pursue this option: notably stamp duty and the Age Pension assets test. The Multicultural Communities Council of South Australia (sub. 52) considered these were key areas needing reform.

The 2008 Senate inquiry on housing affordability recognised the disincentive effect of stamp duty, and called for state and territory governments to consider exemptions for older Australians who are downsizing their principal residence (SCHAIA 2008).

In its 2010 Budget, the NSW government eliminated stamp duty from 1 July 2010 to 1 July 2012 for those over 65 years old who sell their home to move into a newly-built dwelling worth up to \$600 000, in an effort to encourage them to trade down to smaller homes (Munro and Chancellor 2010). Critics of this initiative suggest that it will be of limited value and the aim of encouraging older Australians

to move to more suitable housing would be better served if the newly built dwelling criterion was removed.

The review of *Australia's Future Tax System* (the Henry Review 2010) also criticised stamp duty on a number of grounds. It noted that stamp duty creates a disincentive for people to buy or sell property, which can result in people not living in the house they really want to live in or staying too long in a house that could be better used by somebody else. This disincentive is determined by the size of the tax in comparison to the non-tax costs of moving, such as real estate agent fees and removal costs (Henry Review 2010). As indicated in table 12.3, stamp duty can double the total cost of moving.

**Table 12.3 Stamp duty expressed as a tax on moving in capital cities<sup>a</sup>**

	<i>Value of median home, June 2009</i>	<i>Stamp duty payable</i>	<i>Other moving costs</i>	<i>Total cost of moving</i>	<i>Effective tax rate on moving</i>
	\$	\$	\$	\$	%
Sydney	544 000	19 970	21 320	41 290	94
Melbourne	441 900	18 484	18 257	36 741	101
Brisbane	419 000	5 915	17 570	23 485	34
Perth	450 000	15 390	18 500	33 890	83
Adelaide	359 000	14 280	15 770	30 050	91
Hobart	336 000	10 990	15 080	26 070	73
Canberra	458 000	18 240	18 740	36 980	97
Darwin	537 100	26 586	21 113	47 699	126

<sup>a</sup> Other moving costs assume real estate agent fees of 3 per cent on the value of the home as well as a flat \$5000 cost in all States. Stamp duty payable assumes that the buyer is not entitled to concessions such as first home buyer assistance. These estimates overstate the monetary non-tax costs of moving for those vendors who choose not to engage a selling agent or professional removalists.

Source: Henry Review (2010, p. 255).

The Henry Review also noted that stamp duty is inequitable as it falls most heavily on people with a preference for housing consumption and on those who move more often because the effective rate of tax declines as the cost of stamp duty is spread over more years of occupancy.

The Review concluded that stamp duty is a highly inefficient and inequitable tax which, among other things, deters older Australians from selling their home and moving to more appropriate accommodation, and recommended the removal of stamp duty.

The Commission supports the removal of distortionary imposts. Having regard to the arguments in the Senate inquiry (SCHAIA 2008) and the Henry Review, and in the context of the disincentive that stamp duty introduces to the decision of older

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Australians to move to more appropriate housing (NSW HMMS State Council, sub. DR646), the Commission endorses in principle the Henry Review's conclusion that stamp duty should be removed.

The assets test for the Age Pension also represents a barrier to downsizing. Many pensioners do move to more appropriate housing as they age and their care needs change, Sane and Piggot (2009), for example, using the Household, Income and Labour Dynamics In Australia data set, have shown that the exemption of the principal residence from the assets test clearly operates to inhibit residential mobility and trade-downs. Australian Unity (sub. 265) and Lend Lease Primelife (sub. 424, attach. 6.2) also argued that the current test is a major disincentive for pensioners to release equity from their home to assist with care costs or with moving to more appropriate housing (either owner-occupied or rented). If the assets test were relaxed so that people could keep their Age Pension (or a higher percentage than present) after selling their home, they might move, releasing equity to help pay for their aged care. Further, Australian Unity argued, changing the assets test would have a limited cost to government since the default behaviour (not selling and moving) means they keep the Age Pension anyway.

The Commission acknowledges that the current assets test has a significant deterrent effect on people's willingness to sell their home and move to more appropriate housing, particularly if that would involve renting or other forms of periodic payment for accommodation — including residential care. As discussed in chapter 7, the assets test can also induce people to pay large sums into residential care accommodation bonds, as such bonds are also exempt from the Age Pension assets test.

The Henry Review examined the current income and assets tests for income support payments (including the Age Pension). It recommended these tests should be replaced with a comprehensive means test which, among other things, would 'continue the means test exemption for owner-occupied housing up to a high indexed threshold' (Henry Review 2010). Under the recommended changes, a surplus on the sale of one's principal residence would still be included in the means test for the Age Pension (Henry Review 2010).

The current Age Pension assets test provides an incentive for older Australians to invest in their principal residence, encouraging capital into an asset that may not necessarily yield the best return for the individual or the nation. However, the issue of designing a more appropriate assets test for the Age Pension extends beyond the context of aged care, and is one more appropriately considered in a general economy wide context.

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Given that this inquiry cannot presume that reform of the current Age Pension assets test will occur, chapter 7 proposes an Australian Age Pensioners Savings Account scheme which would reduce the distorting effects that the assets test has on people's choice of housing and on their choice between owning, or renting, that housing. Among other things, this scheme should remove a constraint on the growth of rental contracts in retirement villages since the incentive to own one's principal residence (to maintain the Age Pension) would no longer apply. Chapter 7 also proposes an aged care asset test for the purpose of determining the financial capacity to make a care co-contribution which is neutral in its treatment of the form in which older people hold their wealth.

## 12.2 Improving the age friendliness of communities

Several submissions highlighted the importance of developing age-friendly communities to complement age-friendly housing in helping older Australians to age where they live rather than move to residential care (box 12.6).

In recent years there has been a growing awareness among all levels of government in Australia of the importance of developing age-friendly communities. State, territory and local governments are particularly active in pursuing this goal.

Policies in this area have benefitted from the age-friendly city model developed by the World Health Organization (WHO) under its *Age-Friendly Cities Project* in 2006. That project identified the characteristics of the urban environment that make it more 'age-friendly' and produced a checklist of essential features of age-friendly cities (WHO 2007a) and a guide to global age-friendly cities (WHO 2007b).

At the Australian Government level, the *National Strategy for an Ageing Australia* identified the importance of age-friendly infrastructure and community support (Andrews 2001). Government initiatives to advance this goal include the *Local Government Population Ageing Action Plan 2004–2008*, a nation-wide program of workshops with the theme '*A Community for All Ages — Building the Future*', funding for *Healthy Spaces and Places*, and work to date on developing a *National Urban Policy* (box 12.7). More generally, Lui et al. (2009) observed that the Government's commitment to social inclusion could assist the development of age-friendly communities, although they note that how this may occur is unclear.

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### Box 12.6 Participants' views on age-friendly communities

Age-friendly neighbourhoods are a central plank in the National Aged Care Alliance's vision for older Australians. It noted that optimum care and support can only be achieved with government commitment to, among other things:

- an integrated public and community transport system, designed to comprehensively support and accommodate the needs and aspirations of the entire community, including older people;
- urban design that ensures integrated public and living environments that are safe and accessible for all ages and promote active involvement in community life. (sub. 88, p. 6)

Entry to residential care (or hospital) can be ameliorated by reducing social isolation, improved housing and age-friendly neighbourhoods (ECH, Eldercare and Resthaven, sub. 100).

Denise Pendleton highlighted the cost of not providing age-friendly communities:

But what threatens my plans [for independent living in my community] more than anything else is the dereliction of responsibility by officers at both state and local levels of government who are responsible for the provision of safe and accessible infrastructure necessary for me to be able to live independently in my community as I intend. ... But it appears there are also major gaps in planning and compliance processes which need to be addressed in order to maximise opportunities for our ageing population to enable them to remain active members in their communities. (sub. 116, p. 1)

The Brotherhood of St Laurence stated:

It is important not only to consider types of housing and their design but also to consider the neighbourhood environment. Housing for the older person needs to have shops and services within walking distance or easily accessed by public transport close by. Neighbourhoods need to be age-friendly with paving, street lighting, public toilets, benches and open spaces, in order for the older person to participate in community life and to feel safe. (sub. 294, p. 7)

The South Australian Government noted:

Universal design in the public realm (i.e. footpaths and public spaces) is also important to ensure that older people with limited physical mobility (and no access to a motor vehicle) can still walk or use a gopher safely to access local services. This is supported strongly by the South Australian Government through the *30 Year Plan for Greater Adelaide*. (sub. 336, p. 21)

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### Box 12.7 Australian Government initiatives to advance age-friendly communities

Between 2004 and 2008, the Department of Health and Ageing (DoHA) entered into a partnership with the Australian Local Government Association (ALGA), under the *Local Government Population Ageing Action Plan 2004-2008*. This included the creation of a website resource for councils which showcased news, research, data, information and innovative practices to assist local government to plan for an ageing population.

In 2006, DoHA held a nation-wide program of workshops with the theme, 'A Community for All Ages — Building the Future'. This scheme was to encourage architects, planners, builders and policy makers to rethink how they design homes and communities to sustain health and wellbeing.

Developing age-friendly communities was also supported by Government funding for *Healthy Spaces and Places*. This was a collaborative effort by the ALGA, the National Heart Foundation of Australia and the Planning Institute of Australia (PIA) to provide a national guide to support and complement planning and design initiatives of state, territory and local governments. Bridge and Elias (2010) consider this initiative has great potential to deliver social, economic and health returns through better planning of our built environments.

As part of its commitment to improving the liveability, sustainability and productivity of cities, the Government is developing a *National Urban Policy*. This work is framed by the challenges of population ageing and includes a focus on the housing needs of older people and what is required to make urban environments more liveable/age-friendly.

Sources: Australian Government (2010j); PIA (2009); Santoro (2006).

At the state and territory government level, all governments have introduced strategies to address the challenges of an ageing population (table 12.4) and to develop age-friendly communities. For example, in NSW, the strategy includes a focus on liveable homes and communities which (among other things) calls for a review of planning criteria to encourage a walkable and wheelable community with local public spaces that are safe and pleasant for people to use (NSW DPC 2008). In Victoria, the focus includes factoring in the needs of older people into strategic and residential land use planning, increasing public transport and local transport options and improving the accessibility to that transport for people with mobility challenges (DPCD 2010b).

Some states also have particular initiatives to advance the goal of developing age-friendly communities. In South Australia, for example, under the *Age Reform Agenda: Adding Life to Years*, the Office for the Ageing is developing guidelines for the certification of neighbourhoods, residential developments and cities as 'Age Friendly' (Government of South Australia, sub. DR740). The guidelines, developed in accordance with the WHO criteria, will facilitate the design of environments that

are safe, secure and provide services and infrastructure that are both accessible and inclusive for older people.

A feature of state level initiatives for developing age-friendly communities is the central role accorded local governments. For example, local government is a key player in implementing the *Tasmanian Plan for Positive Ageing*, with all 29 local councils having partnership agreements with the Tasmanian government (Tasmanian DPC 2007).

**Table 12.4 State and territory governments' ageing strategies**

<i>State/territory</i>	<i>Strategy</i>
New South Wales	Towards 2030: Planning for our changing population
Victoria	Ageing in Victoria: A plan for an age-friendly society 2010–2020
Queensland	Positively Ageless — Queensland Seniors Strategy 2010–20
South Australia	Improving With Age: Our Ageing Plan for South Australia
Western Australia	Generations together: A guide to the Western Australian active ageing strategy
Tasmania	Tasmanian Plan for Positive Ageing: Second five-year plan
Northern Territory	Building the Territory for all Generations: A Framework for Active Ageing in the Northern Territory
Australian Capital Territory	Strategic Plan for Positive Ageing 2010–2014: Towards an Age-Friendly City

*Sources:* NSW DPC (2008); DPCD (2010b); Queensland Government (2010); Government of South Australia (2006); WA Department for Communities (2006); Tas. DPC (2007); DCM (2007); DHCS (2009).

Local governments — with responsibility for matters such as physical infrastructure planning and development, traffic management, and open space planning — are uniquely positioned to influence the age-friendly nature of our communities. In 2006, ALGA produced a report on *Age friendly built environments: Opportunities for local government*, which included a range of strategies to achieve age-friendly communities, such as those to:

- promote age-friendly built environments
- create safe and secure pedestrian environments
- foster age-friendly community planning and design
- improve mobility options for seniors (ALGA 2006).

Throughout Australia, local governments have been active in developing strategies and in implementing actions to achieve age-friendly communities, in their own right (City of Salisbury, sub. 263; Penrith City Council, sub. 351) or in partnership with state governments and other organisations (box 12.8).

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**Box 12.8 Examples of cooperative approaches to developing plans for age-friendly communities**

In NSW, COTA's Age Friendly Environments Working Group has representatives from the Faculty of the Built Environment (University of NSW), National Roads & Motorists' Association (Australia) (NRMA), Local Government and Shires Associations, Alzheimer's Australia NSW, The Benevolent Society *Apartments for Life*, Independent Living Centre NSW, Housing NSW, Waverly Council, Marrickville Council, Sydney City Council, Wyong Shire Council, People with Disabilities, the Australian Domestic and Family Violence Clearinghouse and consumers.

In Victoria, the *Local Government Positive Ageing Project* (which ran from 2005 to early 2009) was a joint initiative between the MAV, COTA Victoria and the Victorian Department of Planning and Community Development (DPCD). The project aimed to build the capacity of local government to plan for an ageing population and to provide leadership in promoting 'age-friendly' communities that create opportunities for senior Victorians to live active and fulfilling lives.

Sources: COTA NSW (2009); MAV (2009).

Local government plans have been profoundly influenced by the WHO's checklist and guide. A report commissioned by the Municipal Association of Victoria (MAV) into the use of the WHO Age-Friendly Cities Guide and Checklist found that by the end of 2009, 73 of the 79 Victorian councils had completed a positive ageing strategy, borrowing heavily on that work (MAV 2009, p. 2).

While some coordination of efforts to advance age-friendly communities has emerged (under the ALGA umbrella for example) there appears to be no national focus or formal bringing together of best practice across Australian, state, territory and local governments. As the Brotherhood of St Laurence noted:

Although some local governments are attempting to address these issues [providing an age-friendly built environment], there are no national guidelines to ensure that this is a requirement now and into the future. (sub. 294, p. 7)

Although the WHO guide and checklist provide a common model for informing government approaches to developing age-friendly communities, there may be merit in assigning responsibility for overseeing progress and developments in this area to the Local Government and Planning Ministers Council.

ALGA (sub. DR762) and the MAV (sub. DR822) noted they would welcome national leadership to assist in the planning and implementation of age-friendly environments. The City of Boroondara (sub. DR717) considered that local government is best placed to plan for and coordinate actions to achieve age-friendly housing and neighbourhoods.



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Alternatively, the Government's initiative in developing a *National Urban Policy*, to improve the liveability, sustainability and productivity of cities, could provide an avenue for a national approach to developing age-friendly communities.

### **12.3 Improving rental choices for older Australians**

For those who are not home owners, the availability and affordability of rental accommodation are major influences on whether they can age in their communities or need to move into residential care (AHURI 2009, 2010; Howe 2003; Judd et al. 2010).

However, there are widespread concerns that the supply of such accommodation is insufficient to meet the future demand from an ageing population:

Older non-home owners on a fixed low income have limited choices if they want to move to accommodation more suited to their needs. Given the decreasing affordability of rent levels in the private rental market and the increasing cost of dwellings for purchase, particularly in major capital cities, appropriate housing options for older people on fixed low incomes are extremely restricted. (ACSA 2004, p. 7)

Older people's housing choices are limited by a shortage of suitable and affordable housing. This is particularly so for low-income older renters and people with low or modest assets. (The Benevolent Society 2010, p. 29)

Housing affordability has decreased dramatically in Australia ... Along with the decrease in housing affordability, there is also a lack of accessible housing suitable to the needs of persons experiencing age-related frailty or disability. ... Increased options for low cost social housing also needs to be factored into planning to ensure that the most disadvantaged older people in our community are appropriately housed ... (South Australian Government, sub. 336, p. 20)

Without sufficient stock of appropriate and affordable housing there will be a crisis in aged support and care, as such housing is critical to both older people's welfare and quality of life and has a major impact on the capacity of other support and care services to deliver effective outcomes. (COTA Australia, sub. 337, p. 36)

For low-income older renters, or for older people with limited income and assets, there is a limited choice of appropriate and affordable housing. (ACT Government, sub. 365, p. 9)

These concerns should be viewed against a background of the broader housing market, where underlying demand is greater than supply and has led to pressure on house prices and rent levels, and of general government housing policies aimed at improving housing supply and affordability for the community overall.

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## Supply of rental accommodation for older Australians

According to the ABS (2009a), in 2007-08, households where the reference person is aged 65 years or over (older households) accounted for 108 600 public rentals and 114 200 private rentals (table 12.1). Older households, though, constituted 29.6 per cent of all public rentals whereas they constituted only 5.9 per cent of all private rentals (NHSC 2010). The low private share may explain why the private rental market generally might have little incentive to invest in age-friendly accommodation (excluding niche providers of age-specific living options and shared housing) (Davey et al. 2010).

Australia has a shortage of affordable rental housing and, as a result, both public and private rental markets are pressed to meet the demands of older renters (NHSC 2010). This situation led the Country Women's Association of NSW to observe:

Of very great concern is the tremendous number of older people crying out for appropriate public housing ... (sub. DR669, p. 3)

Governments have recognised the need to increase the supply of affordable housing, and are acting to do so. On this issue, Catholic Health Australia noted:

Governments in recent years have renewed their involvement in social housing, targeting those who are disadvantaged in the housing market, including the homeless and those at risk of homelessness. ... The need for publically supported housing, however, is not unique to older people as the need can arise at any stage of a person's life cycle, quite unrelated to the frailty of older age. (sub. 217, p. 25)

In addition to their general housing policies, Australian, state and territory governments have recently increased their commitments to providing affordable housing for all Australians, with significant changes in housing policy and initiatives in the delivery of housing assistance (AIHW 2009a). Major recent initiatives in these areas are shown in box 12.9.

These initiatives will substantially increase the supply of social and affordable housing. But despite this increase, National Housing Supply Council (NHSC) projections (figure 12.1) indicate that the gap between demand and supply for social and affordable rental housing will widen from around 2012 onwards (NHSC 2010). These projections point to a need for these initiatives to be extended if the shortfall in supply is to be overcome and if older renters are to be able to obtain aged care services while living in the community.

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## Box 12.9 Recent major affordable housing initiatives

### *The National Affordable Housing Agreement*

In 2008, the Council of Australian Governments (COAG) agreed to a National Affordable Housing Agreement (NAHA) for Australia's affordable housing strategies and included funding previously provided through the Commonwealth State Housing Agreement. The NAHA included \$400 million for building new social housing to provide up to 2100 dwellings by 2010.

### *The Australian Government's Social Housing Initiative*

The Social Housing Initiative (SHI), announced in February 2009 as part of the Nation Building — Economic Stimulus Plan, will provide over \$5.6 billion to state and territory governments. Stage 1 will see the construction of up to 19 300 social housing dwellings by 2011-12. Over 5300 of these dwellings will target older Australians. In Stage 2, some 16 500 dwellings are to be constructed, with 99 per cent of these to comply with universal design principles (FaHCSIA, pers. comm., 9 August 2010). A further 10 000 dwellings that would have otherwise been lost to the social housing stock over the next two years will also receive maintenance and refurbishment.

### *The Australian Government's National Rental Affordability Scheme*

Launched in July 2008, the National Rental Affordability Scheme had the aim of increasing the supply of rental dwellings by 50 000 units by 2012 and to reduce the cost of rental housing for low and moderate income individuals and families.

The Scheme offers annual indexed incentives for 10 years. The two key incentives are a Government incentive currently of \$6855 per dwelling per year as a refundable tax offset or payment and a state or territory government incentive currently of \$2285 per dwelling per year in direct or in-kind financial support. The incentive is provided annually on the condition that throughout the 10 year period the dwelling is rented at 20 per cent below the market rent to eligible low and moderate income households.

If the target of 50 000 homes by 2012 is reached, the scheme will be expanded to fund a further 50 000 homes.

### *The National Partnership Agreement on Social Housing*

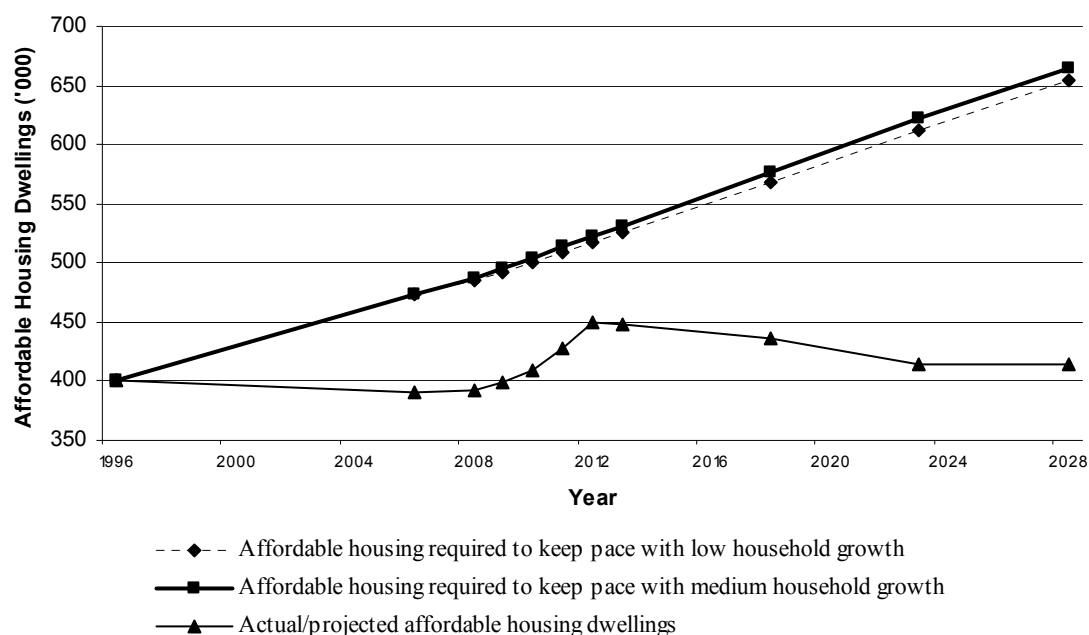
This agreement involved the Australian Government providing capital funds to state and territory governments for building at least 1600 new social housing dwellings by 2009-2010. There was no particular emphasis on providing housing for older people, but one criterion was that projects 'should adhere to universal design principles that facilitate better access for persons with disability and older persons'.

### *State and territory government initiatives*

State and territory governments have set up programs to help build capacity in 'growth' organisations, for example through funding to assist larger not-for-profit bodies with business improvement strategies in order to meet registration requirements. They are also supporting public-private partnerships involving community housing providers.

Sources: Housing NSW (2010); Jones et al. (2010), NHSC (2010); PC (2010b).

**Figure 12.1 Social and affordable rental housing demand and supply**



**Assumptions:** 70 per cent of 50 000 National Rental Affordability Scheme (NRAS) dwellings have not-for-profit/endorsed charities as tenancy managers, 35 000 NRAS dwellings included, distributed over 2009 to 2012. NRAS dwellings exit affordable housing stock as they leave the scheme. 19 300 Social Housing Initiative dwellings over years from 2009 to 2012. 600 A Place To Call Home dwellings are distributed across years 2009 to 2013. 1700 Social Housing National Partnership Agreement dwellings distributed across 2010 and 2011. Projection does not continue the trend from 1996 to 2006 in actual stock through sale and demolition.

Data source: NHSC (2010, p. 89).

Some participants claimed that changes to current housing policies regarding the eligibility for housing authority status (and, thus, access to government funding) would help increase the supply of social housing. Wintringham, a not-for-profit (NFP) organisation, noted the benefits of qualifying for this status:

... we have created a housing subsidiary, Wintringham Housing Ltd, which has successfully applied to the Victorian Housing Registrar at the Office of Housing to become a Housing Association and therefore eligible for growth funds. (sub. 195, p. 14)

Benetas and ACSA argued that current eligibility rules constrain new entrants from providing social housing:

Many NFPs are not in a position to become registered housing providers, but need access for government grants and funding for housing developments for older people. Consideration needs to be given to allow NFPs with land holdings and the ability to develop this land for older persons' housing to be given access to government housing grants and funding without become registered housing authorities. (Benetas, sub. 141, p. 35)

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... aged care providers are not routinely recognised by Federal and State Governments as legitimate players in the provision of housing for people on low and medium incomes. Aged care providers should be able to compete on a level playing field with other housing providers for government funding and asset transfers. (ACSA, sub. 181, p. 29)

Similarly, the Macedon Ranges Shire Council, in discussions with the Commission, referred to these eligibility rules as a barrier to local governments providing social housing. The Council has previously described this problem:

... the potential for growth of the Macedon Ranges social housing program is constrained by its current structure. It appears that all future housing growth funds provided by State Government will only be provided to registered housing organizations. But ... Macedon Ranges Shire Council is unable to register as a Housing Association under the regulatory system established by the State Government. (2007, pp. 19–20)

However, the scale of projected unmet demand shown in figure 12.1 has led to calls for housing policy to focus more on facilitating the development of age-specific housing (Brotherhood of St Laurence, sub. 294; Blake Dawson, sub. 465). Similarly, Alzheimer's Australia WA noted:

Surprisingly, given aging population concerns and a projected increase in the prevalence of dementia, a coherent housing policy for older Australians does not exist. ...

Locally and internationally, there has been development of a range of community based group and other housing models, which could potentially provide alternative accommodation opportunities for older Australians, e.g. the Green House, Eden Alternative, Humanitas, and Abbeyfield. However, without significant investment, a comprehensive state and local government review and revision of planning laws and regulatory standards, and a review of the Aged Care Act 1997, progress in this regard will be very slow. (sub. 345, pp. 13–14)

ACSA (sub. 181) and COTA Australia (sub. 337) drew attention to the projected shortages in social and private rental markets, and stressed the need for a whole-of-government housing policy for older people which is focused on maintaining and enhancing the existing stock of homes, and increasing the supply of affordable and appropriate housing:

These figures dramatically highlight the need for a more concerted, well-resourced and specific focus on housing supply for older Australians than has been the case for many years. COTA believes the Productivity Commission must draw this to the attention of governments ... (COTA Australia, sub. 337, pp. 35–6)

ACSA (sub. 181) and COTA Australia (sub. DR565) called for a national older persons' housing strategy. A central feature of that national strategy is action to support and upgrade over 30 000 independent living units (ILUs) built between the

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1950s and the 1980s (box 12.10), reflecting concerns that they are at risk of being lost as a source of affordable housing (ACSA, sub. 181; Australian Unity, sub. DR836). In addition, major elements of that strategy are a national approach to HMM services and adopting universal design principles in built environments and urban design. These are discussed in sections 12.1 and 12.2, respectively.

The Benevolent Society, too, supported a national older persons' housing strategy, noting that it should, in addition, include:

review of planning controls to encourage the conversion of existing housing to age-friendly smaller units, construction of 'granny flats' and dwellings that cater for multi-generation households, incorporation of more smaller dwellings into new developments, and flexible housing designs that can adapt to changing household composition and ages. (sub. 252, p. 18)

The Benevolent Society also highlighted the significant role ILUs play in providing housing for older people. It noted the poor quality of much of that housing stock and called for greater investment in social housing for older people, including ILUs (sub. 252).

#### **Box 12.10 Independent living units: COTA's view**

Over 34 700 ILUs were developed between 1954 and 1986 with Commonwealth Government assistance.

Funding for the ILU program was transferred from the Commonwealth to the states in 1986, placing them in competition for funding with State Housing Authorities and community housing organisations. The result is that ILUs have been largely ignored by funding bodies ever since. Despite precarious funding, ILUs remain an important social housing option for older people with relatively low assets and incomes.

Despite ILUs currently providing 27 per cent of all social housing for older Australians, there is no systematic approach to funding the capital work now required. Much of the ILU housing stock is now between 40–50 years old and in urgent need of upgrading, reconfiguration and in some cases, replacement. Most of the units are small (one bedroom) and below community standards. Organisations, both large and small, are increasingly deciding that they can no longer afford to operate ILUs.

At a time when the large number of older people with unmet housing needs is increasing, this forgotten but very significant social housing sector urgently needs an injection of capital that will enable them to continue to provide secure housing for older people with low incomes and limited assets.

*Source:* COTA Australia (sub. 337, attach. 4).

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This particular issue is already registering at the Australian Government level. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) is aware of the role played by ILUs in the provision of age-appropriate housing and of concerns about the state of the existing housing stock. There is, however, limited information on the ILU sector and FaHCSIA, as a first step to inform future policy in this area, commissioned a national survey of providers of ILUs (FaHCSIA, pers. comm., 24 November 2010). The survey, which began in August 2010, was undertaken jointly with ACSA and COTA Australia, with input from DoHA (ISR 2010). Preliminary results suggest that 26 per cent of the ILUs counted in a 2002 survey are no longer available for people on low incomes (ACSA, sub. DR730).

The Commission notes that the Government already has a range of housing policies aimed at improving the supply and affordability of housing for the community overall. It has also, with state and territory governments, committed to the specific housing initiatives listed in box 12.9. State and territory governments also have specific policies aimed at housing older people or that focus on older people within general programs. These policies and programs include:

- housing strategies to set policy and longer term directions (box 12.11)
- reforming planning requirements to facilitate the supply of age-friendly housing
- housing and support services to link homeless and other vulnerable older people with care and secure housing options (NHSC 2010)

Any national older persons' housing strategy would need to be integrated with these existing national, state and territory government policies.

In addition, COAG has endorsed a housing supply and affordability reform agenda and timeline (COAG 2010c). It agreed that the Ministerial Council for Federal Financial Relations, together with a representative of ALGA, would examine housing policy work already underway in other COAG processes to determine whether that work provides the best opportunities for substantial improvement in housing supply and affordability. The Ministerial Council will examine all current and future work in other COAG processes that will affect housing supply and affordability. This will ensure a cohesive national approach and that work is progressing to achieve good housing policy outcomes (COAG 2010c).

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### Box 12.11 **Examples of state and territory policies aimed at housing older people**

#### New South Wales

*New directions in social housing for older people:* a five year plan (2006–2011) which focuses on providing more appropriate housing for older people and linking housing assistance programs to support services so that older people can age in their homes.

#### South Australia

South Australia is working to increase the supply of affordable housing through implementation of its 15 per cent inclusionary zoning policy which delivers affordable housing opportunities, including retirement living, to low to moderate income households.

#### Northern Territory

*Housing the Territory:* a public housing strategy announced in March 2009 which is designed to, among other things, create more rental housing that is affordable for low and middle income households and build more publicly funded housing, including seniors' villages.

*Sources:* Government of South Australia (sub. DR740); NSW DoH (2006); NT DoHLGRS (2009).

In the face of the growing challenge of housing an ageing population, and of enabling them to receive aged care services in their homes, there is merit in a national level assessment of how well the housing needs of people as they age are being met within existing general housing policies and within the recent specific initiatives listed in box 12.9. That assessment would identify what changes or additional policies (including extending the specific initiatives and means by which financially disadvantaged older Australians could better access private retirement village or ILU accommodation on a rental basis) might be required to ensure those needs are met. Further, in view of the COAG reform agenda noted above, COTA Australia considered this national level assessment should be integrated with current COAG level initiatives for affordable housing (DR565).

FaHCSIA would be well placed to contribute to such an assessment. The Office for an Ageing Australia could also assist in that assessment by helping to ensure that the interfaces with other policies affecting older people (such as aged care support and health) were considered in reaching a view on the adequacy of existing housing policies to cater for our ageing population. Arising from that assessment, a national strategy to meet the growing demand for affordable and suitable housing for older Australians should be developed.



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## Affordability of rental accommodation for older Australians

The Commission's previous research found that population ageing will create pressure for greater housing assistance to lower-income older people who do not own their homes and need to access the rental market (PC 2005b). More recently, the NHSC noted that there will be a considerable increase in the number and proportion of older people seeking housing assistance for private and public rental accommodation (NHSC 2010). For many of these, affordability will be a major problem:

Commonwealth Rent Assistance and the aged pension will not be adequate to deliver affordability outcomes for the aged in the private rental sector. (Wood et al. 2010, p. 2)

The shortfall in housing projected by the NHSC (and the upward pressure this will place on rent levels) means rental assistance will need to increase if governments are to address the affordability problem facing public and private renters (including older renters). This issue was examined by the Henry Review, which concluded:

Rent Assistance payment rates should be increased so that assistance is sufficient to support access to an adequate level of housing. Maximum assistance should be indexed to move in line with market rents. Rent Assistance should be extended to public housing tenants, with recipients generally paying rents that reflect market rates, subject to transitional arrangements.

A new source of funding should be made available in respect of the tenants who have high housing needs, such as those with high costs due to disability or people likely to face discrimination in the private market. The payment would be based on the needs of recipients and where practical directed by them to providers of their choice. (2010, p. 491)

The Commission notes that changes along these lines would help address its concerns about the adequacy of housing assistance to lower-income older people who do not own their own homes and are required to rent on the open market. The Commission believes that options to enhance the ability of financially disadvantaged older Australians to rent privately should be explored as a matter of priority. Initiatives to deal with the increasing rental pressures on financially disadvantaged older Australians should form part of the national strategy proposed in recommendation 12.3.

### RECOMMENDATION 12.3

***The Council of Australian Governments, within the context of its agreed housing supply and affordability reform agenda, should develop a strategic policy framework for ensuring that an adequate level of affordable housing is available to cost effectively meet the demands of an ageing population.***

## 12.4 Regulation of retirement living options

Retirement living options are an important form of accommodation for older Australians. They also offer a pathway to address the housing and community needs of particular groups (Multicultural Aged Care, sub. 243, Blue Care, sub. 254). Congregate retirement living options also offer advantages in that community care can often be provided to residents more efficiently than in the broader community (Lend Lease Primelife, sub. 305; UnitingCare Australia, sub. 406; AHC, sub. DR509; Aged Care Queensland Inc, sub. DR647).

Retirement villages constitute the main retirement living option (table 12.5), although residential parks (caravan and manufactured home parks) are growing in importance (table 12.6) (Consumer Affairs Victoria 2009).

**Table 12.5 Retirement village accommodation in Australia, 2010**

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Total
Number of establishments									
Retirement villages	600	356	262	393	192	38	1	28	1 870
Number of contained dwellings									
Serviced apartments	2 910	1 672	1 495	1 071	282	53	0	22	7 505
Independent units	33 682	21 841	21 400	14 199	13 026	1 390	64	1 407	107 009
Total dwellings	36 592	23 513	22 895	15 270	13 308	1 443	64	1 429	114 514

Source: RVA (sub. 424, p. 16).

**Table 12.6 Residential park accommodation in Australia,<sup>a</sup> 2010**

Period	Establishments	Capacity				Total capacity
		On-site vans	Other powered sites	Unpowered sites	Cabins, flats, units and villas	
	no.	no.	no.	no.	no.	no.
Short term residence <sup>b</sup>	1 425	12 827	123 607	32 297	28 318	197 049
Long term residence <sup>c</sup>	213	3 704	15 230	1 659	7 494	28 087

<sup>a</sup> Comprising establishments with 40 or more powered sites and cabins, flats, units and villas. <sup>b</sup> Short term accommodation is defined as residence for less than two months. <sup>c</sup> Long term accommodation is defined as residence of two months or more.

Source: ABS (2010d).

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Retirement villages are increasingly catering for older people requiring aged care and community support services. This has seen a growing number of villages being built which are integrated with residential aged care or built with serviced apartments and assisted living units which can readily accommodate the delivery of aged care support in these dwellings (Jones et al. 2010; RVA 2010; RVA, sub. 424). Retirement living options with a mix of self-care, low care and high care all on one site was the most popular choice reported in a survey by Tablelands Futures Corporation (sub. 194).

The Retirement Village Association (RVA) estimated that the 1870 villages identified in table 12.5 accommodated over 160 000 residents (sub. 424). This number of residents is comparable in size to the number in residential aged care.

Nationally, retirement villages house about 5.3 per cent of the population over the age of 65, although some states have a significantly higher rate, with Western Australia at about 7 per cent and South Australia nearing 8 per cent (RVA 2010). Significantly higher rates occur in regional growth areas such as Mandurah in Western Australia (18 per cent), Maroochy in Queensland (17.2 per cent) and Gosford in NSW (over 14 per cent) (JLL 2008).

Since the 1970s, retirement villages have been the fastest growing type of housing oriented to the needs of older people in Australia (Stimson 2002). Moreover, this form of accommodation is expected to grow in importance (Tablelands Futures Corporation, sub. 194; Aged Care Queensland, sub. 199, appendix 7). An indication of this growth was provided by Masonic Homes Limited, citing results from a Colliers International report on retirement living:

Considering the market penetration rate [of retirement village living] has increased from 3.5 per cent in 2001 to 5.0 per cent today we would expect this trend to at least continue over the next two decades ... and equal 6.0 per cent by 2016 and 7.2 per cent by 2026. This would equate to approximately 370 000 persons choosing to reside in a retirement village by 2026. (sub. 124, pp. 16–17)

The RVA considered that the combination of an ageing population and a greater understanding of the benefits of retirement village living could result in national penetration rates in excess of 7.5–8 per cent by 2025 (RVA, sub. 424).

A variety of tenure arrangements is used in retirement villages, for example, leases, licences, body corporate and strata titles, company titles and unit trusts. Rental models are emerging, although these mostly occur in community, social or special needs retirement village housing (RVA, sub. 424).

Although residential parks are growing in importance as retirement living options, they accommodate only about 0.9 per cent of households (13 935 households) with a reference person 65 or older (Davy et al. 2010). Almost all long term residents of

housing-oriented residential parks own their own dwelling and rent the site, although a small proportion rent both the dwelling and the site. No residents own the site, which has implications for security of tenure.

## The regulatory framework for retirement living

Retirement villages are regulated by specific legislation in each state and territory (table 12.7). The legislation covers most aspects of retirement village ownership, operation and management. Each jurisdiction has its own definition of what is and what is not a retirement village (Minter Ellison 2010).

**Table 12.7 Retirement village state/territory legislation**

<i>Jurisdiction</i>	<i>Key legislative instruments</i>
New South Wales	<i>Retirement Villages Act 1999</i> Retirement Villages Regulations 2009
Victoria	<i>Retirement Villages Act 1986</i> Retirement Villages Regulations 1 and 2
Queensland	<i>Retirement Villages Act 1999</i> Retirement Villages Regulations
South Australia	<i>Retirement Villages Act 1987</i> Retirement Villages Regulations
Western Australia	<i>Retirement Villages Act 1992</i> Retirement Villages Regulations Fair Trading (Retirement Villages Code) 2009
Tasmania	<i>Retirement Villages Act 2004</i> Retirement Villages Regulations
Australian Capital Territory	Retirement Villages Industry Code of Practice
Northern Territory	<i>Retirement Villages Act 1995</i> Retirement Villages Regulations

*Sources:* Davy et al. (2010), ; NSW Department of Finance and Services (sub. DR889).

Broadly, areas regulated by the legislation include the establishment and registration of retirement village schemes, operators' disclosure obligations to prospective residents, the process of entry by residents into villages, the relationship between residents and operators during occupation, the financial operation and management of villages, and the process of departure by residents from villages (Minter Ellison 2010).

The different approaches adopted by state and territory governments mean retirement village legislation varies widely across jurisdictions. Some have lengthy and detailed legislation, while others have comparatively little and the ACT currently has none other than a Code of Practice. Further, common areas that are regulated in many jurisdictions are often dealt with in different ways (Minter Ellison 2010).

Residential parks are regulated by state and territory legislation. In some jurisdictions they are covered under Residential Tenancy Acts, while others have specific residential park legislation (table 12.8). In some cases, residential park living may be regulated under retirement village legislation. In Victoria, for example, a retirement village is defined by its function and not by type of operator. Thus, if a residential park operates as a retirement village it may be regulated under Victoria's Retirement Village Act (COTA Victoria 2009).

**Table 12.8 State/territory legislation of residential parks**

<i>Jurisdiction</i>	<i>Key legislative instruments</i>
New South Wales	<i>NSW Residential Parks Act 1998</i> <i>Residential Parks Regulation 2006</i>
Victoria	<i>Residential Tenancies Act 1997</i> <i>Residential Tenancies (Caravan Parks &amp; Movable Dwellings) Regulations 1999</i>
Queensland	<i>Manufactured Homes (Residential Parks) Act 2003</i> <i>Residential Tenancies Act 1994</i>
South Australia	<i>Residential Parks Act 2007</i> <i>Residential Tenancies Act 1995</i>
Western Australia	<i>Residential Parks (Long-stay Tenants) Act 2006</i> <i>Residential Tenancy Act 1987</i> <i>Western Australian Caravan Parks and Camping Grounds Regulations 1997</i>
Tasmania	<i>Residential Tenancy Act 1997</i>
Australian Capital Territory	No specific legislation
Northern Territory	No specific legislation

Sources: Davy et al. (2010); NSW Department of Finance and Services (sub. DR889).

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## Are regulatory changes warranted?

### *Alignment with Commonwealth Government aged care regulation?*

The terms of reference request the Commission to examine whether the regulation of retirement specific housing should be aligned more closely with the regulation of the aged care sector.

Some participants favoured such alignment. Carne Reidy Herd Lawyers (sub. DR533) argued that multi-faceted developments (where retirement housing and aged care facilities are co-located) cause difficulties for developers. They noted that legal and practical issues arising from this collage lead to complex contractual relationships for providers and consumers, and increase compliance costs in developing and maintaining disparate legal structures. They called for harmonisation of legal frameworks to address this concern.

The Retirement Village Residents Association (RVRA) also expressed dissatisfaction with current regulatory arrangements because they do not guarantee transition from retirement village living to residential care where that care is operated by or co-located with their residential village. The RVRA considered this concern would be solved by aligning retirement village regulation with that of aged care:

The benefits of Retirement Village living could be maximized if the responsibility for the villages was being taken by those government bodies which are responsible for hostel and nursing home care. ... even if a Retirement Village has a hostel or nursing home, attached to it or close by, it does not operate on the same basis as the self-care village, and village residents have no rights to a place within hostel or nursing home accommodation. If there was better alignment within the whole of this accommodation sector, the transition for a village resident, or for their spouse, to further care could be made easier and less traumatic. (sub. 30, p. 1)

However, even under current aged care regulation, residential aged care providers are unlikely to guarantee a place for a potential resident at some unspecified time in the future. This stems from the interplay of a number of factors: the current quota system, the uncertain demand for limited residential care places, and the commercial imperative on residential aged care providers to operate at maximum occupancy. Several of their concerns are being addressed through other proposed reforms contained in this report.

The Commission's proposal to remove the current quotas on residential care places (recommendation 7.1) would take one of these factors out of the equation. This change would give retirement villages greater scope to provide for the transition to residential aged care — an option clearly valued by retirement village residents.

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This outcome would not require any alignment of regulation. Further, the Commission’s proposals for a single integrated system of care provision and for consumer choice of an approved provider/s and the mix of care would mean retirement village residents will be better able to access increasing levels of care in their own dwellings. This partly addresses concerns about residents not being able to age in their village community (LHI Retirement Services, sub. DR591).

Accordingly, the Commission considers that aligning retirement village regulation with that of aged care would provide no guarantee of the outcome sought by RVRA.

Sunrise Supported Living favoured aligning some aspects of retirement village regulation with that of aged care to address perceptions that the quality of care available in villages is sub-standard. It noted:

Retirement Villages do not require formal accreditation and have no governance to ensure standards are met. The opinion of many of the general public and health professionals is that the quality of care provision is not regulated and therefore must be sub standard. In our Village that is certainly not the case, but we struggle to get that message across to aged care referral sources. (sub. 38, p. 3)

To address this concern, Sunrise Supported Living recommended introducing:

... a level of governance and legislation in line with the aged care sector — e.g. Quality Reporting to ensure standards are met across all community service providers. (sub. 38, p. 3)

However, the National Presbyterian Aged Care Network (sub. 110) believed that aged care style regulation for retirement villages was overly prescriptive (and, by implication, imposed an excessive cost burden). If aligning regulation adds to the regulatory burden of developing and operating retirement villages, it would prejudice the supply of retirement village housing and their affordability. Blue Care expressed similar concerns:

Extension of the aged care regulatory environment to retirement villages is not appropriate for people living independently or with support. The burden of regulation would add to the cost of retirement living for consumers and may lead to reduced supply. (sub. 254, p. 16)

The RVA argued that aligning regulation is not needed in view of the industry’s rigorous self regulation and independent assessment of standards:

Villages are not subject to the same legislative compliance that governs aged and community care, although the [Retirement Village Association] has developed a widely accepted accreditation scheme that undergoes continuous improvement. The Australian Retirement Village Accreditation (ARVA) scheme was established to ensure member villages provide the highest levels of quality to residents. (sub. 424, p. 19)

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Further, the RVA stated that its system of accreditation successfully promotes high service standards without adding a heavy compliance burden for operators. This, it claimed, contrasts with aged care, where the administrative burden imposed by the accreditation system means resources are deployed away from customer care and into office-based compliance tasks (sub. 424).

Peak bodies covering the aged care sector (for example, ACSA, sub. 181) and individual providers also argued that retirement villages were just another form of housing and it was not appropriate to regulate them under aged care regulation. ECH, Eldercare and Resthaven, for example, noted that:

Regulation of the retirement village and retirement living sector remain the province of State and Territory Governments and separate from Federal aged care regulation. (sub. 100, p. 5)

and concluded:

We see the regulatory control of retirement housing as being outside the Federal aged care system and remaining at State level. Retirement villages are but one housing option for older people ... Housing is a State Government responsibility and should not be confused with the responsibility for aged care services that might be provided to the occupant. (sub. 100, p. 16)

The South Australian Government supported the providers' position that alignment is not warranted, noting that:

In South Australia the retirement village industry generally interacts well with the aged care system, with residents being able to access HACC and packaged care within their homes.

The regulation of retirement villages should not be aligned more closely with the aged care system. (sub. 336, p. 19)

A possible reason for aligning regulation might be if the co-location and integration of retirement village living and residential aged care creates an excessive regulatory burden on operators. However, in its discussions with various operators, none indicated to the Commission that this was the case, and all noted that the separate regulation was not an issue for them. In this regard, Capital Cove recommended:

Where villages choose to provide care services through dedicated and licensed facilities within the boundary of a retirement village, that those facilities continue to be governed by the requirements of the *Aged Care Act*, with no cross reference to the separately regulated retirement village component. (sub. 452, p. 15)

Under current arrangements, retirement villages offering aged care services are regulated under separate state/territory and Commonwealth legislation. The Commission's proposed reforms will not change this situation. However, its proposals to remove restrictions on the number of community care packages and



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residential bed licences will provide much greater scope for retirement village operators to expand their aged care offerings.

In view of the above, the Commission concludes that aligning retirement village regulation with that of aged care is not warranted. Accordingly, retirement village regulation should remain the province of state and territory governments.

RECOMMENDATION 12.4

***The regulation of retirement villages and other retirement specific living options should remain the responsibility of state and territory governments, and should not be aligned with the regulation of aged care services.***

#### *Changes to state and territory retirement village regulation?*

Participants raised other concerns with retirement village regulation which, they argued, justified changing state and territory legislation. These concerns may be categorised according to the perspectives of consumers/residents and providers/operators.

#### *Consumer/resident perspective*

Submissions were critical of the regulation of retirement villages in a number of (interrelated) areas. Of particular concern were:

- complex and confusing contracts that were presented to new entrants
- inequitable financial terms and conditions (particularly for deferred management fees and the sharing of capital gains on the re-sale of village units)
- prudential oversight and security of residents' investments.

Some submissions observed that residents' contracts are often written in vague or general terms, and were complex and confusing (Pam Graudenz, sub. 70; RVRA, sub. 30). This situation raised fears that vulnerable residents were being exploited by retirement village operators and managers (Aged Care Crisis, sub. 433; Charles Adams, sub. DR508; J. Wynne, sub. 368; Name withheld, sub. DR899; Rob Harvie, sub. 104). For some participants, such as Leone Huntsman, these concerns were sufficient to dissuade them from recommending retirement village living to others:

... the retirement village is a wonderful model for living for people as they age. However, I would advise friends against buying into retirement villages until the lack of protection currently afforded residents is rectified. (sub. 71, p. 1)

Blue Care acknowledged that the retirement village industry has not done a good job in explaining the financial arrangements facing potential entrants (sub. 254). It

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also offers a pure rental model which, as well as being a very affordable housing option (as most residents using this model are eligible for rental assistance), also simplifies the financial arrangements facing residents.

Submissions were critical also of the financial arrangements facing residents. Pam Graudenz (sub. 703) and Neville Carnegie (sub. 89) highlighted the significant differences in entry costs, the deferred management fee retained by developers and capital gains distribution. As an example of the latter, Rob Harvie (sub. 104) noted that the share of capital gains retained by the developer on re-sale could vary from 10–100 per cent. Robyn Gwynne and the Association of Residents of Queensland Retirement Villages (ARQRV) gave examples of how onerous these exit costs can be:

Some \$50 000 will be imposed on me when I sell due to exit fees, which diminishes my future buying power considerably. (Robyn Gwynne, sub. 90, p. 1)

... an 81 year old ... sold her retirement village unit for \$380 000 but was left with less than \$70 000 from the sale after the village operator deducted more than \$300 000 in exit charges, including a DMF of more than \$200 000. (ARQRV, sub. DR550, p. 3)

However, providers (Blue Care, sub. 254) and residents' associations also acknowledged that cheap entry costs for retirement village living is made possible by exit or deferred management fees:

[exit fees] ... are an essential part of any viable village business model — they allow retirees to leverage their capital to obtain a standard of living that their income would not otherwise support, on the basis that they pay it later, from their capital. (ARQRV, sub. DR550, p. 4)

Nonetheless, the ARQRV (sub. DR550) considers that this business model is fundamentally inconsistent with industry self regulation, and believes that residents' lack of bargaining power must be offset by robust government regulation.

The ACT Retirement Village Residents Association (sub. DR611) noted that the issue of capital repair and capital replacement liability is also an area where there is great dissatisfaction amongst residents, and is an area which is mostly ignored or not clearly stated in current legislation.

To help address the problem of complex and confusing contracts, the RVRA (sub. 30) and Charles Adams (sub. 33) proposed national legislation, incorporating standard contracts for each of the different types of financial arrangements (for example, leasehold, loan-license and strata title). Similarly, CHOICE noted that there is a lack of transparency in retirement village contracts with respect to the legal and financial risks a person is exposed to, and proposed:

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... standardised contracts should be implemented which will assist consumers in comparing the different types of financial arrangements available within ... retirement villages and in making an informed decision as to which option is best for their personal circumstances. (sub. DR725, p. 2)

As a matter of principle, such contracts should embody transparent financial terms and conditions to facilitate fully informed decision making by new entrants. This approach would be consistent with the consumer protection focus of retirement village legislation and with the thrust of the RVA's accreditation system.

Some participants considered rental style contracts would resolve the problem of complex and confusing contracts. Charles Adams observed:

A visit to the United States will show that the system over there has significant advantages.

The majority of residents pay a straight monthly rental lease. They are without a devious contract with high front end charges that the operators have been able to foist on uninformed Australians so that they can then short deliver since the residents generally are trapped by their contracts. (sub. DR508, p. 2)

A national survey of village operators confirmed that consumer dissatisfaction with current contracts is an important and growing issue (Grant Thornton 2011a). The survey found that while the loan-lease financing model is the most widely used, it might not appeal to future consumers from the baby boomer cohort. The survey concluded that the sector will need to provide contract options that meet consumers' preferences rather than perpetuating current financing models (Grant Thornton 2011a). While this could include greater use of rental models (and there are no legislative barriers to this occurring) the report notes that past attempts to market rental models have had limited success (Grant Thornton 2011a).

Finally, Pam Graudenz (sub. 70) and Neville Carnegie (sub. 89) also queried the adequacy of prudential regulation and monitoring of the financial structures of retirement village developers and operators. The consequences of poor regulation in this area can be serious for residents. Neil Carnegie, for example, referred to past instances in NSW when vulnerable elderly people who 'purchased' their retirement village units lost all their capital when the operator went bankrupt. These concerns have added relevance in view of Prime Retirement and Aged Care Property Trust's recent move into receivership.

With regard to this last area of concern, the Commission notes that commercial failures and their consumer consequences are economy-wide issues, and not confined to the retirement village arena. Commonwealth Government regulation and regulators (for example, the Australian Securities and Investments Commission and the Australian Prudential Regulation Authority) exist to address these issues.

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These (and other) concerns about current state and territory legislation should be viewed in the context of a responsive regulatory environment. Particularly important in this regard is that state and territory legislation has shifted away from the focus of protecting investors, prevalent prior to the mid-1980s, and towards protecting consumers/residents (Aged Care Queensland, sub. 199).

Moreover, state and territory legislation inherently focuses on issues of importance in their jurisdiction, and can be reviewed on a regular basis and amended to correct deficiencies:

A hallmark of the retirement villages legislation in Australia is the growing pace and scope of review and amendment by the governments in most jurisdictions. This is driven to a large extent by the increasingly consumer-focussed agendas being adopted by governments everywhere. (Minter Ellison 2010, p. 5)

In Western Australia, for example, ongoing monitoring of problems in the operation of retirement village legislation occurs through complaints handled by the Consumer Protection Division of the Department of Commerce. Information received through this means feeds into the legislation reform process. In addition to the current review of legislation in Western Australia, the Australian Capital Territory is also examining the possible introduction of retirement village legislation.

The RVA also emphasised that its members are now subject to a rigorous self regulation system via their accreditation process, which does much to address the sorts of concerns raised in submissions (sub. 424). Although Neville Carnegie claimed the RVA accreditation system ‘lacks accountability and credibility’ (sub. 89, p. 4), the South Australian Government indicated that its application to the industry more generally would benefit village residents:

... the investigation of the introduction of an accreditation system for retirement villages may be of more practical use and benefit residents. There is a voluntary accreditation system operated by the Retirement Villages Association (RVA). It is noted that there are minimal complaints regarding village practices from member villages of the RVA. (sub. 336, p. 19)

The concerns identified in submissions should also be viewed in the context of survey evidence that shows very high resident satisfaction rates. Research commissioned by the RVA in NSW found that for 98 per cent of residents, moving to a village either ‘met or exceeded their expectations’ (Capital Cove, sub. 452, p. 25). Capital Cove also supplied evidence of a similar result for residents in villages operated by the St Ives Group — a major retirement village and community care provider in Western Australia (sub. 452). These findings are consistent with earlier evidence from Stimson (2002) which showed retiree satisfaction levels with villages to be very high.

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The ARQRV (sub. DR550) was sceptical of reported satisfaction rates, noting a survey bias to existing rather than former residents. It observed that many of the problems in the industry arise at the point of exit, so the dissatisfaction of former residents will be unrecorded. CHOICE (sub. DR725) and the RVRA (sub. DR606) also noted that existing residents might be disinclined to respond truthfully for fear of retribution. (An issue also raised by Pat Noyce (sub. DR865) and more generally by Clara Jones (sub. DR870)). The RVRA cited a South Australian study to support this view (Knowles 2000).

*Provider/operator perspective*

Concerns from the providers' perspective centred on:

- constantly changing legislation
- legislative changes not being driven by evidence or mindful of the industry's self regulation system
- significant differences in legislation across jurisdictions.

The industry highlighted the constantly changing legislative environment which, it argued, adds to costs and dissuades investment (Capital Cove, sub. 452). A report commissioned by the RVA described this situation thus:

Future changes have the potential to impact financial returns and increase compliance costs. This volatile regulatory environment presents operators with risks and challenges not typically encountered in other business sectors. (Minter Ellison 2010, p. 5)

The RVA also noted these changes have a cost which is ultimately borne by retirement village residents:

However, the constant changes and up-scaling of various aspects of regulation only serves to increase consumer uncertainty and adds cost to the industry. The net result is often the requirement to raise service charges, which impacts the resident and does not promote affordability. (sub. 424, p. 25)

A more fundamental concern for some providers was that, in their view, much of this change was ill advised (not informed by evidence) and did not deliver benefits to warrant the cost of that change. Capital Cove, for example, was critical of the growing regulatory burden despite there being no research evidence showing there is a 'problem in the industry' (sub. 452, p. 24). It claimed that the increase in regulation over the last 15 years has delivered no measurable improvement in outcomes (sub. 452). To address the lack of evidence based legislative change, Capital Cove proposed:

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That Governments assisted by the industry commission independent research into Retirement Villages to assess the attitudes and issues of existing residents, with a view to structuring legislation to address any issues requiring attention. (sub. 452, p. 26)

The RVRA (sub. DR606, p. 5), however, argued that while an increase in regulation may not have ‘improved outcomes’, it prevented a decline in the quality of outcomes for residents.

Further, providers viewed much of the changing legislation as unnecessary because the industry’s self regulation accreditation system was a credible alternative to deal with any problems (RVA, sub. 424). Aged Care Queensland regarded an industry led accreditation scheme as the best regulatory option to provide consumer assurance, facilitate government oversight and drive public accountability (sub. 199).

Providers viewed the lack of consistency in retirement village legislation across jurisdictions (noted above) as a major impediment for the industry. The RVA argued this situation creates considerable confusion and administrative costs for operators managing national portfolios. The Business Council of Australia also considered that, for some companies, this presents a barrier to their national expansion (sub. 274). Moreover, with large listed entities and developers increasing their presence in the industry, this problem is growing:

... [the industry] is struggling under the weight of regulatory burden that exists on a state-by-state basis. Given the changing profile of the sector, in which some operators span multiple states and have to adapt to multiple legislative requirements ... Many operators are faced with the management of complicated business models that increase administrative and compliance costs. (RVA, sub. 424, p. 25)

To address this concern, the RVA sought ‘... more certainty and transparency in regulation, which could in turn be applied across jurisdictions’ (sub. 424, p. 26). The RVA and Capital Cove suggested that this objective could be assisted by legislation incorporating a requirement for villages to be accredited under the RVA’s national accreditation scheme (sub. 452). The RVRA also thought a national approach was warranted:

All State Governments have different legislation covering Retirement Villages, and can be poorly drafted, or biased towards operators. Hence, there are no cohesive guidelines for Retirement Villages around the country. A national approach ... would be a great step forward in eliminating confusing and convoluted legislation and the uncertainty and disputation which often accompanies Retirement Village living. (sub. 30, p. 2)

While village residents’ associations accept the need for nationally consistent legislation and support moves to that end, they oppose basing it on the RVA self regulation model (ACT Retirement Village Residents Association, sub. DR611;

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ARQRV, sub. DR550; RVRA, DR606). In addition, those associations and the National Seniors Australia Knox Branch (sub. DR580) consider any move to nationally consistent legislation should be informed by research which also represents the interests of residents and potential residents.

In defence of the accreditation regime, Aged Care Queensland Inc (sub. DR647) noted that ACSA and ACAA have signed up to a national approach using the RVA standards, and that the scheme will be designed, developed and delivered by Quality in Practice (a subsidiary of the agency that introduced general practice accreditation in Australia).

Some ‘harmonisation’ of retirement village legislation has already occurred and, it appears, more is on the way:

... most States and Territories enacted specific retirement villages legislation in the 1980s and 1990s. Importantly, Queensland and New South Wales repealed their legislation and replaced it with more detailed and comprehensive legislation in 1999, which now serve as the benchmark for recent, current and future reforms in the other States and Territories. (Minter Ellison 2010, p. 6)

NSW Fair Trading and Consumer Affairs Victoria are ... exploring the possibility for enhanced consistency in retirement village contract terms and pre-contract disclosure requirements (NSW Department of Finance and Services, DR889, p. 1)

The Commission agrees that there is merit in pursuing greater consistency of legislation across jurisdictions, particularly as the growing presence of larger corporations presages the emergence of a more national market. That legislation would, however, still remain the responsibility of each state and territory government.

Further, that process should have regard to the interests of all parties (providers, current and potential residents, governments). As the Villa Maria Society (DR734, p. 12) noted, this process should be one where ‘all stakeholders are effectively consulted during the review process’. The RVA supports this approach:

We recommend that an industry taskforce with state government, industry and resident representation be set up to work alongside COAG in aligning the legislation across the jurisdictions. (sub. DR900, p. 6)

The Law Institute of Victoria drew attention to the work of the Property Law Reform Alliance (PLRA), which is pursuing a ‘Simpler Retirement Living Titling’ project:

The PLRA ... has proposed that the project analyse approaches in each jurisdiction to retirement living title, prepare a comparative matrix of retirement living title laws and processes, identify preferred processes for retirement living title laws and processes and

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develop an options paper on retirement living title laws and processes by May 2013. (sub. DR897, p. 10)

and suggested that this project could inform any COAG initiative.

The Commission considers that while the development of consistent principles and regulation should proceed at the state and territory government level, COAG would be an appropriate vehicle to oversee the development of nationally consistent legislation.

#### RECOMMENDATION 12.5

***State and territory governments should pursue nationally consistent retirement village legislation under the aegis of the Council of Australian Governments.***

#### *Changes to state and territory regulation of residential parks*

The Commission's consultations with stakeholders identified concerns about security of tenure and whether the layout of residential parks and the dwellings in them were up to the task of facilitating adequate ageing in the home or the delivery of aged care (including access for emergency vehicles such as ambulances).

On the first of these, some stakeholders noted that rising real estate prices have increased the likelihood of residential parks being sold to developers and, thus, of residents being dispossessed. There is, however, no simple solution to this concern. For example, more secure or longer tenancies would see owners raise entry costs or ongoing fees to compensate for not being able to sell when the land becomes more valuable for other uses. Greater security would thus be at the expense of reduced affordability. This catch-22 situation has led some states to introduce regulation to ensure tenancy terminations are signalled longer in advance, and to improve complaint handling and arbitration procedures.

On the second, the Commission notes that residential parks are subject to regulation designed to protect the health and safety of occupiers and residents. For example, regulations mandate minimum distances between structures and minimum set backs from roads to allow emergency access in a caravan park during a fire (PWC 2010, p. 8). Whether these regulations remain appropriate in the face of an ageing Australia and a changing age composition of residents is an issue for regulators in each state and territory.

The Commission supports the view that, as in Victoria, where residential parks function as retirement villages, they be treated as such under the retirement village legislation of the respective state or territory. Where this is the case, those



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residential parks would be included within the Commission's recommendations (above) for nationally consistent regulation for retirement villages.

## **12.5 Residential care building regulations**

This section only deals with particular building regulations affecting residential aged care facilities. Other factors affecting residential care are discussed elsewhere in the report.

Some participants drew attention to the excessive burden associated with building regulations applicable to residential aged care facilities. The Illawarra Retirement Trust (IRT), for example, noted:

Currently, residential aged care buildings are the sole development type in Australia to be regulated by legislative requirements additional to the BCA [Building Code of Australia]. Neither hospitals nor other highly complex buildings face such a superfluous burden. The Federal aged care certification requirements almost entirely mirror the BCA requirements, creating unnecessary red tape and inefficiencies. (sub. 356, p. 7)

Similarly, the Aged Care Industry Council (NSW & ACT) Building Committee (sub. 429) observed that certification has run its course, and that the building requirements for residential aged care should default to the BCA.

The Commission recently examined building certification for residential aged care as part of its review of regulatory burdens on business (PC 2009a). Its report included recommended changes to fire safety declarations and building certification requirements. Amaroo Care Services Inc (sub. 98) noted that these recommendations offered scope to reduce the complexity and cost of the building accreditation. ECH, Eldercare and Resthaven (sub. 100) also called for the Government to act on those recommendations.

The Australian Government has accepted the Commission's recommendations to introduce exceptions reporting for fire safety declarations and to incorporate residential care building requirements into the BCA. For the former, it noted:

Ongoing monitoring of the safety and environment of a residential aged care facility, including the management of fire risks and compliance with fire safety requirements, occurs through the accreditation process and the requirement to meet the Accreditation Standards. Exceptions reporting will be introduced requiring approved providers that are assessed as not meeting the requirements of state and territory or local authority requirements to report to DoHA to allow for ongoing monitoring.

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The necessary legislative amendments will be made so that exceptions reporting can commence in respect of compliance in the 2010 calendar year. (Australian Government 2009a, p. 12)

The Government subsequently amended the Quality of Care Principles 1997 under the *Aged Care Act 1997* to replace the annual Fire Safety Declaration process with an exception reporting process. From 1 July 2010, approved providers of residential aged care are only required to notify DoHA if they become non-compliant with any applicable state or territory laws (including local by-laws) relating to fire safety in respect of any residential care service operated by the approved provider (DoHA 2010j).

For the latter recommendation, the Government stated:

The Government will consult with the Australian Building Codes Board (ABCB) and aged care stakeholders to develop a proposal by 30 June 2010 to consolidate building requirements for the ABCB's consideration. (Australian Government 2009a, p. 13)

Since then, DoHA has been consulting with aged care stakeholders and the Australian Building Codes Board. Although feedback has indicated support for incorporating privacy and space ratios into the BCA, it has also identified technical issues to be addressed and raised possible alternative approaches. DoHA is considering the implications of the issues raised through the consultation process and will consult further with the Australian Building Codes Board.

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## 13 Informal carers and volunteers

### Key points

- Informal carers provide the majority of direct care to older Australians and often play a key role in the co-ordination of formal care services. Their role is not only fundamental to those they care for, but for the functioning of the aged care system overall.
- The relative availability of informal carers is expected to decline in the future. The decline could be moderated somewhat by ensuring that carers are appropriately supported in their caring role.
- The Commission supports the development of a National Carer Strategy but also considers there is an immediate need to develop additional supports for carers from the existing base of programs in the aged care system.
- Carers should be better supported in their caring role through a variety of measures.
  - The proposed Australian Seniors Gateway Agency would assess the capacity of informal carers to provide ongoing support when assessing an older person's needs.
  - The proposed Carer Support Centres should be developed to undertake assessments of carers needs. Where appropriate, these centres would also deliver specialist carer support services including carer education and training; emergency respite; carer counselling and peer group support; and carer advocacy.
- Action in other areas can also improve support for carers, including trials and evaluations of various respite options.
- Volunteers play a smaller but nonetheless important role in the delivery of aged care services and improve the quality of life for older people.
  - The potential pool of volunteers is expected to increase in the future but the aged care sector will need to offer meaningful volunteer experiences to attract and retain them.
- Funding for services which engage volunteers in service delivery should take into account costs associated with:
  - volunteer administration and regulatory requirements
  - appropriate training and support for volunteers.

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Most of the care of older Australians is provided on an informal basis by family, neighbours and friends. This accords with the preference of most older people — they want to be cared for by someone they trust, who has time for them, who respects their right to make their own decisions and who helps them maintain their dignity and independence (chapter 4). In addition, extended family, neighbours, friends and volunteers can provide support that facilitates a level of social inclusion between older people and their wider community.

Informal carers of older people have been labelled the ‘invisible’ aged care workforce as they undertake their caring role out of the public spotlight and often with limited recognition and support. In commenting on their role, an OECD Health Policy Studies report describes family carers as ‘the backbone of any long term care system’ (Colombo et al. 2011, p. 13).

This chapter sets out the scope and scale of the contribution made by informal carers of older Australians (section 13.1) and reasons for governments supporting carers (section 13.2). It then examines the current system of support and services for carers (section 13.3), how to improve this system (section 13.4) and finally the role of volunteers and options to support and encourage volunteering (section 13.5).

## **13.1 Some facts about informal carers**

In 2009, there were around 2.6 million informal carers providing assistance to disabled and older Australians according to the Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (ABS 2011b). Around 750 000 of these informal carers were primary carers — that is, the person who provides the most informal assistance. The majority of people who receive care from a primary carer have a disability with either a profound or severe activity restriction.

There were significantly more primary carers in 2009 compared to that estimated in the previous ABS survey in 2003, but this was offset by a reduction in the number of non-primary carers over this period. As a result, the overall number of informal carers was relatively stable but the proportion of carers in the population fell from 13 to 12.2 per cent (ABS 2004, 2011b). Chapter 3 contains a discussion of factors expected to give rise to a decline in the relative availability of informal carers in the future.

In relation to caring for older Australians, around 350 000 primary carers provided assistance to an older person aged 65 or over (appendix H). Around 242 000 of these primary carers lived in the same household as the person that they cared for. Information linking the primary carer with the person being cared for is only

available for this group. Information about the recipients of care from primary carers not living in the same household and all non-primary informal carers was not collected in the latest ABS survey.

The majority of primary carers of people aged 65 years and over care for their spouse or partner, while a smaller, but still significant, proportion of older Australians are cared for by a son or daughter (table 13.1).

**Table 13.1 Relationship of primary carer to the person being cared for**  
Primary carers of people aged 65 years and over, 2009

<i>Relationship</i>	<i>Number of primary carers</i>	<i>Per cent</i>
Spouse or partner	166 623	69
Son or daughter	58 007	24
Other (includes father or mother, relative, friend or neighbour)	17 659	7
<b>Total</b>	<b>242 288</b>	<b>100</b>

*Data source:* ABS Survey of Disability, Ageing and Carers 2009, CURF.

The number of hours of caring provided by primary carers varies considerably. In 2009, more than 40 per cent of primary carers spent over 40 hours per week in caring activities while just under 40 per cent spent under 20 hours per week (ABS 2011b).

Around 40 per cent of all primary carers are employed, split evenly between full- and part-time work. While the unemployment rate for primary carers is comparable with non-primary carers (around 5 per cent), their workforce participation rate is significantly lower (42 per cent compared to over 65 per cent for non-primary carers) (ABS 2011b). This relatively low participation rate might be due, in large part, to the demands and pressures of their caring role.

## **13.2 Reasons for supporting carers**

Governments provide support for carers in recognition of the valuable contribution they make to society and the costs to them of providing care. The Department of Health and Ageing (DoHA) acknowledged that a reduction in family caring would add significantly to the cost of formal care services:

... 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 [Gross Domestic Product] — that is, about 9.9 per cent of the contribution of GDP (gross

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value added) of formal health care. If these services were no longer available, the cost of replacing the work done by informal carers would be much higher. (sub. 482, p. 37)

The desirability of supporting carers, however, depends on trading off the costs and benefits of doing so, including the benefits and costs for older people requiring care and the carers and taxpayers. Colombo et al. in an OECD Health Studies report, *Help Wanted? Providing and Paying for Long-Term Care* argued that:

... supporting carers is an arrangement where all parties can benefit. There are at least three potential 'wins' from supporting carers:

- For the care recipient, because LTC [long term care] recipients prefer to be looked after by family and friends.
- For the carer, because carers provide care out of love or duty, despite the fact that they incur economic, health and social consequences as a result.
- And for public finances, because supporting the supply of family care can help maintain the public, formal parts of the system... Significant reductions in family caring would put public LTC systems under financial strain. (2011, pp. 20-21)

The economic value of informal caring is estimated to far exceed that of formal care. Access Economics (2010b) estimated that informal carers provide around 1.32 billion hours of care each year and if informal care were to be replaced with services purchased from formal care providers and provided in the home, the replacement value would have been in excess of \$40 billion per annum in 2010.

But caring comes at a cost to carers and their families. Caring is associated with less paid work, a higher risk of poverty and increased prevalence of health problems. As Carers SA said:

Most people who take on the role of carer experience significant levels of disadvantage to their financial wellbeing through cost of care and the loss of participating in the paid workforce. (sub. DR758, p. 7)

DoHA also acknowledged the impact that caring can have on carers' physical and mental health:

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... Of concern also are the studies that show carers have much poorer physical and mental health than non-carers. (sub. 482, p. 57)

A recent comprehensive review of international evidence by the Colombo et al. reaches a similar conclusion.

While unpaid carers provide a valuable service to society and looking after family members or friends brings great rewards, there is growing concern about increased psychological distress, strain and overall health deterioration ... Without adequate

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support, informal caregiving might exacerbate employment and health inequalities for these groups of [high intensity] carers. (pp. 97, 103)

Weighing up the costs and benefits suggests a role for governments in supporting informal carers. Indeed, the Australian Government acknowledges the vital role that informal carers play in caring for older Australians and the obligations they take on through a variety of supports, including income support and respite services (section 13.3).

Many government statements and public inquiries have highlighted the importance of informal carers and the contributions they make. They have also identified that many informal carers are financially and socially disadvantaged and may have poor health, partly as a result of their caring activities.

In response, changes have been recommended to the support mechanisms available to informal carers and those they care for. For example, the National Health and Hospitals Reform Commission (NHHRC) recommended:

... carers be supported through educational programs, mentoring and timely advice to allow them to participate in health decisions and communications (subject, of course, to the consent of those they care for). To sustain them in this role, carers must have better access to respite care. (2009, p. 124)

This view was echoed by the *Pension Review Report* which considered that:

Sustaining the role of informal care in service delivery will require a different model of informal caring, possibly involving a mix of daily in-home assistance, group day care and respite services. The availability of tailored support from the services systems would enable carers to better combine caring with employment and their other interests and responsibilities. (Harmer 2009, p. 117)

### **13.3 Current system of support available for informal carers**

Under current arrangements, support is provided by governments for informal carers of all Australians with a disability to varying degrees. Informal carers of older Australians have access to dedicated carer support services as well as programs designed to support all informal carers.

#### *Information and referral services*

In addition to general information about aged care and aged care services that is available on DoHA's Aged Care Information Line and website (including

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publications and facts sheets), information and support for informal carers is provided through the Commonwealth Respite and Carelink Centres.

The Carer Information and Support Program also funds the development and distribution of informal carer information products. It includes education programs for carers and information about government programs that support carers. Some products are specifically tailored to be appropriate and sensitive to the needs of carers from culturally and linguistically diverse backgrounds (DoHA, sub. 482).

Carers Australia is also funded to provide informal carers with specialist advice and resources, professional counselling through the National Carers Counselling Program, and education and training. These services are delivered through the network of Carer Associations in each state and territory (DoHA, sub. 482).

In addition, carers' associations and a variety of disease specific community organisations (such as the state and territory branches of Alzheimer's' associations) provide information as well as education and training services to informal carers. A number of these services are funded by government but through user charges and other private income.

### *Respite services*

The Australian Government, as well as state and territory governments, fund a range of respite services, including the National Respite for Carers Program (NRCP), other residential respite, Home and Community Care (HACC) funded centre-based day care, Day Therapy Centres and respite provided as part of Veterans' Home Care.

Respite services enable informal carers to take a break from their caring role by providing appropriate care alternatives for relatively short periods of time (currently up to 63 days in total over a financial year). Options include:

- in-home respite (including overnight)
- day respite (either in community or residential settings)
- residential respite (which may be for extended periods).

Most respite is pre-organised but there is also limited emergency respite.

While there are no reliable data for the total amount of respite provided to informal carers of older Australians, data are available for certain programs. For example, in 2009-10:



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- there were 59 602 admissions to residential services, equating to 1.35 million days of respite
  - the NRCP provided over 5.1 million hours of respite in a variety of settings (DoHA 2010n).

### *Income support and financial assistance*

Some carers are not able to undertake substantial employment as a direct result of their caring responsibilities. The Australian Government recognises this and offers income support through the Carer Payment. The base payment is means tested and paid at the same rate as other social security payments (basic rate of \$670.90 per fortnight from 20 March 2011). It is not designed to be paid at an income replacement rate. In 2008-09, around 52 050 carers for older people received a Carer Payment (about a third of all Carer Payment recipients) at a cost of about 687 million (DoHA, sub. 482).

The Australian Government also offers eligible carers, with significant caring responsibilities, the Carer Allowance to assist in covering some of the costs incurred as part of their caring activities (\$110 per fortnight from 20 March 2011). The payment is not means tested and most recipients of the Carer Payment also receive the Carer Allowance. In 2008-09, around 128 000 carers of older people received a Carer Allowance (about 40 per cent of all Carer Allowance recipients) at a cost of about \$485 million (DoHA, sub. 482).

Eligible carers may also receive a variety of other supplementary income support payments and subsidies, such as the Carer Supplement and utilities subsidies, from both the Australian and state and territory governments.

### *Broad policy development to recognise and support carers*

The Australian Government is developing a National Carer Recognition Framework for all carers, comprising two pillars — the *Carer Recognition Act 2010* and the National Carer Strategy (NCS).

The *Carer Recognition Act 2010* commenced on 18 November 2010. The Act:

... acknowledges the significant role of carers and the importance of ensuring that the needs of carers are considered in the development, implementation and evaluation of policies, programs and services that directly affect them or the care recipient(s). (DoHA 2010r, p. 1)

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The Act contains a *Statement for Australia's Carers* which reframes certain fundamental human rights principles in a carer context (box 13.1). The Act sets out how carers should be treated and considered by Australian Government public service agencies in developing both internal and external policies. It does not establish carers' rights or create legally enforceable obligations for carers, public service agencies or associated providers (Phillips and Magarey 2010). Similar legislation has been introduced by state and territory governments.

### **Box 13.1 Statement for Australia's Carers**

Part 2 of the *Carer Recognition Act 2010* sets out a Statement for Australia's Carers:

1. All carers should have the same rights, choices and opportunities as other Australians, regardless of age, race, sex, disability, sexuality, religious or political beliefs, Aboriginal or Torres Strait Islander heritage, cultural or linguistic differences, socioeconomic status or locality.
2. Children and young people who are carers should have the same rights as all children and young people and should be supported to reach their full potential.
3. The valuable social and economic contribution that carers make to society should be recognised and supported.
4. Carers should be supported to enjoy optimum health and social wellbeing and to participate in family, social and community life.
5. Carers should be acknowledged as individuals with their own needs within and beyond the caring role.
6. The relationship between carers and the persons for whom they care should be recognised and respected.
7. Carers should be considered as partners with other care providers in the provision of care, acknowledging the unique knowledge and experience of carers.
8. Carers should be treated with dignity and respect.
9. Carers should be supported to achieve greater economic wellbeing and sustainability and, where appropriate, should have opportunities to participate in employment and education.
10. Support for carers should be timely, responsive, appropriate and accessible.

As part of the National Carer Recognition Framework, the Australian Government is also developing the NCS which builds on and complements state and territory carer policies. To inform the 10 year strategy agenda, the Government is undertaking broad community consultation to better support carers by ensuring that:

Policy, programs and services for carers are coordinated, responsive and targeted at all stages of caring. (Australian Government 2010h, p. 8)

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Consistent with the issues discussed throughout this chapter, the goals of the NCS are:

- better recognition for carers
- better support to help carers work
- better information and support for carers
- better education and training for carers
- better health and wellbeing for carers (Australian Government 2010h).

The NCS will be important in developing comprehensive support services for carers of all groups of people with a disability.

Given that carer support is currently administered in an ad hoc way across a number of programs and jurisdictions, the Commission supports the development of the NCS but notes that its development is in an early stage. As such, the carer support services and initiatives outlined in this chapter should be developed from existing carer support programs within the aged care system. Where appropriate, these services should be harmonised and streamlined with carer support services for other groups (including carers of people with disabilities, mental health conditions or medical infirmities) as part of the implementation of the NCS. However, the Commission considers that any actions to improve carer support services should be implemented without waiting for the release of the NCS.

## **13.4 Ways to better support informal carers**

Participants to this inquiry highlighted a number of areas in which carers could be better supported. The main areas included:

- navigating the care system
- ensuring carers have the skills to care
- access to timely and appropriate respite and other supports (including transport and assistive technologies) to reduce the caring burden
- carer participation in the workforce (including greater workplace flexibility).

This section looks at each of these areas and evaluates the recommendations of previous inquiries, where relevant. Much of the discussion and reforms proposed in this section are relevant to all informal carers, including carers of younger people with disabilities.

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## **Navigating the care system**

Carers said that the aged care system is complex, difficult to navigate and carer support is currently administered in an ad hoc way across a number of programs and jurisdictions.

### *Accessing information and services*

Timely and appropriate access to information about the aged care system, carer support, and other support services (such as health, financial and social services) is essential to ensure carers access the services they, and those they care for, need and are entitled to receive. Complex, inconsistent and unclear information about the aged care system increases the burden on carers and can reduce their willingness to continue in their caring role. This was an issue raised in a number of submissions (Carers Australia, sub. 247; Fairfield City Council, sub. 183; Psychogeriatric Care Expert Reference Group, sub. 299). Carers NSW summarised the problem:

For the Australian aged care system to be accessible, the information needs of carers must be met. The provision of information must be simplified and improved so that older people and carers are informed of what services exist and how to access them. Carers should not have to spend time, energy and resources they do not have to find out what they need, nor should they ‘stumble’ upon services and supports long after they are first required. Accessing the necessary services should not depend on chance. (sub. 211, p. 7)

Carers also expressed concern about the lack of coordination of services available both to the people they care for and the services available to them as carers.

The proposed Australian Seniors Gateway Agency (the Gateway) will not only assist older people to access information about services but also assist carers by reducing the time and frustration they report in navigating the current system and in accessing services for those they are caring for and themselves. The Commission is also recommending that the support provided by carers to older Australians be considered in the Gateway’s assessment of an older person’s needs, as the needs of the person being cared for and those of the carer are linked.

The Commission envisages that there are two ways that informal carers would access carer support services — either as part of an older person’s aged care service entitlement from the Gateway or by contacting a carer support service directly (section 9.1).

An entitlement as a result of a Gateway assessment should be required for older people to access planned respite services, including day therapy, and essential

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transport services. The Gateway could refer carers to other carer support services, however, carers would be able to access specialist services directly.

Specialist carer support centres should be established and undertake a comprehensive and nationally consistent carer assessment of individual carer's needs to determine what types of support are appropriate. Services delivered by these centres may include support group facilitation, counselling, education and training activities, and advocacy. Emergency respite services could also be accessed through these centres. As part of the Commission's proposals, the Gateway services and these centres would be developed from the existing carer support programs but replace the current Carelink and Carer Respite Centres.

### **Ensuring informal carers have the skills to care**

Informal carers are often under-prepared for the task of caring, despite their best intentions. For example, many carers are not properly trained in safely lifting and moving people or dealing with challenging behaviours, such as by a person suffering from dementia. Such a lack of knowledge and training can have an adverse effect on the carer's health and wellbeing and the experience of the person they care for.

Evidence suggests that interventions which support carers through education and training are likely to improve outcomes for carers and the older people they care for, particularly if those being cared for suffer from dementia (Brodaty et al. 2003; Selwood et al. 2007). However, support services need to be coordinated, appropriate and targeted to ensure that they are effective. These support services are not intended to decrease the caring load but provide mechanisms by which carers can provide better quality care and continue to be willing to maintain a caring role.

Organisations representing carers, community aged care providers and carers themselves argued strongly for more education and training opportunities for informal carers so they can develop the skills necessary to provide quality care and reduce premature burnout.

Various organisations that support and represent carers' interests — including the state and territory branches of Carers Australia and Alzheimer's Australia — offer courses, workshops and seminars to assist carers in managing their caring role and the stresses associated with caring and other aspects of their lives. These organisations make some materials available in electronic formats (for example, online or on DVDs) to assist carers who may not be able to physically attend education and training sessions, such as those in rural and remote areas.

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There are also a number of government programs aimed at better educating the carer population and increasing their skill base, but the majority of these programs have been developed in an *ad hoc* manner. This was recognised by the House of Representatives *Inquiry into Better Support for Carers*, which recommended that the Australian Government ‘develop a national strategy to address the training and skills development needs of carers’ (HRSCFCHY 2009, p. 92).

The Commission supports this recommendation and considers that targeted and coordinated education and training activities to better prepare and support carers are essential. Access to appropriate education and training services, including formal training courses (where applicable), would be determined through a carer assessment.

The Government’s commitment to the NCS also provides an opportunity for revisiting the delivery of carer education and training as well as the quantum of funding devoted to it.

## **Access to respite and other support services**

### *Respite services*

The extent of unmet need for respite services by informal carers of older Australians, or even for all carers in total, is not known. However, informal carers and organisations that represent them report that there are significant problems in obtaining assessments for respite care and the services themselves, for both planned and emergency respite (chapter 5).

A lack of flexibility in the delivery of respite services is also an issue for many informal carers. As Carers NSW said:

Respite needs to be more flexible, and driven less by fixed program structures and more by the needs of the people who use it. It is the services who must meet the needs of the people, instead of the current situation where it is the carers and older people who must meet the needs of the service or go without. Better respite is fundamental to making caring, and therefore the aged care system, sustainable. (sub. 211, p. 6)

There are also restrictions (usually governed by the specific program) on what type of respite can be provided, and what other services (such as domestic assistance) can be delivered as part of a respite service. For example, DoHA noted:

... 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

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may receive different levels of support and their contribution levels may vary, even when they have the same means. (sub. 482, p. 49)

The circumstances of informal carers and the person they are caring for are likely to be unique and this points to the need for support services to be flexible. Carers are also more likely to use services that provide choice and carer input into how resources are used. The consumer-directed care model proposed by the Commission (chapter 9) should give older Australians and their carers more flexibility to choose services, such as respite, that are best suited to their needs. According to Carers WA, such initiatives provide wider benefits to the community:

Supporting carers with the provision of flexible respite services can save a later, much more costly, crisis-driven response such as early entry to residential aged care or into hospital. (sub. 276, p. 13)

The reporting basis for the determination of respite days, particularly residential respite, is a concern for older Australians and their carers. Centrelink operates on a calendar year basis while DoHA and residential aged care services operate on a financial year basis. From the experience of a member of the Association of Independent Retirees (NSW):

It is extremely difficult for carers to satisfy both departments given the different systems and financial periods. (sub. 303, p. 8)

The Commission considers that this administrative anomaly should be corrected.

Some organisations representing the interests of carers have asked for more flexible funding models to be available for both planned and emergency respite, given the difficulties many carers face accessing respite currently. Carers Australia (sub. DR761) and Alzheimer's Australia (sub. DR656) proposed a number of options to broaden access to respite.

- Individuals other than the primary carer (such as other family, neighbours or friends) should be able to apply to provide formal respite services.
- Service providers could administer an entitlement budget and negotiate arrangements and contracts with the respite provider chosen by the care recipient (including friends, neighbours or family).
- Respite entitlements could be cashed out by care recipients who could then access respite that suits their needs.

Providing flexible respite options could be particularly useful for Indigenous carers and for carers in rural and remote locations where there may be limited capacity for formal care services to provide timely respite.

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The Australian Government has acknowledged that respite services need to become more accessible, available, affordable and responsive (Australian Government 2010h). As such, reform of the respite system is expected to be one of the key areas of change as part of the development and implementation of the NCS. In the interim, pilot trials should be developed and evaluated to determine which, if any, of the above options offer an effective way of improving the delivery of planned and emergency respite.

### *Other support services*

The availability of other support services, especially transport options and assistive technologies, can contribute to the ability and willingness of carers to continue caring.

Transportation services contribute to maintaining social inclusion as they are an essential linking service between older people and their community. However, many older people do not have easy access to affordable transport, and informal carers (and volunteers) often provide such services and spend a considerable amount of time and money doing so.

Appointments and other activities generally occur during business hours, and this can adversely affect the capacity of the informal carer to participate in the workforce. The benefits of respite may be reduced or even negated if the carer is required to transport the older person between home and the respite location.

Community transport schemes provide valuable assistance to older people and, indirectly, to their carers. These schemes often draw on volunteers (who may be reimbursed for their 'petrol costs') and contribute to the social capital of local communities. The Commission proposes that such schemes continue to be funded (including through partial block funding, as appropriate) in recognition of the important role that they play (section 9.2). In addition to not for profit and private service providers, local councils can often be a focus for organising a community based scheme.

Assistive technologies can increase the independence of frail older people and reduce the physical and emotional burden on carers. For example, wheelchairs, home modifications and, in some cases, lifting devices, can limit the amount of time required of carers and the amount of physical exertion and, as a result, the injuries that carers may sustain as part of their caring activities. Greater access to these technologies can also reduce carer burnout and avoid or defer the use of more intensive aged care services. Chapter 12 explores the potential for expanding home



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modification programs to support carers by increasing the safety and independence of older people for whom they care.

Often carers can neglect their own health (physical and mental) needs and they need to be reminded to care for themselves. Counselling, peer group support and advocacy services can also play a useful role in supporting carers. Henry Brodaty observed:

Supports for families pay dividends ... Counselling and education with ongoing support can reap long lasting dividends in enabling family carers to support people with dementia at home longer. (sub. 45, p. 1)

Such support mechanisms are also important in culturally and linguistically diverse communities. As noted by the Multicultural Access Projects, Metro North (Melbourne):

Culturally sensitive and competent emotional support and counselling will help to build strengths and resilience in many families, and assist them to make the best arrangement for the older person. (sub. 379, p. 15)

Therefore, in addition to the specialist carer support centres referred to earlier, more generalist support services for informal carers need to be available across Australia through community services that cater for specific needs, including culturally and linguistically specific support groups, disease specific support groups and peak bodies.

## **Carer participation in the workforce**

Greater carer participation in the workforce can bring benefits to the carer, those being cared for and the wider community. However, consideration of more targeted incentives and flexible working arrangements might be required to encourage more carers into the workforce.

### *Incentives for carers to engage in paid employment*

There are significant benefits from carers establishing and maintaining their connection to the workforce. In this context, Carers Australia observed:

Many carers report that their employment status can have a dramatic impact on their social inclusion as they lose social contact in their working lives if they need to disengage from the workforce. (sub. 247, p. 15)

Many carers would like to more fully engage in paid employment but some carers are restricted in their level of participation for a variety of reasons, including inadequate access to affordable, alternative caring services and restrictions on

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income support payments. Increasing workforce participation of carers will require a platform of support services, including appropriate respite and essential transport, to allow carers to feel confident that they can temporarily relinquish their carer responsibilities.

As the Taskforce on Care Costs (TOCC 2007) previously highlighted, the structure of the Carer Payment works against maximising workforce participation as it does not take into account the additional costs associated with alternative care arrangements when carers are at work.

Further, Carer Payment recipients are restricted to 25 hours per week of any combination of work, study and volunteering. On this issue, the *Pension Review Report* indicated that:

... further consideration should be given to more robust eligibility criteria which focus on the actual level of care provided, rather than the use of a cap on the number of hours of work. (Harmer 2009, p. 143)

Even so, improved incentives to promote carer engagement in the workforce, particularly for recipients of the Carer Payment, may have limited success as many of these carers move between income support arrangements and have poor connections with the workforce (Harmer 2008, 2009).

### *Working arrangements for carers*

Submissions from organisations representing carers, governments and consumers argued that carers should be better supported through greater workplace flexibility. For example, the South Australian Government acknowledged that there can be inflexibilities in working arrangements for those with caring responsibilities:

... it becomes more difficult to access or continue in paid employment that is open and flexible enough to acknowledge and allow irregular working conditions to assist the carer in their caring role. Consequently, women with care responsibilities are often restricted to part-time or occasional work. (sub. 336, p. 10)

Alzheimer's Australia WA also said:

Measures aimed at reconciling the conflicting pressures of paid work and care should be addressed through workplace-based policies that allow flexible work, time off and paid care leave and/or home care and other services that can substitute for informal care so that informal carers can take or retain paid employment. (sub. 345, p. 12)

In an increasingly constrained labour environment, employers will need to consider the flexibility of their workplace arrangements to ensure the attraction and retention of experienced and valued employees. This sentiment has been echoed by Colombo et al.:

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Care leave and flexible work arrangements help carers address the balance between workplace obligations and caring responsibilities, and so can induce the supply of both. (2011, p. 22)

Some submissions called for the *Fair Work Act 2009* to be amended to allow all carers to request flexible working hours as is available for carers of children under school age or under 18 years with a disability.

The Commission's parallel inquiry into disability care and support reported that the National Employment Standards (section 65(1) of the *Fair Work Act 2009*) do not meet the legitimate needs of parents with caring roles for children with a disability aged 18 years and over (PC 2011b). The draft report proposed that the Act be amended to permit parents to request flexible leave from their employer if their child has a disability and is over 18 years old, subject to a National Disability Insurance Scheme assessment indicating that the parent is providing a sufficiently high level of care. If the *Fair Work Act 2009* were to be amended along these lines, consideration should be given to including a right for carers of older people to request flexible working arrangements, if evidence can be produced (such as a Gateway assessment) that they are providing a sufficiently high level of care.

#### RECOMMENDATION 13.1

***The Australian Seniors Gateway Agency, when assessing the care needs of older people, should also assess the capacity of informal carers to provide ongoing support. Where appropriate, this may lead to approving entitlements to services for planned respite and other essential services.***

***Carers Support Centres should be developed from the existing specialist carer support service programs to undertake a comprehensive and consistent assessment of carer needs. Such centres should be directly accessible to carers as well as through the Gateway and would also deliver carer support services, including:***

- ***carer education and training***
- ***emergency respite***
- ***carer counselling and peer group support***
- ***carer advocacy services.***

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## 13.5 Volunteers

### The role of volunteers

Volunteers contribute substantially to the delivery of some aged care services and their roles vary depending on the setting in which they are engaged. In residential settings, their role is primarily to complement care delivery through improving the quality of life of residents by providing entertainment and companionship. In community settings, their roles can be more diverse, from providing ‘quality of life’ services to more fundamental roles, such as preparing and delivering meals and providing home maintenance services and community transport.

Volunteering activities benefit the recipients, volunteers and the social capital of the broader community. Interactions between volunteers and older people can promote social inclusion and improve health and welfare outcomes. In turn, this can reduce the need for formal community aged care services and/or reduce the likelihood of premature entry into residential care.

In 2006, there were 5.2 million volunteers aged 18 and over who provided 713 million hours of service to the community (ABS 2007d). Over 1.1 million of these volunteers provided assistance in the community services area. However, data currently collected shed little light on trends for volunteering in community services and social activities which are specifically targeted towards older Australians.

There have been a number of government initiatives designed to increase the level of volunteering in residential aged care, particularly through the Australian Government Community Visitors Scheme for aged care. These initiatives have had some success, with the number of volunteers attending residential aged care facilities increasing by 55 per cent between 2000 and 2009 (ABS 2001, 2010a).

Previous research shows that the potential pool of volunteers in the community is expected to be larger in the future, primarily as a result of the retirement of the ‘baby boomers’ (PC 2005b). However, this does not necessarily translate into more volunteering in the aged care sector. Bapcare, relating their experience, said:

The ageing of the population is changing the profile of volunteers willing to support the aged care sector. The hours volunteers are willing to donate seem to be decreasing. Early retirees, who tend to have been well represented among volunteers, now have different pressures and choices to previous generations. Their family obligations may well be different; this can include aged parents who are still alive and grandchildren with both parents working. Coupled with this, early retirees have broader life style choices including travel and a wide range of volunteer opportunities. (sub. 212, pp. 45-46)

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Looking forward, the South Australian Government considers:

It is critical that an aged care system for the future supports small volunteer based organisations as they are most likely to be responsive to the needs of their community and deliver a cost effective service. Support includes ensuring that the regulatory administrative and reporting burden is sustainable and that governance and training support is provided to assist in both the delivery of quality care services and their sustainability. (sub. 336, p. 18)

The Australian Government is in the process of developing a National Volunteering Strategy to ‘articulate the Government’s vision and commitment to volunteering in Australia, highlight the key issues and flag the emerging trends in volunteering over coming years’ (Australian Government 2010e, p. 2). The strategy will also identify key barriers to volunteering, including regulatory barriers, and seek to develop and encourage appropriate policy responses. It is due for release in 2011 to coincide with the 10 year anniversary of the Year of the Volunteer (Australian Government 2010e).

### **Options to encourage more volunteers into aged care**

Submissions to this inquiry and previous research, such as the Commission’s study into the *Contribution of the Not-for-Profit Sector* (PC 2010b), indicate that there are a number of barriers to people undertaking volunteering activities, including the increasing costs of engaging volunteers, regulations surrounding volunteer involvement (such as liability and negligence) and personal costs associated with volunteering. For example, the Multicultural Communities Council of Illawarra stated that the:

Volunteering supported model is currently experiencing significant barriers and challenges. Costs to petrol prices, low remuneration returns, lack of bilingual volunteers, and a drop in volunteering rates is creating significant challenges in the sector, particularly in regional areas. (sub. 286, p. 12)

One of the major barriers is the significant cost associated with recruiting, organising, training and managing volunteers. These costs are predominantly incurred by organisations for which they are often not funded or relatively underfunded when the full costs of engaging volunteers are considered. Many organisations need to employ full-time volunteer coordinators or combine this role with another position, such as an activities officer or diversional therapist (Diversional Therapy Australia, sub. 175).

Older people are considered vulnerable citizens and those working or volunteering with them are required to have a background check to ensure that older people are not put at risk of exploitation or abuse. Most organisations incur the costs of

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background checks, which may cost up to \$52 per volunteer depending on where the check is undertaken. Some jurisdictions have taken steps to reduce these costs. For example, the South Australian Government offers free background checks for volunteers in organisations working with vulnerable groups (Volunteering Australia 2009). The Australian Capital Territory (ACT) Government has introduced legislation that also proposes to offer this service to volunteers free of charge (Stanhope 2010).

In addition, the ACT legislation proposes a 3-year portable registration system to allow volunteers (and employees) to move between organisations within the ACT without the need to be rechecked (Stanhope 2010). Portable background checks may reduce the regulatory burden on volunteer organisations and formal care providers, and should be considered by other jurisdictions. Ideally, work should be undertaken on the development of a national system for background checks to remove the need for volunteers to be rechecked in each jurisdiction.

Other regulations, particularly related to occupational health and safety and food safety, can also affect the capacity of organisations to use volunteers, especially periodic volunteers, and impose costs that reduce the number or quality of services provided (chapter 15; appendix F; PC 2010b).

As outlined in previous research, the application of regulations designed to protect workers, volunteers and consumers should be proportionate to the risks posed. Funding arrangements should take into account the costs associated with regulations and training where these activities significantly increase the costs of engaging volunteers.

In the Commission's view, government support for services that use volunteers in the provision of aged care services should be funded to cover the fixed costs of the service to give certainty to all involved. This funding should adequately cover expenses associated with providing support and training, human resource management and regulatory costs. User charging would cover the additional costs associated with providing services to individual clients (chapter 9).

Some volunteering activities may impose substantial costs on the volunteers themselves, and this can act as a disincentive. The aged care sector is at risk of losing volunteers in areas where substantial costs may be incurred, such as transport services and delivery of meals (DutchCare, sub. 128). Some organisations reimburse volunteers for these out-of-pocket expenses, but others cannot afford to do so. As such, the potential pool of volunteers available to provide aged and community services could be reduced, especially among those with low incomes (such as pensioners).

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Through its *Volunteer Grants 2010* initiative, the Australian Government has supported over 253 000 volunteers in more than 6000 organisations to assist with:

... the costs of training courses for volunteers, and to undertake background screening checks for their volunteers. Funding is also available to purchase small equipment items to help volunteers, and to contribute towards fuel reimbursement for their volunteers, including those who use their cars to transport others to activities, deliver food and assist people in need. (FaHCSIA 2010c, p. 1)

As illustrated above, the Australian Government recognises that volunteering activity can be adversely affected by costs borne by volunteers in undertaking these roles. For services where there are predictable out-of-pocket expenses incurred by volunteers, full or partial re-imbusement of these expenses should be included in funding arrangements.

In addition to reducing barriers to volunteering, consideration could be given to improving the image of providing volunteering services to older people. Such initiatives could be targeted at ‘baby boomers’ and younger people for maximum effect. For example, Charles Stuart University called for the:

Development of programs aimed at school-aged children (primary and secondary) that highlight the need for volunteering and the benefits of volunteering ... (sub. 121, p. 9)

RECOMMENDATION 13.2

***Funding for services which engage volunteers in service delivery should take into account the costs associated with:***

- ***volunteer administration and regulation***
- ***appropriate training and support for volunteers.***





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## 14 The formal aged care workforce

### Key points

- The formal aged care workforce predominantly comprises nurses, care workers and general support staff, including cleaners, laundry workers and catering staff. Medical practitioners and allied health professionals provide health care services which complement, and affect the demand for, aged care services.
- Aged care services are labour intensive, particularly direct care services. As such, access to a sufficient and appropriately trained labour supply is essential to ensure that quality and safe care can be delivered when and where required.
- The demand for aged care workers is expected to significantly increase over the next 40 years as a result of the increasing number of older Australians requiring care and support and a decline in the relative availability of informal carers.
- The supply of workers is problematic. The formal aged care system currently faces difficulties in attracting and retaining workers. These difficulties are expected to intensify due to increasing competition for workers as the overall labour market tightens in response to population ageing.
- A comprehensive aged care workforce strategy needs to be independently developed to identify and address ongoing and future workforce issues.
- Workforce strategies should include:
  - paying fair and competitive wages, improving access to education and training, developing well articulated career paths and better management, extending scopes of practice, and reducing regulatory burdens
  - ensuring that the pricing of services recommended by the proposed Australian Aged Care Commission takes into account appropriate staffing levels, skills mix and remuneration arrangements
  - providing more training opportunities including professional development for staff, particularly those in remote locations.
- While the delivery of many training courses is of high quality, there are some registered training organisations that are not delivering accredited courses to the standard required and there is a need to review the content and delivery of vocational education and training courses.
- Putting in place measures to facilitate the transfer of skills (including language skills) by reducing the regulatory burdens and costs associated with employing aged care workers from overseas is likely to pay significant dividends in the future.

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As outlined in chapter 3, the demand for aged care workers in Australia is expected to rise significantly as a result of the increasing number of older Australians requiring care and support and a decline in the relative availability of informal carers. This chapter examines the implications for the formal workforce. Issues affecting the availability of informal carers (the principal means of delivering care to older Australians) and volunteers are discussed in chapter 13. Appropriate access to medical and allied health professionals is also an important aspect of delivering quality care to older Australians and is discussed in chapter 10.

This chapter outlines the scope of aged care workforce considerations and provides an overview of the current aged care workforce (section 14.1). An analysis of future aged care workforce requirements is presented in section 14.2. Issues related to improving the attractiveness of the aged care sector, including remuneration, the working environment, and education and training, are explored in section 14.3.

## **14.1 Who delivers care services to the aged?**

### **Scope of workforce considerations**

Many older people require a variety of different care and support services. Most of these services are provided by family, friends and other informal carers (chapter 13). Personal and health care services represent the vast majority of services provided under the aged care system.

Services are also delivered through health and other social support systems, including disability and welfare. The capacity of the aged care system to provide timely and appropriate care can be significantly affected by access to services in other support systems, especially health services. A number of benefits can be realised where the interfaces between these systems are improved, including seamless service delivery and a reduction in service gaps for the client, enhanced efficiency in service delivery and reduced incentives to shift costs between services.

A range of support services are delivered to many older people by workers who do not require aged care specific skills (for example, tradespeople involved in home modifications, drivers involved in community transport or cooks preparing meals for residents). It is important that there are enough of these types of support workers that are appropriately trained, but the education and training of these workers should be considered in the context of their respective sectors. However, some aged care support workers are covered by the relevant industry award, such as cleaners in

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residential aged care, and the capacity of employers to pay fair and competitive wages is considered in the remuneration discussion (section 14.3).

### **The importance of labour in caring for the aged**

Caring for older people is labour intensive and requires a variety of skills. The aged care sector competes for care workers with a number of other sectors, primarily the health sector and the social and community services sector, but also with other sectors in the economy. There is a relative shortage of qualified workers in most of these sectors and there is strong competition for workers, especially nurses although this, as yet, has not flowed through to higher wages. This competition is expected to intensify as the demand for aged care, disability care and health care services increases and the broader Australian labour market tightens as a result of population ageing.

There may be some opportunities to reduce the labour intensity and alter the skill mix involved in delivering aged care through new models of care and the use of assistive and information technologies. However, most applications of technology adopted by aged care providers have acted to complement the workforce — for example, by improving the working environment and improving the quality of care — rather than substitute for it. It would not be prudent to assume that technological developments will significantly reduce the relative demand for labour in the future, although demand side pressures should lead to ever more efficient ways to deploy labour.

### **Profile of the current aged care workforce**

Aged care employees make up around 23 per cent of the total health care and social assistance industry workforce (ABS 2009b; Martin and King 2008). Aged care employees involved in direct caring activities represent around 25 per cent of all employees engaged in health and community services occupations (AIHW 2009b; Martin and King 2008).

As noted by the Commission previously (PC 2008), data on the entire aged care workforce is not comprehensively nor consistently collected and reported. The Australian Bureau of Statistics (ABS) only collects detailed information about the residential aged care workforce while the community aged care workforce is part of a broader category which encompasses all workers involved in the delivery of community care services, including disability services. Other work undertaken to map the aged care workforce, such as that by Martin and King (2008), provides

better coverage than the ABS data but still is considered to underestimate the total aged care workforce.

There were an estimated 262 000 people working in the aged care sector in late 2007 (Martin and King 2008). Of these, 175 000 provided services in residential aged care facilities (RACFs) and 87 000 provided aged care services in community settings. The vast majority of these workers (79 per cent) provided direct care services to older Australians while the remainder delivered support services.

Compared to the broader health and community services industry and all industries, residential and community aged care employees are more likely to be female, work fewer hours and be older (table 14.1).

**Table 14.1 Workforce characteristics: profiles for selected sectors, 2007**

	<i>Residential aged care</i>	<i>Community care</i>	<i>Health and community services</i>	<i>All industries</i>
	%	%	%	%
Female	93	91	79	45
Part time	69	59	42	28
45 years or older	60	70	46	37

Sources: DEEWR (2008); Martin and King (2008).

There is some evidence to suggest that the direct care workforce is being under-utilised, with a significant proportion of this workforce reporting that they would like to work more hours. Martin and King (2008), found that:

- in community care over 40 per cent of the workforce would like to work at least one hour more per week
- in residential care over 27 per cent of the workforce would like to work at least one hour more per week.

It is difficult to determine trends in the total aged care workforce over time due to limitations in the data collected and the irregularity of data collection, especially for community aged care workers. Despite these limitations, there is evidence to suggest that the workforce is growing in response to the increased supply of aged care services. For example, Martin and King (2008) reported that the residential aged care workforce grew by just over 10 per cent between 2003 and 2007. ABS sub-industry workforce data also shows a steady increase in total residential aged care workers (ABS 2009b).

Given the increasing importance of aged care services into the future, the Commission believes there is merit in developing more appropriate classifications

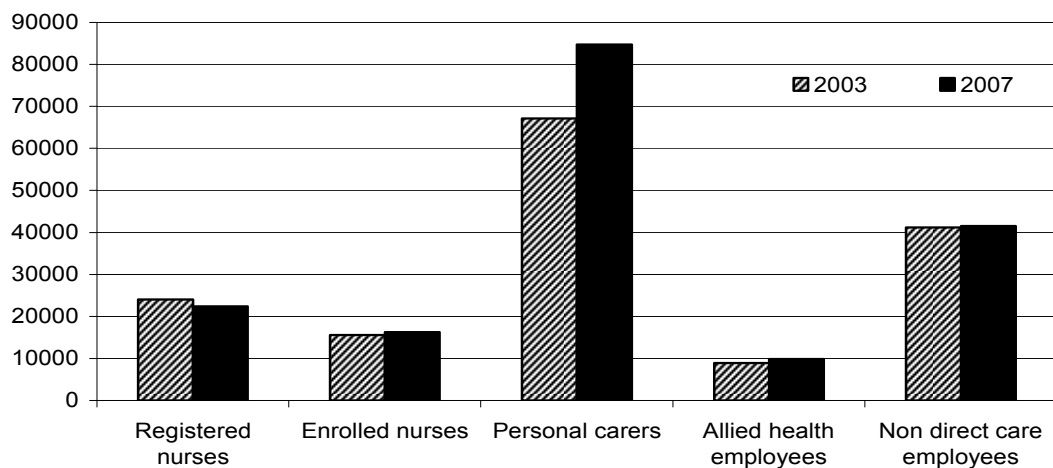
for improving the collection of data on the number and skill levels of workers in the aged care sector. For example, consideration should be given to redefining the ABS sub-industry classifications to reflect changes in aged care policy (for example, by reflecting the development and expansion of relatively intensive community aged care programs — CACP, EACH and EACH-D).

### *Residential aged care workforce trends*

As illustrated in figure 14.1, personal carers have accounted for almost all of the growth in the residential aged care workforce since 2003. This occurred while there was an overall rise in both the number of residents and their dependency level, as reflected by the increasing proportion of high care residents in RACFs.

**Figure 14.1 Residential aged care employment**

Total employees, 2003 and 2007



*Data source:* Martin and King (2008).

There is a trend towards employing less skilled (and lower cost) staff in residential settings in the delivery of direct care services. Despite an increase in the workforce overall, the number of full-time equivalent registered and enrolled nurses working in RACFs fell from 27 210 to 23 103 between 2003 and 2007 (table 14.2). This represents a decrease from 35.8 per cent to 29.3 per cent of all full-time equivalent direct care employees in only four years, with most of the reduction occurring at the registered nurse level.

While the substitution towards less skilled workers may be partly driven by financial constraints and difficulties in attracting and retaining nurses, the scopes of practice for some personal carers have also been widened (for example, undertaking medication management). Such initiatives have many benefits, including increasing

the workplace satisfaction of personal carers and improving their skills. Importantly, as recognised by the Australia Health Ministers' Advisory Council, it meets a fundamental workforce principle that:

... to ensure the best use of scarce workforce resources, wherever possible, services should be delivered by staff with the most cost effective training and qualification to provide safe, quality care. (2005, p. 9)

**Table 14.2 Residential aged care employees engaged in direct care<sup>a</sup>, 2003 and 2007**

Occupation	2003				2007			
	Number of employees	%	Full-time equivalent	%	Number of employees	%	Full-time equivalent	%
Registered nurse	24 019	21.0	16 265	21.4	22 399	16.8	13 247	16.8
Enrolled nurse	15 604	13.1	10 945	14.4	16 293	12.2	9 856	12.5
Personal carer	67 143	58.5	42 943	56.5	84 746	63.6	50 542	64.1
Allied health employees	8 895	7.4	5 776	7.6	9 875	7.4	5 204	6.6
<b>Total number</b>	<b>115 660</b>	<b>100</b>	<b>76 006</b>	<b>100</b>	<b>133 314</b>	<b>100</b>	<b>78 849</b>	<b>100</b>

<sup>a</sup> Full-time equivalent data is only available for employees engaged in direct care activities, not all employees.

Source: Martin and King (2008).

Reforms aimed at increasing competition between providers and innovations in models of care and scopes of practice, together with team-based health care, have the potential to offer further improvements in delivering safe, quality care, as well as enhancing the productivity of the workforce.

### *Community care workforce snapshot*

There were an estimated 87 500 employees delivering community aged care services in 2007 under the six community aged care programs — HACC, CACP, EACH, EACH-D, Day Therapy Centres and the NRCP (Martin and King 2008). This is probably an underestimate of the total number of community care workers due to limitations in data collection.

Community care workers, equivalent to personal care workers, comprised over 80 per cent of direct care employees in 2007. There is limited use of enrolled nurses and registered nurses — 2.5 and 10 per cent of the workforce, respectively, in 2007. This reflects the large number of low intensity care services delivered in community settings that do not require high levels of clinical skills and qualifications.

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## 14.2 Future aged care workforce requirements

An important consideration when examining labour force supply and demand is the substitutability of labour across occupations. Australia's labour force supply is limited in several dimensions:

- first, by the working age population
- second, by the participation in the labour force of those of working age (the participation rate), for both men and women and by age range
- third, for those that seek employment, the relative scope for not only obtaining a job, but also the number of hours that the potential worker wants.

Government policy can affect the quantity and quality of labour supply in a number of ways. A sound policy approach can remove distortions that discourage people who have a capacity to undertake work, allowing them to enter or return to the labour market. It can also provide incentives for the under-employed to increase the hours that they work — one example of which might be a more flexible industrial relations system. Policy also has a role in promoting skill development in the areas where it is required which, in turn, can lead to a better qualified and more capable labour force. Migration policy can increase the supply of labour through both skilled and unskilled migration.

Within these parameters, however, there is a limit to the supply of labour that can be mobilised in Australia. Aged care is difficult to target directly as it is just one of many sources of demand for labour at a range of skill levels. It is in this context that the report examines aged care labour force issues.

### Projections of aged care workforce demand

The industry and governments recognise that Australia faces a significant shortfall in coming years of appropriately skilled aged care workers — nurses, carers and allied health workers (PC 2008). Given the fundamental reforms recommended by the Commission, there are various, and at times opposing, impacts on the demand for skilled workers. For example, the lifting of supply of restrictions on community and residential places is expected to increase the demand for services. This is likely to be offset to some extent by higher co-contributions which may temper somewhat the demand for formal services. The complex demand and supply environment, long lead times for education and training, and data problems mean that, at best, projections out over long time horizons are indicative only (PC 2005).

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That said, DoHA in its initial submission to this inquiry stated:

Assuming that the ratio of number of aged care workers to the size of the population aged 70 or over remains constant, then by 2050 a total of 827 100 will be engaged in the provision of aged care ... [This] will account for about 4.9 per cent of all employees in Australia. (sub. 482, p. 38)

DoHA's estimate indicates that under current policy arrangements the aged care workforce will need to increase by between two and three times as a direct result of Australia's ageing population. The Australian Government has invested substantially in education and training through increasing the number of courses for registered and enrolled nurses and care workers, and has developed various incentive programs to encourage workers to enter or re-enter the aged care sector. Programs to increase the skills of personal care workers through vocational education and training have been acknowledged as beneficial by participants to this inquiry (for example, Havilah Hostel, sub. 384).

Australia is not alone in facing the challenges of delivering quality aged care to an ageing population. A recent OECD Health Policy Studies paper concluded that:

In absolute terms, by 2050, the demand for LTC [long-term care] workers (on an equivalent full time basis) is expected to about double in Japan, the USA and Canada, and about triple in Australia, New Zealand, Luxembourg and the Slovak Republic. (2011, p. 78)

As outlined in chapter 3, the significant increase in the number of older people and a relative decline in the availability of informal carers will result in a significant increase in the demand for aged care services. As aged care services are labour intensive, the delivery of these services will require a commensurate increase in the aged care workforce.

The Commission has calculated that, based on the estimated demand projections under its proposals and assuming that models of care are maintained at 2007 levels, there would be need for about 980 000 aged care workers by 2050. Information about the underlying data and assumptions used in calculating this estimate can be found in appendix E.

In responding to these demand pressures, the supply of personal care workers and enrolled nurses will be driven by the relative attractiveness of aged care compared to alternative employment options. Basic personal care skills can be developed reasonably quickly, but so can the skills associated with similar paying work. While most aged care providers will support skill development, current remuneration and working conditions are considered strong disincentives to entering and staying in the sector.



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Registered nurses and allied health professionals will also be in greater demand. As is the case for personal care workers, the key to attracting and retaining these workers will also be to offer fair and competitive remuneration and satisfying working conditions. Competition from other employers, such as hospitals and specialised health services, will intensify as demand for these services also grows.

The Commission's proposed phasing out of supply constraints in community and residential care is likely to increase the demand for workers over the next few years. This is particularly the case for community care, where it is expected that the rate of growth will be relatively high and the capital investment required to expand is relatively low. Indeed, there are concerns about the capacity of some registered training organisations to deliver adequately trained personal care workers with enough practical experience to deliver quality care in a community setting with limited supervision.

Given the inherent uncertainty of projecting demand and supply over a long time horizon, there is a need for either an ongoing or periodic evaluation of the key demand and supply factors, including the models of care employed and technological developments. Such an evaluation could either be undertaken as part of the systemic review proposed as an element in the Commission's implementation plan (chapter 17) or be an ongoing role for an appropriate agency.

## **Models of care**

Models of care will change in the future in response to:

- changes in the underlying client mix
- enabling providers to deliver a wider range of services,
- changes to the characteristics and scopes of practice for workers
- technological advances and changing regulatory requirements.

As summed up by the Community Services and Health Industry Skills Council (CSHISC), there is a need for greater skills development to facilitate models of service delivery which:

... emphasise maintaining functional independence for individuals and meeting complex demands ... This continues the need to develop more advanced career paths within service provision roles and to develop management capacity. (2010, p. 7)

This sentiment was echoed by a number of submissions which consider that changes to the current models of care are necessary to provide person-centred care with the appropriate skill mix (Debra. King, sub. DR530; Michael. Fine, sub. DR592).

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The underlying client mix is expected to change as a result of an ageing population and an increasing diversity in care needs and preferences. Reflecting consumer preferences, and in response to the relaxation of supply constraints, more older people are expected to receive a broader range of services in the community at high levels of intensity. In addition, the recent trend towards higher intensity services being provided in residential settings is expected to continue, requiring more highly skilled care workers, such as registered nurses and clinical care specialists, to deliver these services.

Models of care will also evolve in response to the wider range of services that providers will be able to offer. For example, the Commission is proposing that aged care providers also be allowed to deliver certain health services, such as sub-acute care.

Scopes of practice changes may result in a further expansion of the roles of some workers, including personal carers and allied health assistants. However, these skills will only be developed if workers have an incentive to invest in the associated training. Having clearly defined career paths with commensurate remuneration to reflect these increases in skills would provide financial incentives to workers.

Further, there may be greater scope for clinical care specialists to deliver more services in aged care settings, particularly if limitations on the range of services aged care providers can offer are relaxed. Current funding arrangements make it uneconomical for such workers to be employed by aged care providers directly but there is the potential for this to change in the future.

Reducing the regulatory burden may also affect models of care by allowing providers to better use the skills of their workers. Some submissions have noted that poor skill mix and regulatory restrictions on who can undertake what tasks have resulted in qualified nurses becoming ‘conditioned to work as part of a production line’ (Y.H. Jeon, sub. DR593, p. 1).

The adoption of assistive and information technologies may also prompt changes to the models of care. For example, greater use of in-room hoists in residential settings and the adoption of communication technologies for consultation and monitoring in community settings will lead to adjustments in care models.

But positive change will need managers who have the vision to develop and adopt new models of care, to set up rigorous trials, to evaluate their outcomes and to disseminate the results. This will require the development of leadership skills, including at the middle management level, to execute these changes successfully.

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### 14.3 Addressing direct care workforce challenges

A number of aged care providers report increasing difficulty in attracting and retaining staff. Martin and King (2008) report that the number of RACFs with at least one equivalent full-time vacancy for a direct care worker increased from 37 per cent to 50 per cent between 2003 and 2007. For community care service providers, 29 per cent indicated that they had vacancies for direct care workers at the time of the survey in 2007. Residential care providers indicated that they had most difficulty attracting registered nurses in a reasonable period of time, while community care providers had relatively more difficulty finding community care workers.

Martin and King (2008) also indicated that the sector overall has a high turnover rate, with around one in four personal carers having spent less than a year with their current employer. Turnover in residential aged care is one third higher than for the health care and social assistance industry and slightly higher than for the economy in general (ABS 2008c). Baptistcare (WA) outlined its experience with high turnover in a tight labour market:

Our staff turnover is currently running 29% per annum (and on the increase as resource projects in WA come on line). It peaked two years ago with the previous resources boom in WA at almost 38%. This is typical of the industry in WA (based on recent network benchmarking). Such a high turnover has a major impact on operating costs (recruitment and training), operational efficiency and, importantly, has implications for quality of care. (sub. 426, p. 6)

Froniditha Care provided an industry perspective about the challenges arising from the poor image of the sector:

The issues for Froniditha are shared by the industry at a national level ... concerning the image of aged care, career structures and pay discrepancies between the acute sector and aged care. (sub. 436, p. 10)

The Australian Nursing Federation (Victorian Branch) noted:

The preliminary findings of the 2010 University of Melbourne longitudinal study reveal a worsening picture, with 44.5% of participants who had left aged care at the time of the study citing working conditions, inadequate staffing levels, poor staff resident ratios, too much paperwork or poor pay as their reason for leaving. Significantly, the study also found that poor working conditions had driven some staff to retire earlier than they otherwise would have done had working conditions been better. (sub. 341, p. 70)

The Quality Aged Care Action Group captured the concerns of many participants:

We recognise that there is a shortage of nurses across the health system and that aged care is suffering as part of this. We also know that there are added barriers to attracting

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nurses to aged care: lower wages, high workloads and difficulty meeting professional responsibility, less nurses in the skill mix means less opportunity for professional collaboration and support, and the limited career paths and barriers to accessing professional development. (sub. 346, p. 10)

For some providers, recruitment and retention challenges are exacerbated not only by high turnover, but also by the relatively high use of temporary or ‘agency’ staff. These factors affect the capacity of providers to deliver continuity of care, put more stress on ‘regular’ workers, negatively affect the working environment (including for visiting health care professionals) and can unsettle older people, thus reducing the quality of their care experience. In addition, there can be substantial costs associated with high turnover rates, including advertising for new positions, inducting new workers into the organisation, training them, and employing agency staff to fill shifts. In some cases, it may be more cost effective for providers to invest in higher wages, rather than incur the costs associated with high turnover rates.

The Commission notes, however, that during its industry visits it met with a number of providers and their staff who said they had minimal turnover and virtually no use of agency staff. When questioned, both providers and staff attributed this to good management practices. The variability of management within the aged care sector is an important determinant of the attractiveness of individual service providers as places of employment — it is also fundamental to ensuring the sustainability of the industry as a whole, since high turnover rates reduce continuity of care for care recipients and the overall efficiency of labour and make it even more difficult to meet the demographic and skills challenges. While there have been significant investments aimed at improving the clinical care skills of aged care workers, there has been much less focus on developing management capacity and anecdotal evidence suggests that the majority of managers were formerly clinical staff with limited experience in management roles.

Improving the attractiveness of aged care and developing a sustainable workforce to meet future demand will require an integrated approach in a number of areas, particularly paying staff competitively, fostering a rewarding working environment (especially through better management) and providing further opportunities for skill development (including increasing scopes of practice) and exploring the opportunities to source care workers internationally.

Action in one area alone will not be enough to set the industry on a sustainable path. A recent OECD Health Policy Studies paper considers a multi-faceted approach essential to developing an aged care workforce which can meet the challenges of delivering care to ageing populations around the world (Colombo et al. 2011).

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There is a role for government in setting prices for care services which enable employers to pay fair and competitive wages. In addition, governments can also take action to support the delivery of quality education and training, and reduce unnecessary regulatory burdens. Solutions also lie with aged care providers, as they too have a responsibility for ensuring that they provide an attractive workplace.

Innovations in governance arrangements have been suggested by some participants in developing an appropriate workforce policy response. This issue is reviewed later in this section.

## **Remuneration**

The relatively low remuneration of aged care workers is consistently raised as a key issue in attracting and retaining workers. There are a number of factors that have kept wages relatively low, including:

- inadequate price setting and indexation of care subsidies
- poor bargaining positions of a highly feminised, part time workforce which has had limited success in raising wages significantly above the relevant industry awards.

### *Care workers and support workers*

Carer workers, including assistants-in-nursing, personal care workers and community care workers, deliver the majority of aged care services to older Australians. However, both providers and unions consider that their remuneration does not reflect the underlying value of their work. For example, Amaroo Care Services advised that:

While aged care workers may have a passion for their work in making a difference for the elderly they care for or support, it remains a sad indictment upon our social values when an entry level zoo keeper attracts a base rate of \$19.50 per hour for tending to animals while an entry level personal carer or support worker only attracts \$15.90 per hour for providing care to our elderly in accordance with a new Australian industry award that came into effect during July 2010. (sub. 98, p. 14)

United Voice, representing many care and support workers, has argued that the process of conventional enterprise bargaining has failed to deliver wage growth in the aged care sector to a level that is 'fair' when compared to workers with similar qualifications in other industries.

The lack of opportunity for effective enterprise bargaining has contributed to the ongoing undervaluation of aged care employees' remuneration. This in turn has meant the wages of aged care employees are behind relevant community standards.

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Employees at all levels, and particularly at levels where employees hold vocational education qualifications, are paid significantly less than other employees performing work requiring the same levels of qualification and/or experience. (sub. DR845, p. 16)

In this context, United Voice maintained that a certificate III aged care worker was comparable in skill to a certificate III metal worker. However, wages between the two sectors are substantially different where metal workers have been able to exercise bargaining strength and wages are significantly higher as a result (earning between \$23 and \$34 per hour).

Recent cases presented before Fair Work Australia (FWA), such as the Equal Remuneration Order and Low-Paid Authorisation, may not, in themselves, substantially raise the level of pay for historically low paid staff in aged care and comparable community services sectors (box 14.1). However, whether by this mechanism or by bargaining between employers and employees directly, the Commission's recommendations provide an opportunity to address a pay anomaly by putting the aged care sector on a sustainable footing.

The large proportion of part-time and casual employment (not always by choice) translates directly to the total take home pay of these workers and makes the sector relatively unattractive for workers (including a number of males) who are looking for full-time employment.

The current *Aged Care Award 2010* and continued funding restrictions may also limit the capacity of providers to attract and retain support workers with specialist skills, such as 'maintenance staff, builders with expertise in disability modifications, gardeners, bus drivers and catering staff' (National Presbyterian Aged Care Network, sub. 110, p. 7).

### *Registered and enrolled nurses*

Registered and enrolled nurses are also relatively poorly paid compared to those performing similar roles in alternative settings. For example, the Australian Nursing Federation (ANF) submitted that:

A national shortage of nurses and the wages gap between nurses working in the aged care sector and nurses working in the public hospital sector is exacerbating recruitment and retention difficulties in the aged care sector. The wages gap currently stands at 44.6% or \$393.77 per week national average under an Award and 15.2% or \$168.52 per week national average under an Enterprise Bargaining Agreement (EBA). (sub. 327, p. 2)

This gap has been widening over time, as outlined by the Commission previously (PC 2008).

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### **Box 14.1 Fair Work Australia and the aged care sector**

Fair Work Australia (FWA) handed down decisions in the first half of 2011 on two cases affecting workers in the aged care sector — the Equal Remuneration Order (ERO) and the Low-Paid Authorisation (LPA).

#### **Equal Remuneration Order**

The ERO application sought principally to apply the wage rates and classification structure of the Queensland Social and Community Services (SACS) award to employees in the SACS industry nationally. The Queensland SACS rates were initially fixed in an equal remuneration decision by the Queensland Industrial Relations Commission in 2009.

FWA reached the conclusion that for employees in the SACS industry there is not equal remuneration for men and women workers for work of equal and comparable value by comparison with state and local government employment. However, FWA also concluded that there were significant differences between the ERO and the Queensland case. As such, it considered that adjustments to the modern award were a more appropriate means to redress gender-based undervaluation of work but did not agree that the gap in pay was entirely attributable to gender. At this stage, it is unclear how the modern award will be adjusted.

#### **Low-Paid Authorisation**

The LPA applications sought to rectify the historic undervaluation of personal care and support workers in the residential aged care sector (regardless of whether they are covered by an enterprise agreement or the award) in specified areas and enrolled nurses in the aged care sector in Western Australia. The intention of the application was to permit United Voice and the Australian Workers' Union (QLD Branch) to bargain for a multi-enterprise agreement covering all employees named in the applications.

FWA accepted that in general terms employees in the aged care sector are low-paid and those under award agreements should be granted a LPA to pursue a multi-enterprise agreement. However, it also decided that employees covered by enterprise agreements should be excluded from the LPA. At this stage, it is unclear what the final outcome will be for those covered by the LPA.

*Sources:* FWA (2011a, b).

Some providers indicated in consultations that they pay the equivalent or above public sector wage rates for highly qualified staff, such as registered nurses and facility managers. Other providers also indicated that paying competitive wages is important to attracting and retaining staff, but inadequate funding and indexation mechanisms do not allow them to do so (chapter 5).

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While it is not known how many aged care nurses are paid under award agreements compared to enterprise bargaining agreements, the College of Nursing claimed that relatively low remuneration in aged care settings:

... strongly supports the community and health professionals' belief that aged care nursing is inferior; this creates workforce issues around recruitment and retention and overarching work force planning. (sub. 86, p. 7)

The disparity in wages between the public health system and the aged care system can create issues within the aged care system. For example, some combined aged care and health services (such as multi-purpose services in New South Wales) are operated by state government health departments and pay public sector wage rates. As such, these services can be more attractive to workers and can potentially exacerbate attraction and retention difficulties facing aged care providers in the same geographical location.

As with personal carer workers, there are limited financial incentives for nurses to upgrade their clinical skills to become clinical specialists or nurse practitioners. For example, many nurses have undertaken training to enable them to practice as nurse practitioners, but the funding of care services means that aged care providers cannot afford to employ them in these roles.

### *Realising fair and competitive wages*

As the Australian Government is a significant source of funding for services employing aged care workers, it will incur the budgetary consequences of wage rises to the extent they are reflected in increased subsidy levels. The Australian Government, in its submission to the Equal Remuneration Case for Social and Community Service Workers, noted that:

If any additional Government funding is provided, it would likely come at the expense of other Government funded services. (Australian Government 2010g, p. 10)

The National Aged Care Alliance, in its submission argued for:

... a dynamic and resourced workforce planning regime with adequate funding to ensure sufficient skilled, appropriately qualified and competitively remunerated staff are attracted to and retained in aged care and respected for their work. (sub. 88, p. 8)

Increased funding will not necessarily be reflected in increased wages for aged care workers. For example, previous attempts by the Australian Government to encourage aged care providers to 'pay competitive wages' have not narrowed the wages gap for nurses. One of the reasons cited for this was that there was no specific requirement for providers to direct the extra funding towards higher wages (PC 2008).



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As competition for skilled health workers intensifies, it will be increasingly difficult for aged care providers to withhold salary increases in the context of higher funding levels. In the Commission's view, it is unlikely that wages for aged care workers will become or remain competitive unless there is an independent mechanism for assessing the efficient cost of delivering care and setting scheduled care prices accordingly. To this end, the Commission is proposing that the prices for care services be recommended to the Australian Government by the Australian Aged Care Commission (AACC) following an independent analysis and for the recommendations to be published to ensure transparency (chapter 15). This analysis should take into account the need to pay fair and competitive wages to all aged care workers as well as the appropriate skill mix and staffing levels for the delivery of those services. In doing so, however, the AACC should avoid being overly prescriptive as to the labour force structure which could restrict the scope for providers to be innovative in their models of care and the recruitment and deployment of their workforce. For example, some providers may choose to have relatively more high skilled (or low skilled) workers or to substitute capital for labour. The Commission considers it important that providers are able to differentiate their product offerings from their competitors to drive innovation and service quality.

While there may be concerns about higher funding levels flowing through to wages, providers are unlikely to be able to staff their services in a tight labour market unless they pay competitive wages. However, the industry has historically used the award as a benchmark in setting wages for personal carers and support workers. It may be that the award remains an important mechanism by which fair and competitive wages are determined.

It should be noted that increases in wages to fair and competitive levels will increase the quantum of public funding for aged care, whether under the current aged care system or the Commission's proposed system. It would equally flow through to the level of public expenditure projected by the *Intergenerational Report 2010* (Australian Government 2010d). Importantly, therefore, funding increases related to fair and competitive wages are independent of, and separate from, the fiscal impacts of the Commission's proposed aged care reforms.

In increasing the level of the sector's funding to recognise the need for higher wages, the Government should be cognisant of the distortions caused by the fringe benefits tax (FBT) exemptions available to workers in Public Benevolent Institutions and public and not-for-profit hospitals. FBT exemptions can lead to different after-tax salaries for nurses undertaking the same work who are notionally on the same gross salaries but work for different providers (box 14.2).

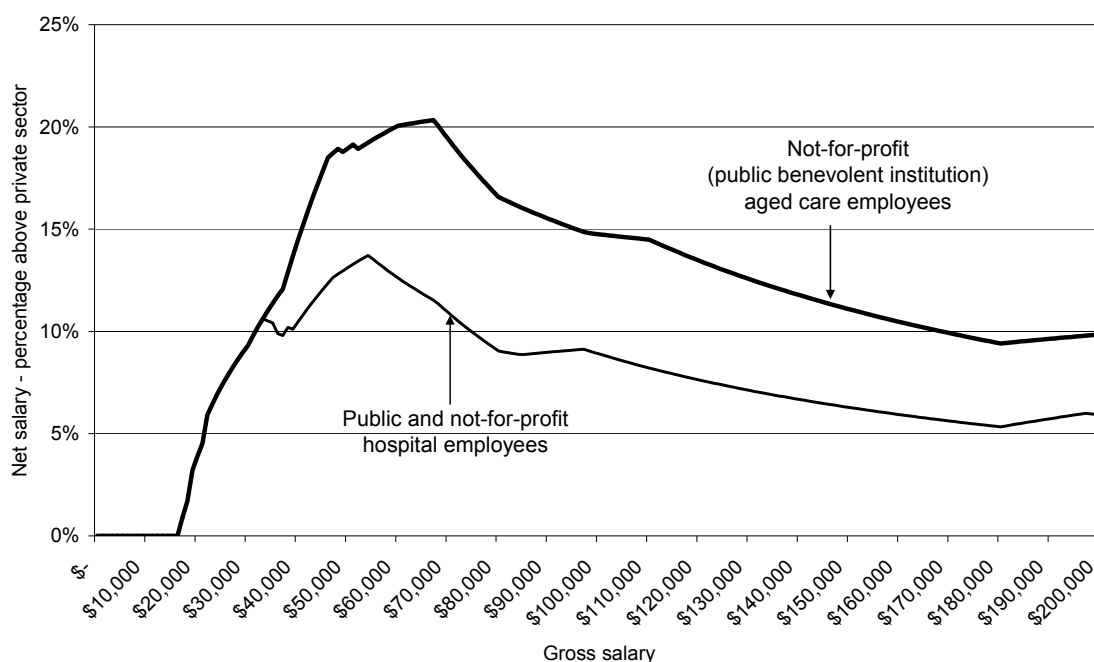
## Box 14.2 FBT concessions and competitive wages

One of the difficulties workers face in comparing wages is differences in taxation treatment of wages from different employers. This arises because of fringe benefits tax (FBT) exemptions provided to employees at public and NFP hospitals and employees at NFP aged care providers. Where workers at these institutions use these exemptions, their take home pay can be considerably higher than that of their counterparts earning the same before-tax wage. For example, an employee of an NFP aged care facility on \$65 000 per annum could have a take home pay that was 20.3 per cent more than an employee on the same salary at a private aged care facility (figure 14.2).

This occurs because employees of NFP aged care facilities can claim up to \$30 000 in FBT concessions, while employees of public and NFP hospitals can claim up to \$17 000 in FBT concessions. And the range of expenditure eligible for these concessions is broad, including groceries, rent and mortgage payments. In addition, these limits do not include the uncapped meal entertainment benefit, although some organisations impose a de facto limit on their employees' use of the benefit.

Figure 14.2 Fringe benefit tax benefits

After tax salary: percentage increase compared with for-profit aged care employees<sup>a</sup>



<sup>a</sup> Excludes potential benefits from the meal entertainment allowance. Assumes that employees at each income level use the full relevant FBT concessions: \$17 000 for public and NFP hospital employees and \$30 000 for NFP aged care providers.

Sources: PC (2010b) and Commission estimates.

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An increase in the level of remuneration for aged care workers will have a flow-on effect to other factors affecting the workforce. For example, the image and reputation of the sector as an area where caring work is valued would be enhanced by better wages. In addition, the quality and continuity of care may be increased as workers are more content to stay in the sector and turnover is reduced. In turn, this may allow more funding for education and training to be targeted towards up-skilling the workforce, rather than basic training for new entrants who are unlikely to stay for long under current conditions.

RECOMMENDATION 14.1

*The Australian Aged Care Commission, when assessing and recommending scheduled care prices, should take into account the need to pay fair and competitive wages to nursing and other care staff delivering approved aged care services and the appropriate mix of skills and staffing levels for the delivery of those services.*

## **Working environment**

There are many rewarding features of aged care work which are often overlooked in discussions around recruitment and retention. Unlike some other health care settings, aged care offers employees the opportunity to develop longer term relationships with many of the people for whom they care. It can also offer greater flexibility, especially for workers who want a fixed roster as opposed to a rotating roster, or who want part-time employment. In addition, it can provide opportunities for nurses to use a wider range of their clinical skills and judgement in the delivery of quality care.

The government and the aged care sector could work together to promote these ‘positive’ characteristics so as to raise the profile of the sector to potential workers, particularly younger workers. For example, undergraduate nurse education could promote aged care positively as an industry within which to develop a career through advanced clinical placements in ‘teaching aged care facilities’ (see below) and the introduction of undergraduate electives that offer students an opportunity to undertake specific gerontological nursing education and training.

However, the reality also needs to reflect the rhetoric, particularly in regard to work environments, so that workers who are attracted to delivering aged care services have a desire to stay in the industry over the long term.

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Overall, direct care staff appear to be under increasing pressure to provide quality care. There is some evidence to indicate that workloads for aged care workers have increased. Between 2003 and 2007, the ratio of residents to full-time equivalent direct care staff increased from 1.85 to 1.99 (AIHW 2004b, 2008b; Martin and King 2008; Richardson and Martin 2004). This occurred during a period where the acuity of residents increased, as represented by the increasing proportion of high care residents.

At the same time as the acuity of residents increased, the proportion of personal care workers also increased and the proportion of registered nurses decreased.

The view that staff are under increasing pressure was shared in *Who Cares for Older Australians?* which reported that:

... many residential direct care workers feel that they do not have sufficient time or opportunity to engage in the caring tasks for which they were employed. (Martin and King 2008, p. 28)

Submissions and consultations indicate that the aged care working environment is characterised by heavy workloads resulting from strenuous physical activity, excessive regulatory reporting requirements and other administrative burdens (Manningham Centre, sub. 325; Queensland Nurses' Union, sub. 409). As a result, staff satisfaction is low and this may lead to high turnover which then contributes to an even more stressful working environment for staff at all levels.

Various proposals to improve the working environment of aged care workers and the quality of care they provide include introducing mandatory staffing ratios, the licensing of care workers and using information and assistive technologies to increase the time available for caring and to reduce the physical burden associated with caring activities.

### *Staffing ratios*

Staffing ratios can provide a transparent mechanism to link the funding of care services with the provision of sufficient staffing resources to promote the delivery of an appropriate quality of care as well as staff satisfaction in the workplace.

While participants to this inquiry unanimously agreed that there were critical levels of staffing required to provided quality care, they held differing views about whether mandatory staffing ratios were an appropriate mechanism to deliver the care required and to improve working conditions for staff.

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Unions representing nurses, and a number of nurses themselves, argued strongly for the introduction of mandatory staffing ratios to ensure the provision of appropriate standards of nursing care, particularly in residential settings. For example, the ANF considers that there should be:

... a guaranteed minimum of 4.5 hours of nursing care per resident per day... to be allocated equally across registered nurse, enrolled nurse and the nursing assistant [personal carer] workforce at an enterprise level. (sub. DR919, p. 1)

This staffing level is more than the average number of hours delivered to residents in 2007 as reported by Martin and King (2008).

Many other participants also supported the introduction of staffing ratios (box 14.3).

**Box 14.3 Participants' views supporting the introduction of staffing ratios**

Amanda London, an enrolled nurse working in aged care for three years:

... mandatory staffing levels are needed in the aged care sector to keep quality staff in the industry, and to ensure good standards of care in the future. (sub. DR500, p. 1)

Australian General Practice Network:

... insufficient staff ratios and staff shortages in RACFs frustrate health practitioner's efforts to provide quality care and discourage health professionals from providing services to RACFs. They also impact on the quality of care and overall wellbeing of residents. The introduction of measures that support appropriate staffing ratios in RACFs and promote sustainability, capacity and competency of the aged care workforce are critical first steps to address these barriers. (sub. 295, p. 14)

Aged Care Crisis Inc.:

Nurses and carers frequently report that they are not able to care for residents properly, given the conditions and time restraints imposed on them. It is clear that providers of aged care generally strive to operate with the fewest staff possible — at times placing vulnerable residents at risk. Most settings which care for vulnerable individuals, for example hospitals and child care centres, operate within a mandated staff/person ratio. It is intolerable that frail, older people do not have this protection. (sub. DR520, p.2)

Australian Nursing Federation (Victoria):

...legally mandated and fully funded nurses/PCW to resident ratios will provide an effective and transparent mechanism to realise adequate and stable staffing levels and provide the appropriate skill mix in residential aged care settings. Similarly, such a mandate has the potential to reduce the increasingly intolerable and unsafe workloads suffered by nurses and PCWs and in doing so resolve the most significant factor militating against the recruitment and retention of a sustainable aged care workforce and of quality of care – while at the same time improving the capacity of the aged care system to meet the complex care needs of residents. (sub. DR603, p.12)

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Aged and Community Services Australia (ACSA) held a contrary view:

ACSA sees aged care primarily as a social and independent life care model rather than a pure medical or clinical one. Within this clients are able to exercise choice about the nature of the care they receive. Therefore providers must have capacity to change the staffing mix depending on the needs and desires of clients. (sub. DR730, pp. 35-36)

While the Commission agrees that aged care is not purely about medical or clinical care, as discussed in chapter 6, health care is a component of aged care. And, as outlined in box 2.4, care subsidies paid using the Aged Care Funding Instrument (ACFI) are paid for three care domains, one of which is 'complex health care'. In practice, however, the delivery of care by personal care workers and nursing staff needs to accommodate the changing needs of the care recipients.

As discussed in chapter 10, there is some evidence to suggest that higher nursing hours translates into better care outcomes but the evidence for aged care is not as strong as it is for acute care. Indeed, a number of participants pointed to the lack of hard evidence in this area. United Voice (formerly the Liquor, Hospitality and Miscellaneous Union), for example, said:

... there is dearth of Australian research into staffing ratios currently applying in residential aged care facilities and minimum staffing levels that are necessary to achieve acceptable quality outcomes. (LHMU, sub. 335, p. 11-12)

And ACSA suggested that mandatory staffing ratios in Victoria's public aged care facilities do not demonstrate better care:

There is no evidence to suggest that set ratios provide or guarantee better quality care. The Victorian Public Sector residential facilities operate with ratio and they do not argue that their care is better than other providers. (sub. 730, p. 36)

The ANF (Victorian Branch), however, indicated that the mandatory staffing ratios in that state have improved working conditions:

They have proved the crucial ingredient to reducing intensification of work, and improving staff satisfaction, attraction, recruitment and retention of high quality nursing staff to public sector aged care services in Victoria. (sub. 603, p. 13)

The College of Nursing indicated that an agreed staff ratio adapted to the resident mix:

... is an important tool in ensuring quality care and staff satisfaction. (sub. DR554, p.2)

However, they also commented that:

It is also recognised that issues around staffing mix and levels will not be entirely addressed with a simple mathematical ratio of staff : resident being put in place. Addressing this issue may require a comprehensive review of 'care' requirements and associated models of care/staffing skill mix. (College of Nursing, sub. DR554, p.2)

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Further, imposing mandated staffing ratios could lessen incentives for providers to invest in innovative models of care. Innovations, such as through the application of technology and redesigning work practices, will be important in assisting the aged care sector to meet the expected increase in the demand for services.

In addition, some participants including the ANF and ACSA, observed that the introduction of staffing ratios in aged care where there is not currently the workforce capacity to meet the requirements imposed would present some difficulties.

On balance, the Commission considers that, at this stage, the imposition of a simple staff ratio is a relatively blunt instrument, particularly given that the care resident profile of every facility will be ever changing. Such ratios become particularly problematic for small facilities, and a rigid application of ratios could create operational difficulties for these facilities. Further, the existing quality accreditation process (supported by the complaints handling process) provides a mechanism for encouraging providers to apply an appropriate skills mix and staffing level in the delivery of community and residential aged care services (appendix F).

Beyond this, the Commission is proposing to strengthen the quality assurance framework by requiring that quality indicators be published to help care recipients and their families make informed choices about the quality of care and to enhance transparency and accountability around how funds are spent on care. The Commission is also suggesting that a facility publishes indicators staff qualifications and skills together with a profile of care recipients, as part of the proposed Quality and Outcomes Data Set (chapter 10).

That said, the Commission is also proposing that the AACC, an independent body, would undertake a public benchmarking study to determine the prices associated with entitlements to care services. This benchmarking study would need to take into account the appropriate staffing level and skills mix in the delivery of service entitlements to identify an efficient price for service delivery. The basis for determining prices would be transparent, which would impose a higher level of accountability on providers to allocate the appropriate skills mix and staff level to deliver quality care for a specific entitlement.

The Australian Government has engaged the ANF to undertake a ‘Researching Staffing and Skills Mix in Residential Aged Care Project’ (sub. DR919, p. 2). In effect, this project will address the earlier mentioned College of Nursing comment about the need for a comprehensive review of ‘care’ requirements. The outcomes of this research project should feed into the benchmarking study and a similar project should be undertaken for the delivery of community aged care services.



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### *Licensing of all direct care workers*

Licensing of all direct care workers was suggested as a mechanism to improve the quality of aged care services and lessen the supervisory burden on nursing staff. While there are national registration (licensing) requirements for enrolled and registered nurses which specify scopes of practice, a professional code of conduct and requirements for continuing professional development, there are no such requirements for personal care workers.

Participants put forward a variety of views regarding the need to apply a licensing regime to the personal care workforce (box 14.4).

One argument for a licensing regime is that because personal care workers provide health care services as part of delivering aged care, they should be licensed in the same way as other health care professionals — that is, through professional registration. However, aged care services are a combination of both personal care and health care and it is unclear how much health care, if any, is delivered by personal carers.

Given the similarities in roles, any licensing regime that was applied to care workers of the elderly would arguably also have to apply to care workers of other vulnerable groups, particularly child care workers and care workers providing services for people with a disability. As workers in these other sectors do not generally provide health care related services, it would not be appropriate to impose a health profession licensing framework on these workers.

Another argument advanced in favour of a licensing regime is that it would promote more uniform skill outcomes among personal care workers and, hence, improve the quality of care provided. Licensing through a mechanism similar to that for health professionals would produce workers who had defined scopes of practice, minimum qualifications and the requirement to undertake ongoing professional development. However, such a regime could exacerbate current workforce shortages, particularly in areas where there is already a tight labour market or where there are limited opportunities to undertake training and secure qualifications. As explained by ACSA:

If licensing was introduced then a large number of current workers would not comply and our experience is that many do not want to pursue formal qualifications. Licensing would make it even more difficult for providers in RRR [regional, rural and remote] and mining areas to fill positions. We would argue that professional development and role definition are the legitimate role of the employer in conjunction with the employee. (sub. DR730, p. 36)

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#### **Box 14.4 Comments on the need to licence personal care workers**

Several participants were in favour of the introduction of a licensing regime for personal care workers.

##### **Australian Nursing Federation (ANF):**

ANF argues that assistants in nursing, however titled, should be regulated ... The licensing of this group of care workers will afford them benchmark education and make them accountable to the public for their practice... (sub. 327, p. 11)

##### **Mercy Health:**

We recommend a move to registration of PCAs [personal care assistants] to establish a base skill set nationally and to enhance the professionalism of this segment of the workforce. Registration of PCAs would enhance the attractiveness of the role and provide increased assurance to families that their loved ones are cared for by registered professionals. (sub. DR781, pp. 3-4)

##### **J. M. Wynne:**

Registration creates a body that vets candidates and supervises the standard of training... It leads on the establishment of professional associations that develop codes of conduct. (sub. DR568, p. 27)

In contrast, a number of participants opposed the introduction of a licensing arrangement for these workers.

##### **Catholic Health Australia (CHA):**

CHA considers that licensing of itself will do little to address the workforce pressures faced by the sector. Closer attention to the matters such as remuneration and workforce supply... especially measures to upgrade the skills of the workforce, have the potential to make a far greater positive impact on workforce issues... (sub. 217, p. 17)

##### **Alkira Aged Care:**

The registration of all workers would most definitely have a negative impact upon the ability to attract staff. (sub. DR686, p. 8)

##### **Health and Community Services Union (HACSU) Tasmania:**

HACSU is opposed to the licensing of personal carers in aged care. This would result in significant additional administrative burdens on the aged care sector without any appreciable gain. (sub. DR799, p. 19)

##### **Royal College of Nursing, Australia (RCNA):**

RCNA believes that it is premature to be considering the licensing of unregistered personal care workers. (2011, p.1)

Many submissions arguing against a licensing regime considered that a more appropriate and effective approach to increasing the skill levels of personal carers was through greater investment in education and training. For example, United Voice (formerly the Liquor, Hospitality and Miscellaneous Union) indicated that it:

... recognises the concerns of stakeholders over the quality of care. However, we believe that investment in training and qualifications of aged care workers is a more

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nuanced, effective mechanism than simplistically requiring a licensing system. (sub. 335, p. 14)

In regards to concerns about the accountability of the actions of personal carers, Royal College of Nursing, Australia (RCNA) maintained that:

Currently, the legal responsibility for hiring appropriately skilled workers rests with employers, as it does in all other employment contracts. External registration adds a further dimension to this employment arrangement that is arguably unnecessary in the case of unlicensed care workers, as it imposes a level of accountability that extends beyond their employer. (sub. 352, p. 6)

The RCNA has outlined an alternative to licensing in its submission to the Australian Health Ministers Advisory Council on options for the regulation of unlicensed health practitioners, concluding:

Prior to any further consideration of registering personal care workers (however titled) RCNA believes it is critical to scope and develop a nationally endorsed practice framework for care workers (both qualified and not) that includes codes of ethics, codes of conduct and competency standards to assist and guide unlicensed care workers and the nurses to whom they report in the delivery of competent and safe care. (2011, p. 2)

The Australian Government allocated \$3.5 million over three years in the 2010-11 Budget to explore a national scopes of practice and competency framework for personal carers and assistants in nursing, including in aged care facilities (Australian Government 2010c). Like the RCNA, the Commission supports this initiative in preference to the implementation of a licensing system at this time.

Another alternative to a licensing regime would be the introduction of a ‘working with vulnerable persons’ requirement for aged care workers, as is required for those working with children. Such a requirement could strengthen the current criminal history checks required for personal carers working in aged care by also including a risk assessment. The introduction of a consistent and transferrable ‘working with vulnerable persons’ requirement for all people working with these groups may also improve worker mobility between sectors and jurisdictions, and be relatively efficient to administer. The Commission notes that legislation for a ‘working with vulnerable people’ checking system has been introduced into the ACT Legislative Assembly but has not yet been enacted (Birch 2011).

On balance, the Commission considers that a licensing regime for all carer workers is not appropriate and could introduce a level of inflexibility within the aged care system that could exacerbate labour shortages. Ensuring the delivery of quality care is more appropriately addressed through the accreditation process, training, professional development and other mechanisms. It should also be noted that

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providers have a responsibility and duty to provide quality care and it is therefore incumbent on them to ensure that their employees have the appropriate skills and experience.

### *Reducing regulatory burdens and embracing technology*

The excessive regulatory burdens associated with the accreditation process, acquittal mechanisms for funding, and mandatory reporting requirements for missing residents and assaults, were frequently identified as reducing work satisfaction and preventing greater productivity.

Submissions, such as Anglicare Sydney (sub. 272), generally indicate that the administrative and reporting burden was high, despite the introduction of the ACFI reducing it to some extent. Indeed, Manor Court Werribee Aged Care Ltd questioned the need for so much regulation:

Why do our staff need to spend 40% of their working time completing paperwork? It is under 20% in the hospital system. (sub. DR529, p. 2)

Both a reduction in unnecessary reporting (chapter 15) and the introduction of integrated information technology platforms for care administration could increase worker productivity. Simplified and streamlined information technology systems have the potential to reduce the amount of time spent by aged care staff in both reporting and coordination activities (for example, medication management and electronic reporting — box 14.5).

Electronic personal aged care records will assist in both reducing errors and avoid duplication in record keeping (chapter 9). The attachment of advanced care plans to these records will further enhance the continuity of care, especially where the care recipient moves between community, residential and acute care (hospital) settings.

In addition, the greater use of information technology to aid the process of providing care may increase the attractiveness of the sector to younger workers who are familiar with such technology and are looking to use it in their work.

The introduction of some assistive technologies (for example, in-room hoists and tracking devices — box 14.5) may reduce the physical burden on aged care workers and may also reduce time spent finding and transporting equipment to where it is needed. Such initiatives are likely to increase the amount of time that workers can spend with clients and improve occupational health and safety.

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### **Box 14.5 Role of technology in improving working environments**

Information and assistive technologies can improve the aged care work environment by reducing the physical and administrative burden on employees. As such, they can enable providers to support their workforce and better meet the needs of their clients.

In the area of information technology, a number of initiatives have been proposed to streamline reporting requirements and reduce the burden on care staff. Electronic medication management, care plans and quality reporting systems all have the potential to substantially reduce the paperwork burden and, to some degree stress, for staff, and improve care quality and continuity for older people receiving care.

In the area of assistive technology, there appears considerable potential to reduce the level of physical exertion and increase the time staff can spend with residents by introducing in-room lifting hoists. They can reduce workplace injuries (and compensation premiums) and resident injuries associated with lifting, repositioning and mobilising. In-room hoists also reduce the time staff spend looking for and moving other lifting devices, and can be used when the need arises.

Global positioning devices and other technologies that can assist in the location of necessary equipment may assist staff in more efficiently delivering the care required.

*Source:* Summit Care (2010).

## **Skills development and career paths**

Opportunities for skills development, career paths and increased scopes of practice are important aspects of aged care that can be improved to attract and retain high quality direct care staff and to develop management skills. However, as noted above, workers must have incentives to develop their skills and this is not reflected in current remuneration patterns.

Consultations with providers indicate that those who report low turnover and limited use of temporary staff place a high value on supporting professional development. However, some of these providers also report that they are financially constrained in their ability to develop capacity and to support professional development, particularly as this requires giving employees paid time off to undertake education and training activities.

This problem is exacerbated in rural and remote areas where it can be difficult (and/or expensive) to find substitute staff and there are substantial costs associated with sending an employee to another location for training. For many in the rural and remote workforce who have family and/or community responsibilities, travel to undertake training can be exceedingly difficult. As such, there is a clear need to increase the level of locally delivered training within regional settings in order to

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attract and retain local staff. This is particularly so for Indigenous staff who may not be willing to travel away from their communities for extended periods. Further, the lack of provision of housing both for staff and trainers in remote areas is a significant problem that requires attention. These issues are canvassed more extensively in chapter 11.

An issue raised consistently in submissions, consultations and hearings was the considerable variability in the education and training levels of personal carers and enrolled nurses, even between those with comparable qualifications (particularly at the certificate III or IV level) (box 14.6).

According to participants, one of the main contributors to this variability seems to be the marked differences in the delivery of courses by Registered Training Organisations (RTOs). For example, Aged Care Queensland (ACQ) submitted that:

... the current outcomes for delivering training are more heavily weighted on numbers rather than quality. ACQ members have reported concerns with fast track training programs, which deliver certificate III in less than a month. These programs undervalue the work of the sector, do not effectively link to the workplace, and are not conducive to quality training outcomes... (sub. 199, p.27)

Other participants were also critical of the poor quality of training provided by some RTOs, primarily in terms of the quality of trainers and assessors, course length and the extent and nature of practical experience included in training programs. Sophie Curtis, sharing her experiences, noted:

This course [Certificate III in Aged Care] can be delivered in as little as 3 months from a small office with no equipment or infrastructure and may include little or no practical placement...

I know of a RTO that employed a trainer that had qualified with Certificate III in Aged Care only 12 months before and whose industry experience was extremely basic... I have also been told of RTOs in Melbourne that offer this qualification in less than 2 weeks. (sub. DR693, p.2)

Although standards for the delivery of vocational education and training (VET) courses exist, it would appear that they are not being adequately monitored. As such, it would appear that the national standards for the registration and auditing of RTOs should be more rigorously enforced by VET regulators to ensure quality and consistency in course delivery and student outcomes.

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## **Box 14.6 Participants views on the quality of VET course delivery by RTOs**

Clare Dewan and Associates:

In relation to training I have observed the results of having little or no quality control processes in place for the Registered Training Organizations. While some produce excellent results, and some work closely with employers to obtain the results the employers want, there are too many who do not produce the results which are in either the interests of the employees or the industry... (sub. 119, p. 2)

Amaroo Care Services:

Frequently we receive applications from newly qualified personal carers who have been 'fast-tracked' through a 2 - 4 week Certificate III course who really have little idea of what they might be required to do on the job, having had insufficient course work and practical experience. The variance in quality of the training differs so much between RTOs and the industry requires greater consistency. Clearly a Certificate III and IV should equate to same standard. (sub. 98, p. 15)

Tablulam and Templer Homes for the Aged:

The current situation of a PCW being qualified as a Cert. 3 Aged Care Worker after 3 weeks of classroom and 2 weeks of workplace placement (without a qualified mentor/tutor) is totally indefensible and unfair to the PCW and the recipient of their attempts to care... The need for a minimum educational and industry standard is paramount if we are ever to get an overall, acceptable level of care for the frail elderly in Australia. (sub. DR535, p. 2)

VincentCare Victoria:

In part, the issues with PCWs relate to the inadequate quality control of the registered training organisations (RTOs) who deliver PCW courses. The implementation of such measures would ensure recipients of these courses receive adequate training to enable them to fulfil the necessary requirements of working in aged care. The length of the courses (both classroom contact time and practical placement hours) between RTOs is variable; ranging from an extremely short course of a couple of weeks with no clinical placement through to course over a period of months with participants completing 60 – 100 hours of practical aged care experience. (sub. 258, p. 19)

ANF (Victoria):

The most significant concern we have relates to the commitment of the employer to provide training, the quality of the training course on offer where it is offered, the mode of delivery and the standards and quality of the registered training organisation (RTO) providing the education. (sub. DR603, p.8)

ECH, Eldercare and Resthaven:

While the RTO sector is regulated there is great variation in the quality and competency levels of graduates. There is a national training framework with defined learning outcomes but the number of core competencies/units in each course varies significantly. The actual course time can vary from a couple of weeks to six months full-time, depending on credit transfers and recognition of prior learning. Much more consistency is needed through, perhaps, the introduction of a national curriculum and audits of RTO courses. (sub. 453, pp. 4-5)

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Some participants, such as Clare Dewan and Associates, called for a broad review of the training system:

There needs to be a review into what the training has degenerated to and what is required to ensure people undertaking training are actually required to train in practical aspects of aged care so when they get into the sector they have the skills required for medication administration, hands on care and empathy for the residents/clients. (sub. 119, pp. 3-4)

There has been significant investment in education and training for personal carers by the Australian Government aimed at increasing the qualifications and skill levels of these workers. While the intent of this policy is commendable, it would appear that some training organisations are not delivering the desired outcomes for students or the aged care industry.

The Australian Government has identified that there are systemic problems with the VET system as a whole and is undertaking a broad range of reforms in the sector to create a national system of quality assurance and regulation, including establishing the Australian Skills Quality Authority and strengthening the Australian Quality Training Framework (Evans 2010). However, as this process is in the early stages of implementation, the Commission considers that an independent and comprehensive review of aged care courses, such as a National Strategic Industry Audit, is warranted to identify why there is such large variability in course delivery and what improvements are necessary to ensure that students demonstrate pertinent competencies on a more consistent basis.

Widened scopes of practice for workers can play an important role in the quality and efficiency of care delivery and in worker satisfaction, and will become increasingly important as broader health workforce shortages become more acute. The Community Services and Health Industry Skills Council (CSHISC) has worked with industry, governments and training institutions to develop a range of courses which enable workers to develop the skills they require in the delivery of aged care services and to undertake courses that can widen their scopes of practice, including in allied health assistant streams.

These courses should be promoted within the aged care sector to allow workers to diversify their skills and take on new roles in the provision of aged care services. More generally, for those workers interested in taking on more responsibility and undertaking further study to develop their skills, a number of career paths should be available to keep them motivated to stay in the sector. However, for these initiatives to be taken up, skills development should be rewarded through a graduated wage progression structure at clearly defined levels of competence.



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The potential to increase scopes of practice is not limited to less skilled workers. In this area, the CSHISC is proposing to develop a range of advanced practice and leadership courses to promote further clinical skills development and enhance the management skills of workers in these roles. In relation to the development of clinical skills through ongoing professional development and nurse education, the RCNA considers that:

... work is needed to encourage the development of CNS [Clinical Nurse Specialist] and CNC [Clinical Nurse Consultant] roles so that their clinical seniority and expertise can contribute to quality care outcomes and the development of new clinically-effective models of care. (sub. 914, p. 1)

There is also significant potential for the expansion of nurse practitioners in aged care with the regulatory and funding impediments reduced by recent Government changes which facilitated access to Medical Benefits Scheme and Pharmaceutical Benefits Scheme subsidised care and medications. However, it is imperative that the pricing of care services allows aged care providers to consider implementing innovative models of care which involve nurse practitioners in care delivery.

Developing and implementing widened scopes of practice for health workers (including those working in aged care) is one of the tasks of the recently formed Health Workforce Australia, which was created following the Commission's report into *Australia's Health Workforce* (PC 2005a). The Commission notes that this project is in its early stages of development.

In Australia, there are currently only a limited number of specialist 'teaching aged care services' and student experiences of placements in mainstream aged care facilities are not always positive. Research suggests that student placements in facilities which offer a variety of tailored clinical experiences can have a significant effect on the attitudes of students towards older people and increase the attraction of the aged care sector as a graduate destination (Abbey et al. 2005; Robinson and See, sub. 231).

In addition to providing positive placement experiences, teaching aged care services can 'provide an infrastructure to support a robust and much needed program of research' (Robinson and See, sub. 231, p. 2) and support the development of management skills. These services also have the potential to provide opportunities for trainee doctors and allied health students to learn to work with older people in aged care settings. Such initiatives may increase the willingness of health professionals to provide services to older Australians.

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The Australian Government recently announced it will support the establishment of teaching residential aged care services over four years (Australian Government 2010c). The Commission supports the direction of this commitment but considers the non-ongoing nature and the relatively small level of funding to be inadequate to address current and future workforce shortages in the sector.

The expansion of graduate programs for registered nurses in aged care settings can provide a platform to develop specialised clinical and management skills in a collegiate mentoring environment. Some larger providers, such as BUPA Care (sub. DR794), recently initiated such programs as one approach to attracting more nurses into their operations.

Although these programs are only relatively new, submissions indicate that they have increased the recruitment of graduate nurses into the aged care sector and improved the variety of options available to registered nurses upon graduation. While larger aged care providers may have the economies of scale to develop such programs, it is unlikely that smaller providers will have the same capacity. To address projected workforce demand, there may be a role for the Australian Government to support the development of graduate nursing programs for organisations that do not have the capacity to take on graduates in a supernumerary capacity (that is, in addition to normal staff rostering through the induction process).

#### RECOMMENDATION 14.2

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

- ***vocational training for care workers entering the sector and looking to upgrade their skills***
- ***adequate tertiary nursing places to meet the anticipated demand from the health and aged care sectors***
- ***advanced clinical courses for nurses***
- ***management courses for health and care workers entering these roles.***

#### RECOMMENDATION 14.3

***The Australian Government, in conjunction with universities and providers, should fund the expansion of ‘teaching aged care services’ to promote the sector and provide appropriate training for medical, nursing and allied health students and professionals.***

*Given industry concerns about the variability in training outcomes for students, the Australian Government should undertake an independent and comprehensive review of aged care-related vocational education and training (VET) courses and their delivery by registered training organisations (RTOs). Among other things, the review should consider:*

- *examining current practices that may be leading to variability in student outcomes, including periods of training and practicum*
- *reviewing procedures to ensure that VET trainers and assessors possess required current practice knowledge*
- *identifying whether regulators are adequately resourced to monitor and audit RTOs using a risk-based regulatory approach and have appropriate enforcement regimes that allow for appropriate and proportional responses to non-compliance by RTOs*
- *identifying reforms to ensure students demonstrate pertinent competencies on a more consistent basis.*

## **International migration**

Skilled migration may also have a role in boosting the size and quality of the aged care workforce. A number of submissions argued for greater temporary or permanent migration of nurses and care workers (Alzheimer’s Australia NSW, sub. 455; Catholic Health Australia, sub. 217; DutchCare, sub. 129). For example, Catholic Health Australia stated:

Consideration also needs to be given to augmenting the local workforce by sourcing suitable staff from overseas, including staff who could receive further training in Australia. (sub. 217, p. 15)

An OECD Health Studies Report has commented that international migration of aged care workers may have a substantial and increasing role in meeting future workforce challenges (Colombo et al. 2011). It notes that some OECD countries have successfully increased their aged care workforces through targeted migration. However, language and cultural differences may adversely affect care quality due to communication barriers and lack of familiarity with equipment, medications or work practices.

There is some potential for Australia’s aged care industry to source workers from overseas to help to meet the expected growth in demand for aged care services. A discussion paper by Aged and Community Services Australia (2011) has outlined

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the recent experiences of their members in recruiting overseas workers (box 14.7). Some providers have found recruiting personal carers through mainstream skilled visa programs (such as the section 457 visa program) to be virtually impossible due to the restrictions placed on these programs (ACSA, sub. DR730).

**Box 14.7 Advantages and weakness of recruiting overseas workers**

The advantages of recruiting overseas workers include:

- decreased agency costs
- easier and cheaper than trying to constantly advertise
- improved overall retention, if workers are treated well.

The disadvantages of recruiting overseas workers include:

- upfront time, cost and effort
- long lead times
- no guarantees the visas will be issued
- workers moving to another employer
- financial and emotional costs of assimilation
- prejudice or fear on part of some residents
- higher level of initial and ongoing supervision, particularly where there are concerns about clinical competence.

*Source:* ACSA (2011b).

In evidence provided at hearings, some providers told of employing registered nurses from overseas to work as personal carers for up to 2 years. Registered nursing qualifications obtained overseas are not automatically recognised in Australia and these prospective registered nurses have to undergo further assessment before they are allowed to practice. As personal carers, these workers were said to generally provide a higher quality of care than the average carer.

In addition to the transferability of nursing qualifications, providers who indicated mixed experiences in attempts to use skilled workers through sponsored migration programs citing the issue of English-language proficiency as a constraint on sourcing aged care workers, especially higher skilled workers, from some countries.

Targeted programs to increase the aged care workforce could be particularly useful in the provision of appropriate care for older Australians from non-English speaking backgrounds if the language skills of migrant workers and clients from linguistically diverse backgrounds were aligned (chapter 11). However, these workers will also

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require competent English skills to communicate with management and other workers, and to complete care documentation. As such, they may require training either before they migrate or as part of their employment.

In locations where there is expected to be a medium to long term shortage of care workers, providers and government should work together to explore ways in which foreign workers with appropriate skills can supplement the local aged care workforce. On this issue, the Commission also notes the broader considerations surrounding the recruitment of competent health workers from less developed countries.

Overall, with the expected future demand for care workers due to the ageing of Australia's population and expectations for high quality care in a labour-intensive sector, the need for foreign workers to supplement the local labour force is likely to become more important. Putting in place measures to facilitate the transfer of skills (including language skills) by reducing the regulatory burdens and costs associated with employing care workers from overseas is likely to pay significant dividends in the future.

### **A strategic direction for aged care workforce policy**

A number of participants have indicated during this inquiry that there is need to develop a strategic approach to addressing workforce issues. For example, ACSA considers that:

... our industry requires a more sophisticated workforce planning approach at a strategic and operational level because at present we do not know how many workers we will need in given areas, what qualifications they will require and where they are going to come from... Regional and local understanding of workforce needs is critical. Providers need assistance to understand about competitors in the market from within the industry and from outside; the qualifications that will be in greatest shortage; and local labour shortage numbers. (sub. DR730, p. 34)

Similarly, Dr King, co-author of the *Who Cares for Older Australians? A Picture of the Residential and Community Based Aged Care Workforce, 2007* (Martin and King 2008), believes that:

What is required is a comprehensive analysis of the impact of the changes to the model of care for the workforce. Without such an analysis, the aged care workforce will lack planning and adequate development... (sub. DR530, p. 2)

Indeed, the Australian Government has previously recognised workforce issues as a key part of the *National Strategy for an Ageing Australia* (Andrews 2001) which resulted in the release of a National Aged Care Workforce Strategy covering

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residential aged care in 2005 (box 14.8). This strategy identified many important workforce issues (such as education, training and development) which have also been raised in this chapter. However, it did not highlight the key issue of remuneration and the role of the Australian Government as price setter and main funder of the aged care sector.

#### **Box 14.8 National Aged Care Workforce Strategy**

The National Aged Care Workforce Strategy was developed to identify the profile of the residential aged care sector and its needs between 2005 and 2010.

The strategy aimed to provide a people management and development framework for a sustainable and viable aged care sector. This framework outlined seven objective areas to increase the attractiveness and sustainability of the aged care sector:

- workforce profile — the sector contributes to, and has access to, reliable data for effective, collaborative planning and management of the workforce
- workplace practice models — these models address current and future needs
- leadership and management — can develop competent, effective and innovative teams
- education, training and development — underpin the sector
- a responsive workforce — the sector has the staffing numbers and skills to develop and maintain a positive workforce which responds to changing client profiles and can focus on resident outcomes
- status and image — the professional and community status and image of the sector makes it a desirable place to work
- effective linkages — the National Aged Care Workforce Strategy is linked to other relevant strategies, policies and plans.

*Source:* DoHA (2005).

While significant financial resources have been devoted to executing the National Aged Care Workforce Strategy, it is unclear how much progress has been made in achieving the strategy's stated objectives in the five year timeframe it was intended to cover. In commenting on the strategy, ACSA stated that:

While it is a useful document it is out of date and only addresses direct residential aged care staff. It fails to plan for community care, allied health and ancillary workers. This document should be updated and made more inclusive of all health care professionals that work in the industry as a matter of urgency. It would capture the myriad strategies that are required to address this multifaceted problem in a practical way within a broad environmental analysis. (sub. DR730, p. 35)

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The Commission considers that the activities and outcomes of the National Aged Care Workforce Strategy should be fully evaluated and publicly released.

In the Commission's view, there would be value in key stakeholders (such as governments, peak industry bodies, Skills Australia and CSHISC) monitoring the extent to which existing workforce initiatives are effective or require modification and/or new initiatives to progress workforce development and sustainability. Skills Australia should have a role in workforce planning for the aged care sector, particularly in relation to the VET system. In addition, Health Workforce Australia should investigate all components of the aged care workforce together by including carers and the community care workforce in a single analysis. It should also report back to government regularly to help identify challenges that need to be addressed. The five year review proposed as part of the Commission's implementation plan could be used to examine, among other things, the workforce sustainability issue.





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## 15 Regulation — the future direction

### Key points

- The aged care system needs to be regulated to manage risks to the wellbeing of older Australians and the fiscal risk to taxpayers. However, the current regulatory framework is unsatisfactory and there is scope to improve its efficiency and effectiveness while ensuring an acceptable approved standard of care.
- A variety of regulatory problems have been identified throughout previous chapters and problematic governance arrangements inhibit best practice regulation. There has also been an overly adversarial approach to enforcing regulation, reducing the resources available to monitor those providers that deserve greater scrutiny.
- Duplicate and overlapping regulation of quality leads to higher costs while jurisdictional variations increase complexity for both providers and consumers.
- The future focus of regulatory reform should be on:
  - concentrating the Department of Health and Ageing’s responsibilities for aged care primarily on policy advice and development, funding independent advocacy and community visitors, and funding special programs and grants
  - consolidating regulatory functions in an independent regulatory commission — the Australian Aged Care Commission (AACC). Its functions would include administering regulations covering the quality of residential and community care, the supported resident ratio obligation and prudential regulation. The AACC would also promote the quality of care through educating providers and assisting them with compliance and continuous improvement and, where necessary, enforce the regulations. It would also handle individual complaints and undertake systemic reviews. Individuals and providers, who do not agree with the decisions of the AACC, would also be able to request an independent review of the decision. Arm’s length appeals to decisions of the AACC (and the Australian Seniors Gateway Agency) would be heard by the Administrative Appeals Tribunal. The AACC would also monitor, report and transparently advise the Australian Government on prices and costs in aged care
  - widening the range of available enforcement tools, adopting a risk-based approach to handling complaints and enforcement, streamlining reporting and embracing technology in receiving and transmitting information between government and providers
  - reducing the burden of aged care regulation
  - continuing to simplify jurisdictional responsibilities and harmonise regulation.

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Currently, aged care services are primarily funded and extensively regulated by the Australian Government. These regulations cover price, quantity and quality. However, all levels of government are involved to some extent, with some state and local governments also directly providing aged care services.

This chapter outlines a framework for regulation that puts into practice the policy and funding reforms outlined earlier in this report and the features of best practice regulation.

To establish what regulatory changes are needed it is useful to: understand why regulation is needed (chapter 4); have in mind some ‘best practice’ yardsticks against which to assess the current regulatory arrangements; and understand the current regulations. Further elaboration on these is provided in appendix F.

Section 15.1 provides a brief summary of the current regulatory arrangements. The proposed regulatory reforms are outlined in the following four sections. These include:

- improving Australian Government governance arrangements (section 15.2)
- implementing ‘responsive regulation’ with appropriate standards and streamlined reporting (section 15.3)
- reducing both the extent and burden of regulation (section 15.4)
- clarifying and simplifying jurisdictional responsibilities and harmonising regulation (section 15.5)

Chapter 17 sets out the transition path to implementing the Commission’s proposed reforms for aged care, including regulation.

## 15.1 What are the current regulations?

### Australian Government

As noted earlier in chapter 2 and touched on in chapter 10, two Government acts, the *Aged Care Act 1997* (the Act) and the *Home and Community Care (HACC) Act 1985* (the HACC Act) govern aged care. (Further details are set out in appendix F.)

The key points are:

- *residential aged care* is primarily regulated under the Act and the associated 22 Aged Care Principles as well as Determinations
  - quality standards are assessed on the basis of four Accreditation Standards (together with 44 indicators and expected outcomes) which are set out in the

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- Quality of Care Principles 1997 under the Act. In addition, there are also three Residential Care Standards (together with 35 indicators and expected outcomes) and three Specified Care and Services for Residential Care Services (together with 33 indicators and expected outcomes) set out in the Quality of Care Principles, with the latter to be provided in a way that meets the Accreditation and Residential Care standards (as the case requires)
- the Act contains prudential regulations and providers who accept bonds or entry contributions are subject to these regulations, including the Liquidity, Records and Disclosure Standards within the User Rights Principles 1997. These prudential requirements are supplemented by others in the *Aged Care (Bond Security) Act 2006*.
  - *packaged community care* (Community Aged Care Package (CACP), Extended Aged Care at Home (EACH), Extended Aged Care at Home Dementia (EACH-D)), Multi-Purpose Services (MPS), innovative care and transition care are regulated under the Act
    - From 1 March 2011, three Community Care Common Standards (together with 18 outcomes) apply to packaged community care as well as the National Respite for Carers Program (NRCP) and Flexible Care (appendix F).
  - *basic community care* (HACC) is regulated under both the Act and the HACC Act
    - From 1 March 2011, three Community Care Common Standards (together with 18 outcomes) apply to basic community care (appendix F).
  - a division within the Department of Health and Ageing (DoHA) — the Office of Aged Care Quality and Compliance (OACQC) — is responsible for aged care regulation policy advice. In addition it has overarching responsibility for accreditation, compliance and enforcement of a range of aged care regulations (the Act, the HACC Act and the Community Care Common Standards (DoHA 2010d))
    - generally speaking OACQC makes all enforcement decisions but whether or not it also accredits or checks compliance depends on the type of aged care
      - ... for residential aged care, day-to-day administration of accreditation and compliance checking is undertaken by the Aged Care Standards and Accreditation Agency (ACSAA). DoHA monitors compliance of approved providers with all their other responsibilities under the Act
      - ... for packaged community aged care and the NRCP, the monitoring of compliance with quality of care is undertaken by OACQC through the process of Quality Reporting

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- ... for basic community aged care (HACC), day-to-day responsibility for administering all aspects of the regulation (including enforcement sanctions) is delegated to the states and territories
  - the OACQC also has overarching responsibility for complaints handling in relation to all community and residential aged care services funded under the Act. This is administered on a day-to-day basis through the Complaints Investigation Scheme (CIS).
  - the Office of the Aged Care Commissioner (OACC) provides a review mechanism for all community and residential aged care services funded under the Act
  - the Administrative Appeals Tribunal (AAT) is the main avenue for appeals to administrative decisions.

Figure 15.1 provides an overview of the current organisational and governance structures for Australian Government regulation of aged care: DoHA advises on regulation policy, monitoring compliance with quality standards for packaged community care and the NRCP and making enforcement decisions associated with quality standards for packaged community care, the NRCP and residential aged care; complaints handling is undertaken by the CIS within DoHA; accreditation and assessing compliance of residential aged care with quality standards is undertaken by the ACSAA; and the OACC is an independent review mechanism.

## **State, territory and local government**

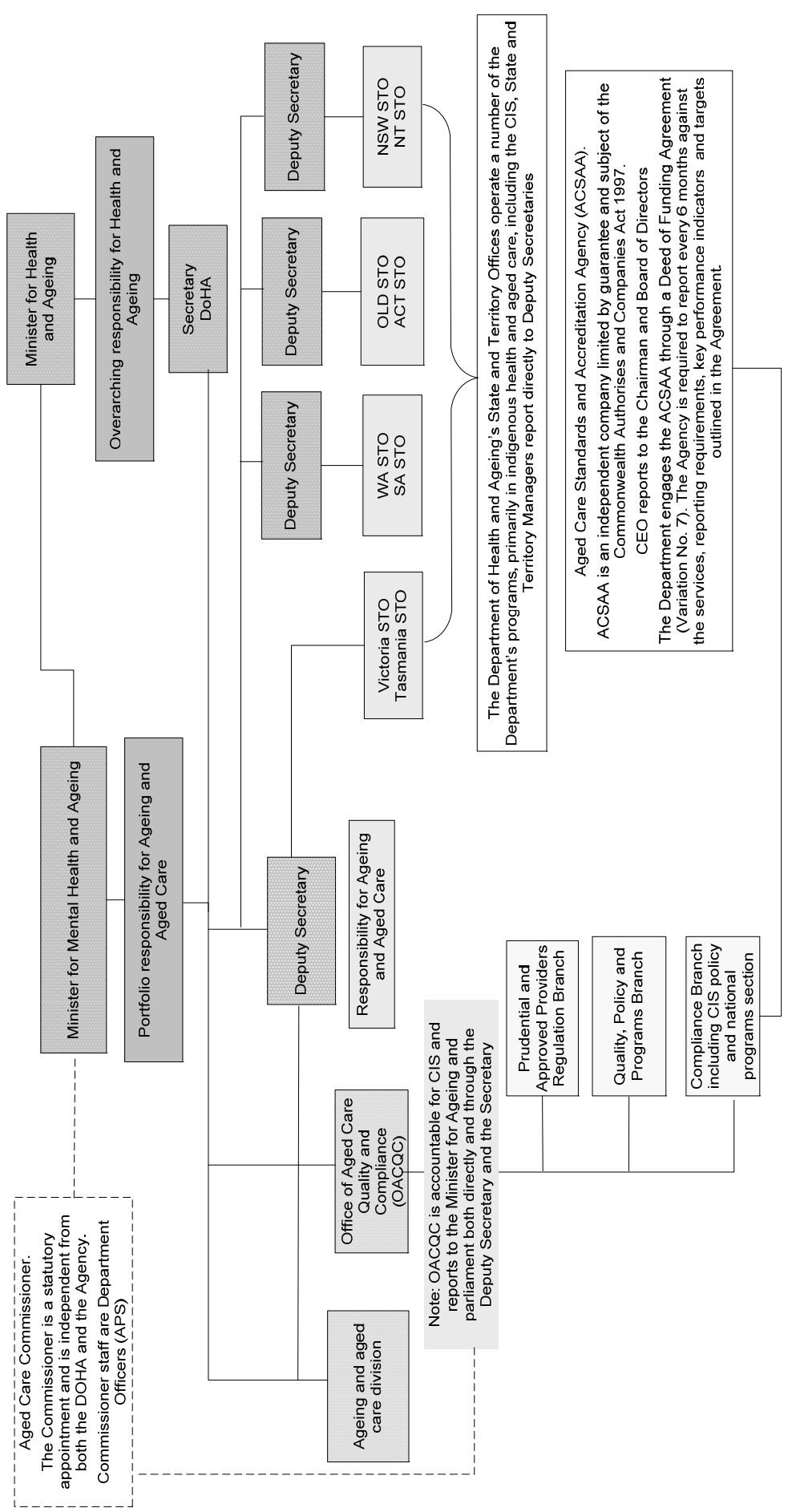
Currently, states and territories have regulatory responsibility for basic community care funded through the HACC program. In addition, state, territory and local government regulation in a range of other areas also affects the provision of aged care, for example building codes, fire standards, food safety, occupational health and safety, planning approvals, and health services (chapter 2).

## **Regulatory arrangements from 2012**

In April 2010 as part of the National Health and Hospitals Network (NHHR) reforms (chapter 2; COAG 2010a) it was announced that from 1 July 2012 the Australian Government will be responsible for regulating:

- packaged community (CACP, EACH and EACH-D) and residential aged care delivered under Government aged care programs, as currently
- basic community care services (HACC) for people aged over 65.

**Figure 15.1 Current Australian Government governance structure for aged care regulation<sup>a</sup>**



<sup>a</sup> This diagram is a modified version of the diagram on p. 26 of the Walton Review.  
Source: Walton Review (2009).

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However, because Victoria and Western Australia are not party to these reforms, these jurisdictions will remain responsible for the day-to-day regulation of all HACC services, irrespective of the age of the recipient. The Commission recommends that all jurisdictions agree to the national aged care arrangements (recommendation 15.6).

A variety of regulatory problems have been identified and documented in the preceding chapters. Having regard to these problems, the features of best practice regulation — including establishing good governance arrangements, choosing appropriate standards, implementing a ‘responsive’ regulatory model which encourages and enforces compliance, and developing streamlined reporting arrangements (appendix F) — and the reforms proposed in this inquiry, the following sections outline the proposed future direction of Australian aged care regulation.

## **15.2 Improving Australian Government governance arrangements for aged care**

One of the key lessons emerging from the broad sweep of regulatory experience is to separate regulatory responsibility from policy responsibility in governance arrangements. Good practice governance arrangements also involve ‘arm’s length’ separation of appeals about the actions of the regulator from the regulatory body itself. Comparing the current Australian Governance arrangements in aged care (which do not clearly separate policy, regulation and appeals) with contemporary governance practice suggests there is a significant opportunity to reform these arrangements to achieve a more effective structure.

The Council of the Ageing (COTA) Australia agreed with the need for reform:

The relationship and divisions of responsibility between [DoHA] on the one hand and the [ACSAA], the Aged Care Complaints Investigation Scheme and the National Aged Care Advocacy Program on the other, need to be redesigned to clarify boundaries, strengthen roles and ensure greater independence of quality agencies from the funder and the regulator. COTA believes that all compliance, complaints and advocacy programs should be and be seen to be independent of the funder, i.e. the federal department. (sub. 337, p. 39)

Aged Care Crisis (ACC) expressed concern about the conflict of interest inherent within the system of aged care:

ACC has analysed the interdependencies of the CIS, [ACSAA] and the [OACC] and DoHA. Although all three bodies have distinct roles, final decision regarding regulation and compliance ultimately rest with DoHA. (sub. 433, p. 1)

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ACC was also concerned that:

- approved residential aged care providers are able to overturn independent Aged Care Assessment Team (ACAT) assessments of a person as high care to one of low care, with implicit acquiescence from DoHA
- the OACC can only review (and not overturn) decisions made by CIS and in some instances DoHA has ignored the concerns of the OACC. Accordingly, ACC says that the OACC's 'power and authority is illusory' (sub. 433, p. 10).

A recent Australian National Audit Office (ANAO) audit also noted that the involvement of DoHA (as the regulator) in assisting some providers to negotiate ownership transfer from a troubled provider to an alternative provider while also possibly having to institute future compliance action against the alternative provider 'poses some risk to the perceived objectivity and impartiality of the regulator' (ANAO 2009, p. 20).

Previous reviews and submissions to this inquiry have canvassed these types of governance issues (for example, the Walton Review (2009)). Submissions have mainly focussed on accreditation arrangements (including the overlapping responsibilities between ACSAA and DoHA) and complaints handling. For example:

[DoHA] is responsible for managing the funding provided by government for the system. It has a responsibility to manage those funds in a prudent manner. It also has responsibility for maintaining and ensuring quality care is provided within the system, a position not necessarily compatible with its funds management role. In addition, it controls entry to the system through its assessment processes and as well as being the regulator of the system, investigates complaints about the system, and penalises providers for infringements of the system. These roles are not all compatible and create conflicts of interest within the department, ignore the principles of natural justice, and fail to adequately serve the interests of any of the stakeholders within the system. While the Department will point to the existence of the Aged Care Standards Agency and the Complaints Investigation Service as agencies which address some of these conflicting priorities, neither is truly independent, nor operates at a truly arms length fashion. (Baptistcare, sub. 426, p. 5)

These governance issues should be addressed by establishing a national independent regulatory regime which brings together a number of functions currently undertaken by multiple jurisdictions, agencies and departments. As detailed below, the Commission is proposing the establishment of the Australian Aged Care Commission (AACC).

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## Regulating the quality of residential aged care

The main purpose for regulating the quality of residential care is to manage the risks to the care of residents as well as to assure the public that providers of these services are fit for purpose (chapters 4, 10 and appendix F).

Historically and internationally, the regulation of quality in a number of service industries typically occurs through government-based investigations into compliance and the imposition and enforcement of sanctions when there is non-compliance.

Accreditation schemes are often a voluntary and industry-led element of the process of quality assurance rather than being mandated as part of a system of regulation.

Accreditation is an internationally recognised evaluation process that is used in many countries to assess the quality of care and services ... (ACSAA, sub. 354, p. 2)

Somewhat uniquely, only in two countries — Australia and New Zealand — is there an explicit incorporation of accreditation into the process of regulating the quality of residential aged care (Australian Government 2007c).

Although ACSAA does not regard itself as a regulatory body (it regards DoHA as the regulator (subs. 354 and DR763)), it does have some regulatory responsibilities — accrediting residential aged care facilities and assessing the performance of these facilities against the four Accreditation Standards and the 44 associated indicators and expected outcomes.

In this context, Aged Care Crisis (ACC) (sub. DR520) drew attention to one of the conclusions from a 2007 evaluation of the impact of accreditation:

Accreditation is a key component of a robust regulatory framework. (Australian Government 2007c, p. xii)

While ACSAA has no enforcement powers, if a provider remained non-compliant with accreditation standards at the end of its timetable for improvement, until recently, ACSAA was able to recommend to the Secretary of DoHA that sanctions be imposed. However, following recent changes to the Accreditation Principles (see below), ACSAA is required only to advise the Secretary of DoHA in writing about the evidence (DoHA, pers. comm., 6 June 2011).

In addition, ACSAA has the capacity to vary or revoke a facility's period of accreditation. Since all residential aged care homes must be accredited (by ACSAA) in order to receive funding from the Australian Government through residential care subsidies, the Commission regards ACSAA's capacity to vary or revoke accreditation as a quasi-enforcement power.



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ACSAA (sub. DR763, p.5) emphasised that while its legislative responsibilities are multiple, its key responsibility centres on supporting and encouraging quality improvement through a strongly collaborative approach with stakeholders. It argues that this activity does not align with an inspectorial approach. The Commission's view, however, is that under a 'responsive regulation' model, these two roles can work in harmony (appendix F).

In March 2008, DoHA initiated a review of the accreditation processes and standards. Submissions to the DoHA review closed on 17 July 2009. The review received 147 submissions from a range of stakeholders. Subsequently, DoHA split this review into two separate reviews: one on accreditation standards, the other on accreditation processes. It also chose not to publish submissions to these reviews.

Nonetheless, a number of submissions to this inquiry attached a copy of their submission to these reviews and others made their submissions available on their websites. Many of the issues canvassed in these submissions apply to considerations of the over-arching regulatory framework and associated governance issues. Issues raised in those submissions are summarised in box 15.1.

Arising from the review of accreditation processes, on 20 May 2011 the Australian Government (2011b) issued the Accreditation Grant Principles 2011 (superseding the previous Accreditation Grant Principles 1999). According to the statement, the amendments to the 1999 Principles:

- remove or amend outdated provisions;
- streamline the accreditation process;
- make the Principles more logical, consistent and better able to be understood;
- enhance consumer engagement; and
- provide greater clarity and consistency of administrative processes. (Australian Government 2011b, p. 1).

Although, at the time of writing, DoHA's review of Accreditation Standards was not completed, it was in its final stages. DoHA's website indicated that following the closure date (13 May 2011) for comments on the *Draft Revised Standards for Residential Aged Care* (DoHA 2011b), it will:

... work closely with [its] Technical Reference Group to further refine the draft Standards. A further draft will be made available to [DoHA's] Ageing Consultative Committee for comment. It is anticipated that once this work is completed, a pilot of the Standards will be undertaken. The pilot will be developed and conducted in collaboration with the [AACSA]. (DoHA 2011c)

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### Box 15.1 **Reforms sought in submissions to DoHA's review of the accreditation processes and standards**

- a simpler, more consumer-oriented and outcomes-focussed regulatory framework (National Seniors Australia (NSA) 2009; UCA NSW, sub. 369; J.M. Wynne, sub. 368)
- greater independence in accreditation, derived from improved governance arrangements (COTA sub. 337, Attachment 6; Victorian Health Services Commissioner, sub. 349)
- increased engagement with consumers (NSA 2009; COTA, sub. 337 Attachment 6; Commonwealth Ombudsman, sub. 290)
- enhanced gathering of statistical information — focussed on measuring resident outcomes — from an appropriately sized sample of residents (UCA NSW, sub. 369 Attachment D), preferably augmented with social engagement measures to enable a better insight into quality of life (NSA 2009)
- more open, transparent and comprehensive information to consumers, including performance information and best practice information, to drive quality and inform consumer choice (NSA 2009; UCA NSW, sub. 369; ACC, sub. 433; OPRG, sub. 25). Such measures could be centred around a set of national outcome measures accessed on a My Aged Care website (UCA NSW, sub. 369) similar to the United Kingdom's (UK) Care Quality Commission (School of Management UTS, sub. 8). The ACA (sub. 433) has drawn attention to the use of privacy concerns as a barrier to transparency or accountability
- an appropriate mix of skills in accreditation assessment teams (NSA 2009; UCA NSW, sub. 369; ACA, sub. 433; Maree Bernoth, sub. 253) together with a focus on training as assessor skills are critical to the identification of deficiencies and consistency of findings (UCA NSW, sub. 369, Attachment D)
- reducing the ability of providers to nominate assessors (NSA 2009; ACC, sub. 433)
- a simpler self-assessment process for providers (UCA NSW, sub. 369, Attachment D) backed by a rolling program of accreditation audits (NSA 2009) with a preference towards targeting residential care homes considered at risk for more regular review audits (UCA NSW, sub. 369, Attachment D)
- a greater emphasis on unannounced visits (including in non-business hours) to create incentives for continuous improvement in the quality of care together with accreditation periods no longer than three years (NSA 2009; ACC, sub. 433; Combined Pensioners and Superannuants Association of NSW (CSPA), sub. DR760). In this context, the ACC (sub. 433) noted Victoria's Community Visitor Program through which trained, volunteer members of the community make regular unannounced visits to residential care which are documented in annual reports
- greater competition in accreditation arrangements (COTA, sub. 337, Attachment 6).

*Sources:* NSA (2009); inquiry submissions.

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DoHA have advised it will seek to provide revised draft standards to the Ageing Consultative Committee and to place an updated version of the draft standards on DoHA's website (DoHA, pers. comm., 6 June 2011). When that review is finalised, DoHA will advise the Australian Government on any proposed amendments to the Accreditation Standards contained in the Quality of Care Principles 1999.

### *Competition in accreditation arrangements*

Competition in accreditation arrangements occurs in many industries (notably the health sector) and was an approach previously recommended in the Banks Review (2006). However, there are divergent views on this matter. The Australian Government (2006a) and Senate Community Affairs References Committee (SCARC) (2005) argued for one accreditation agency, to ensure consistency in assessment and to prevent providers from forum shopping for a 'soft' auditor. But, COTA (sub. 337) argued for greater competition in the accreditation market as a way of facilitating the separation of ACSAA's accreditation and education function from its 'policing' role. While the Productivity Commission acknowledged these different views in its review of regulatory burdens, it recommended the introduction of competition into accreditation arrangements (PC 2009a). The Australian Government in its response to that report (Australian Government 2009a) maintained its earlier view (Australian Government 2006a) and did not accept the Commission's recommendation.

ACSAA (sub. 354) noted that in many other countries, an accreditation agency for long term care which is related to, but at arm's length from, government is not unusual. ACSAA also drew attention to the risks associated with introducing multiple Designated Auditing Agencies which were outlined in the Auditor General of New Zealand's (2009) review of arrangements for checking standards in residential care homes. ACSAA paraphrased the risks in the following terms:

- conflict of interest that could compromise the integrity of audits. The risk that homes might select the cheapest or most lenient audit organisation
- commercial pressures might compromise the auditor's independence
- multiple auditing organisations might interpret the standards differently
- auditors might have inadequate skills and expertise. (sub. 354, p. 10)

While the Commission has generally received support in relation to the proposed regulatory arrangements, feedback from some submissions have called for the Commission to reconsider its draft report recommendation to not introduce competition into accreditation arrangements and merge it into the new independent regulator.

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Some submissions (for example, ACSAA (sub. DR763) and ACSA (sub. DR730)) pointed to the competitive market for accreditation of disability and health care in Australia as an appropriate model for aged care accreditation arrangements. There are currently 13 health accreditation agencies; each with different historical forces underlying their development. At the time of writing, a new model of health care accreditation is the subject of public consultation via a Regulation Impact Statement. The proposed new model (to be agreed by the Council of Australian Governments (COAG)) involves changes to governance arrangements (in particular, the separation of the organisation setting the standards from the organisations doing the accrediting) and the development of nationally consistent standards for high risk health services, with all relevant agencies agreeing to assess against these standards where relevant.

By contrast, the historical development of aged care quality and safety standards is markedly different. Aged care Quality Standards have been set by the Act and a government-owned monopoly (ACSAA) established under the Act to monitor compliance with these standards and to assist providers to continuously improve quality. Given this history, opening up aged care quality accreditation is problematic (but not impossible).

The United Kingdom (UK) has recently established an independent regulator covering a broad range of health and care services. The UK's Care Quality Commission (CQC) draws information, including — but not exclusively — from (voluntary and competitive industry-based) accreditation systems when making its decisions about whether or not to register a provider. The provider registration process (managed and determined by the CQC) appears very similar to the Australian accreditation process for aged care which, in turn, links into the determination of the approved provider status.

The Commission argues that one of ACSAA's primary activities (accreditation and monitoring provider compliance with the Accreditation Standards) is a key element of provider approval (registration) and an integral part of the 'fit for purpose' assurance process

ACSAA (sub. DR763) argued that another of its activities (promoting and assisting achievement above the minima) should not sit within a regulatory commission. However, the Commission contends that a regulator is able to undertake this type of activity through implementing a 'responsive regulation' model. For example, (voluntary) arrangements for rewarding excellence in care homes in the UK are currently being developed by the CQC in association with all their stakeholders and the expertise of the Social Care Institute for Excellence (CQC 2011c)).

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A final consideration is whether the net benefits of establishing a competitive market for accreditation would outweigh the net benefit from bringing accreditation arrangements into a regulatory body. As ACSAA said, it is likely that a competitive accreditation model, which would require the centralised auditing of multiple accreditation agencies, would not only add to costs but also bring with it some risks (including conflict of interest). Also, the benefit of feedback loops for lessons learned to a central repository could suffer if there were multiple accreditation agencies.

Having reconsidered the arguments for and against competitive accreditation arrangements, the Commission maintains the view that aged care accreditation should not be subject to competitive arrangements but should be included within the functions of the proposed independent regulator (recommendation 15.1).

### *Consumer engagement*

ACSAA (sub. 354), while acknowledging the importance of consumer engagement in the accreditation process, also recognised that it was limited in the former process. ACSAA said that it had recently commenced dialogue with consumer groups to discuss how gathering information on resident experiences could form an ongoing part of assessment as well as to consider the concept of incorporating consumers as members of assessment teams. Recent changes to the Accreditation Grant Principles have also enhanced consumer engagement (DoHA 2011k).

Considerable research on the capacity of aged care residents to provide feedback on quality can inform this process (Braithwaite 2001; Braithwaite et al. 2007; chapter 10). National Seniors Australia (NSA 2009) also pointed to the example of the Netherlands and its approach to consumer engagement for both accrediting and assessing standards in residential and community care. The UK's CQC also actively seeks consumer views in assessing the quality of care in both residential aged care and community aged care (CQC 2011a and b).

As discussed in chapter 10, the independent regulator (the AACC) should actively engage consumers in assessing the quality of care. The Commission is also recommending the establishment of a stakeholder advisory committee to provide advice to the AACC in relation to consumer and industry interests (recommendation 15.1).

### *Investigations into non-compliance*

Under the Act, both DoHA and the ACSAA have responsibilities for monitoring compliance of residential aged care facilities. While ACSAA is focussed on

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assessing providers' compliance with Accreditation Standards under the Act's Accreditation Principles, DoHA's role is wider, covering providers' responsibilities in matters such as certification, fees and charges, and specified care and services.

As noted previously by the Commission, this can be confusing for providers:

While [ACSAA] and [DOHA] have a protocol regarding actions each organisation takes when non-compliance is identified or suspected, the protocol allows both organisations to make independent decisions — which increases the potential risk of duplication. (PC 2009a, p. 65)

The ANAO also said:

DoHA is a regulator and [ACSAA] assesses compliance against the Accreditation Standards. While their roles are separate but complementary, confusion can arise in the minds of stakeholders in some circumstances, such as when the two organisations are working within the same home simultaneously. (2011, p. 24)

For example, alongside audit reports which are not helpful to providers because they are 'generally bland and inappropriately similar', UnitingCare Ageing NSW & ACT (UCA NSW) noted that:

The current practice of publishing both the audit report of the assessment team and the [ACSAA]'s decision is confusing when the [ACSAA]'s decision differs from that of the assessment team's recommendations. (sub. 369, Attachment D, p. 52)

While ACSAA (sub. DR763) notes there are good reasons for the transparency and apparent similarity of its reports, it does recognise the demand for more information to be contained in its reports and is considering how to develop a 'consumer friendly' report.

To add to this confusion for providers regarding monitoring of compliance, the CIS can refer accreditation issues to ACSAA that have arisen from complaints to DoHA.

To address this potential confusion, the Productivity Commission (2009a) recommended the respective agencies clarify their roles (regarding the monitoring of provider compliance with accreditation standards) and communicate the agreed protocol (explaining actions each organisation takes when non-compliance is identified or suspected). The Australian Government's (2009a) response accepted the recommendation and agreed to undertake further consultation with the Ageing Consultative Committee on the issue. DoHA (pers. comm., 6 June 2011) advised the following steps have been taken to address this matter:

- the Aged Care Complaints Scheme (the Scheme) is developing a fact sheet outlining the roles, responsibilities and actions that are taken by ACSAA and the Scheme as well as the role of the OACC in relation to the processes and decisions of the scheme and the conduct of ACSAA

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- the Scheme has been educating aged care stakeholders, through presentations and discussions, about its role and the role of ACSAA
  - DoHA is seeking to better articulate the roles and responsibilities of DoHA and ACSAA by revising the *Communications and Referral Protocol*.

Notwithstanding attempts to address this issue, on balance the Commission considers that it is better to limit potential confusion and increase the efficiency of regulation through establishing a single entity responsible for investigations of non-compliance.

### *Summing up ...*

Bearing in mind that one of the primary functions of ACSAA is a regulatory one — that is, the assessment of the residential care facilities that it has accredited — and the confusion which currently arises from the perceived doubling up of investigations into non-compliance, further changes to governance arrangements surrounding regulation are warranted. In particular, while acknowledging its achievements (Australian Government 2007c) and the respect that ACSAA has gained from many providers in the industry:

... [when] seen against the backdrop of the need at the time of its introduction, for urgent and effective action to raise standards ... we believe the system has serviced consumers and providers well. (UCA NSW, sub. 369, p. 34)

it is also apparent that the current structure it currently operates within is problematic for a number of reasons.

First, under the Australian Government's policy, *Governance Arrangements for Australian Government Bodies* (Department of Finance and Administration 2005), regulatory agencies are more appropriately governed under the *Financial Management and Accountability Act 1997* (FMA Act). ACSAA is a company limited by guarantee that is wholly-owned by the Commonwealth, and subject to the *Corporations Act 2001* and the *Commonwealth Authorities and Companies Act 1997* (CAC Act). The policy notes that company structures are more appropriate for commercial and entrepreneurial functions.

In response, ACSAA (sub. DR763) implied that as only 65 per cent of their revenue is sourced from Government it should remain a Commonwealth-owned company limited by guarantee. There are, however, numerous FMA Act-based regulators that collect fee revenue (largely from industry) to help to defray the costs of regulation.

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Further, ACSAA's sole member is the Minister for Ageing. At the same time, ACSAA also operates under contract to DoHA. This situation creates a potential conflict of interest for the Minister for Ageing as both the sole shareholder and the major contractor of this company's services.

There has been a trend over several years for regulatory agencies to be established under (or transferred to) the FMA Act, rather than the CAC Act. For example, on 1 July 2007, the Australian Securities and Investments Commission (ASIC) and the Australian Prudential Regulation Authority (APRA) moved from governance under the CAC Act to the FMA Act, and the Australian Fisheries Management Authority (AFMA) moved on 1 July 2008. In 2009, Fair Work Australia and Safe Work Australia were both established under the FMA Act.

Second, the current governance arrangements for accreditation need to be reconsidered within the context of an enhanced consumer-oriented and outcomes-focussed approach to assessing the quality of care. Moreover, many features of best practice 'responsive regulation' (appendix F) are difficult to achieve when one aspect of regulatory responsibility (that is, accreditation and the assessment of performance against Quality Standards) is structurally separated from compliance investigations and enforcement decisions surrounding quality. Regulatory behaviour would be enhanced by locating quality assessment within the same organisation that receives consumer complaints, monitors compliance, provides information on ways that providers could improve the quality of their care services and makes the enforcement decisions. As UCA NSW noted:

Such a reconsideration is all the more merited given just how onerous the current quality system is for providers. (sub. 369, p. 35)

Finally, if quality assessment were to be expanded to cover both residential and community care (discussed below), reform of the current arrangements would be required:

Looking to the future, an increased emphasis on community care would sit more naturally with a different approach to quality regulation. (UCA NSW, sub. 369, p. 27)

The UK's recently established CQC demonstrates that it is possible for an independent regulator to administer a wide range of regulatory functions across a range of health and care services (for example, hospitals, mental health facilities, residential aged care facilities and community care).

The Commission notes the ACC's (sub. 433) views that ACSAA's two main roles (first, managing accreditation, and second, promoting high quality care and assisting industry to improve service quality (sub. DR763)) are conflicting and some



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arrangements are subject to potential bias. However, these two functions can be complementary — especially within the context of moving towards a ‘responsive regulation’ model (appendix F). The creation of an independent regulator under the FMA Act would also be a significant step toward reducing the potential for perceived bias.

The Commission is proposing that ACSAA be administered under the FMA Act as a statutory office within the proposed Australian Aged Care Regulation Commission. The office (ACSAA) would be headed by a statutorily appointed Commissioner for Care Quality.

Some submissions (for example, Baptist Community Services NSW & ACT (sub. DR689) and J.M. Wynne (sub. DR568)) were concerned that if the new regulator was created through a merger of existing DoHA and ACSAA staff together with some other functions, then not much change would occur in practice.

Education and training of staff around a new approach to regulation will be needed ... There may be a need to recruit new staff to implement a changed approach to regulation. (Baptist Community Services NSW & ACT, sub. DR689, p.4)

While the day to day behaviour of a regulator partly reflects its leadership and the culture of its employees as well as its legislative backing, the development of a new regulatory body is an opportunity for strong leadership to drive the implementation of a ‘responsive regulation’ model across all parts of the organisation. The attributes of this ‘responsive regulation’ model should also be reflected in the legislation that the regulator must administer.

The Commission also envisages that the current Board of Directors of ACSAA could become an advisory committee to that Commissioner. In addition, in order to facilitate greater consumer engagement in the administration of regulations surrounding the quality of care, this advisory committee should be supplemented with the appointment of one or more consumer representative positions, covering the views of care recipients, carers and personal advocates.

## **Regulating the quality of community aged care**

The rationale for regulating the quality of community aged care is similar to the rationale for regulating residential aged care (chapters 4, 10 and Appendix F).

In relation to *packaged* community aged care (defined in section 15.1), the Australian Government (through DoHA) entirely funds and regulates this type of aged care under the Act and in accordance with Community Care Common Standards (DoHA 2010d).

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By contrast, the funding and regulation of *basic* community aged care (defined in section 15.1) is subject to a division of responsibilities between federal and state and territory governments. Anglicare Sydney noted that:

... there is no single set of standards to report against but rather a plethora of standards and frameworks that creates significant overlap at a time when community care programs are increasing, in number and service type. (sub. 272, p. 14)

Historically, according to Weiner et al., this arrangement:

... has resulted in protracted negotiations on many aspects of the program, including standards. (Weiner et al. 2007, Appendix B, p. B-4).

Since 2001, state and territory governments have implemented the HACC Standards Instrument using one of two methods (box F.5, appendix F). While there is a HACC minimum data set (DoHA 2010k) and all jurisdictions have provided annual business reports since 2003, no agreement has been reached on the release of these findings and no publicly available information is available on the extent to which HACC services meet the national standards (Weiner et al. 2007).

From 1 July 2012, these complex jurisdictional responsibilities will be simplified, with the Australian Government (through DoHA) taking responsibility for funding and regulating basic community aged care on a day-to-day basis. But some complexities remain because, at the time of writing, the Victorian and Western Australian Governments are not parties to these reforms.

A number of submissions suggested that a single regulator be responsible for both residential and community aged care. For example:

If the funding model for aged care is to change to one covering both residential and community care, then it would be appropriate to implement a regulatory system that encompasses both areas. (Mercy Health, sub. 215, p. 10)

To limit the potential for confusion and overlapping regulation, to increase the efficiency of regulation and to facilitate best practice regulation, a single organisation should administer the regulation of quality, and investigations of non-compliance, across all aged care regulations for which the Australian Government has responsibility.

Approval of care providers for Australian Government funding of both residential and community aged care is currently undertaken by DoHA, while accreditation of residential aged care is undertaken by ACSAA. Both approval and accreditation are required for a provider to obtain Government funding but they are managed through separate processes. With the proposed move to a single independent regulator (the AACC) and the proposed operation of ACSAA as a statutory office within that body, the Commission envisages these two processes would be streamlined.

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The Commission proposes that the AACC would have responsibility for approving both community and residential aged care providers for Australian Government subsidised services and the right to limit, suspend or terminate such approvals where there is non-compliance. On-going approvals of residential and community care providers would be dependent on maintaining appropriate accreditation (as necessary) together with compliance with other aged care regulations. As proposed below, appeals against the decisions of AACC would be available initially within the AACC via an independent case review process (similar to Centrelink's Authorised Review Officer process) and then, if necessary, to the Administrative Appeals Tribunal (AAT). In addition, individuals would continue to be able to access a review of their case by the Commonwealth Ombudsman. Improved resourcing of personal advocacy and a strengthened Community Visitors Program (discussed below) would also bolster consumer confidence in the proposed complaint handling and review arrangements.

These reforms should also greatly strengthen the decision making processes and remove the potential for, and perception of, political influence inherent in the current process.

In addition, in consideration of the efficiency requirements and the consumer and industry obligations of the AACC, the resulting governance arrangements should be subject to review following a suitable period after the creation of that Commission.

## **Regulating prices**

As discussed earlier in this report (chapter 7), the Commission is proposing that AACC's regulatory responsibilities would include the monitoring and reporting of prices charged to consumers and the costs of care (recommendation 15.1). The AACC would also be responsible for transparently advising the Australian Government on a scheduled set of care prices and subsidies across the various elements of the aged care system and a rate of indexation.

## **Prudential regulation**

The Commission is proposing that the responsibility for administering the prudential regulation of accommodation bonds paid to residential aged care providers be separated from the policy development of prudential regulation.

In this context, the recommendations and guidance from the ANAO (2009) audit on the *Protection of Residential Aged Care Accommodation Bonds* are relevant. That

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report made seven recommendations, all of which have been agreed to by the Government (appendix G).

As part of a broad consultation process in anticipation of putting new arrangements in place by 1 July 2011 (DoHA, pers. comm., 11 November 2010; Australian Government 2010d), DoHA released an issues paper (DoHA 2010g) and a consultation paper (DoHA 2011a).

Commenting on DoHA's issues paper, the Australian Guardianship and Administration Council stated:

The proposed initiatives if implemented, will significantly address the concerns that we have raised in our earlier submission. This would be a most positive development although the actual separation of the management and investment of such significant accommodation funds ... from the 'arms' of the 'approved providers', is still something that the Commission may care to consider. (sub. 478, p. 4)

The amendments to prudential regulation (see below), do not involve separating the management of bonds from providers. However, even if the Australian Government were to create a separate trust fund to hold all future accommodation bonds, prudential regulations would continue to apply to the current stock of accommodation bonds held by approved providers. Prudential arrangements would also be required to manage the trust fund balance in these circumstances.

The Commission notes the wide range of views in submissions to DoHA's (2011a) consultation paper on the prudential regulation measures to be implemented from 1 October 2011. For example, NSA (2011, p.3) considers that '... the government's aims in increasing protections for aged care residents' savings held as accommodation bonds have not been met ...'. By contrast, COTA (2011, p.5), while raising some issues, 'welcomes the proposed tightening of the prudential arrangements for accommodation bonds'. While Aged and Community Services Australia (ACSA) (2011, p.3) says '... there is not any evidence to suggest there is a real problem with bond management practices currently in place in the sector.' By contrast, Morgan Stanley Australia (sub. DR678) argues for tighter prudential regulation. In relation to the timing of the proposed amendments to prudential regulation, UCA shares ACSA's (sub. DR730) view that the implementation of prudential regulation should be delayed, stating that:

Any proposed changes to Prudential Requirements should be considered in the context of the response to the Productivity Commission Report by the Commonwealth Government. (sub. DR839, p. 37)

On 26 May 2011, the Australian Government introduced amendments to the Act designed to enhance the prudential framework around accommodation bonds. Many of these were previously announced as part of a 2010-11 budget measure

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(\$21.8 million over four years) to strengthen protections for accommodation bonds held by aged care providers. The amendments include:

- applying more stringent requirements on how accommodation bonds can be invested
- introducing criminal penalties for the misuse of accommodation bonds
- giving greater information gathering powers to DoHA to better monitor approved providers
- strengthening reporting requirements in relation to how bonds are used
- removing restrictions on the use of income derived from accommodation bonds, retention amounts and accommodation charges (Australian Government 2010c and 2011c).

Chapter 7 addresses a number of options which are designed to reduce not only the risk around accommodation bonds but also the current incentives which have been driving up the average dollar amount of these bonds. On the other hand, because the way in which accommodation bonds can be used has widened (Australian Government 2011c) there will be an offsetting increase in risk. But the size of this offsetting increase in risk is unlikely to completely offset the reduction in risk if the Commission's proposed recommendations are implemented. In other words, the net effect on risk from implementing the Commission's proposals is likely to be a reduction in the level of risk around accommodation bonds.

The Trustee Corporations Association of Australia (TCAA) also argues risk is further reduced if accommodation bonds are held

... by independent trustees to give surety and reduce potential of government liability. (sub. DR690, p. 3)

Accordingly, the TCAA has asked that this matter be revisited.

The Commission, however, suggests the proposal to establish trust fund arrangements for accommodation bonds should be reconsidered when transition arrangements are reviewed (chapter 17).

Notwithstanding the expected net overall reduction in the risk of accommodation bonds, prudential regulation remains important. In addition, in the Commission's view the cost of the Australian Government guarantee of accommodation bonds should be borne by the providers through the setting of a fee (recommendation 7.4). Arguably, the cost of prudential regulation should also be borne through the setting of a fee arrangement. Conceptually, both these fees could vary according to the risk of the provider. In practice, however, such an arrangement is likely to be too

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complicated. Nonetheless both a charge on the prudential regulation and the Government guarantee would more fully reflect the cost of bonds.

In relation to the Commission's draft proposal to have the AACC administer prudential regulation, the Salvation Army Aged Care Plus (SAACP) (sub. DR567) suggested regulation should be mainstreamed wherever possible. Grant Thornton (2011b) inferred the Australian Prudential Regulation Authority (APRA) should administer the prudential regulation of aged care bonds. This is consistent with Lend Lease Primelife's (LLP) submission to DoHA's (2011a) consultation paper:

Rather than new regulation, [DoHA] and Treasury should consider bringing accommodation bonds into the definition of 'Financial Product' and as such, each Approved Provider would need to hold an Australian Financial Services Licence or be an Authorised Representative of someone who does. The compliance and regulatory regime is established and understood and was designed to provide investor protection in the first place. It would, without much in the way of additional regulation, provide the protections proposed. Any additional protections required can be included as a condition of the Australian Financial Services Licence. (LLP 2011, p. 2)

In the light of these suggestions, the Commission's view is that the administration of prudential regulation could be undertaken by either the proposed AACC or another relevant regulator (APRA). Alongside the need to ensure prudential regulations are not excessive, the key issues are to:

- separate the responsibility for administering aged care prudential regulation from the responsibility for policy development
- position the administration of regulation where it is most efficiently and effectively conducted.

For practical reasons, the Commission's recommendations on the proposed AACC's responsibilities have included prudential regulation (recommendation 15.1). Nonetheless, the Commission acknowledges that the Australian Government is better placed to decide which regulatory agency is likely to provide the most efficient and effective conduct of this particular regulation.

Discussion surrounding the consumer disclosure requirements under the recently amended prudential regulation of aged care accommodation bonds is in section 15.4.

## **Regulating supported resident ratios**

The Commission has recommended (recommendation 7.5) the maintenance of ratios (or quotas) for supported residents in most residential aged care facilities and, further, that a pilot to test the workability of the trading of these quotas within a

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region be undertaken (recommendation 17.6). These quotas will be set by the Australian Government from time to time but the Commission envisages that AACC's responsibilities would be to administer any related regulations (including the checking of provider's compliance with these regional supported resident ratios).

## **Communicating with stakeholders**

In the context of adopting best practice regulation, the AACC will need to undertake regular communication with all stakeholders in relation to its regulatory responsibilities and activities, including information on the appeals processes. In doing so, it will need to have strong internal feedback loops. It will also need to liaise with DoHA, the Australian Seniors Gateway Agency (the Gateway, see chapter 9), and the AAT to ensure consistency of approach.

In undertaking its role in monitoring, reporting and transparently recommending to Government the prices and costs in aged care, the AACC would also need to liaise with the Hospital Pricing Authority (chapter 7).

Its information products should also be available to consumers in a variety of readily accessible and digestible formats, including different languages (chapters 9 and 11).

It will be vital for the AACC to demonstrate impartiality and balance in its decision making through appropriate transparency of its processes and decisions (section 15.3). As part of its communication role, the Commission will also be responsible for the collection and dissemination of data and research (chapter 16).

Responding to the draft report, a number of submissions called for greater consumer involvement through two-way communication with government agencies (box 15.2).

As noted earlier, the Commission envisages that the AACC would seek input and advice from a range of stakeholders, notably consumers and their representatives. This should be formalised through establishing an advisory board to the AACC, similar in structure to those in other regulatory agencies, such as the Australian Competition and Consumer Commission.

Moreover, as discussed in chapter 10, to further drive consumer involvement in care decisions, enhance the accountability of providers and provide additional incentives for providers to deliver quality services, the Commission is proposing (recommendation 10.1) that the AACC collect and publish standardised performance information.

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## Box 15.2 **Submissions called for greater consumer involvement in regulation**

The Quality Aged Care Action Group Inc said:

Aged care reform must incorporate consumer participation at all systems levels. The opportunity must be taken to ensure this is built in, rather than 'added on'. We want genuine, long-term and structured involvement by consumer representatives in all levels such as the proposed Gateway and within the Australian Aged Care Regulation Commission. (sub. DR809, p. 3)

The Australian Psychological Association called for a 'bottom up' approach to consumer engagement, stating that:

... the proposed Australian Aged Care Regulation Commission be tasked with an additional key function of developing a comprehensive engagement framework to enable consultation with consumers, stakeholders and Government agencies so that any subsequent consultations involve consumers from the outset. (sub. DR824, p. 12)

Medibank Private noted that:

Publishing data on the operation of the aged care industry would assist in increasing transparency and drive improvements in standards of care delivery. (sub. DR819, p. 5)

While Robert Wilson said:

I also would like to see more public information available regarding aged care services – complaints, accessible annual reports, staff mix, staff turnover, credentials of office bearers and administrators, and respite feedback from consumers. I think a facility such as 'My Aged Care' must be a consideration (as per My School). (sub. DR745, p. 1)

## **Complaint handling, reviews and appeals**

Complaints can come from several sources. They can be the result of consumer complaints (usually about a particular provider) or the result of a consumer's or a provider's complaint about the enforcement decision(s) of a regulator. The latter is more appropriately described as either a review or an appeal.

Well structured complaint handling with rights to independent appeals processes is an important feature of good governance arrangements (appendix F).

### *Improving the structures for complaint handling ...*

As figure 15.1 shows, while the Australian Government's aged care CIS reports directly to the OACQC within DoHA, it also has reporting arrangements in practice which are spread across DoHA.



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In 2009 the Walton Review (2009) (the Review) examined the CIS. The Review largely focussed on complaint handling in relation to residential aged care facilities. It also received a small number of submissions relating to community care.

The Review documented a number of difficulties experienced by consumers, providers, staff working in the CIS and the OACQC. A summary of the key issues identified by the Review is contained in box 15.3.

**Box 15.3 Summary of key issues identified in the *Review of the Aged Care Complaints Investigation Scheme (CIS)***

- The need for the CIS to improve its communication processes with both consumers and providers.
- The importance of encouraging a range of options for managing complaints — from resolution at the local provider level, to mediation and investigation by the CIS.
- The perception that as the funder and regulator of aged care services, [DoHA] is not the appropriate body to manage the complaints investigation process.
- The need to revise the complex management and accountability structure within the CIS and the Office of Aged Care Quality and Compliance to ensure more effective complaints management.
- The impact of the workload and competing priorities of CIS staff on the ability to achieve quality outcomes.
- The need for more specific and ongoing training for CIS staff.
- The necessity to amend current CIS processes and practices to achieve a more efficient and effective system which achieves satisfactory outcomes for all parties.

*Source:* Walton Review (2009, p. 5).

According to the Review, these difficulties largely emanated from the design and inadequate structure and location of the CIS:

In comparison with other complaint bodies the CIS ... is in a rudimentary complaint management phase and does not yet have the attributes of best practice complaint management. ... The lack of time frames, lack of focus on early resolution and often poorly executed investigations are a consequence of bad design and not the fault of the managers of CIS or the investigation staff.

Further, the consequence of a complaint system that is not housed in the one body impacts on the way staff see their roles and responsibilities. Staff I spoke with saw themselves primarily as employees of [DoHA]. This impacts on how they respond to departmental challenges, which may or may not be in conflict with good complaint management. (Walton Review 2009, p. 72)

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Accordingly, the Review's key recommendations largely centred on governance arrangements.

To deal with the inadequate design and structure, the Review recommended the CIS be restructured into three separate divisions: Assessment and Early Resolution; Investigations; and Communications and Stakeholder Management (recommendations 3.2–3.4).

The Review also recommended the establishment of an independent Aged Care Complaints Commission and the creation of the position of Aged Care Complaints Commissioner who would report directly to the Minister for Ageing (recommendation 3.6).

The Review outlined a raft of additional recommendations for immediate implementation within the existing structural framework of the CIS (recommendation 3.7). These recommendations covered: recruitment and training; clinical advice; risk assessment framework; information collection and investigation; natural justice; provisions to review decisions; relationship between the CIS, the Commissioner, the ACSAA and other relevant bodies; processes, practices and timeliness of responses to complaints; and other issues.

Finally, in relation to risk assessment, the Review suggested that the structure of the CIS has resulted in an overly risk averse approach to the handling of complaints:

CIS have adopted a very low threshold of risk in their assessment of complaints for investigation ... There is also the perception that if they make a mistake in the assessment, harm may befall the resident (and possibly reflect badly on the CIS). Fear of mistake becomes a significant factor in complaint management when a risk assessment framework is not used, or inconsistently applied. (Walton Review 2009, p. 52)

Accordingly, the Review suggested that the CIS adapt the New South Wales Department of Health Risk Severity Assessment Matrix in the context of aged care complaints, after review and appropriate modification.

In response to the Walton Review recommendations, the Government (in its 2010-11 Budget) committed \$50.6 million over four years to improve the CIS' procedures to manage complaints and reduce its caseload. These included: more timely responses to complaints through early risk assessment and resolution; greater access to clinical expertise; improved processes, procedures and training for the scheme; a broader range of options for resolution of complaints; an enhanced communications strategy for the scheme; and better access to seek an independent review of the scheme's decisions and processes (DoHA, pers. comm., 11 November 2010). This budget measure also provided additional funding for

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ACSAA to meet the likely rise in referrals from the expanded Aged Care Complaints Investigation Scheme (Australian Government 2010c).

The Victorian Health Services Commissioner, in her submission to this inquiry, expressed concerns around the inherent conflict arising from an organisation being the funder, regulator and investigator, and concerns around the provision of natural justice to the parties of CIS. The submission also supports the Review's recommendation to establish an Aged Care Complaints Commission independent from DoHA. In addition, the submission argued:

Recommendations made by the [OACC] are not always accepted but it is not so much the relationship between the CIS and the [OACC], [ACSAA] and other relevant bodies which is the issue, it is the structure that is the problem.

... consideration should be given to the establishment of a discrete conciliation arm within the independent Commission, similar to the conciliation functions in my office. (sub. 349, pp. 1–2)

The OACC also supported the Review's recommended approach to creating an independent complaints body, but with the additional caveat:

Such a body would determine complaints and be subject to review of its administrative decision-making processes by the Commonwealth Ombudsman. (sub. 444, p. 12)

The OACC (sub. 444) also:

- suggested that a complaints body should have the capacity to refer matters directly to: relevant Health Service Commissioners (HSC) in relation to hospital complaints; the Australian Health Practitioner Regulation Agency (AHPRA) in relation to complaints about health care professionals; and relevant police authorities and/or coroners
- argued that the complaints body should also deal with complaints about all Commonwealth funded aged care organisations and/or programs (for example, ACATs, HACC), provide education and information to a range of industry and consumer organisations (to maximise its quality improvement commitment) and — aligned with the Victorian Health Services Commissioner's submission — consider establishing a discrete conciliation arm. In addition, it suggested that the complaints body establish an internal review mechanism prior to access to an appeals mechanism for dissatisfied parties and that it be funded from a separate parliamentary appropriation with concomitant accountabilities and reporting
- argued for a complaints management process that is 'clearly independent and transparent, meets natural justice requirements, attempts to resolve complaints simply and inexpensively at the local level within an entity that provides a nationally consistent policy and administrative framework' (sub. 444, p. 12).

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The importance of separating complaints handling from the funding department was also echoed in submissions from COTA (sub. 337), the Commonwealth Ombudsman (sub. 290) and Blake Dawson (sub. 465). In addition, Blake Dawson noted that this separation may result in:

... less pressure on [DoHA] to respond to concerns raised by the media or other political pressures in relation to the investigation of complaints. (sub. 465, p. 42)

The Commonwealth Ombudsman (sub. 290) noted that complaints it receives often perceive that the current system of regulation is not sufficiently independent of DoHA or the aged care industry. In this vein, the Commonwealth Ombudsman's submission reiterated the need for an independent assessment of care needs and that the results of this assessment be amenable to merits review:

For example, a person can appeal to the Administrative Appeals Tribunal (AAT) about an ACAT assessment that results in a limitation on their approval as a care recipient, but if a provider successfully argues to DoHA that the person requires a different level of care, despite there being no limitation on the ACAT assessment, the person does not have recourse to the AAT. (sub. 290, p. 10)

The Commonwealth Ombudsman is also of the view that while the current complaints process meets regulatory needs it often places parties in an adversarial position rather than helping parties resolve complaints:

Many of the aged care complaints to the Ombudsman's office evidence dissatisfaction with the outcome of the investigation of complaints taken to the CIS or the [O]ACC. In our view this is principally because the CIS and [O]ACC investigate complaints from a regulatory perspective. They consider whether or not there has been a breach of the aged care standards (some of which are very broadly worded), and whether any breach warrants the issuing of a *notice of required action*. Complainants, on the other hand, seek acknowledgement of or redress for past events, or the resolution of an issue which is personal to them.

... The current complaints scheme has not provided the type of resolution mechanism required in circumstances where there will be an ongoing relationship between the facility and the care recipient. (sub. 290, pp. 19–20)

Blake Dawson reiterated the point that the adversarial culture is a function of the way the CIS operates under its legislation:

In our opinion, replacing the previous complaints scheme under the Aged Care Act, which permitted mediation or conciliation of issues, with the current investigation scheme in 2006, has resulted in an unsatisfactory and skewed system. The only possible responses to a complaint are an investigation or the exercise of the Secretary's discretion not to investigate the complaint (which we understand rarely occurs). (sub. 465, p. 42)

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To resolve this problem, Blake Dawson argued for a broader framework so that ‘while it remains possible to conduct an investigation of serious issues, other means of dispute resolution are also available where appropriate’ (sub. 465, p. 43). Options would include: informal resolution, including giving an apology; mediation; conciliation; formal investigation; and referral to relevant registration bodies (where the complaint concerns registered professional staff) for action following an investigation.

A number of submissions (for example, TLC Aged Care, sub. 392) raised the issue of potential conflicts arising in providers’ handling of some psycho-geriatric patients in relation to the ‘security of tenure’ and ‘duty of care’ statutory obligations. Blake Dawson suggested one remedy for dealing with the circumstances under which individuals can and should relocate which involves complaint handling processes being ‘empowered to consider whether a determination should be made enabling a resident to be relocated in specific circumstances’ (sub. 465, p. 44).

Finally, the Commonwealth Ombudsman noted that there is currently no requirement to provide a complaint and redress mechanism under the Flexible Program which covers Indigenous aged care. The Ombudsman also noted that over 1000 complaints have been received through outreach since the creation of the Ombudsman’s Indigenous Unit in 2007 (very few Indigenous Australians complained to the Commonwealth Ombudsman prior to the formation of this unit). Accordingly, the Commonwealth Ombudsman recommends regular outreach of complaints services to ensure accessibility for all, including Indigenous Australians.

The Commission accepts the need to create a complaints handling process which is separate from the funding and policy department. At the same time, however, best practice regulation (appendix F) suggests that complaint handling should form part of an independent regulator’s functions. Such an arrangement facilitates appropriate feedback loops (including in a risk assessment framework) to the regulator’s management of compliance and, where necessary, enforcement.

Feedback on the draft report reinforces the need for such feedback loops to encourage increased quality. For example, Nicole Brookes said:

The process of complaints management needs to be contextualised under a case management framework, whereby there is accountability and ownership of problems, there is a comprehensive consultation and collaboration process; outcomes evaluation and an up-skilling and learning program developed strategically into the system development. This cannot be undertaken in isolation, nor as a separate process to accreditation and quality management. Whilst it is commendable that this report holds complaint review as a significant component of this change process, so too does the

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implementation need to consider the philosophy of complaints to improve rather than just condemn and find fault. (sub. DR612, p. 11).

The Commission supports the approach in the Walton Review's (2009) recommendations (3.2 to 3.4) to restructure complaints handling into three functional groupings: Assessment and Early Resolution; Investigations; and Communications and Stakeholder Management. A discrete Conciliation component, within the Early Resolution function, is also supported. In addition, an outreach component should also form part of the AACC's Communications and Stakeholder Management function. Complaints should be able to be referred to other regulatory agencies as appropriate. Empowering the complaint handling process to make determinations which balance conflicting regulations (for example, security of tenure and duty of care) should also occur.

To accommodate the key elements of the Walton Review, and to ensure structural separation from DoHA, the Commission is proposing a statutory office be established within the new independent regulatory body (the AACC) and be headed by a Commissioner for Complaints and Reviews. This office would have a broad range of complaint handling and review functions, but would not be an appeals body.

The current Aged Care Commissioner's position and role would be replaced by this position and function.

The Commission also considers that the proposed aged care complaint and redress mechanism should be available to all aged care recipients, including Flexible Care and Multi-Purposes Services.

The Law Council of Australia (sub. DR826, p.2) while commending the proposed complaint handling processes proposed in the draft report noted some residual concerns remain in relation to ensuring procedural fairness.

Integrating [ACSAA] and complaints under the proposed [regulator], as suggested above, will go some way to alleviating conflicts of interest. However, residual concerns about conflicts of interest remain and will need detailed consideration. For example, access to information, and whether information gathered in relation to a complaint will be available to the Agency and protections in place to ensure procedural fairness. (sub. DR826, p. 2)

The Commission anticipates that this issue would be addressed when the detailed structure of the AACC is formulated.

Responding to the draft report, many consumers continued to highlight difficulties with the complaint handling processes. For example, Donna Moses said:

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Residents/persons responsible can complain to the ACCIS (Aged Care Complaints Investigations Scheme) if they consider that a [RACF] is breaching a Standard &/or an Aged Care Principle, but having been through this process myself, I can testify to what an ordeal it is and what little result it achieves. (sub. DR545, p. 1)

COTA (sub. DR565) also felt that a mechanism for carers to complain needs to be included within the scope of the new regulator's complaint handling and review responsibilities. This issue was also raised by ADACAS:

It is not obvious that the CIS identifies whether or not the family carer has permission of the care recipient to make the complaint to the CIS. ... Any proposed change in service provision of regulatory oversight needs to develop strategies to maximise the opportunities for care recipients and family carers to complain about service providers in a manner that minimises the fear of retribution. (trans., p. 1401)

Further, the Public Interest Advocacy Centre was concerned that:

... to a fair degree, the aged care complaints system in Australia has lost the trust of Australian consumers. (sub. DR835, p. 2)

In February 2011 DoHA released a discussion paper (DoHA 2011f) on the proposed complaints management framework developed in response to the Walton Review's recommendations. The discussion paper noted that the proposed framework was consistent with the Commission's draft recommendation to restructure complaints handling into three separate areas. Submissions to DoHA's discussion paper closed on 22 March 2011. Forty two submissions were received and were made publicly available (DoHA 2011g).

Having considered the responses to that discussion paper, new complaint handling processes are set to be delivered through 2013-14 (DoHA 2011d). On 26 May 2011, the Australian Government introduced amendments to the Act to rename the Investigations Principles 2007 as the Complaints Principles to 'demonstrate the shift of the complaints scheme from investigations to the resolution of complaints' (Australian Government 2011c, p. 28) as well changing the Principles to describe the revised complaints scheme.

According to DoHA (2011e) these reforms also include:

... expanded options for resolving complaints, including local resolution where possible; a risk-based approach for escalating and considering complaints; strengthened focus on procedural fairness; improved communication and stakeholder engagement; ensuring Scheme staff are skilled and effective; and improved transparency and accountability. (DoHA 2011e)

Although the reforms to complaints management may refocus and improve complaint handling, the Commission is proposing to further enhance consumer

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confidence in the workings of the complaints processes by proposing the establishment of a Community Visitors Program (recommendation 15.3).

... *reviews and independent appeal*

While complaints and reviews (both individual and systemic) are best handled by a statutory office within an independent regulator, appeals are best dealt with at arm's length from the regulator and decision maker. Existing aged care appeal arrangements currently occur through the OACC and the AAT.

Wesley Mission Victoria noted there is merit in instituting an intermediate appeal body between the independent regulator and the AAT:

... Perhaps a formal review process that is independent of the accreditation Agency that can be undertaken before going to the AAT, for example, an Aged Care Ombudsman. (sub. 311, p. 13)

The Commonwealth Ombudsman (sub. 290) also considered that the time frame of:

- 14 days for a person to appeal to the OACC is too short
- 28 days for the right to appeal to the AAT in relation to a determination by Centrelink or the Department of Veterans' Affairs on the persons assets should be aligned to the usual time frame for appeals for decisions for these organisations, which is 13 weeks.

Finally, the ACC has requested that careful consideration be given to the appointment of the head of an appeal body:

Not only should there be no conflict of interest in the appointment of those charged with ensuring our aged-care system is fair and equitable, but that there should also be the *perception that no conflict of interest occurs*. (sub. 433, p. 9)

The Commission supports the need for a separate mechanism to determine appeals at arm's length to both the proposed independent regulator (AACC) and the proposed Gateway (chapter 9). The independent appeals process should be available to both providers and consumers in relation to the determinations of AACC and the Gateway. This avenue should be used when complaint handling and review within these two agencies has been exhausted. However, the Commission is also mindful of Government policy not to unnecessarily duplicate existing administrative appeal arrangements (primarily the AAT) where practical (Department of Finance and Administration 2005).



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The Commission is confident that the establishment of a statutory office within the AACC, headed by a Commissioner for Complaints and Reviews, will enable complaints to be handled in a manner which is aligned with ‘responsive regulation’.

The Commission’s draft report proposal to have independent appeals to decisions of the AACC and the Gateway heard by the AAT (possibly supplemented by the creation of an internal Aged Care Division) as the first and final avenue of appeal received a mixed reaction.

Reflecting the general consensus of submissions that did not support the draft report proposal for appeal arrangements, the Australian Federation of TPI Ex-servicemen and Women (sub. DR682) stated that:

For older Australians, having to appeal to the AAT is daunting, confusing and expensive, and will indirectly put undue pressure on them to decide against proceeding with the airing of their legitimate grievances.

Clearly, for older Australians an intermediate review level would be more appropriate and user friendly. One approach would be to have an internal review by a senior officer of the particular agency, then as necessary a review by a further independent review level where legal representation is not allowed. (sub. DR682, p. 15)

However, the Public Interest Advocacy Centre (PIAC) said:

If there is a rigorous internal review system, with institutional separation between the original decision makers and those determining the appeal, then PIAC suggests this would obviate the need for a review body between the complaints body and the Administrative Appeals Tribunal. (sub. DR835, p. 5)

The Commonwealth Ombudsmen (sub. DR786) also pointed to the value of developing an internal review process for decisions, especially where the AACC is able to direct a particular mode of complaint resolution. In addition, the Commonwealth Ombudsman noted:

While I envisage that the introduction of a complaint conciliation stream may reduce or change the nature of consumer appeals, consideration should be given to fee waiver for appeals to the AAT by or on behalf of all aged care recipients and also to an extension of the allowable time in which to appeal, should they elect to complain to the Ombudsman first. (sub. DR786, p. 2)

The Commission supports the proposal to extend the allowable time to appeal but does not support the Ombudsman’s proposal to a fee waiver for consumers appearing at the AAT, on the grounds that a zero price on any good or service typically results in its over-consumption compared to socially optimal levels.

Other submissions (for example, CHA, sub. DR748) called for the establishment of an intermediate appeal agency (similar to the Social Security Appeals Tribunal

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(SSAT)). In a similar vein, NSA (sub. DR580) has called for the establishment of an Aged Care Ombudsman. The Law Institute of Victoria (sub. DR897) and Elder Rights Advocacy (sub. DR680) also suggested the Commonwealth Ombudsman be given powers to undertake merit reviews of individual cases.

The worth of another appeal mechanism will be partly determined by the checks and balances in the AACC's proposed arrangements. If the AACC has broad discretion in conducting its duties and making its decisions, this would open the scope for appeals about the decisions it makes. However, if legislation specifies in detail the basis for any AACC decisions — thus circumscribing discretion — then the AAT process could be a relatively efficient way of dealing with appeals (because the process is the main driver of any decisions).

Given that legislation is likely to continue to be relatively tightly prescribed, although there will be increased discretion for complaint handling to determine the process for complaint resolution, the Commission's view is that a separate internal review office should be included within the Complaint Handling and Review division of the proposed AACC. As noted by the OACC (2011) in her submission to DoHA's discussion paper on proposed changes to complaint handling processes (DoHA 2011f), facilitating appropriate feedback loops from complaint handling and review to provider practices has obvious implications for the quality of care:

The focus of these reforms is rightly on resolving complaints at the most appropriate level while at the same time ensuring that the rights and safety of elderly Australians are protected and they get the best possible care.

However, should not a dual consideration be quality improvement? As we all know, international literature supports the view that people who complain about health and disability services generally want an apology, a good and open explanation, and to know that it won't happen to someone else. In many cases it is too late to undo what has occurred, but people can get considerable comfort, and it will assist in resolving a complaint, if they can be assured that their complaint has made a difference and improved the care for someone else. Focusing on this will assist with getting complainants to successfully engage with, and support, [alternate dispute resolution] processes. (OACC 2011, p. 5)

At this stage, the Commission does not consider that an intermediate appeals body which sits between the AACC and the AAT is warranted. Procedural fairness (and natural justice principles) would appear to be met with the development of a separate internal review office within the statutory office of Complaints and Review. The Commonwealth Ombudsman complements this arrangement by offering another review path prior to a formal appeal to the AAT. The presence of such an internal review process within the AACC provides a less daunting and less expensive avenue for consumers than an initial appeal to the AAT and could also

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help to improve the quality of care through the presence of strong feedback loops and communication strategies with stakeholders.

As Centrelink undertakes assessments of individual incomes and assets on behalf of DoHA, it is appropriate that the Centrelink Authorised Review Officer (ARO) process — in conjunction with intermediate appeal arrangements in the SSAT — would remain for individual appeals to the financial assessments made by Centrelink.

RECOMMENDATION 15.1

*The Australian Government should establish a new independent regulatory agency — the Australian Aged Care Commission (AACC). This would involve:*

- *the Department of Health and Ageing ceasing all its regulatory activities, except the provision of policy advice to the Australian Government on regulatory matters, including advice on the setting of quality standards*
- *establishing the Aged Care Standards and Accreditation Agency as a statutory office within the AACC*
- *establishing a statutory office for complaints handling and reviews within the AACC*
- *establishing a stakeholder advisory committee to provide advice to the AACC in relation to consumer and industry interests*
- *establishing it as a Prescribed Agency under the Financial Management and Accountability Act 1997.*

*The AACC would have three full time, statutory Commissioners:*

- *a Chairperson*
- *a Commissioner for Care Quality*
- *a Commissioner for Complaints and Reviews.*

*Key functions of AACC would include:*

- *administering the regulation of the quality of community and residential aged care, including compliance and enforcement*
- *promoting quality care through educating providers and assisting them with compliance and continuous improvement*
- *approving community and residential aged care providers for the provision of government subsidised approved aged care services*
- *administering prudential regulation and all other aged care regulation, such as supported resident ratio obligations*

- *monitoring, reporting and assessing costs and transparently recommending a scheduled set of prices, subsidies and a rate of indexation for approved aged care services*
- *handling consumer and provider complaints and reviews*
- *providing information to stakeholders, including disseminating and collecting data and information.*

RECOMMENDATION 15.2

*The Australian Aged Care Commission’s (AACC) Commissioner for Complaints and Reviews should determine complaints by consumers and providers in the first instance. Complaints handling should be structured into the three areas: assessment, early resolution and conciliation; investigations and referral; and communication, stakeholder management and outreach (including rural and remote and Indigenous outreach). A separate review office should be developed to hear and determine initial appeals of individual cases as well as to conduct ‘own motion’ systemic reviews within the AACC.*

*The Australian Government should abolish the Office of the Aged Care Commissioner.*

*The Australian Seniors Gateway Agency should establish a separate complaints handling and review office to deal with complaints about its decisions, including assessments and entitlements. These matters would not be subject to complaint handling or review by the Australian Aged Care Commission.*

*All appeals in respect of decisions of the AACC and the Australian Seniors Gateway Agency should be heard by the Administrative Appeals Tribunal. The allowable time in which to appeal should be increased to 13 weeks from the current 28 days.*

## **Access to independent individual advocacy**

According to Queensland Ageing and Disability Advocacy Inc, individual (or consumer) advocacy:

... plays a valuable role in the provision of aged care services. It is an effective means of early resolution of issues; often preventing issues going through formal complaints processes such as the [CIS], and promotes an environment of continuous quality improvement. (sub. 207, pp. 3-4)

The Aged Rights Advocacy Service (ARAS) also noted that advocacy provides:

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... a non-conflicted, independent voice for vulnerable older people, which supports them to resolve issues to their satisfaction (sub. 137, p. 4)

In addition, appropriately staffed advocacy services are also important for special needs groups (Jo Harrison, sub. 190, Multicultural Disability Advocacy Association of NSW, sub. 144).

Freedom of advocacy is one of the features of good governance arrangements (appendix F), covering both individual advocacy and policy advocacy.

The Australian Government funds organisations to provide aged care consumer advocacy in each state and territory under the NACAP. NACAP has its legislative basis in the Act, and the Advocacy Grant Principles 1997 (appendix F). In addition to providing independent advocacy and information to recipients or potential recipients (or their representatives) of aged care, advocacy also perform an educative role for aged care recipients and approved providers on the rights and responsibilities of care recipients. As such advocacy helps to ensure quality service provision for an inherently vulnerable sector of the community.

In 2009-10, services under NACAP undertook over 4100 advocacy cases, handled 5300 general enquiries and provided over 1600 face-to-face education sessions (DoHA 2010n). However, as ACC (sub. 433) noted, due to the existence of other state-based consumer advocacy arrangements, it is likely that these are under-estimates of the actual number of advocacy cases involving aged care.

ARAS drew attention to the Walton Review's recognition of the relatively high case load for consumer advocacy organisations. ARAS also pointed to the instability that is created by NACAP's annual funding arrangements and that growth funding would also be required if advocacy was to be formally included in an early resolution stage within the complaint handling process (as recommended by the Walton Review):

The current year by year funding of the NACAP is detrimental to keeping our experienced staff however, and we would advocate that the NACAP would benefit from tri-annual funding which applies to most other programs, and an increase in funding if the CIS is to refer more cases. The other three programs operated by ARAS receive three year recurrent funding from the HACC Program which enables some stability.

... there is a need to establish appropriate growth funding to enable increased access to advocacy as outlined in the CIS [Walton] Review recommendations. (sub. 137, p. 5)

In response to the draft report, the CPSA raised concerns about NACAP's effectiveness and suggested:

To ensure better access to NACAP by residents, CPSA recommends that a community visitor scheme be employed similar to those present in the disability sector. Visitors

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would regularly enter aged care facilities to ensure the rights of residents were being upheld and advocate on their behalf if need be. CPSA also believes that complaints data held by NACAP state bodies should be made public. (sub. DR760, p. 15)

While some of the demands on advocates are likely to be relieved through improved information provision to consumers via the development of the Gateway (chapter 9), a continuing role for independent personal advocacy is also envisaged. But because not everyone will require a personal advocate in the first instance, in practice there will need to be some eligibility rules developed around access to subsidised consumer advocacy.

Because of the importance of independence in, and freedom of access to, consumer advocacy in aged care, advocacy should be subsidised and governed in a way that allows these organisations to be independent of DoHA, the Gateway and the AACC. That is, while advocates are funded directly by DoHA, consistent with the usual practice, they are funded and governed in a way that allows them to be independent.

The Commission supports governments continuing to fund independent individual advocacy that can be accessed by all recipients (and their carers) of Government funded community and residential aged care.

As discussed earlier, a strong Community Visitors Program should also be developed alongside independent advocacy. This program would sit alongside the existing Australian Government's National Aged Care Advocacy Program (NACAP) It could be developed either separate to or based on a strengthening of the existing Australian Government Community Visitors Scheme (CVS) — whose primary objective centres on social inclusion — but would be more akin to a number of other community visitors schemes and programs mentioned in a number of submissions, including by Legacy (sub. DR607), NSA (sub. DR832) and J. M. Wynne (sub. DR568). For example,

NSA also commends the Community Visitors Program of the Office of the Public Advocate in Victoria as a potential model that may be adopted ... as an effective way of improving the current lack of consumer confidence in the existing system. This community visitor's model is completely different to that which currently sits within the Department of Health and Ageing as it is stronger and independent. (NSA, sub. DR832, p. 18).

Box 15.4 compares the Australian Government's CVS in aged care with a range of community visitors programs in other jurisdictions. Many of the other programs centre on the protection of individual rights of people in the scope of the program. Visitors in these programs may also deal with complaints and offer advocacy.

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## Box 15.4 Features of various community visitor programs and schemes across jurisdictions

The Australian Government's aged care Community Visitors Scheme objective:

... is to provide one on one volunteer visitors to residents of Australian Government subsidised aged care homes who are socially isolated and whose quality of life would be improved by friendship and companionship. (DoHA 2007a, p. 1).

The Victorian Government's Office of the Public Advocate (OPA) Community Visitors:

... are volunteers who work with the Office of the Public Advocate (OPA) to protect and advocate for the rights of people with a disability.

... are empowered by law to visit Victorian accommodation facilities for people with a disability at any time, unannounced, and monitor and report on the adequacy of services provided, in the interests of residents and patients.

... talk to residents/patients to identify issues of concern. Community Visitors then liaise with staff and management to resolve these issues. Broader or more serious issues are referred to OPA. (OPA 2011)

The Queensland Government's Community Visitor Program:

... is designed to protect the interests of adults who live in designated care facilities and have impaired capacity or a mental or intellectual impairment and cannot make their own decisions.

... make(s) regular unannounced visits to care facilities on a regular basis to make sure the rights of adults are being protected.

... inquire(s) into issues raised by residents or their representatives, and [tries] to resolve complaints on behalf of residents.

... [has] reports [that] can help to raise awareness of resident's interests, and ... encourage[s] management to use them to improve care at their facility[s]. (Queensland Government 2011)

The Northern Territory Government's Community Visitor Program:

... is an independent service located in the Anti-Discrimination Commission. Its purpose is to protect the rights of people receiving treatment under the *Mental Health and Related Services Act (NT) 1998*.

The program:

- Offers a specialist mental health complaints service;
- Provides advocacy and support for people receiving treatment and/or their carers;
- Is responsible for inspection of records, including complaints registers and seclusion registers; and
- Monitors services in inpatient facilities (such as Cowdy Ward and JRU in Darwin and the Mental Health Unit in Alice Springs).

The functions ... are achieved through two mechanisms, community visitors and community visitor panels. (Northern Territory Government 2011)

*Sources:* DoHA (2007a); OPA (2011); Queensland Government (2011); Northern Territory Government (2011).

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Assuming access to independent advocacy (through, for example, the NACAP) would remain and complaints investigation would be provided through the AACC, the proposed Community Visitors Program for aged care would be focused on protecting the rights of residents in RACFs. Visitors would also be empowered to make regular unannounced visits to RACFs at any time and monitor and report on the adequacy of services provided, in the interests of residents. Visitors would also talk to residents to identify issues of concern and liaise with management to resolve these issues where minor. Where broader and more serious issues were identified or raised, visitors would also be able to refer residents to advocacy (provided through NACAP) and refer broader and more serious issues to the AACC.

RECOMMENDATION 15.3

*The Australian Government should implement an independent statutory Community Visitors Program for residential aged care facilities akin to the operation of other types of statutory visitor programs operating in other residential settings (for example, disability and children’s residential services) and in other jurisdictions, to promote and protect the rights and wellbeing of residents.*

## **Putting all this together**

Drawing on best practice governance arrangements (appendix F), the Commission’s recommended governance arrangements for policy development and advice, consumer advocacy, regulation and appeals are represented in figure 15.2.

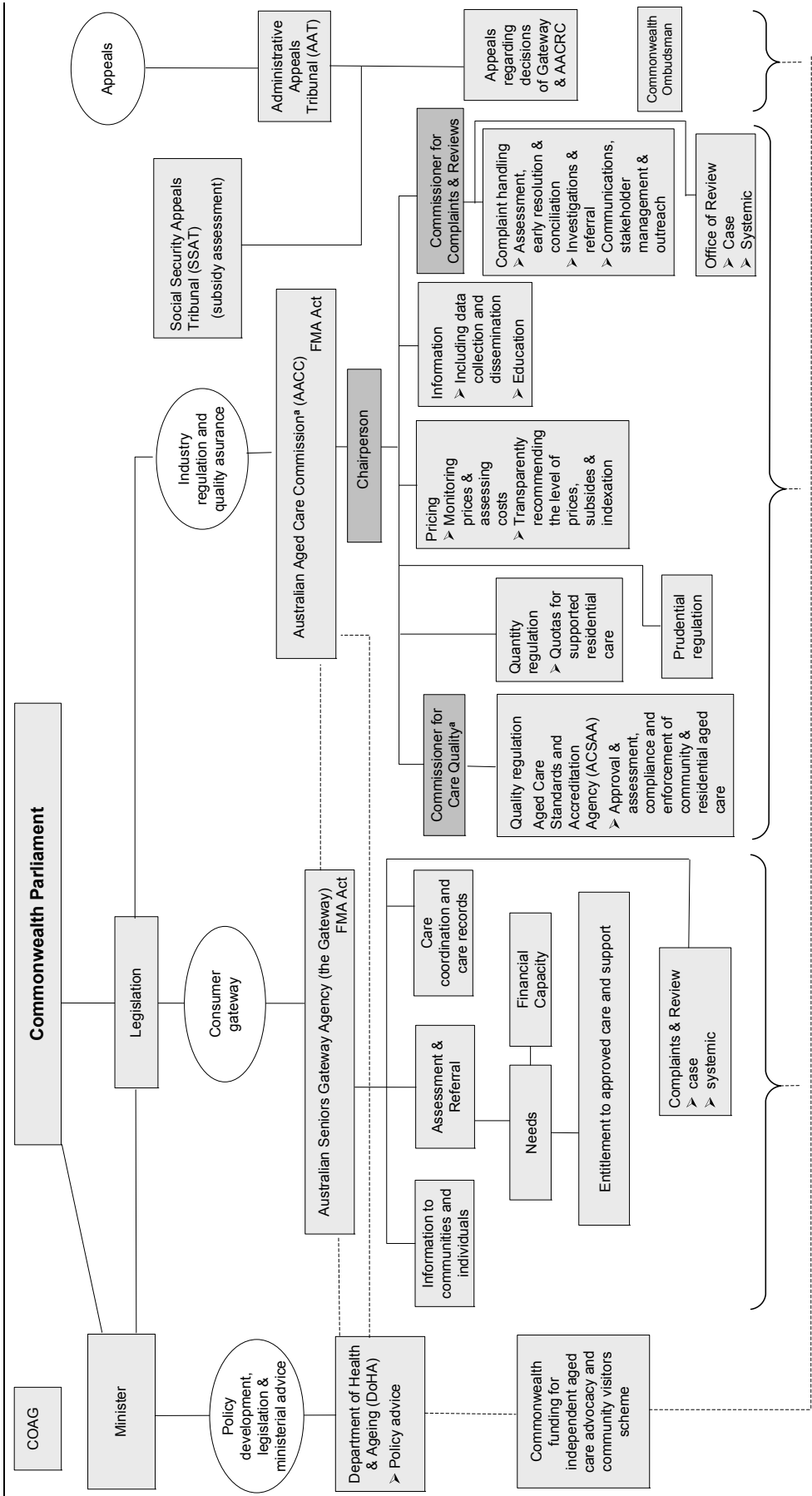
This governance diagram also includes the recommended approach for consumer directed care (chapter 9) which establishes a gateway for older people seeking information about, and access to, aged care services — the Gateway — that is separate from DoHA and the AACC. The backbone of the system would be an expanded system of electronic care records, which would include information on assessment, eligibility, services used, payments made to recipients and referrals.

The Commission envisages that a formal Memorandum of Understanding between DoHA, the Gateway and the AACC in relation to the interactions of each body would be agreed and published.

These governance arrangements should be subject to review after five years of operation.



**Figure 15.2 Suggested Australian Government governance arrangements for aged care**



**a** Advisory committees (with broad ranging membership) would also be established to support the AACC and the Commissioner for Care Quality.

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## **15.3 Implementing ‘responsive regulation’ with appropriate standards and streamlined reporting**

Best practice regulation involves not only establishing appropriate governance arrangements (section 15.2) but also: determining an appropriate set of standards; implementing approaches to encourage and enforce compliance; and streamlining reporting arrangements (appendix F).

### **Developing appropriate standards for quality care and prudential regulation**

The choice of regulatory standard is a matter of judgement by governments based on assessments by policy makers using the Principles of Best Practice Regulation (COAG 2007; appendix F). In the context of aged care, the main consideration is to balance any systemic risks of poor outcomes for recipients against the effects of onerous duplicate and inconsistent regulation. The Commission’s proposals regarding the disclosure requirements for accommodation bonds and mandatory reporting requirements for missing residents (section 15.4) are examples of the tensions which need to be balanced in establishing regulatory standards.

Under the proposed arrangements, the AACC would be required to administer regulations covering standards in two key areas: quality of care and prudential regulation.

#### *Quality of care — residential aged care*

Currently the Act has a two-part quality assurance process that covers certification of buildings and environment, and certification and accreditation of care standards for residential care (chapters 2 and 10). Having adopted a number of Commission recommendations regarding regulatory burdens in aged care, the Government is currently working to remove the certification of buildings and environment from the Act and to modify the Building Code of Australia, as appropriate (chapter 12). These changes will leave the Act with its primary focus on quality of care standards and prudential regulation.

Weiner et al. described the current Australian quality standards for residential aged care as:

... very broad and non-specific to allow providers considerable latitude in demonstrating how they achieve quality goals. (Weiner et al. 2007, p. vi)

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While praising the flexibility implicit in the Australian accreditation standards and the way that it encourages assessors to communicate with providers and users to establish whether and how the expected outcomes have been achieved, Weiner et al. (2007) also outlined a number of concerns with these standards. These include whether:

- the common quality system across a heterogeneous range of dependencies is appropriate
- the general nature of standards leaves too much flexibility for providers and assessors (with the latter subject to possible ‘regulatory capture’ by the former)
- it might be possible to develop a middle ground between broad standards and specific standards which allow the development of more systematic, quantifiable measures of the quality of care that could be used over time to compare facilities or to benchmark the whole system to track changes over time
- the standards provide enough incentive for providers to improve quality above the lowest common denominator.

The accreditation standards also offer no guidance on what is an acceptable mix or level of staffing (chapter 10). For example, J. Michael Wynne noted the importance the number and skills of staff for quality care and suggested that knowledge of these would help to empower consumer choice. He argued that residential facilities should be required:

... to disclose the number and skills of the staff they employ and to educate potential users of the nursing homes of its importance. (sub. DR568, p. 13)

While a national framework to streamline and standardise documentation was issued in 2005, complaints by providers remain (box 15.5; chapter 5). Also, as discussed in chapter 10, while ACSAA makes its decisions publicly available along with a copy of the assessor’s full report, these reports are often not user-friendly for lay readers.

In relation to developing outcomes-based (or performance-based) standards, the Queensland Nurses Union (QNU) drew attention to the Steering Committee for the Review of Government Service Provision’s (SCRGSP) (2010b) report, noting that:

... [the SCRGSP] commented that for several aspects of aged care services, indicators are not fully developed and there is little performance reporting available. We concur with the Commission’s priorities for the future which include:

- continued improvement of efficiency indicators, including for HACC services and assessment services;
- improved reporting of waiting times for residential aged care;

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- improved reporting of long term aged care in public hospitals;
  - further development of outcome indicators. (QNU, sub. 409, p. 18)

In this context, QNU pointed to a need to ensure the development of appropriate performance measures (and associated data collection) before moving to fully adopt and implement performance-based standards.

### **Box 15.5 Common criticisms of the accreditation process**

Too much focus on documentation in accreditation ...

A common criticism is that assessors focus too much on documentation to demonstrate that systems are in place, rather than looking directly at actual care practices and the outcomes that result ... Providers argue that the amount of time taken to complete desk work is time that could have been better spent attending to residents. (Weiner et al 2007, Appendix B, p. B-7).

And in investigations of non-compliance.

... once again direct care staff are left feeling that the paperwork is more important than the service and care provided to our elderly. (Fronitha Care, sub. 436 , p. 9)

There are different regulatory approaches in aged care and acute care:

The present aged care standards are focused more on the achievement of minimum standards than on the idea of continuous quality improvement. In contrast to the EQuIP program in Hospitals, aged care standards compliance is enforced via a range of sanctions available to the Commonwealth Government under the Aged Care Act. Best practice accreditation systems focus on quality improvement to find the underlying causes of errors or system failures so that their future incidence can be reduced. (Mercy Health, sub. 215, p. 9)

As discussed earlier, DoHA is still progressing the review of accreditation standards (which commenced in March 2008). At the time of writing, a range of options, including new draft standards, had been circulated for comment to stakeholders through the Ageing Consultative Committee. This committee has suggested changes to the range of options (DoHA, pers. comm., 11 November 2010). The Australian Government (through DoHA) is currently undertaking a public consultation process to consider the proposed changes to accreditation standards prior to finalising and drafting amended Quality of Care Principles (DoHA, pers. comm., 6 June 2011).

ACSAA noted that DoHA's review of accreditation standards was likely to recommend a strengthening of standards in regard to outcomes. ACSAA's preference

... is a focus on outcomes standards then if they are not available revert to process standards when there is evidence the process will deliver a positive outcome. (ACSAA, sub. DR763, p. 8)

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The Commission supports the strengthening of accreditation standards in regard to outcomes, where possible and practical (chapter 10). However, in the absence of information on the exact nature of the proposed changes to the existing quality of care standards and the ensuing comments on them, the Commission is not in a position to make detailed comments. That said, the development of accreditation standards should be consistent with the *Best Practice Regulation Handbook* (Australian Government 2010e) and be subject to periodic review.

### *Quality of care — community aged care*

Quality of care regulations in community aged care differ with those in residential aged care. First, because community care is delivered into people's homes it is often much more difficult to regulate in practice. But, second, community care typically involves a choice by the individual to trade-off a potential increase in risk against maintaining their own perceptions about the quality of life in community versus residential care. This perspective on the difference between residential and community care in developing appropriate standards has been put forward by Dianne Beatty:

Given community care is only one of usually many contributors to older people's lives in their homes and that older people living in their homes are effectively choosing quality of life and risk over the comparative safety of residential aged care, we recommend that:

- community care be not subject to the accountability and responsibility documentation levels and systems applied to residential aged care. (sub. 413, p. 4)

The quality of HACC and community aged care packages are currently subject to a range of different quality standards across jurisdictions. The development of these quality standards have been praised while the actual standards themselves have been criticised. For example:

Notwithstanding the progress made in implementing Quality Reporting across the community care programs, the process remains focused on service outputs. The process does not measure the quality of the respite experience, and hence its value, for the person with dementia and their carer. A shift in focus to the outcomes of service use, not just service outputs, is essential to supporting quality service provision, and suitable outcome measures need to be developed and adopted in quality assurance systems. (Bruen and Howe 2009, p. 53, attachment to Alzheimer's Australia, sub. 468)

The Commission has previously called for outstanding issues to be resolved so that jurisdictions can agree to a common set of community care quality standards and reporting arrangements consistent with the methodology and principles supporting Standard Business Reporting (SBR) (PC 2009a, p.86). The majority of these remaining problems appear to have been remedied, with Community Care Common

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Standards (appendix F) implemented by most jurisdictions from 1 March 2011 (with Queensland starting later).

In relation to reporting arrangements which are consistent with the SBR, DoHA has indicated that it is currently trialling an automatic financial reporting arrangement for community care providers under the NRCP. It has also indicated that once SBR has been tested, opportunities for expanding its application will be considered, subject to a compelling business case (DoHA, pers. comm., 11 November 2010).

Responding to the draft report, the Attendant Care Industry Association of NSW Inc (sub. DR614) noted that many providers are ‘drowning’ in regulation and the Community Care Common Standards only remedies some of the overlapping regulation faced by providers.

Publicly available information on the extent to which HACC, packaged community care, and NRCP services meet these new national Community Care Common Standards is also important for care recipients to be able to choose between providers and for broader public accountability. However, it is unclear from the guidelines (DoHA 2010d) whether the results and the performance measures will be made publicly available.

Consistent with best practice, a review of these Community Care Common Standards should be conducted at an appropriate point in the future.

#### RECOMMENDATION 15.4

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

#### *Prudential regulation*

Strong prudential regulation along with transparent reporting requirements are important to ensure accountability in the aged care industry (Financial Planning Association of Australia, sub. 376).

As noted previously, and in view of the rapid growth in the quantum of accommodation bonds which the Government guarantees, in April 2010 the Australian Government announced some changes to strengthen the prudential regulation of accommodation bonds. Following an open and transparent consultation process, on 26 May 2011 the Government introduced a number of

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amendments to the Act (Australian Government 2011c), as summarised in section 15.2

The Commission is strongly of the view that any proposed revisions to aged care standards (including quality care and prudential regulation) be developed in a way that is consistent with COAG's Principles of Best Practice Regulation. Further, proposed changes to prudential standards applying in aged care should also be consistent with broad prudential standards.

### **Taking steps towards encouraging and enforcing compliance**

Putting into practice 'responsive' regulation involves adhering to the principles of consistency, proportionality and transparency (appendix F). Other best practice arrangements include implementing a risk-based approach to ensure compliance (ANAO 2007).

#### *Consistency*

The principle of consistency ensures that similar workplace circumstances lead to similar enforcement outcomes. However, current governance arrangements which duplicate investigations into non-compliance potentially give rise to some inconsistent enforcement outcomes.

Robert Wilson has noted that the inconsistent approach to collecting consumer information between basic (that is, HACCC) and packaged community care, in turn, could lead to inconsistent enforcement decisions:

Unfortunately in [packaged community care] there is no engagement of consumers in evaluation or review of services (for example through the Quality Review process). (sub. 185, p. 5)

There are also perceived inconsistencies in the gathering of information for accreditation reviews. For example:

There have been reports by care staff of inconsistent evidence requirements, leading to delays and rework. (Blue Care, sub. 254, p. 58)

Such inconsistency in information gathering could arise for two different reasons. One is the result of adopting a risk-based approach to investigating potential problems. The other reason could be associated with differences between ACSAA and the CIS investigations processes, which in turn could lead to inconsistent enforcement outcomes.

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The Australian Nursing Federation (ANF) (Victorian Branch) is concerned that inconsistent enforcement outcomes arise because only those providers that get ‘caught’ are the ones who receive sanctions, while other similar (non-compliant) providers that manage not to get caught are treated differently:

On this point, ANF (Vic Branch) is regularly advised by our members of reports that an RAC facility can be deemed to be compliant with accreditation standards at the time of a scheduled visit from the Agency, yet the same home may become non compliant very shortly thereafter, or when the Agency undertakes an unannounced visit to the same home. (sub. 341, p. 24)

In response to this concern of the ANF (Victorian Branch), ACSAA (sub. DR763) notes that such a turn-around in compliance-status can occur during a follow-up visit. For example, ACSAA notes that most follow-up visits are conducted because the original assessor reported concerns about sustainability of the provider’s systems or ACSAA is in receipt of information about an occurrence that is on the list of significant risk creators (for example, loss of key personnel).

The OACC also pointed towards material in the Walton Review which provide evidence of inconsistency in enforcement outcomes:

... There was some discussion from providers about the miscommunication of outcomes. Some providers said that the investigator may relay one view of the outcome of a site visit but the finalisation letter advises a different outcome. (sub. 444, p. 8)

However, to the extent that the regulation of basic community aged care continues to be the subject of a number of jurisdictional responsibilities (even within the context of Community Care Common Standards), there is a possibility of some inconsistency in enforcement outcomes. That said, the Commission’s regulatory recommendations should reduce the likelihood of such inconsistencies.

### *Proportionality*

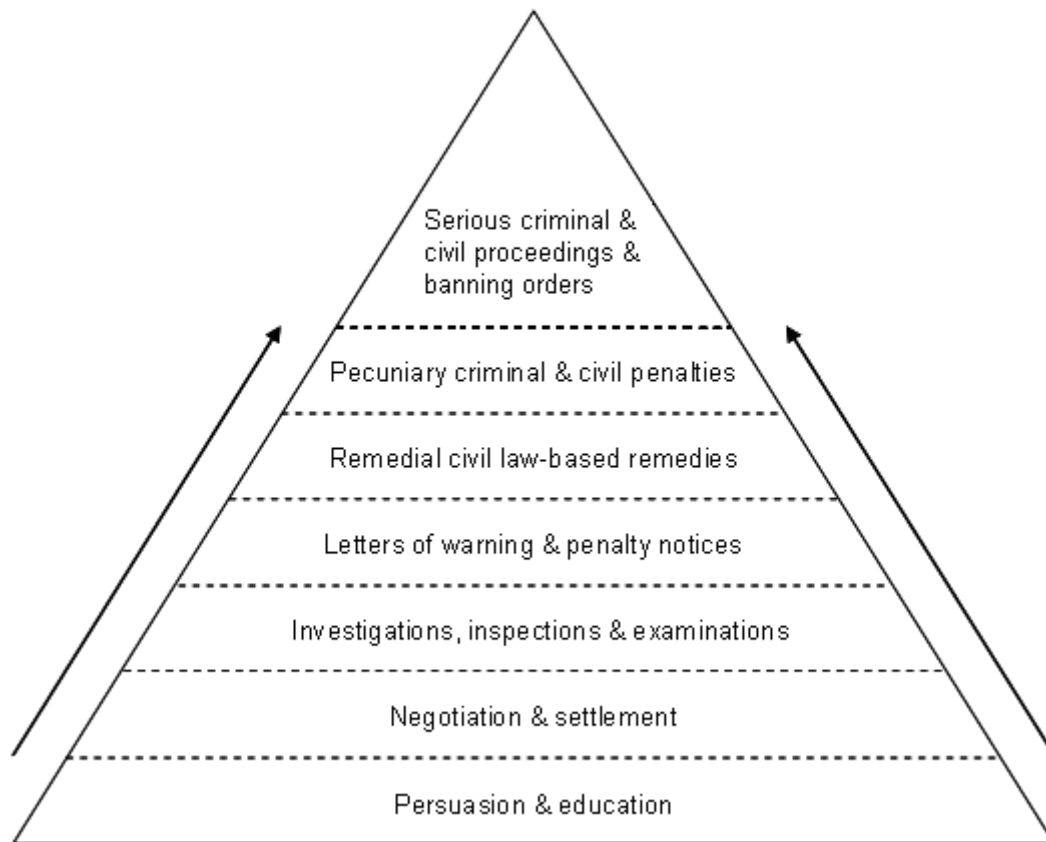
The proportionality principle focuses on the need for enforcement responses to be proportional to the seriousness of non-compliance. This is a key feature of the ‘responsive regulation’ model, where a regulator’s compliance and enforcement policy is based on a pyramid-shaped escalation of sanctions. The less severe (more often used) ‘advice and persuade’ options are reflected in the lower half of the pyramid while the more severe (but less often used) punitive strategies are represented at the peak of the enforcement pyramid (figure 15.3 and appendix F).



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Figure 15.3 Example of a compliance and enforcement pyramid<sup>a</sup>

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<sup>a</sup> Adapted from Gilligan, Bird and Ramsay (1999).

Source: PC (2010c, p. 112).

Currently, there is a range of enforcement tools that can be imposed on approved residential care providers for non-compliance with the Act (box 15.6). The imposition of these on approved providers is also dealt with in the Sanctions Principles 1997.

Many of the suspensions outlined in box 15.6 involve a loss of income for the facility while the revoking of a residential aged care facility's approved provider status amounts to its closure. If a provider's approval is revoked, the provider can agree to certain arrangements to ensure that the revocation does not take effect. If the sanction notice specifies that this is an option, the provider can agree to:

- provide, at its expense, training for officers, employees and agents
- provide security for a debt owed to the Australian Government
- appoint an adviser or an administrator, approved by the Australian Government
- transfer some or all of its allocated places to another approved provider.

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### Box 15.6 **Enforcement tools able to be imposed under the Act**

The Secretary of DoHA can impose one or more of the following sanctions, by notice, in writing:

- revoking or suspending approval as a provider of aged care services
- restricting approval to existing services or places
- restricting funding to existing residents
- revoking or suspending the existing allocation of places
- varying the conditions of approval for allocated places
- prohibiting the further allocation of places
- revoking or suspending extra service status
- prohibiting granting of approval for extra service status
- revoking or suspending certification
- prohibiting the charging of accommodation charges or accommodation bonds
- requiring repayment of grants
- appointing an adviser instead of revoking approval as a provider of aged care services
- appointing an administrator instead of revoking approval as a provider of aged care services.

*Sources:* DoHA (2009f, p. 237); Sanctions Principles 1997.

DoHA has also established adviser and administrator panels and the Sanctions Principles sets out the timetable for nominating and appointing people from those panels for enforcement purposes.

Sanctions on residential aged care facilities can be imposed in two ways. Either:

- immediately (if there is an immediate and severe risk to the safety, health or wellbeing of residents as a result of the provider's non-compliance) or
- after issuing a series of notices (if there is no immediate or severe risk).

The notices include: a notice of non-compliance; a notice of either intention to impose sanctions, remedy the non-compliance or impose sanctions to a specific part of the non-compliance; and a notice of a decision on whether to impose sanctions.

In relation to non-compliance with accreditation, DoHA (2009f) indicates that ACSAA can organise a review audit and DoHA can impose one of three types of

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sanctions: vary the period of accreditation, revoke accreditation, or not revoke accreditation, in which case DoHA may agree on a timetable for improvement.

The OACC pointed towards evidence from the Walton Review which showed that some consumer participants:

... considered that the actions required through an NRA [Notice of Required Action] were merely a slap on the wrist and not in proportion to the issue complained about or the breach found. (sub. 444, p. 9)

Similarly, responding to the draft report Kerry Williams supported the ability to issue fines in some circumstances:

... breaches of the Aged Care Principles 1997 [should be met] with a financial penalty not just a nasty letter. Without meaningful and material fines or punishments the basis of the Aged Care Principles 1997 is majorly flawed. (sub. DR501, p. 1)

Weiner et al. (2007) noted that, unlike enforcement systems in a number of other countries, the imposition of fines are not featured and have not generally been raised as an option in the Australian context. However, significant fines can create unintended consequences, especially for small providers.

The Commission notes that as the aged care system transitions away from its heavy reliance on quantity restrictions in residential aged care (for example, through removing bed licences and extra service places) the range of enforcement tools available to the regulator should be expanded. In addition, as the AACC (and its statutory office, ACSAA) take over the day-to-day administration of the quality of community care (via Community Care Common Standards), there will also be a need to develop a wide range of enforcement tools for community aged care.

Other types of enforcement options to assist the AACC to manage risk in the light of a serious and high risk complaint (for example, elder abuse) alongside usual processes for complaints, compliance visits and independent consumer advocacy could include:

- the power to refer serious matters with potential criminal liability to the appropriate jurisdiction — for example, in New South Wales, under changes to the *Crimes Act 1900* (NSW), people who seriously neglect elderly citizens in their care could face up to five years' jail (Hatzistergos 2010)
- greater use of fines — under the corporations law the Commonwealth has the power to levy a fine against an incorporated entity. For example, in cases of elder abuse, where a provider (either community or residential) has failed in their duty of care or contributed by way of negligence a financial penalty could be imposed on the entity

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- appointing an appropriately qualified external team (rather than a individual adviser or administrator (box 15.6)) to take over the administration of a residential aged care facility.

Peninsular Health (sub. DR784) noted that where a pattern of non-compliance in one area is emerging that the AACC should distribute the relevant information and advice to providers.

Reflecting the principle of proportionality, the UK's independent regulator of health and social care (the CQC) has available a wide range of enforcement sanctions (including criminal liability and fines) (CQC 2010a).

Finally, in the context of the 'responsive regulation' model's enforcement pyramid (figure 15.3), the Commission notes that ACSAA is broadly responsible for the bottom half while DoHA is broadly responsibilities for the top half of this pyramid. The Commission's proposal to establish ACSAA as a statutory office within the proposed independent regulator (the AACC) will support this new body to implement an approach to administering regulation which is consistent with 'responsive regulation'. Importantly, one body (the AACC), rather than two bodies (ACSAA and DoHA), would be responsible for implementing this model's enforcement pyramid.

#### RECOMMENDATION 15.5

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

Given the continued involvement of a number of states and territories in the regulation of basic community care, harmonisation of enforcement tools to ensure the proportionality principle is adhered to will involve negotiation and agreement — between the Australian, Victorian and Western Australian Governments in particular. The Commission can find little evidence of benefits arising from a split system given the desirability of developing a seamless care and support system across Australia.

***In the period prior to the implementation of the Commission's new integrated model of aged care, all governments should agree to reforms to aged care services delivered under the Home and Community Care (HACC) program to allow the Australian Government to be the principal funder and regulator. However, in the event that they do not agree, the Victorian and Western Australian Governments should agree to harmonise (from 1 July 2012) the range of enforcement tools in HACC delivered aged care services.***

### *Transparency*

The principle of transparency enables regulators to demonstrate impartiality and balance in the decisions they make. Aside from the lack of transparency in reporting the results of national standards assessments for basic community care, there are a number of other areas where transparency could be improved. For example, the OACC (sub. 444) noted the problems arising from the lack of transparency in the complaints process outlined in the Walton Review. Blue Care also noted that the procedures around complaints lack transparency:

The [CIS] investigates all complaints made to them by visiting the facility usually for a whole day and asking for a large range of seemingly irrelevant material including interviews with people unrelated to the incident in question. In some cases the matter will be referred to [ACSAA], but it is unclear when this is meant to occur. (sub. 254, p. 62)

The Victorian Health Services Commissioner also pointed to, among other things, the lack of transparency in the regulatory processes around complaint handling:

... Communication is inadequate, investigators do not have complaints specific training, the CIS's processes are not accessible to the complainant and there is a lack of clinical expertise. There is insufficient referral for expert advice. (sub. 349, pp. 1–2)

The Lesbian and Gay Solidarity (Melbourne) also suggested:

That CIS provide more public information about the majority of the complaints: where have they come from e.g. residents of facilities, their families, suppliers of services to a facility etc; the kind of complaint e.g. treatment, food, discrimination, the quality of care, unqualified staff, intimidation of residents so that they are afraid to use formal methods to complain, financial abuse of the elderly etc. (sub. 115, p. 24)

With the establishment of the AACC, it will be important for its work practices to embed transparency in decision making. The approach should also build on the findings and recommendation 1 of the ANAO's recent audit of *Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care*

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*Homes* (ANAO 2011). In particular, the ANAO recommended that — in order to improve transparency on the rights and responsibilities of the different stakeholders — DoHA develop a Service Charter (and report annually against it) and ACSAA report annually against its existing *Charter of Commitment to Service Quality*. (DoHA and ACSAA have agreed to this recommendation.)

### *Risk-based approach*

The emphasis in the ‘responsive regulation’ model is on using a risk-based approach such that those assessing compliance are also able to carry out compliance and enforcement actions. In this context, it is important that the AACC has access to a range of tools to manage risk in the light of a serious and high risk complaint. Situations of elder abuse and life threatening risks to the health of the frail elderly are examples of two such risks.

As the ANAO (2003, p. 19) noted, to ‘... be effective, the risk management process needs to be rigorous, structured and systematic’. However, by itself risk management is not enough, otherwise it may become a procedure-based exercise. Tacy (2004) explained that employees need to be engaged in and have ownership of all the various elements of good public sector governance (see ANAO 2003; Barrett 2003; McPhee 2007) to make a risk-based approach work. In turn, this is a function of the behaviours and values of the organisation’s leaders and of the overall culture of the organisation.

It is imperative that the AACC adopt good public sector governance arrangements (ANAO 2003 and 2007; Department of Finance and Administration 2005) that facilitates an appropriate risk-based approach to its compliance and enforcement activities. In particular, the AACC should also incorporate the findings and recommendation 2 of ANAO (2011), which suggested DoHA develop a common risk profile for each approved provider and undertake aggregate analyses of the information contained in these risk profiles. (DoHA has agreed to this recommendation.)

### **Putting into place streamlined reporting arrangements**

The Commission’s *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services*, noted as a key point that:

Many industries complained of overly burdensome, duplicative and redundant reporting requirements. Extending the SBR principles and methodology to many of the sectors covered in this review could substantially reduce the reporting burden. (PC 2009a, p. XIX)

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As highlighted in submissions to this inquiry, the reporting requirements often take up management and staff time which could be better directed towards other activities, primarily the care of residents (chapters 5, 10 and 14).

While ACSAA notes that it has promoted the use of IT, it also objected to the inference that it was the accreditation process itself that contributed to the frustration expressed by many providers regarding the amount of documentation. It noted that:

To date, the evidence does not support the proposition that such documentation is required by the accreditation process exclusively for the purpose of assessment of the performance of the home.

... Arguably some documentation is undertaken as a protective strategy by aged care workers. (sub. DR763, p. 10)

In February 2011, ACSAA announced a project to ascertain ‘what, if any, documents people create exclusively for the purpose of accreditation and developing a strategy to stop the practice’ (sub. DR763, p. 10).

While the current scope of SBR is to reduce the burden of business-to-government financial reporting, there is broad potential for SBR methodologies to ease regulatory burdens in other sectors, including aged care (box F.3, appendix F).

In implementing the National Quality Reporting Framework (NQRF) (now known as Common Care Community Standards) for community aged care, the Australian Government (2009a) indicated that the NQRF will be implemented broadly in line with the objectives of Standard Business Reporting (DoHA, pers. comm., 11 November 2010).

No such process currently appears to exist for streamlining reporting in residential aged care.

As illustrated by the introduction of the Australian Government’s e-health initiative, there is significant scope for information technology to reduce the burden of reporting. The AACC should explore the case for embracing technological advances in receiving and transmitting information from and to providers in line with SBR. This could be facilitated by imposing a requirement that all providers submit key reports electronically to the AACC.

RECOMMENDATION 15.7

***The Australian Government should introduce a streamlined reporting mechanism for all aged care service providers (across both community and residential aged care) based on the model used to develop Standard Business Reporting.***

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## 15.4 Reducing the extent and burden of regulation

There appear to be two main areas in which regulation has extended beyond what might be considered reasonable. First, are quantity and price restrictions. Second, are a number of other areas associated with service delivery where regulations have inexorably grown in response to incidents involving aged care residents — following such an incident, the Government is pressured to ‘act’, leading to ever more regulation, often without examining the efficacy and efficiency of the additional regulation.

### Reducing existing quantity and price restrictions

Historically, the Australian Government (as the predominant funder of aged care) has sought to limit its fiscal exposure by limiting supply.

In residential care, this has mainly occurred through capping the number of bed licences. Consequently, to manage fiscal risk and in order to ensure that providers do not abuse local market power created by this supply restriction, price controls — covering fees (determined by ACFI), basic daily living fees and high care accommodation charges — have also been established (chapter 5).

In community care, chapters 5 and 9 document a number of quantity restrictions and restrictive pricing arrangements. The consequences of these restrictions are: long waiting times for assessment of needs; the limited number, nature and funding of ‘packages’; reduced competition; and the inability of providers to respond to demand.

Recommendations in previous chapters to address these problems include the progressive removal of quantity constraints, improved price setting processes and the partial liberalisation of prices.

#### *Appropriate prudential regulation of accommodation bonds remains necessary*

As the recommendations from this inquiry include the retention of (limited) accommodation bonds as one form of funding of residential aged care, a variety of related prudential regulations will continue to apply.

As noted above, enhanced prudential arrangements for accommodation bonds have been introduced into the Australian Parliament and the Commission suggests (section 15.3) that these amendments to the Act be subject to consideration of broad prudential regulation and COAG’s Principles of Best Practice Regulation.



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While the Australian Government (2009) accepted in principle a number of recommendations to change prudential regulations in the Commission's 2009 *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services* report, it did not accept the Commission's recommendation in relation to consumer disclosure requirements. In particular, the prudential regulations include mandatory requirements which require providers to disclose the following information to residents and potential residents:

- a statement about whether the provider complied with the prudential standards in the financial year
- an audit opinion on whether the provider has complied with the prudential standards in the relevant financial year
- the most recent statement of the aged care service's audited accounts.

As indicated in its response to the Commission's (PC 2009a) recommendation on this issue, the Government had planned to evaluate these consumer Disclosure Standards (Australian Government 2009a) but this did not proceed (DoHA, pers. comm., 11 November 2010). Previously, Aged and Community Services Australia has been critical of the reporting requirements associated with prudential regulation (PC 2009a). By contrast, Aged Care Crisis (sub. 433) support full transparency and disclosure to consumers of all aspects of residential aged care.

While the ANAO's (2009) audit on the *Protection of Residential Aged Care Accommodation Bonds* did not make any recommendations which were specific to these current consumer disclosure requirements, it did recommend that DoHA develop a client service charter and regulatory code of conduct in relation to the prudential regulation of the bonds and that DoHA report annually on performance against this charter. This client service charter has been finalised (Australian Government 2011c) and made publicly available to external stakeholders on 1 February 2011 (DoHA, pers. comm., 6 June 2011).

The Government also operates an Accommodation Bond Guarantee Scheme — which guarantees the refund of accommodation bonds to residents in the event that a provider becomes insolvent.

In the light of the recently announced strengthening of prudential regulations of accommodation bonds (Australian Government 2011c) and given that all seven ANAO (2009) recommendations in relation to the prudential regulation of accommodation bonds have been accepted, in its draft report, the Commission considered there was not a strong case for continuing the mandatory disclosure requirements to consumers. To reduce the (not insignificant) disclosure burden associated with servicing incumbent and prospective care recipients, the

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Commission’s draft report recommended the removal of their ‘mandatory’ status, while making them available on request.

In response to the Commission’s draft proposal in this area, a number of submissions (while noting the regulatory burden in this area) did not agree with the premise that consumer’s be required to request such information. For example, COTA stated:

As a general principle COTA does not favour an approach that means people have to know what questions to ask before they get the information they may need. ... an alternate approach may be to provide a simple statement saying the provider complies with the prudential arrangements each year and letting people know how they can access further information. (sub. DR565, pp. 14–15)

And Mary Lyttle from Elder Rights Advocacy said:

... why should the onus be on the person to ask? It should be on the provider to disclose. (trans., p. 79)

Having considered this feedback, the Commission recommends that providers should disclose (in a simple statement) they have met all necessary prudential regulations and be required to make available financial information on request.

#### RECOMMENDATION 15.8

***The Australian Government should amend the residential aged care prudential standards to require residential aged care providers to disclose (to care recipients or prospective care recipients) whether they have met all prudential regulations in the current and previous financial years. At the same time, providers should be required to indicate that the following would be made available on request, rather than automatically:***

- ***an audit opinion on whether the provider has complied with the prudential standards in the relevant financial year***
- ***the provider’s most recent audited accounts.***

### **Removing other restrictions**

Chapter 5 documented a number of areas where regulation has grown in response to incidents involving residential aged care residents, and which, in turn, has created burdens and limited choice and flexibility.

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### *Regulation relating to residents' safety is at times burdensome*

In relation to a number of regulatory burdens relating to residents' safety, the Commission (PC 2009a) made a number of recommendations and the Australian Government (2009a) responded by establishing the previously mentioned review of the accreditation standards and processes and by seeking opportunities to harmonise the arrangements for police checks, including learning from developments through COAG's Exchange of Criminal History Information about People Working with Children Project, being progressed under the *National Framework for Protecting Australia's Children 2009-2020* when this information becomes available (DoHA, pers. comm., 11 November 2010). The Australian Government, however, did not accept the Commission's (2009a) recommendation in relation to missing residents.

In this inquiry, several participants — namely the Aged and Community Services Association of NSW & ACT (ACSA NSW) (sub. 140) and Baptistcare (sub. 426) — raised the examples of the reporting of missing residents, police checks and the mandatory reporting of assaults as added regulatory burdens on approved providers. Some of these were regarded as 'additional regulations other than the normal checks and balances afforded to the acute sector' (Baptistcare, sub. 426, p. 6).

### *Missing residents*

The regulations on reporting missing residents require providers to report to DoHA those residents who have been reported missing to the police within 24 hours of the report to police. These requirements are set out in the Act's Accountability Principles 1998.

While some submissions (ACSA, sub. DR730; ACSA NSW, sub. 140; National Presbyterian Aged Care Network, sub. 110) argued that these regulations be repealed, others such as the Aged Care Association of Australia (ACAA) (sub. 291) and Blue Care (sub. 254) argued for modifications to them because of the increase in the compliance costs and regulatory burden associated with these and other reporting requirements. Benetas (sub. 141) is currently trialling a tracking device that triggers an alarm when the resident moves outside specified coordinates. The device also enables the person to be easily found. Extending such technology across the industry may make redundant these regulatory requirements.

Elder Rights Advocacy supported the draft report proposal to amend the missing resident reporting requirements:

Amendments to reporting of missing residents ... seem reasonable, and should ensure the most appropriate agency (the police), are actively engaged as early as possible to locate residents and ensure their safety. (sub. DR680, p. 11)

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Other organisations (for example, the Association of Independent Retirees (Queensland), sub. DR549; NSA, sub. DR580) opposed any loosening of service provider requirements in reporting missing residents.

The Commission's regulatory burdens report (PC 2009a) noted that the short reporting time frame (24 hours) takes resources away from the priority at hand (reporting to the police and finding the missing resident). While the reporting requirement allows DoHA to offer prompt support to the family of the missing resident and ensure a quick assessment of whether or not the facility concerned had the appropriate systems in place, a longer reporting time frame would still allow any systemic problems to be dealt with once the initial emergency has passed. The proposed independent regulator (the AACC) would receive these reports under the proposed new governance arrangements for aged care.

RECOMMENDATION 15.9

***The Australian Government should amend the missing resident reporting requirements in the Accountability Principles 1998 to allow a longer period for providers to report missing residents to the Australian Aged Care Commission, while continuing to promptly report missing residents to police services.***

*Mandatory reporting of assaults*

In relation to the compulsory reporting of assaults, the OACC (sub. 444) pointed to the difficulties and complexities faced by providers in relation to compulsory reporting of assaults. For example:

While providers fulfil their obligations under the Act by making reports of prescribed matters, the CIS has, at times, used the report to find the provider in breach of their responsibilities. The providers felt this was contrary to the legislative intent.

... Providers also explained that it was damaging to the team environment, in that it could set staff members against each other. (sub. 444, p. 8)

Drawing on the results of an on-line survey on compulsory reporting of assaults and the outcomes of an industry 'think tank', ACSA NSW (sub. 140) argued that a comprehensive review of the compulsory reporting of assaults be undertaken.

The regulations on compulsory reporting of assaults require all approved providers of residential aged care to report to DoHA and the police all allegations or suspicions of resident physical abuse within 24 hours of the allegation being made or the suspicion being raised. The reporting requirements apply to all except in very specific and sensitive circumstances. (These regulations are in sections 63–1AA and 96-8 in the Act.)

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The Commission acknowledges that sensitive and ethical concerns are raised when considering these issues. Having a conciliation function within the complaints area of the regulation Commission is also likely to assist in promptly remedying these types of issues (recommendation 15.2). As the regulations are relatively new, it would be more appropriate to address this issue within the context of the proposed broader review of the new reforms (chapter 17).

In its draft report, the Commission sought views on whether a review of mandatory reporting is warranted and, if so, the specific areas of the current policies that may require review or modification. Of the small number of responses, there were mixed views.

Consumers or consumer-based groups were concerned about the possibility of a dilution of protections in place to deal with situations of elder abuse (for example, the CPSA, sub. DR760; Elizabeth Hannan, sub. DR672; Older Women's Network NSW, sub. DR684; and the Light Residents & Ratepayers Progress Association, sub. DR913).

Providers (Aegis Aged Care Group, sub. DR564) and industry peak bodies (ACSA, sub. DR730) suggested that it was time for a review. ACSA suggested some amendments in the event that these reporting requirements were not repealed.

Others, such as the National Presbyterian Aged Care Network (sub. DR547), cited a summary of the arguments for and against mandatory reporting by Mason (1997) and pointed to the findings of the New South Wales Wood Special Commission in relation to the problems surrounding mandatory reporting in the area of child protection.

Best practice principles suggest a review of the current mandatory reporting of assaults should occur at some future stage but there is not enough evidence to suggest that this is an immediate priority.

## **15.5 Clarifying and simplifying jurisdictional responsibilities and harmonising regulation**

Both the harmonisation of community care standards (the Community Care Common Standards) and the reforms to funding and regulatory arrangements for HACC (from 1 July 2012 under the National Health and Hospitals Network Agreement) are significant steps towards simplified jurisdictional responsibilities. However, until Western Australia and Victoria agree to the reformed HACC arrangements, the regulation and funding of community aged care will continue to

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be subject to different jurisdictional arrangements across Australia. Accordingly, the Commission supports COAG continuing to work towards achieving simplified jurisdictional responsibilities in relation to HACC until such time as it is incorporated into the new integrated model of care (recommendation 15.6).

Notwithstanding the harmonisation of quality of community care regulation through the development of Community Care Common Standards, some organisations (such as Australian Home Care Services, sub. DR509) that operate across multiple legislative and programmatic jurisdictions note that they will continue to encounter regulatory burden. The submission from the Attendant Care Industry Association of NSW (sub. DR614) also drew attention to this issue. In addition, Australian Home (sub. DR509) suggests the compliance regimes across aged and disability sectors should be aligned.

A number of previous reports (Banks Review 2006; PC 2008 and 2009a), as well as submissions to this inquiry, have pointed to areas where duplication or regulatory overlap are causing problems. The main issues fall within five areas: the building code; retirement village legislation; infectious disease outbreaks, occupational health and safety, food safety and nursing scopes of practice; enduring guardianship, enduring power of attorney and advanced care directives; and elder abuse.

### **The building code**

In relation to the issue of duplicate accreditation arrangements covering aged care buildings, chapter 12 notes that the Australian Government has amended the Quality of Care Principles to replace the annual Fire Safety Declaration process with an exception reporting process.

In relation to incorporating residential care building requirements into the Building Code of Australia (BCA), the consultation process conducted by DoHA has highlighted technical issues that need to be addressed and has raised possible alternative approaches. DoHA is considering the implications of the issues raised through the consultation process and will further consult with the Australian Building Codes Board (chapter 12).

### **Retirement village legislation**

Some submissions called for state and territory government retirement village regulation to be aligned with the Australian Government's regulation of aged care, arguing that this would facilitate the transition of village residents to residential care

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within their community. The Commission found (chapter 12) no compelling case for such alignment. However, changes proposed by the Commission (to remove restrictions on the number of residential care places, to provide a single integrated system of care provision and consumer choice of care providers) will substantially address residents' concerns about not being able to age in their village community.

A number of submissions also raised problems with existing state and territory retirement village legislation from the perspective of consumers and providers. Chapter 12 recommends that while retirement village legislation should remain the responsibility of state and territory governments, those governments should pursue nationally consistent legislation through the standard COAG arrangements.

### **Infectious disease outbreaks, occupational health and safety, food safety and nursing scopes of practice**

The Commission (PC 2009a, pp. 68–72), in relation to the issue of duplicate regulations, drew attention to evidence suggesting that:

- regulations in residential care homes for infectious disease outbreaks like gastroenteritis are more onerous than in health (private and public hospitals) or human services (child care centres)
- because the fourth aged care Accreditation Standard covers physical environment and safe systems, there is a tendency for ACSAA assessors to make judgements and recommendations about occupational health and safety (OHS) matters
- ACSAA assessors attempt to comment on or make recommendations in relation to food safety
- some state and territory legislation on nursing scopes of practice are more prescriptive than the *Aged Care Act 1997*, with such restrictions on nursing practice reducing the efficient management of aged care facilities (and nurses' job satisfaction) without any noticeable benefit to residents.

In relation to the first three points above, the Commission recommended that DoHA use the reviews of accreditation processes and accreditation standards to identify and remove onerous duplicate and inconsistent regulations. As indicated above, the Australian Government accepted this recommendation but, at the time of writing, while the accreditation process review had been finalised, the accreditation standards review had yet to be finalised (DoHA, pers. comm., 6 June 2011).

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## **Advance care planning, elder abuse, enduring guardianship and power of attorney**

The topic of individual choice and the quality of life at the end of life is one that is often unsettling for many people (Gillick 2006; chapter 10). Independent consumer advocacy arrangements can play a role in this context (section 15.2 and chapter 9) and relevant regulatory arrangements cover a variety of legal arrangements, including advance care plans, enduring guardianship and power of attorney.

A number of submissions encouraged the promotion of advanced care planning to facilitate improved choice by individuals and the receipt of palliative and end-of-life care that accords with their wishes (box 15.7; chapter 10).

In 2009, Australia's Health Ministers endorsed the development of nationally consistent best practice guidelines for the use and application of advance care directives. Following targeted consultations in 2010, the National Advance Care Directive Working Group completed the *National Framework for Advance Care Directive* and this document was submitted to the Australian Health Ministers Advisory Council for consideration in 2011 (DoHA, pers. comm., 9 June 2011).

Some submissions have pointed to the confusion and difficulties which arise from jurisdictional differences in legislation relating to ACDs, power of attorney and enduring guardianship legislation. Others indicated that power of attorney and enduring guardianship arrangements were also vehicles for elder abuse by family members and hence required appropriate safeguards (box 15.8).

To support the current COAG initiative to develop a National Framework for Advance Care Directives, there is a case for harmonising state and territory based legislation for enduring power of attorney and enduring guardianship. Protocols for protecting individuals from potential abuse from attorneys and family members — including the ability of advocates, Visitors and providers to refer matters to relevant boards or authorities — should be included in this harmonisation process.

Palliative Care Australia (PCA) (sub. DR731) supported the Commission's proposals regarding the harmonisation of ACDs across state and territory jurisdictions but felt this should be in the context of developing national legislation, national guidelines, forms and associated information.



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## Box 15.7 Advance care planning and individual choice

Roger Hunt suggests that the Respecting Patient Choices Program (RPCP) — jointly funded by the Australian and Victorian Governments — offers an established model for advance care planning that could be rolled out systematically into residential care homes:

Satisfaction with care is improved when residents are given the opportunity to express their wishes about their management, and clinicians show a willingness to respect their wishes. (sub. 12, p. 2)

Palliative Care Australia (PCA) have also pointed to the importance of advance care plans, considering them to be:

... an important social investment to help ensure quality care at the end of life that accords with the individual's needs and preferences. Advance care planning should be consumer driven and controlled, providing a reliable and flexible mechanism to anticipate and express care choices, in partnership with and supported by the health system. Broader application and coordination of advance care planning provides a mechanism to plan and thus better meet patients' needs, while limiting unnecessary hospitalisations. (sub. 77, pp. 14–15)

In addition, General Practice Victoria suggested that:

... The shared electronic health record should also serve as a point of storage for advance care planning documents (i.e. Medical Enduring Power of Attorney, Refusal of Treatment certificates, statements of wishes) as this will enable them to be accessed at any time, from any place including hospital Emergency Departments. (sub. 235, p. 4)

The Centre for Health Communication has called for the further evaluation of existing tools and models of care in the Australian context:

For example The Gold Standards Framework developed by Dr Keri Thomas and her colleagues in the UK for use in the community and now adapted for implementation in Acute Care Settings and Aged Care Facilities and The Respecting Patient Choices Programme, an initiative originally piloted in Melbourne, and now being implemented inconsistently across several other states, including at John Hunter Hospital, Newcastle, NSW. Such initiatives need to involve consultation with all stakeholders involved including GPs, Ambulance Services, Aged Care providers and Acute Facilities. (sub. 280, p. 3)

The Federation of Ethnic Communities Councils of Australia (FECCA) noted some barriers to meeting palliative and end of life care needs in culturally and linguistically diverse (CALD) communities:

CALD seniors face distinctive issues in this regard, as while planning for later life is increasingly recognised as an essential strategy for helping navigate this life stage, extended family, religious beliefs and other cultural considerations often result in CALD communities paying scant attention to later life planning. Barriers to effective end of life planning include the sensitivities that underpin losing ones decision-making ability, legal costs, trust, family conflict, lack of prior experience in country of origin, and handing over control of finances. (sub. DR620, p.16)

W.G. Alcock also said:

The majority of ... patients would welcome the opportunity to make a choice for a dignified and peaceful death. I cannot understand why the government will not grant approval to those who have documented this choice in an advance care directive. (sub. DR495, p.1).

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## Box 15.8 Views in submissions on advance care directives, power of attorney and enduring guardianship

*There is confusion between them ...*

Pam Webster said:

... To ensure that an Advanced Health Care Directive is carried out, it is also important that people appoint a Power of Attorney and have an Enduring Guardianship in place. There needs to be some work done to promote these concepts so that the majority of people have these in place. Even more importantly, there needs to be a change in the legislation in all states and territories across Australia to remove current differences. One way may be to have Federal Government legislation that overrides any differences in the state and territory legislation. (sub. 178, p. 5)

Similarly, The Aged-care Rights Service (TARS) noted:

... the confusion created by the different definitions of Power of Attorney and Guardianship documents adopted by different state legislation. Clarity as to the role of a Guardian and the role of an Attorney across Australia could be achieved through the introduction of Commonwealth legislation. (sub. 322, p. 8)

Taking a step further, TARS (sub. 322) argued for civil and criminal remedies against attorneys who abuse their position under an enduring power of attorney appointment and offered an approach to how this could be achieved.

*... and they can potentially lead to elder abuse*

The South Eastern Region Migrant Resource Centre said:

... There have been instances of carers and family members taking advantage of enduring power of attorney, abusing the privilege for profit. There needs to be a regime of strict safeguards and monitoring if the doctrine of consumer-directed care becomes widespread. (sub. 126, p. 2)

Blake Dawson suggested that from the perspective of a provider it is often unclear whether and how to bring proceedings before a guardianship tribunal or board. They argue that consideration should be given to:

... legislating or facilitating recourse to or access to such bodies by approved providers (without fear, for example, of reprisal from family members) or in establishing a national body that can deal with these issues in the context of providing aged care services. (sub. 465, p. 44)

In addition, Blake Dawson argued for a gateway approach to consumer services. These are described in this submission as 'Senior Living Centres', which provide locally focussed case management and community service centres. In the context of guardianship issues, Blake Dawson suggests that:

Senior living centres could also perform a role in this regard, either through being conferred powers to refer matters to existing guardianship mechanisms or by playing a greater role in direct advocacy and intervention. (sub. 465, p. 44)

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While PCA (sub. DR731) noted that Commission's recommendation to harmonise ACDs is consistent with the *National Palliative Care Strategy 2010* (Australian Government 2010i), another submission felt that the Commission's draft recommendations in relation to ACD's could have gone further. In particular, the Respecting Patient Choices (RPC) 'Making Health Choices' Project Steering Committee remarked that:

... Advance care planning is a key component of effective palliative care. In addition, we support the draft recommendation that legislation and documentation around advance care planning is made nationally consistent ... It is vital that the process of advance care planning is clear and effective regardless of state of residence. Standardised documents and legislation will help to ensure that treatment preferences are known and respected. The process of standardisation needs to be prioritised and achieved in a timely manner.

The draft report clearly highlights the need for improved patient centred care and consumer choice. We were therefore surprised that advance care planning was not included more extensively in the draft recommendations. We would suggest that advance care planning is a key component of consumer choice and patient centred care, and that its inclusion in the reform of the aged care system will help to improve the provision of high quality care and provide protection for this vulnerable population. We believe that the draft report reflects a lack of awareness that the provision of quality advance care planning is a holistic, systematised process that is significantly more complex than ensuring consistent legislation and documentation. (sub. DR803, p. 1)

The Commission acknowledges this view and strongly supports the use of ACDs within the context of enabling high quality care, consumer choice and patient centred care.

### *Elder abuse*

Citing research from the Elder Abuse Prevention Association, the Australian Greek Welfare Society (AGWS) (sub. 225) noted there are approximately 100 000 unreported cases of abuse, neglect and exploitation of elders throughout Australia every year. According to that research, most perpetrators are likely to be a family member. Other research conducted by the AGWS (sub. 225) also suggests that there is little knowledge or understanding of elder abuse and that the most obvious form of abuse is financial abuse. Accordingly, AGWS have called for education and information to enhance awareness of this issue and learning how to access supports, especially among CALD communities.

The Ethnic Communities' Council of NSW suggested that financial abuse of the elderly could lead to homelessness and inhibit their ability to seek access to appropriate services and supports:

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... some older people are at risk of homelessness as a result of loss of assets and income support which are transferred under pressure to their children who either seek to manage their parents' income or absorb it in the cost of caring by their adult children. Lack of independent finances puts pressure on older people's ability to access appropriate services or seek support. (sub. DR648, p. 12)

The Association of Independent Retirees (sub. DR558) contends that shortages of staff along with unqualified staff is akin to elder abuse in RACFs.

The Law Council of Australia noted that while elder law is rapidly emerging as an area of specialised law — because of the unique and complex legal needs of the elderly, which include substitute decision making, guardianship and criminal law relating to fraud and financial abuse. Moreover, the Law Council of Australia stated that:

Laws affecting older Australians have national implications due to Commonwealth regulation and the acknowledged need for harmonisation of State and Territory legislation, as demonstrated by the decision of the Standing Committees of Attorney General (SCAG) to place powers of attorney on their agenda. (sub. DR826, p. 1)

In its response to the draft report, COTA called for the harmonisation of state and territory legislation on elder abuse, saying:

We were disappointed that the report does not say much about elder abuse and has no specific recommendations about it. Currently the States and Territories take responsibility for elder abuse initiatives and services; there is general agreement that this is an under researched and under resourced issue. COTA believes that the report should make a recommendation for harmonisation of legislation and that the Commonwealth should work with the States and Territories through COAG and the Ministerial Council on Ageing to improve data collection, research and initiatives to encourage the identification of elder abuse and to combat it. (sub. DR565, p.25)

Because elder abuse is a criminal offence which applies to a person (rather than an entity) it falls within the jurisdiction of state and territory governments. Moreover, as most elder abuse is likely to be perpetrated by a family member and that power of attorney and enduring guardianship arrangements are vehicles for financial elder abuse by family members, elder abuse law should be harmonised in association with the harmonisation of power of attorney and guardianship laws across jurisdictions.

As discussed earlier, the Commission has also raised the possibility of the AACC having the power to fine providers who have failed their 'duty of care' responsibilities or have contributed to elder abuse by way of negligence.

Finally, responding to the Commission's draft recommendation in relation to onerous duplication and inconsistent regulations, UnitingCare Australia (UCA) (sub. DR839) noted that it was consistent with previous Commission

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recommendations (recommendations 12.6 – 12.8) made in its report on the *Contribution of the Not-for-Profit Sector* (PC 2010b). The Consumers Health Forum (CHF) (sub. DR584) also drew attention to the links between the Commission’s draft recommendations and the National Health and Hospitals Reform Commission recommendations to improve palliative care services in residential and community aged care settings. CHF (sub. DR584) also considered that the list of regulations that required harmonisation across jurisdictions (outlined in the draft report) was not exhaustive and called for further research to identify the full regulatory burden on aged care.

RECOMMENDATION 15.10

***The Council of Australian Governments should identify and remove, as far as possible, onerous duplicate and inconsistent regulations, including in relation to infectious disease outbreaks, occupational health and safety, food safety, nursing scopes of practice, advance care plans, power of attorney, guardianship and elder abuse.***



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## 16 Aged care policy research and evaluation

### Key Points

- An evidence-based policy approach is about providing the best possible evidence to inform the development and implementation of sound public policies. Reliable and accessible data and quality research are essential components.
- In the current framework, data about the aged care sector are regularly collected, but there is limited reporting and publicly available analysis of these data. There are grounds to:
  - increase the availability, accessibility, and coordination of data currently collected by establishing a national data clearinghouse
  - increase the usefulness of data by establishing consistency across datasets, improving linkages of databases and developing more outcomes-based data
  - increase public accountability through greater transparency and independence of research reviews and evaluations.
- Improved and more timely access to aged care data allows greater scrutiny of published findings and results, and better informs public debate and assessment of the sector.
- A more consumer-directed aged care system will require accessible and reliable data and information to assist older people and their carers, as well as governments, providers and other decision-makers.
- Consistent, timely, and accessible data will provide the basis for valuable research into aged care and help build a better evidence base to support ongoing policy evaluation and development.

Reliable and accessible data and quality research are essential for good policy outcomes. However, as noted throughout this report, there is a significant lack of publicly available data and policy relevant evidence in the area of aged care. This limits the scope for comprehensive and independent assessment of the system. It also means that care recipients, their families, and service providers might not be as well informed as they could be in making decisions about care and support needs.

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This chapter looks at the scope for improvement in: data collection and its access by older people and their carers, providers and researchers (section 16.1); building a better evidence base (section 16.2); and research capacity (section 16.3).

## 16.1 Improving data collection and access

Many participants to this inquiry argued that more could be done with the data that are currently collected on aged care. They also argued that there is scope for significant improvements in the collection and dissemination of good evidence to assist the development of aged care policy. Over the last decade or so, aged care recipients, providers and workers have struggled to achieve major reform, despite a number of inquiries and reports. Evidence is increasingly seen as an essential building block to establishing a more convincing case for reform and enhancing the prospect of reform being adopted.

### Coordination of data sets

While data on aged care services are collected regularly, participants argued that the usefulness of these data is limited because of a lack of coordination of some data sets. The New South Wales Government, for example, argued the need for consistent data definitions:

The current maintenance of separate data bases, for example, for the Aged Care Assessment Program Minimum Data Set (MDS) and the [Home and Community Care] MDS, limits the usefulness of routine performance and activity reporting for the purposes of accountability and transparency. Combining these data bases and using consistent data definitions will facilitate future monitoring of access to and use of services by older people and help identify any gaps in service delivery. (sub. 329, p. 11)

Anglicare Sydney saw the need for better coordination of data across both programs and jurisdictions:

Currently a significant amount of data is being captured by Government in various databases for various programs across the country. However there appears to be no intention to consolidate and analyse this data for high level reporting back to the sector on performance and outcomes. (sub. 272, p. 14)

The Aged Care Association of Australia suggested that there was a unique opportunity to better coordinate data collected on aged care services with that held by Centrelink and Medicare:

... between Centrelink and Medicare there is a very substantial database on each person's history, domestic status and financial circumstances. There is a unique opportunity to establish systems which integrate this information and share it among



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the various funding or service provider agencies to try and avoid both the excessive red tape that follows and the constant intrusion into the individual's affairs. A sufficiently robust system should be deployable to safeguard privacy while permitting the sharing of information among the various entities. (sub. 291, pp. 30–31)

The value of data is enhanced when it is collected and disseminated in a consistent and regular way over time.

Central to enhancing the usefulness of data sets and the ability to combine information across data sets and agencies is the alignment of data definitions, processes, protocols and systems. Transitioning to standardised collection processes will take time and incur costs in the short term, due to changes in practice. But for providers, standardised collection could significantly reduce their administrative burden over the longer term. In the Commission's view, greater compatibility of data sets would ultimately build a more effective evidence base in aged care and allow for a more robust comparison of service delivery across Australia.

The Australian Institute of Health and Welfare (AIHW) has made significant progress in promoting consistent databases, including the development of the National Community Services Information Model Version 1.0 and National Community Services Data Dictionaries. Based on the international standard for defining data elements issued by the International Organisation for Standardisation, these models provide a framework for more consistent data definitions and collections for the aged care sector.

The Commission is proposing that its recommended regulatory body, the Australian Aged Care Commission (AACC), should play a central role in coordinating the collection of national data sets on aged care and facilitating the linking to data contained within Medicare and Centrelink (chapter 15).

## **Access to data**

Several participants — including service providers, consumers and research groups — argued that the usefulness of collected data is limited because of the lack of public access to the data sets and data analysis in the current framework. The Benevolent Society, for example, described the current situation for service providers as a 'black hole' phenomenon:

... data is submitted to government and then is never seen again in a format that is useful to the service provider. (sub. 252, p. 9)

Other participants also indicated that this lack of feedback limited the scope for improving practices and service planning, or for developing products that could assist the provision of aged care (box 16.1).

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### Box 16.1 Where does the data go?

The Victorian National Respite for Carers Program argued that there was no ‘feedback loop’ of data provided to the Department of Health and Ageing (DoHA):

All providers contribute data to the DoHA about level of service provision and issues encountered. There is currently no feedback loop. Services would benefit from regional and state-wide information to assist with gap analysis and service planning. (sub. 334, pp. 4–5)

The National Ageing Research Institute:

Data collected via existing auditing and quality assurance processes should be analysed and fed back to the services concerned. This would provide direct evidence to service providers to enable practice improvement. The data currently collected via these processes should also be aggregated and analysed to determine trends and service/quality issues on a population level. This data would provide a wealth of rich information to inform policy. (sub. 260, p. 3)

Dutchcare:

... after 12 years of [Aged Care Allocation Rounds], there is no cumulative or definitive information in the States or Territories on which mainstream providers have received aged care places for [Non English Speaking Background] consumers, how many there are, what type or category they are, where they are, or who uses them ... This lack of data makes it difficult to ascertain whether culturally and linguistically diverse communities have been accorded equitable, or proportional, access to residential and community aged care places through funding round mechanisms. (sub. 128, p. 2)

Challenger Limited noted that the release of DoHA data is essential if financial markets are to create products that would assist retirees and their families to fund accommodation bonds and co-payments for care, and to do so at a lower cost than if they were to self-insure (sub. DR785, pp. 12–13).

Publicly available data and information on the sector would provide consumers and their families with greater information and knowledge in order to make more informed decisions about the care options available to them — particularly in terms of quality assurance. Under a more consumer-directed and provider-responsive aged care system, improved access to data and information will become increasingly important.

The Australian Government provides information on the system and data for consumers through the website [www.agedcareaustralia.gov.au](http://www.agedcareaustralia.gov.au), including a list of, and search option for, residential aged care facilities around Australia (see chapter 10). But a number of participants considered that this was an area where more information could assist care recipients and their families. National Seniors Australia, for example, said:

... more can be done to help consumers and their families make informed choices. Currently, the government’s Aged Care Australia website does not give information

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about the quality of care provided by a residential aged care facility. This makes it difficult for residents and their families to compare providers. (sub. 411, pp. 18–19)

Quality of care information relating to residential aged care facilities can only be found via the latest accreditation reports. These reports, however, are in formal and technical language (not user-friendly) and not necessarily current, which makes it difficult to compare aged care facilities (Weiner et al. 2007; chapter 10). This contrasts with the system operating in the United States, which has a ‘Nursing home compare’ website ([www.medicare.gov/NHCompare/](http://www.medicare.gov/NHCompare/)) that includes a user-friendly star-rating system — based on health, staffing and quality benchmarks — of registered nursing homes.

There are a number of regular publications containing aged care data. Each year the relevant Minister presents a report to Parliament on the operation of the *Aged Care Act 1997*. The report includes extensive information on aged care programs and policies, funding, and compliance with accreditation standards. The AIHW also publishes detailed reports in a number of areas including community care packages, HACC services, residential care, aged care pathways and dementia. These reports largely present data at national and/or state and territory levels of aggregation.

However, there is also a significant amount of data that is collected but is not readily publicly available. Currently, the main repository and disseminator of detailed data on the aged care system is DoHA. While DoHA indicated that no one who had requested data has been denied access, and DoHA responded to numerous data requests made by the Commission as part of this inquiry, participants raised concerns about the timely release of data. For example, Gill Lewin, who was seeking to undertake a randomised controlled trial of a restorative home care program, said:

While the data collection part of the study has been complete for over 18 months, there has been a delay in being provided with the requested data from Commonwealth aged care data sets, and to date only [Western Australian] held data have been made available. As a consequence it is not yet possible to answer the research questions as completely as was initially hoped. The availability of data for this type of research is an issue that needs to be addressed. (sub. 114, p. 1)

Delays in receiving data from DoHA were also experienced by the Commission during the course of this inquiry.

Poor access to, and delays in accessing data can prevent research being undertaken. It can also prevent more detailed and complex analysis of data and limit its usefulness in improving service delivery and care outcomes (UnitingCare Australia, sub. DR839). Poor data access can also prevent scrutiny of research findings, which

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in turn limits informed public debate. Better and more timely access to data on aged care would:

- allow researchers to replicate and verify any published results
- encourage more aged care research, including more detailed and complex analysis
- facilitate the linking of data sets for a more informed assessment of the impact of arrangements across jurisdictions and other policy areas.

The release of more (and more timely) data would also assist the finance industry in making the case for providing debt capital to aged care providers. This has particular significance in view of industry concerns that the Commission's proposed reforms will reduce access to accommodation bonds for some residential care providers.

Access to data clearly needs to preserve the privacy and confidentiality of individuals and providers. There are, however, ways in which information is, and can be, de-identified for wider use (PC 2009b).

- The Australian Code for the Responsible Conduct of Research and the National Statement on Ethical Conduct in Human Research set out principles and guidelines on how to manage research data and protect the privacy and confidentiality of participants (Australian Government 2007a and b).
- The Commonwealth Scientific and Industrial Research Organisation (CSIRO) has developed a tool that integrates health data repositories while retaining privacy and security of individual patient records. Health Data Integration links individual patient records from different data repositories while maintaining privacy by encrypting the demographic data. This enables identifying information, such as the patient's name and date of birth, to be protected (CSIRO 2008).

While privacy and confidentiality safeguards need to be in place, privacy concerns do not have to be a significant barrier to achieving improved accessibility and transparency in the aged care system. In the Commission's view, given that the Government already collects and maintains detailed data sets relating to aged care, the provision of better public access to this data is likely to generate sizeable net benefits.

Benetas highlighted the need to facilitate the dissemination of relevant research as well as aged care data:

In addition to the actual research, there needs to be a focus on the transfer of the knowledge gained from findings to service delivery providers and consumers. In our

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experience, a large amount of research is being undertaken by tertiary institutions and others, but the knowledge gained from the results of this research is not being disseminated in a fashion that is readily available to the aged care industry and consumers. ...

An action research program is currently operating in Canada in which groups of service practitioners, professionals, researchers and consumers have been formed with the express purpose of translating specific research findings into an easy-to-read format which can be utilised by care providers. ... A similar program could be developed in Australia and links with the Canadian program could be established, especially as the Canadian program is keen to forge international ties. (sub. 143, p. 13)

*The Commission is of the strong view that the default presumption should be that data be transparent and automatically released in a timely manner.*

### **Establishing a data clearinghouse for aged care**

Data quality and data access, as well as the subsequent quality of research and evaluations about aged care, can be improved through changes to the collection and reporting requirements that exist in the current framework.

#### *Who should collect the data?*

While the Commission's proposed AACC will play a central role in collecting and co-ordinating aged care data (see figure 15.2), it would still be practical and appropriate for different data collection points and agencies to operate for various areas of the aged care system. For example:

- to determine the level of need of older people and their eligibility for subsidies, DoHA would continue to collect relevant data to inform its policy development
- the Commission's proposed Australian Seniors Gateway Agency would collect data through its role in aged care assessments and care coordination
- the Commission's proposed AACC would collect data through its role of ensuring compliance with accreditation standards by service providers.

In the Commission's view, having more than one collector of data is not a problem in itself. More important is the level of consistency in definitions and data sets, the ability to match and coordinate different sources, and the ease of access to data sets for analysis and research.

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### *Who should store the data?*

To improve access to data sets and facilitate informed research and evaluations, an approved data clearinghouse or central agency to co-ordinate, store and distribute data would provide the necessary contact point for data and information for policymakers, researchers, industry and the wider community.

Aged care data that is collected by various agencies and departments should be directed to the data clearinghouse in a timely manner, and then be made publicly available — subject to confidentiality and misuse conditions — through the clearinghouse.

Given its intended role and function in the aged care system, the Commission's draft report proposed that the AACC would be well placed to take on the role as the data clearinghouse for aged care.

In response, some participants questioned whether the AACC was best placed to undertake this role. The Health & Community Services Workforce Council Inc (sub. DR736, p. 6), while supporting the proposal for a clearinghouse function, expressed concerns that the regulatory function of the AACC may blur the boundary between what data might be needed for regulatory purposes and other data that will assist research and evaluation. Similarly, the AIHW (sub. DR808, pp. 2–4) argued that the AIHW itself would be a better choice to undertake the roles and tasks involved in a national clearinghouse for aged care data, on a number of grounds:

First ... there is a risk that a new body would not be able to obtain the necessary expertise or develop internal infrastructure to a sufficient level in a short period of time to be able to effectively carry out this task. Second, there is the real issue of duplication of infrastructure and expertise that is already held at the AIHW, meaning greater costs to governments and the community than would otherwise be necessary. Finally, there is significant potential for suggestions of conflicts of interest if the prospective Commission is given the dual responsibilities of regulating the sector and making all the data dissemination and reporting decisions. (sub. DR808, p. 4)

Aged Care Crisis supported the view that some data collection would be best conducted by the AIHW (partly to avoid the conflict of interest issue raised above):

We note with interest the offer of assistance by the Australian Institute of Health and Welfare (AIHW) and believe that their expertise, advice and involvement would be of value for the collection of information that gives a broad overview of the operation of the aged care system. (sub. DR901, p. 3)

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However, Aged Care Crisis also considered the AIHW would not be appropriate for other data collection:

The sort of data collection and the type of data needed about the operation of individual nursing homes and services is not however well suited to the AIHW. We believe that involvement of the community is critically important to success in this sector. The AIHW proposal is retrogressive in this regard. (sub. DR901, p. 3)

In light of these concerns, the Commission considers that the AACC should have responsibility for ensuring the provision of a national clearinghouse for aged care data, with the discretion to assign operational responsibility to a separate organisation, such as the AIHW. That decision would take account of the expertise and experience of AACC staff and the cost-effectiveness of alternative arrangements which might allow an early start up by drawing on the capabilities and experience of other bodies.

## **16.2 Building a better evidence base**

Beyond the collection of data sets, there is also a need for rigorous analysis of the data to test and evaluate policies, programs and proposed reforms. Many participants argued the need for a stronger research or evidence base to inform policy (box 16.2). For example, the Futures Alliance said there was an ‘urgent need for ongoing research to provide a solid evidence base for planning, policy development and service provision’ (sub. 44, p. 8). Hal Kendig also said:

Research and evaluation are critical to identifying the support and care needs of frail older people and their carers, and for informing ways of increasing the appropriateness, effectiveness and efficiency of services and other actions on their behalf. (sub. 431, p. 9)

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## Box 16.2 Participants call for a stronger evidence base

### The Royal District Nursing Service:

Quality practice must be underpinned by research and evidence. Currently there is a poor evidence base for many of the practices within aged care. A greater proportion of the total available funding for research must be allocated to aged care if we are to improve the quality, efficiency and effectiveness of aged care services in the future. (sub. 198, p. 5)

### The National Ageing Research Institute:

With the structural and numerical ageing of the Australian population, there is a clear need to review current policies, programs and services and plan for an increased demand on the aged care service system in the future. To do this, a sound evidence base is required.

To build a sound evidence base upon which to develop policy in this area, funding dedicated to ageing research is needed. (sub. 260, p. 2)

### The Australian Association of Gerontology:

... building a robust evidence-base is an essential foundation upon which to develop ageing and aged care policies and reforms to best meet the challenges and opportunities of an ageing Australian population. (sub. 83, p. 2)

### Benetas:

Service delivery improvements and development of new services must be based on strong evidence provided by rigorous research projects and evaluation. While research into the care of older people is already underway, much of it is focuses on physical health and clinical care ... there should be a greater emphasis on research which examines a more holistic view of the wellbeing of older people and their quality of life. (sub. 141, p. 4)

## Research is needed to assess effectiveness

Throughout this inquiry it became apparent that a better evidence base is needed to answer basic questions about many aspects of aged care, including the efficiency and effectiveness of preventative and early intervention measures, of home maintenance and modifications and of assistive technologies. Several submissions also indicated a need for an improved evidence base to answer various other research 'gaps' (box 16.3).



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### **Box 16.3 Some unanswered questions and research ‘gaps’**

The National Ageing Research Institute:

... we don't know what models of community care are most acceptable, effective, cost efficient and feasible in an Australian context.

We know that healthy lifestyle choices, such as adequate physical activity and a healthy diet can prevent or delay the onset of a range of chronic diseases ... Primary health interventions (including education, early intervention) that are supported by government funding incentives should also be trialled and evaluated. (sub. 260, p. 2)

The Australian Association of Gerontology:

... there has been very limited study or quantification of the burden on carers, who are vulnerable to stress, depression, poor health as well as considerable social and economic loss. (sub. 83, p. 5)

Day Therapy Centres (Victoria):

Coping with frailty is a poorly understood area. There is a need for more research into this area and the sort of services that lead to the best outcomes. We also need to promote greater acceptance of this part of the human condition. (sub. 448, p. 7)

Villa Maria (Victoria):

More research into coping with frailty should be supported to identify and develop the services that lead to the best outcomes. (sub. 395, p. 4)

Nicole Brooks (sub. DR612, p. 12) called for more research into case management.

Southern Cross Care (sub. DR642), Alzheimer's Australia (sub. DR656) and The Wicking Dementia Research Network (sub. DR728) considered more resources should be invested in dementia research.

Ballina District Community Services Association (sub. DR718) called for further research into the perceived expectations and views of the baby boomers to shape aged care service models.

Medical Device Partnering Program (sub. DR722), Tech4Life (sub. DR774) and the Australian Academy of Technical Sciences and Engineering (sub. DR802) called for research to identify and confirm potential productivity improvements (as seen in international studies) that might be applicable to Australian systems.

Catholic Health Australia:

There is also a need for further research to identify populations with the potential to benefit from early intervention approaches, and to assess the relative effectiveness of different early intervention and restorative care measures and models. (sub. DR909, p. 10)

The AIHW's submission to the Senate Inquiry into residential and community aged care in Australia identified a number of information gaps. The list included the lack of:

- a currently accepted approach to the measurement of potential or actual demand for formal aged care services

- national level information about the care preferences of potential and current aged care program consumers and their carers and families
- on-going information about the care needs of people who receive Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACH-D) packages and the amount and type of assistance provided through these programs
- cross-program information which could be used, among other things, to develop more robust estimates about the number of people using all aged care services and to build better evidence about utilisation patterns and pathways through the system of aged care services as a whole. (2008c, p. 4)

Better monitoring and evaluation would ensure that government-funded services are accountable and that funds are appropriately allocated between the various service types, as well as providing a basis for future policy development. Evidence on effectiveness would also aid service providers in improving their practices (box 16.4).

#### **Box 16.4 Research on effectiveness: providers' perspectives**

From providers' perspectives, a stronger evidence base on effective aged care and support practices will assist them in better meeting the needs of their clients and help to inform their business and care model into the future.

##### **Benetas:**

In caring for older people, services must take into account the needs of the whole person — physical, emotional, psychological and spiritual. To assist service providers in this work, research has to be undertaken to provide evidence for what is best practice in enhancing the quality of life of older people under their care. (sub. 141, p. 12)

##### **Medibank:**

There is a need to research and build an understanding of 'what works' in age care supports so that these learnings may be applied more broadly to benefit people as they age and improve the quality of services provided. (sub. 250, p. 9)

Providers also have an important role to play in informing the evidence base through their day-to-day practices and practical 'know-how'.

##### **Anglicare Australia:**

In research on older people, service providers need to be involved so that they can impart their knowledge to inform the research and in turn improve their services as a result of the research. (sub. 461, p. 14)

The thin evidence base available on the cost-effectiveness of preventative and early intervention measures is partly because evaluating such strategies is not easy. For example, it can take years for the benefits of social marketing campaigns to become

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evident and many of the benefits are manifested as a ‘non-event’ (for example, enhancing protective factors or reversing or reducing risk factors). As noted in an Organisation for Economic Co-operation and Development (OECD) paper on health promotion and prevention:

Medical or public health-driven preventive interventions struggle to fit into a broad health care resource allocation framework alongside curative, diagnostic and palliative interventions, because of the somewhat uncertain and distant nature of their outcomes. This places them in a league of their own and often makes governments (and, indeed, health insurance organisations) uncomfortable about diverting resources away from uses that have a more immediate and certain return, particularly in a tightly resource-constrained health care system in which it is not even possible to fund all potentially available curative interventions. (Sassi and Hurst 2008, p. 47)

Despite these difficulties, some participants argued that there are potentially large gains to be made from investing in research into preventative health measures for older people (Southern Cross Care (Vic), sub. DR642).

Alzheimer’s Australia, for example, noted that if the onset of Alzheimer’s disease could be delayed by five years, it would reduce the number of those with the disease by half between 2000 and 2040 (sub. 79). In view of the influence of the incidence of dementia on the wellbeing of older Australians, the demand for community and residential aged care and on the overall cost of aged care (chapter 3), research in this area could deliver immense benefits.

Given the claims about the potential cost-effectiveness of prevention and early intervention measures, there is a need to know more about the effectiveness of different interventions in preventing or reducing the likelihood of particular outcomes (such as the need for residential aged care, reduced risk of falls and dementia) and their overall cost effectiveness. As the National Health and Hospitals Reform Commission (NHHRC) said:

Like any spending, our investment in prevention should be both clinically effective and cost effective. (2009, p. 97)

The NHHRC recommended the establishment of a National Health Promotion and Prevention Agency (which was also recommended by the National Preventative Health Taskforce (2009)). Research with a focus on prevention and early intervention for older people could be placed within such an agency.

Broader questions about the appropriate level of home and community-based care and the appropriate balance between resources devoted to residential care and to home and community-based care also need a stronger evidence base to answer.

A widely held view is that providing care in the home is generally more cost effective than doing so in residential aged care. However, because of deficiencies in

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the cost-benefit research on this issue, the true extent of any savings is not known (AHURI 2008). As this view appears to underpin the allocation of progressively greater levels of budget expenditure on home and community-based care, the Australian Government should encourage more rigorous research to better inform policy and program delivery in order to achieve the most appropriate aged care and housing interventions.

A further area where little light has been shed is how efficiently and effectively aged care services are supplied in concert with other health and welfare services. A number of initiatives have been put in place in recent years to improve service interfaces, but there is only limited evidence on how older people receiving aged care interact with other services and how well their needs are being met. As the Commission has previously concluded in its report on *Trends in Aged Care*:

... further research and analysis is required. This needs to be underpinned by better data than is currently available, if we are to move away from a largely static 'stock' view of aged care and develop a much better understanding of 'flows'. For example, to investigate how the care needs of older people change over time; how these changes trigger interactions between different parts of the aged care system (and between the aged care system and the broader health and community welfare system); and how efficiently and effectively the care needs of older people are being met. (PC 2008, p. 90)

## **Assessing outcomes**

A number of participants called for greater use of outcome measures (chapters 10 and 15) — essential for assessing the effectiveness of policy and programs (see box 16.5 for an international example). The Benevolent Society considered an outcomes based approach to be more conducive to improvements in service quality:

Developing an outcomes approach, combined with a better use of mandatory data reporting, is a practical strategy for quality improvement. It could bring a better understanding of the needs of clients, of gaps in funding or services, and of the impact on wellbeing of clients with different socio-economic characteristics or service dosage/type. (sub. 252, p. 9)

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### Box 16.5 Outcomes based data: the United States

The United States Administration on Aging (AoA) provides comprehensive information on consumer-reported outcomes through its *Aging Integrated Database*.

Public access files of annual national surveys of aged care service recipients (through the Older Americans Act program) are provided online ([www.agidnet.org/DataFiles/NPS/](http://www.agidnet.org/DataFiles/NPS/)) and are categorised by services, including case management, home delivered meals and caregiver services. The survey on case management, for example, includes questions such as:

- Does your case manager return your phone calls in a timely manner?
- Do you and your case manager work together to decide what services you need?
- How would you rate the case management services that you have received?
- As a result of the services you receive, are you better able to care for yourself?

These comprehensive surveys (which also provide information on the health status of the individual) allow Americans and others to easily access a vast amount of data and information about service quality, effectiveness and consumer outcomes.

Source: AoA (2010).

The Centre for Health Service Development also said:

Measuring outcomes as a means of improving the effectiveness of services encourages innovation as it demands that service users, their informal carers and providers think about the different ways they can meet their desired goals. By comparing the outcomes for clients who are of a particular type ... then the practical experiences of service users are able to be built in to a quality improvement system. (sub. 343, p. 3)

As mentioned, assessing the effectiveness of aged care services and initiatives is not easy to do. There are limits to which outcomes-based data can be collected and the ability to ascertain the outcome of a particular service or program with certainty. That is, establishing the appropriate timeline to evaluate a program, relating program outputs to wellbeing outcomes, and defining what constitutes a ‘good’ outcome is not always clear (particularly for older people who are becoming more frail with age). The Centre for Health Service Development acknowledged these challenges:

Finding answers about what actually makes a measurable difference for carers and consumers is a complex undertaking, the timelines involved in building sustainable benchmarking systems are long, and workable systems have to be built up from assessment through to care planning and case closure, using rigorous and practical methods that can collect the right data. (sub. 343, p. 3)

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## Using trials and pilot programs to build evidence

Where evidence about the effectiveness of a proposed policy option or program reform is uncertain, it can be good practice to conduct trials or pilot programs before full implementation. The Commission's proposed pilot of a tradeable supported resident obligation (chapter 17) is an example of this. Relatively small investments in trialling policy reforms, the sequential rolling out of policies to facilitate progressive improvement, and the collection of baseline and other data can assist policy design and implementation.

A variety of trials and pilot programs have been used to facilitate experimentation in the design and delivery of aged care services under DoHA's Aged Care Innovation Pool. Currently, trials of consumer-directed care models are being funded through this program (chapter 9). There was support from participants for such trials to build evidence on the effectiveness of policies and programs. KinCare, for example, said:

Some providers have begun piloting consumer-directed care models and the Australian government recently tendered funds for a consumer-directed care pilot. These steps towards increased consumer-directed care are welcome and should be evaluated to begin to establish the foundation of a consumer-centred aged care system. (sub. 324, p. 9)

Internationally, trials and pilot programs have been used, sometimes extensively (as is the case with the United States' long term care system), as a means to ascertain the effectiveness of certain programs and initiatives (appendix D).

### *Evaluation and follow-through*

The value in trials and pilot programs, however, lies in their potential for follow-through action upon evaluation and review. According to some participants, this is a factor that is missing in the experimental aged care initiatives and programs. Some noted that trials can continue to be trials for extended periods or that successful pilot projects can fail to result in programs and continued funding. The Australian Association of Gerontology said:

Unfortunately, clearly demonstrating a successful model of remote community care does not guarantee ongoing funding. To date, the Lungurra Ngoora service has not secured recurrent funding and cannot make the transition from successful pilot to sustainable service. (sub. 83, attachment, p. 2)

Southern Cross Care (Tasmania) also said:

The use of pilot programs to trial services and service delivery models is a sound approach but firm decisions are needed around the continuation or otherwise of the programs following evaluation of pilot programs. An example is the Dementia

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Behaviour Management Assessment Service (DBMAS). This program is funded on a short term basis from the Department of Health & Ageing to, in Tasmania, the state Mental Health Service. The predecessor to DBMAS, the Psychogeriatric Unit or Dementia Support Unit, had an identical delivery model and was a ‘pilot’ for nearly 10 years. The DBMAS is still a ‘pilot’ with no guarantees of ongoing funding. (sub. 267, p. 22)

Trials and pilot programs need to be evaluated and the findings made publicly available so that policy decisions about the continuation (or otherwise) of programs and initiatives can be scrutinised.

A phased approach to the implementation of programs, accompanied by timely post-implementation evaluations before broad scale rollout, is also a sensible way to manage the risks of uncertain evidence, particularly if the costs of implementation and program reversal are low. In this report, the Commission has recommended adopting a phased implementation for some of its recommendations (chapter 17).

### **The need for greater transparency and independence in research**

Participants to this inquiry expressed concern about the lack of transparency of Government research relating to aged care. Hal Kendig, for example, said:

Consultancy reports are seldom released into the public domain where they could inform service improvements.

... The Commonwealth [DoHA] has conducted commissioned studies or evaluations over recent years but few have been released into the public arena where they could be of wider use. The extensive data collected through the aged care assessment teams has been progressively less available for informing aged care research and development. (sub. 431 , p. 10)

Anna Howe also said:

... [DoHA] should be required to release reports on all research and evaluations that it commissions within a set timeframe and actively disseminate these reports. In the event that the Commonwealth and/or other parties involved in advisory committees overseeing joint projects have any reservations about the findings reported, these matters should be set out in a formal response and released with the report. The failure to release these reports raises questions of accountability for the funding involved and of responsiveness to the many agencies and individuals who contribute to such projects.

Without access to these reports, discussion is less well informed than it should be. (sub. 355, pp. 20–1)

There would be value in evaluations being made publicly available to allow for greater scrutiny of findings and provide, where necessary, momentum for further implementation or redesign. As the Commission’s Chairman has argued, public scrutiny of analysis is in itself a ‘useful form of evidence’:

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Transparency ideally means ‘opening the books’ in terms of data, assumptions and methodologies, such that the analysis could be replicated. The wider the impacts of a policy proposal, the wider the consultation should be. Not just with experts, but also with the people who are likely to be affected by the policy, whose reactions and feedback provides insights into the likely impacts and help avoid unintended consequences. Such feedback in itself constitutes a useful form of evidence. (Banks 2009, p. 14)

On 1 November 2010, the Office of the Australian Information Commissioner (OAIC) was officially launched by the Hon. Brendan O’Connor MP, Minister for Privacy and Freedom of Information. Speaking about the reforms to the freedom of information laws, Australian Information Commissioner, John McMillan said:

These changes reflect a broader policy change that acknowledges that information held by the Government is a national resource to be managed for public purposes. We look forward to ensuring that this policy shift becomes a reality for all Australians when they deal with Australian Government agencies. (OAIC media release 2010)

Independence in the evaluation of aged care policy is also important to reduce potential conflicts of interest that may influence the types of projects undertaken and the publishing of findings. As Banks contended:

Good research is not just about skilled people, it is also about whether they face incentives to deliver a robust product in the public interest. (2009, p. 17)

The Australian Nursing Federation maintained that:

... the Australian Government should facilitate continuous, robust independent research into how the aged care system is meeting its obligations outlined under regulatory frameworks. (sub. 341, p. 24)

DoHA currently plays the role of policy-maker, data collector and program and policy evaluator. An independent body to coordinate data collection and allow for greater access to users would help reduce the potential for conflicts of interests to influence the research undertaken and findings. Such an initiative could further enhance public confidence that research findings are reliable.

Key requirements for making research arrangements more effective include:

- increased independence from government and industry, though with close consultation
- improved transparency, including through increased access to data held by government and industry, and wider dissemination of research findings to inform public debate
- greater provision for multidisciplinary input and collaboration.



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With significant public money being invested in research, there is a strong public interest in its timely and public dissemination.

### **16.3 Research capacity**

The Australian Government has shown its commitment to ageing research through a range of initiatives and there are various research institutes and centres focused on ageing (see examples in box 16.6).

In 2002, ageing research was recognised in the National Research Priorities as a means to promote and maintain good health and since then, nationally-focused research programs and networks on ageing research have been established.

In 2003, the AIHW established the *Framework for an Australian Ageing Research Agenda*, which included an Australian Ageing Research Online website initiative to strengthen networks and sharing of research and information between researchers.

In 2005, the Government created the *Australian Research Council (ARC)/National Health and Medical Research Council (NHMRC) Research Network in Ageing Well*, with the goal of increasing ‘the scale, focus, and capacity of Australian research to inform national efforts to respond constructively to an ageing society’ (Centre for Education on Research on Ageing 2009). It also established the NHMRC/ARC *Ageing Well, Ageing Productively* research funding program to provide the impetus for quality research and analysis. Both initiatives concluded in 2010.

In 2010, the ARC announced that an ARC Centre of Excellence for Population Ageing Research would be established in 2011 with the aim of developing world class research on population ageing:

The Centre for Population Ageing Research brings together researchers, government and industry to address one of the major social challenges of the 21st century. It will establish Australia as a world leader in the field of population ageing research through a unique combination of high level, cross-disciplinary expertise drawn from Economics, Psychology, Sociology, Epidemiology, Actuarial Science, and Demography. (ARC 2010)

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**Box 16.6 Research centres with a focus on ageing and aged care****The Australian Institute of Health and Welfare (AIHW)**

The AIHW is a national agency that provides information on Australia's health and welfare through statistics and data development, as well as producing research on a range of issues including ageing and aged care.

**The Centre for Ageing Studies — Flinders University**

The Centre for Ageing Studies (CAS) promotes the need for and undertakes multidisciplinary research, education and policy development to achieve better outcomes for older people. It is multidisciplinary in nature with a focus on the integration of health and social sciences.

**The Monash Research for an Ageing Society (MonRAS) — Monash University**

MonRAS is facilitating a cross-faculty multidisciplinary approach to the study of ageing, that will consolidate and focus the research activities and resources of the entire university to the development of devices, therapies, policies and programs that address significant issues and improve quality of life of older people.

**The Research Centre for Gender, Health and Ageing (RCGHA) — Newcastle University**

RCGHA aims to facilitate collaboration across existing organisations and individuals working in the fields of research, education, products and services required of an ageing population. The Centre brings together businesses and researchers in a dynamic relationship that creates synergies and new alliances.

**Dementia Collaborative Research Centres**

An Australian Government initiative that includes three centres for dementia research focus: assessment and better care (University of New South Wales), early diagnosis and prevention (Australian National University) and carers and consumers (Queensland University of Technology). The findings of this research could help inform Government decisions about the continuity or expansion of the National Dementia Strategy.

**The National Ageing Research Institute (NARI)**

NARI conducts research in ageing and improving the quality of life of older Australians through its focus on care in the community, hospital and residential care settings.

While analysis should be undertaken by those with knowledge and experience in the field, there should also be scope to broaden the knowledge base by allowing verification and analysis by other parties as well — including those who specialise in certain methodologies, academics, and those in industry (PC 2009c).

Head (2010) posits that a good knowledge base for evidence-based policy comprises many participants:

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The knowledge base for EBP [evidence-based policy] is diverse. Systematic research (scientific knowledge) provides an important contribution to policy making, and is undertaken in external institutions as well as in the public service. But science is only one of the inputs for EBP. The larger world of policy and program debate comprises several other types of knowledge and expertise that have legitimate voices in a democratic society. (p. 18)

With Government commitment to ageing research and the large number of institutes and centres around the country, Australia appears well placed to undertake high quality and evidence-based research.

However, a number of participants said there was still insufficient institutional capacity and inadequate funding to undertake quality aged care research in Australia. For example, the National Ageing Research Institute said:

The Australian Government's *Ageing Well, Ageing Productively* Research Program ... initiative has now concluded and there is still a need for a national ageing research program that promotes collaborative, cross-disciplinary research and supports skill development and career opportunities for emerging researchers. (sub. 260, p. 3)

Anna Howe argued for an expanded role (and additional funding) for the AIHW to undertake research into critical issues in aged care (sub. 355, p. 21).

Hal Kendig supported the establishment of an Aged Care and Support Research Program modelled on the Australian Housing and Urban Research Institute — a national research organisation. He was critical, though, of the inadequate resources directed to ageing research and highlighted the need for more funding for research and evaluations:

... Commonwealth support for research and evaluations has fallen to levels far below those that proved to be very valuable in developing and implementing the community and residential care reforms of the 1980s and 1990s. (sub. 431, p. 10)

National cornerstones of information over the past decade — the Ageing and Aged Care Unit in the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS) — have had budget cuts over recent years. The relatively well-funded [*Ageing Well, Ageing Productively*] research program did not fund any research in its designated area of 'Approaches to Care'. Mainstream ARC and NHMRC research programs ... fund some care-related research notably through the ARC Linkages and NHMRC partnership programs and some NHMRC Health Services and project grants. But they are few and far between and not strategically focussed on developing and improving care and support. (sub. DR892, p. 2)

Silver Chain Nursing Association (sub. DR796) and The Benevolent Society (sub. DR805) also argued for additional funding for the national ageing research effort, while other submissions called for more funding for specific areas within aged care (ACON, sub. DR764; Aged Care Queensland, sub. DR647; GLBTI

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Retirement Association Incorporated, sub. DR720; Speech Pathology Australia, sub. DR752; The Royal District Nursing Service – Victoria, sub. DR546; the Whiddon Group, sub. DR551).

Of the calls for additional funding, that by Alzheimer’s Australia has particular significance in view of the affect of dementia on the demand for community and residential aged care (chapter 3):

Despite the important work of the Initiative the level of funding for dementia research in Australia continues to be low, for both biomedical and psychosocial research, compared to other chronic diseases in terms of prevalence, cost to the healthcare system and disability burden. The average annual research funding for chronic illness in Australia from 2002-2007 was \$130 million for cancer research, \$90 million for research on cardiovascular disease, \$40 million for research on diabetes. Dementia receives only \$12.8 million ... (Alzheimer’s Australia, sub. DR656, p. 10)

In the Commission’s 2010 report on the contribution of the not-for-profit sector, it recommended the establishment of a Centre for Community Service Effectiveness, observing that:

Among its roles, the Centre should provide: a publicly available portal for lodging and accessing evaluations and related information provided by not-for-profit organisations and government agencies; guidance for undertaking impact evaluations; support for ‘meta’ analyses of evaluation results to be undertaken and made publicly available. (PC 2010b, p. XLII)

The Commission has also highlighted the importance of establishing programs to ensure ongoing evaluation and costing of government programs:

Australian government agencies providing extensive grants to, or using external agencies for, service delivery should establish evaluation programs to assess the effectiveness and actual cost of their programs. Where related to community services, these evaluations should be posted with the Centre for Community Service Effectiveness. (PC 2010b, p. XLVII)

Australia, though, is not unique in encountering difficulties in the area of ageing research. Other countries and regions have faced similar concerns in recent times (box 16.7; appendix D).

The Commission considers that its proposed national clearinghouse for data and trial/pilot evaluations will encourage more research in aged care and more timely research. Until the consequences of this proposed clearinghouse on the flow of research are evident, a recommendation for more funding to address research shortfalls is premature.

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### Box 16.7 International experience: ageing research

Similar to Australia's experience, there seems to be growing concerns in some OECD countries about a lack of focus on or funding for ageing research.

The United Kingdom has recognised the need for more coordinated research efforts in its recent blueprint, *A strategy for collaborative ageing research in the UK*, launched by research councils and health departments.

The strategy identifies mental wellbeing and enhancing independence of older people as areas of research focus, with the broad recommendation of enhancing collaboration between various research groups:

... we have the potential to make a significant impact by joining forces across disciplines and sectors to bring innovative approaches to tackling complex ageing-related research challenges. (Medical Research Council 2010, p. 13)

In the European Union, there has also been recognition of the lack of sufficient linkages between research institutes on ageing and the need for a more holistic approach. FUTURAGE, a two year collaborative project was launched in 2009 to 'produce the definitive Road Map for ageing research in Europe for the next 10–15 years'.

In the United States, claims of underfunding of research on ageing, and consequent constraints on innovation and attracting researchers into the field, has been a recent concern. In response to these concerns, Richard Hodes, the National Institute of Aging Director, posted an open letter stating:

We at NIA recognize and empathize with the struggle that our constrained funding creates for the research community, and feel that it is vital that we do everything we can to sustain the momentum of investigator-generated research in this successful and vibrant field, as we continue to make a difference in health and well-being in later life. (Hodes 2010)

Sources: AGE Platform Europe (2010); Hodes (2010); Medical Research Council (2010).

Nonetheless, given the:

- estimated scale of future costs of aged care
- substantial and increasing numbers of older Australians whose wellbeing will be affected by the way in which the aged care system operates
- ending of core aged care research initiatives and budget cuts to key agencies providing information on aged care (noted above)

an assessment by the Government of the adequacy of its processes to identify and fund deserving aged care research would appear warranted as a matter of priority.

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RECOMMENDATION 16.1

*To encourage transparency and independence in aged care policy research and evaluation, the Australian Aged Care Commission should be responsible for ensuring the provision of a national ‘clearinghouse’ for aged care data. This would involve:*

- *establishing a central repository for aged care data and coordinating data collection from various agencies and departments*
- *making these data sets publicly available in a timely manner for research, evaluation and analysis, subject to conditions that manage confidentiality risks and other concerns about potential data misuse.*

*To maximise the usefulness of aged care data sets, reform in the collection and reporting of data should be implemented through:*

- *adopting common definitions, measures and collection protocols*
- *linking databases and investing in de-identification of new data sets*
- *developing, where practicable, outcomes based data standards as a better measure of service effectiveness.*

*Research findings on aged care and on trial and pilot program evaluations, including those undertaken by the Department of Health and Ageing, should be made public and released in a timely manner.*

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# 17 Reform implementation

## Key points

- Australia's aged care system is characterised by extensive, complex and interacting government involvement in the funding of services and regulation of their delivery. Fundamental reform of the system raises challenging implementation issues.
- Some of the Commission's recommendations can be implemented quickly. Others will need more time, to allow older Australians, their carers, providers of care services and government agencies to adjust to the changes.
- The Government should establish an implementation framework, comprising:
  - a publicly released timetable for changes (over a five year period) and their expected effects on older people, carers, providers and governments
  - provision for extensive consultation with all stakeholders, including the community more generally
  - feedback processes that enable policies to be refined in the light of new evidence
  - a mechanism to protect existing recipients of aged care services while eliminating the web of multiple levels of existing grandfathering provisions.
- Existing consumers of aged care services in both community and residential care should be protected from significant disruption and risks relating to the transition to the new aged care system.
- Provision should be made to mitigate the risks faced by providers during the transition period to ensure the sustainability of the industry as a whole, while facilitating the exit of less efficient and less capable providers.
- The Commission envisages a three-stage implementation plan:
  - the first stage would cover measures that can be expedited within two years before major legislative amendments pass Parliament
  - the second would comprise the bulk of the Commission's recommendations that require significant legislative change and should be pursued within two to five years of the announcement of the reforms
  - the final stage, from five years after announcement, would involve the full removal of supply restrictions followed by a public review of the operation of the new aged care system.
- An Aged Care Implementation Taskforce should be established to oversee the implementation of the reforms. It should be assisted by a non-statutory Aged Care Advisory Group comprising representatives from consumer groups (including carers), providers and the workforce.

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This concluding chapter of the inquiry report outlines a transition path for the implementation of the Commission's recommendations.

In response to its draft report, the Commission received a number of suggestions that have assisted it to refine and improve the proposed implementation plan. Among these was a particularly helpful submission from the Campaign for the Care of Older Australians (CCOA, sub. DR864) and some of its members especially Catholic Health Australia (sub. DR730), Aged and Community Services Australia (sub. DR748) and the Aged Care Association of Australia (sub. DR777). The CCOA submission outlines some of the implementation objectives and risks from the perspective of industry participants (box 17.1). The Council on the Ageing (COTA), too, has provided a detailed transition discussion which has proved helpful to the Commission (sub. DR565).

The chapter first outlines an implementation framework and principles to guide the process for moving to the proposed system (section 17.1). It then discusses grandfathering arrangements (section 17.2), measures to mitigate key risks during the transition (section 17.3), outlines a broad three-stage implementation plan (section 17.4) and, finally, discusses the major implications of the proposed reforms for older Australians, their carers and providers (section 17.5).

## **17.1 An implementation framework**

In its terms of reference, the Commission has been asked to:

... recommend a path for transitioning from the current regulatory arrangements to a new system that ensures continuity of care and allows the sector time to adjust. In developing the transitional arrangements, the Commission should take into account the Government's medium term fiscal strategy. (p. 3)

The Commission's framework is designed to progressively implement the proposed new model of care in a timely manner. In developing the proposed reforms, the Commission is cognisant of the importance of the Australian Government meeting its medium term fiscal strategy (box 17.2).



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## Box 17.1 Implementation objectives and risks

### Implementation objectives

- Ensure the continuity of quality services for consumers and their families while at the same time responding as soon as possible to community expectations for greater consumer choice and increased service flexibility.
- Allow service providers time and flexibility to adjust their operations and business models, and provide the incentive and certainty to invest in the sector.
- Address the underlying distortions in the current system which are threatening the sustainability of the sector as soon as possible.
- Avoid the emergence of opportunities for price exploitation of consumers.
- Manage the potential for market failure.
- Ensure continuity of access for special needs groups.
- Manage the Government's fiscal risk.
- Recognise the inter-dependencies in the reform measures and the lead times required for their implementation.
- Ensure community support for reform is not eroded by implementation mistakes.

### Implementation risks

- Threat to the viability and valuations of residential aged care homes due to reduced occupancy rates, especially in relation to older multi-bed services.
- Threat to the viability of residential providers because of reduced bond sizes and a possible flight to rental payments.
- Continued under investment in residential high care.
- Under investment in services and accommodation for supported residents and special needs groups.
- Market failure of Home and Community Care (HACC) services with the introduction of entitlement based funding and choice of provider.
- Exploitation of consumers (accommodation payments and additional services) pending the deepening of the market.
- Community resistance to increased co-payments.
- Consumer expectations regarding choice and flexibility not met quickly enough.
- Extent of change may compromise the quality of care.
- Fiscal risk to the Government if needs based assessment is not effective.
- Risks associated with the development and implementation of assessment tools and care funding classification systems across residential and community aged care and carers, and the roll out of the Gateway Agency.

*Source:* CCOA (sub. DR864, pp. 2–7).

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### **Box 17.2 The Australian Government's medium term fiscal strategy**

The Government's medium-term fiscal strategy is designed to ensure fiscal sustainability. The strategy has remained unchanged since the Government's first budget in 2008-09 and is designed to provide a clear and stable basis for the conduct of fiscal policy. The key elements of the strategy are:

- achieve budget surpluses, on average, over the medium term
- keep taxation as a share of GDP below the level for 2007-08 (23.5 per cent of GDP), on average
- improve the Government's net financial worth over the medium term.

*Source:* Australian Government (2011a, pp. 3–4).

The current policy framework applying to aged care is characterised by extensive, complex and interacting government involvement in the funding and regulation of aged care services. Given the need for wide ranging reform, the Commission's proposals raise challenging transitional issues in several areas:

- the consolidation and enhancement of disparate activities into a single information, assessment and care coordination agency (the Australian Seniors Gateway Agency (the Gateway)) which would also establish entitlements to approved services
- the establishment of a fully integrated and flexible approach to the provision of care and support services which is tailored to the needs of individual older Australians, together with the removal of supply constraints on the provision of care and accommodation
- the overcoming of inequities and inefficiencies in the pricing of different forms of care, through a funding regime that empowers consumers to purchase services from competing providers, places greater responsibility on older people who have the financial capacity to contribute to the cost of their care and requires those with the means to be responsible for the cost of their accommodation
- the improvement of governance arrangements through the transfer of regulatory functions such as quality assurance and complaints handling to an independent commission (the Australian Aged Care Commission (AACC)), together with regulatory reform that is less burdensome on consumers and providers and better manages risks.

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The Commission's proposals, if implemented, will substantially change the aged care system. As with any major reform, changes will need to be introduced in a coherent and predictable way. Crucial to the success of the implementation process will be a clear statement by the Government that commits it to a credible package of reforms and a firm timetable for their introduction. Older people and their carers, providers and government agencies will need certainty and time to plan for, implement and adjust to changes. But, crucially, the Government's proposals need to be clear to ensure that the momentum of reform is maintained.

Overall, the Commission considers that most of its recommendations could be implemented within five years of announcement, assuming that the legislative package is enacted within one to two years (box 17.3). That said, in practice, it is likely that some measures may take longer to implement. Even so, by keeping the planned transition period relatively tight, slippage can be managed. Too long a transition period might increase the risk of further slippage and unduly delay benefits from the reform process.

In view of the complexity of the transition and the need for a smooth implementation, the Commission considers it important that the Government establish an Aged Care Implementation Taskforce. This should be chaired by the Department of the Prime Minister and Cabinet and comprise, at a minimum, senior officials from the following departments:

- Attorney-General's
- Families, Housing, Community Services and Indigenous Affairs
- Finance and Deregulation
- Health and Ageing (DoHA)
- Human Services
- Treasury
- Veterans' Affairs.

In addition, when appointed, the chief executives of the AACC and the Gateway should be *ex officio* members of the Taskforce.

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### Box 17.3 Length of the transition period

If a reform is worthwhile and in the national interest, it is well to implement it as quickly as possible. However, the move to a new system creates disruption and may have unanticipated effects. Effectively, the transition period should be as short as practicable.

The reforms proposed in this report will require extensive legislative change and changes to business practice and culture.

Given the lead times in drafting and enactment of a new legislative framework, it is unlikely that the formal new system can commence much before two years from the Government's announcement of its implementation framework, although some non-legislative components and relatively minor legislative proposals could be expedited.

Overall the Commission remains of the view that a five year transition period, with appropriate monitoring and feedback processes, provides the best balance, with a significant risk of a loss of reform momentum if the period is significantly longer. That said, given the interdependencies with other reform proposals (in particular disability, health and hospital) the Government may find it prudent to extend the transition period.

Submissions in response to the Commission's draft report were generally supportive of a five year transition period, although some argued for a longer period. A few examples of comments include:

We further believe that, while other providers and consumer groups might disagree, a five-year transition is very reasonable. Anything more than a five year transition puts off reform, yet again, into the 'never-never'. (Hammond Care, sub. DR666, p. 3)

Five years is an appropriate period of time — any shorter and there might be insufficient time to develop properly the proposed new structures and approaches — any longer and there would be an increasing risk of losing momentum and the requisite political will. (Greg Mundy, sub. DR525, p. 3)

The Australian Government should remove regulatory restrictions on the number of community care packages and residential bed licences over a five-year period. (Aged Care Association of South Australia, sub. DR676, p. 2)

Without a greater impetus early on, momentum for reform may flag and little may be achieved even over a ten year period. There have been fully 30 reports on aged care since the Hogan Review in 2004, but very little action. (Anna Howe, sub. DR856, p. 10)

... the transition period may need to be longer than five years and there may need to be assistance given to the industry during this transition period. (Stewart Brown and Co., sub. DR842, p. 4)

ANGLICARE Sydney is concerned that five years may not be realistic because of the extent of the changes and the impacts they will have on the industry. (sub. DR637, p. 11)

In order to ensure a smooth transition, the implementation of aged care reform should occur over a longer time frame of ten years. (Alzheimer's Australia, sub. DR656, p. 28)

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The Taskforce would thoroughly and carefully manage the transition, consult extensively and take responsibility for the development of the new aged care system. In managing the transition, the Taskforce would need to be cognisant of:

- the evolving disability, mental health, hospital reforms and interfaces
- reaching necessary agreements with the states and territories, including on assessment
- the need to embed feedback processes and enable fine-tuning of the new system
- the development of the new regulatory framework
- the careful monitoring of developments during the implementation that affect vulnerable groups, such as those in rural and remote Australia and Indigenous Australians.

In addition, a non-statutory Aged Care Advisory Group (ACAG) of a manageable size should be established comprising representatives from consumer groups (including carers), providers and the workforce. The ACAG would be a valuable sounding board and early alert for the Taskforce.

The Taskforce would need to consult regularly with the ACAG throughout the implementation period.

RECOMMENDATION 17.1

*The Australian Government should establish an Aged Care Implementation Taskforce to coordinate and manage the transition to the new aged care system, chaired by the Department of the Prime Minister and Cabinet.*

*To assist the Implementation Taskforce, a non-statutory Aged Care Advisory Group should be established comprising representatives from consumers (including carers), providers and the workforce.*

## 17.2 Grandfathering arrangements

The protection of existing aged care consumers and providers from disruptive change arising from policy reform can be achieved, where appropriate, through the continued application of the status quo (grandfathering).

There is already a legacy of grandfathering, particularly in relation to fee schedules, which adds to the complexity of the sector. Indeed, there are multiple levels of Government subsidies and co-contributions based on when a person entered care. As Medicare Australia said:

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Grandfathering existing rules means increased complexity for both providers and Medicare Australia, with multiple sets of rules running in parallel in order to determine payments. ... Note that the costs of maintenance increase with each new layer of business rules. These costs are incurred by both Government and providers, who are increasingly relying on business management systems to run their operations. (sub. DR804, p. 12)

That said, the Commission is also mindful that existing residents of aged care facilities and existing recipients of community care entered their care on the basis of the existing funding arrangements and would be particularly vulnerable during a transitional period to the proposed new system. Accordingly, the Commission proposes that:

- existing residents of aged care facilities, and those who enter prior to the commencement of the new system, should be subject to current arrangements while they remain in residence — this means that any accommodation bonds paid to providers would remain until the resident has departed
- existing users of community care should be subject to current arrangements for all community care services. However, should they need to move to residential care when the new arrangements are in place, they should be subject to the new funding rules.

While it is desirable to protect existing care recipients from disruptive change, particularly as they are vulnerable, it would be preferable to eliminate, within the five-year transition period, all grandfathering arrangements as exist between providers of care services (both community and residential) and the Government (as the principal funder). This could be effected through negotiation where the Government and providers agree to the new arrangements and funding is provided on a one-off lump sum basis to transfer the responsibility of maintaining grandfathering arrangements from the Government to providers. Although this would remove grandfathering provisions that exist between the Government and providers, such provisions would still need to remain between providers and existing consumers for pre-existing service agreements.

In addition, some residential providers have extra service places that are exempt from the supported resident quota. The Commission considers that these facilities and places should retain their exemption for the duration of the transition period, with the exemption being removed when the transition period has concluded (five years).

Following such an agreement, the Government would provide a uniform subsidy for each care recipient (under the new system), while providers would charge

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co-contributions for existing care recipients according to their pre-existing arrangements.

RECOMMENDATION 17.2

*The Australian Government should negotiate with providers of care services to existing care recipients to harmonise care subsidies and other arrangements. It should reach an agreement within five years that would have the effect of removing grandfathering arrangements for existing and new places while protecting existing recipients of care from changes that would impose a new cost upon them.*

*The exemption from the supported resident ratio obligation provided to some extra service facilities should be removed at the end of the transition period as part of a negotiated settlement.*

### **17.3 Mitigating the risks from the reform implementation**

There are a myriad of risks that could manifest themselves during the transition period and beyond (box 17.1). Some result from a potential lack of understanding of the effects of the reforms on the aged care system by both providers and consumers. Others result because some providers do not have well developed business models capable of readily accommodating a more competitive and dynamic environment. Some of these risks are temporary; others systemic.

Another source of risk is if measures from the Commission's proposals are 'cherry picked', removing the integrity and cohesiveness of the reform package. Ad hoc implementation of the reforms could stymie their efficacy and limit the overall benefits. This could increase the risk to future budgets or lead to an overall decline in the quality of care as the population ages and more Australians need care.

#### **Mitigating provider risk**

The reforms proposed in this report are likely to reduce a number of risks faced by the aged care sector by ensuring a sustainable funding model that, in particular, addresses the concerns of under-investment in residential high care and increases funding for supported residents and those in special needs groups.

In the short-term, however, the reforms may increase the risks faced by some residential care providers which have invested significant sums into residential stock.

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A key objective of the reforms is to ensure the sustainability of the aged care system by providing a long-term and credible funding base. But the reforms do not seek to protect each and every existing provider: some providers are relatively inefficient, while others provide services which only just meet minimum standards. Some providers, perhaps due to the nature of their capital stock, are unlikely to have sustainable business models. As noted by Catholic Health Australia:

... many smaller approved providers are already under pressure from rising standards and regulatory requirements, the increased acuity of residents, higher quality assurance and governance requirements, and the increased availability of community care. (sub. DR909, p. 3)

However, the Commission's proposals overall should provide the long-term sustainable financing platform necessary for the continued growth of the industry and continued improvement in the quality of services.

Some consolidation in a very fragmented industry has occurred over recent years. The Commission expects that this consolidation will continue, with efficient and dynamic providers taking over from those that do not have sustainable business models. This will provide further economies of scale and scope, benefiting both consumers and the taxpayer. That said, there will continue to be an important and growing role for niche providers who cater well to specific needs of the aged care community.

One of the key vulnerabilities during the transition period is to residential providers with significant capital investments which are heavily reliant on accommodation bonds. A key implication from the Commission's reform process is a move away from very large accommodation bonds, to those which are more reflective of costs, and to a greater use of periodic payments, which in principle should be profitable to an efficient provider.

Some providers have a skewed balance sheet, with a few very large accommodation bonds that are used to cross subsidise a number of other places. That is, the providers are making significant profits on some beds, but significant losses on other beds (especially those in non extra service high care and those for supported residents).

This is, in effect, a non-diversified holding of beds with a risk that the exit of a person who has paid a very large accommodation bond is not replaced by a new person paying a similar or even higher bond. As noted in chapter 7, the practice over recent years has been for a ratcheting up of the value of accommodation bonds, in line with increases in property values. This is not sustainable, although providers, their bankers and consumers are protected to some extent by the government guarantee on accommodation bonds. As such, there is no strong advocate on behalf



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of the party that takes the residual risk from the unsustainable and inexorable increase in the size of accommodation bonds: the taxpayer.

The Commission's proposals will diversify these risks — reducing the reliance on a small proportion of highly profitable beds. Under the Commission's proposals, all beds — supported and otherwise — will be profitable to an efficient provider. The Commission proposes an early increase in the supported resident accommodation supplement and in the ability for the provider to charge a higher price for non-supported residents in high care. Under the Commission's proposals, a provider should be indifferent about which residents depart, whereas at present this can make a significant difference to the facility. Accommodation bonds will remain subsidised, by virtue of their exemption from the Age Pension assets test. In addition, the Commission's recommendations will lead to an additional stream of income, through increasing use of facilities for sub-acute, transition and respite care. The increasing use of periodic payments should facilitate the growth of these short-term placements.

That said, some providers may suffer liquidity pressures in the short term to the extent that they are unable to replace departing residents who have lodged large bonds. Some providers have very high debt to equity ratios, when accommodation bonds are properly accounted as debt. Effectively, providers can have high leverage — magnifying returns by spreading profits over a relatively small pool of equity and equally magnifying losses by spreading losses over the small pool of equity.

Thus the risks faced by those providers are higher because of this debt leverage, with the Government taking a share through its guarantee of accommodation bonds.

The Commission's proposals will allow providers to discount their accommodation bonds to make them more attractive relative to periodic payments. This may be encouraged by financial institutions to reduce the call on bank debt. In the short term, then, the Commission envisages that accommodation bonds will continue to dominate as a source of funding.

Over time the Commission expects that the industry will move to a systemically higher proportion of equity, more in line with similar industries. This will provide a balance between equity, periodic payments and zero interest accommodation bond debt. This would be desirable as by reducing leverage, it will reduce solvency risk and hence the risk premium charged by financial institutions for debt.

These risks should be kept in perspective. The formal aged care system is unique in that demand is growing inexorably due to the ageing of the population and many payments are effectively government guaranteed. Indeed, under the Commission's

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proposals all future residents should be profitable to an efficient provider, including supported residents and those in what is now non extra service high care.

A reduction in the size and number of accommodation bonds will also reduce the risks to government from its guarantee.

During the transition period, however, the Commission is cognisant of the liquidity risk to smaller providers from its proposed changes and the possible disruption this might cause to consumers. In this context, a small and targeted assistance package for certain providers could be desirable over the transition period. This would be targeted at small providers suffering liquidity problems. This is not, however, a proposal to prop up insolvent providers, which have an obligation under corporations law to cease trading.

The Commission envisages that the assistance package would be in two parts and would apply only through the transition period.

- Firstly, a subsidy of 50 per cent (up to a maximum specified limit) to smaller approved residential care providers to purchase business planning advice, assess options and prospects, including the possibility of closing the business or selling it to another provider.
- Secondly, for those smaller approved residential providers that have liquidity problems (but which are otherwise solvent), because of lumpiness in repaying accommodation bonds arising from bunched client separations, the Government could provide temporary assistance by paying the departing resident his or her bond while negotiating with the affected provider a repayment schedule. Such arrangements would involve a market interest rate plus a surcharge to discourage the use of the facility. Since the Government guarantees the accommodation bond, this facility effectively calls upon the guarantee while outlining a repayment schedule to offset the call upon the guarantee.

The Commission supports the definition used by Catholic Health Australia for a smaller residential provider — that support be limited to approved providers that meet all of the following criteria:

- EBITDA [earnings before interest, taxes, depreciation and amortisation] in the third or fourth quartile
- at least 50 per cent of the building infrastructure is more than 15 years old or the accommodation does not meet the basic standard for supported residents
- less than 100 beds and up to two approved residential services
- evidence of inability to adjust to competitive pressures, such as declining occupancy or an unsustainable business model (eg a hostel configuration which is unsuitable for high care). (sub. DR909, p. 4)

*The Australian Government should provide, during the transition period, capped grants to existing smaller approved residential care providers, on a dollar-for-dollar basis, for financial advice on business planning to assist in assessing their future options.*

*Subject to an audit to demonstrate solvency, the Australian Government should offer — during the transition period — existing smaller approved residential care providers a loan facility for the repayment of accommodation bonds. The Government should charge an interest rate premium on the facility to discourage its use when private sector options are available.*

### **Mitigating consumer risk**

The main risks faced by consumers are disruption caused by the transition (such as the closure of a facility), a lack of access to aged care services when a need arises, and continued poor alignment between care needs and care delivery. Vulnerable older Australians may also not fully understand the implications of the proposed reforms, the need for a more sustainable funding model and the design of the co-contribution regime.

One of the principal objectives of the inquiry is to increase choice for consumers, and to design an aged care system that has the capacity to meet the needs of older Australians in a sustainable way.

As noted in chapter 5, the current system has a number of strengths and weaknesses, among the weaknesses being a constrained supply in many parts of Australia. The reforms proposed in this report will encourage the development of new supply, both in community and residential care.

In the short-term, however, there is likely to be a continued shortfall in residential places in some areas, due to lags in bringing on new supply, and in community care. To mitigate this, the Commission proposes to remove most of the barriers to community care places early to at least provide some of the unmet demand for care services until the industry has had time to develop new residential places and to further develop the workforce to meet the demand.

In expediting the release of more community care places, the Commission is mindful that the full implementation of a seamless community care system is unlikely to be achieved early in the transition period, with the continuation of the gaps between existing package levels. During the first stage of the implementation

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plan, the Commission proposes that an intermediate community care package be introduced at the next Aged Care Approval Round (ACAR) to temporarily plug the gap until the full community care schema has been implemented (see section 17.4 for the details).

There is also a risk in the short-term of residential providers taking advantage of market power to exploit shortages through charging high accommodation prices. The Commission proposes that the new AACC conduct formal price monitoring during the transition period, with the explicit threat of regulation should providers seek to unreasonably exploit their short-term market power.

A further risk for consumers is if — in the move to the new Gateway — there is any disruption in assessment pending the development of a coherent new assessment scheme building on the existing aged care assessment teams. The early creation of the Gateway with the appointment of an appropriately qualified chief executive should mitigate this risk.

Another risk to existing recipients of residential care is disruption should a provider fail due to the Commission's reforms. This risk is mitigated by the Commission's proposal to provide support to the more immediately vulnerable of providers, while not providing an incentive for unviable providers to remain in the industry. It is impossible to guarantee that there will be no disruption during the transition period, but vigilance by the regulator and careful management of the transition period by the Aged Care Implementation Taskforce should reduce the likelihood of significant disruption. On the other hand, the Commission's proposals should lead to an overall improvement in the quality, range and choices available in residential and community care.

Existing recipients of aged care services are also protected through the grandfathering arrangements discussed in section 17.2.

#### RECOMMENDATION 17.4

***The Australian Aged Care Commission should, during the transition period, formally monitor accommodation prices in residential care. If the price monitoring shows that residential providers are systematically charging excessive accommodation fees, the Australian Aged Care Commission should recommend that the Australian Government consider regulatory measures that might be implemented to reduce this practice.***

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## 17.4 Sequencing of reform

Differences in the scale and complexity of the reform proposals, together with a need to introduce some reforms upfront to provide a foundation to secure the benefits of subsequent reforms, suggest that a staged transition is required.

While some reform proposals can be introduced quickly, others will require:

- extensive consultation among older people and their carers, providers, governments, community organisations, the aged care workforce and the community more generally
- protection of existing recipients of care
- preparatory work by the Australian Government, including standards development, legislative and regulatory changes, trials and research and development
- packaging and sequencing of measures to reduce the costs of implementation for providers and governments
- monitoring and review of outcomes to ensure that the new arrangements are working effectively and to manage any emerging unintended consequences.

An important issue is the timing of initiatives to free up quantity and price restrictions. In the Commission's view, there are strong reasons to liberalise quantity restrictions before moving away from regulated prices (box 17.4), especially for residential providers where there are long lags in bringing forward new capacity.

That said, and as discussed in section 17.3, the immediate removal of quantity restrictions could adversely affect providers that have planned and invested on the basis of the current regulations. This suggests the need for a gradual easing of these restrictions followed by price liberalisation, while retaining provisions for price monitoring and regulation.

A key difference between community and residential care is the need for greater capital (buildings and equipment). The lead times for building new residential facilities are long, partly due to planning rules which provides a degree of protection for existing residential providers. This suggests that there is scope for a more rapid opening up of community care, where the barriers to entry are lower.<sup>1</sup>

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<sup>1</sup> Note, under the Commission's proposals, both community and residential providers would continue to be approved in order to obtain Australian Government subsidies.

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### Box 17.4 Which should be liberalised first: quantity or price?

The optimal order for the liberalisation of a highly regulated sector has been the subject of much scholarly debate. Ronald McKinnon, in writing about economic liberalisation, stated:

In securing this noninflationary financial equilibrium, however, there are definite limits on the relative speeds of liberalization in commodity and capital markets and on how fast interventionist policies or planning controls over domestic and foreign trade can be withdrawn. How fiscal, monetary, and foreign exchange policies are sequenced is of critical importance. ... there is an 'optimal' order of economic liberalization. (1993, p. 4)

McKinnon concluded that, in general, prices which are less elastic should be liberalised before those which are more elastic.

Australia's aged care system is regulated in three dimensions: by price, quantity and quality. In general, the control which is least responsive should be liberalised first; that which is most responsive last, although the entire policy direction should be carefully enunciated by the Government to provide a credible and transparent reform path. So, for example, were price to be deregulated first, the quantity controls would lead to price spikes in regions of relatively short supply: price being most flexible would become volatile.

By contrast, if quantity is deregulated first, it is relatively slow in responding to change: new supply, or the withdrawal of supply, rarely occurs swiftly. By relaxing quantity controls first, then, the industry would adjust to the new regime by planning the quantity of aged care services (and residential facilities) based on its expectation of the future direction of prices — volatile shocks in price could be avoided through continuing price controls. However, any pre-existing distortions in regulated prices — such as underfunding or the absence of a direct link to the cost of service provision — would need to be removed to encourage appropriate quantity related adjustments. Subsequently, these modifying price controls could be lifted, particularly if the market was likely to be contestable.

Henry Ergas supported this approach to regulatory reform, stating:

As those changes [quantity controls and the removal of distortions caused by government assistance between forms of care provision] come into effect, and competition became a real factor shaping market outcomes, controls over prices could be eased and eventually eliminated, ensuring efficient providers of aged care could fully recover their costs. (2009, p. 36)

As noted, in liberalising quantity first, though, prices need to be at sufficient levels to provide reasonable returns to service providers.

Sources: Ergas (2009); McKinnon (1993).

The Commission envisages a three-stage implementation process, as outlined below. The discussion is not a comprehensive detailing of each of the Commission's recommendations. Rather, it provides guidance on the sequencing of reform, drawing on examples of key reform measures and when they should be

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implemented. An implementation plan is outlined in schedule A, provided at the end of this chapter.

### **First stage reforms (expediting measures within two years)**

Several of the Commission's proposals could be implemented relatively quickly to address some important deficiencies with the current arrangements. Some of the high priority measures can be implemented without legislative change, while the remainder could form part of a small package of legislative amendments that would be relatively easy to prepare and hence should be able to be expedited.

During the first stage, direct funding of providers would continue as under the current system, as would the care subsidies and co-contributions, although it would be helpful to introduce a mechanism where co-contributions would count towards the lifetime stop-loss limit.

#### *An independent regulator and gateway*

The early establishment of the AACC and the Gateway and the appointment of their chief executives would assist in building credibility in the reform project and should assist in the smooth transition to the new aged care system. Pending more substantial changes in the regulatory environment during the second stage, the AACC could be given carriage of the existing regulatory framework from DoHA (through minor amendments to the *Aged Care Act 1997*).

Similarly, the Gateway, in its initial period, would work within the current assessment system while developing the new assessment regime and building up its capacity.

The early creation of the agencies and the appointment of their CEOs would allow their active participation in the proposed Aged Care Implementation Taskforce as *ex officio* members and reduce the risk of implementation missteps.

Close cooperation and coordination with DoHA during the transition period (and beyond) will be crucial for both the AACC and the Gateway — the Secretary of DoHA and the chief executives of the AACC and the Gateway should sign a memorandum of agreement covering such issues as information exchange, joint and specific responsibilities and consultation.

The AACC and the Gateway would be established as two prescribed agencies under the *Financial Management and Accountability Act 1997* (FMA Act). Concurrently,

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the Aged Care Standards and Accreditation Agency would become a statutory office within the AACC.

An important role of the AACC will be to inform the industry of the revised aged care regulatory system, including, for example, the greater range of enforcement options and how it will affect them. It will also function as the national data clearinghouse for aged care and promote greater dissemination of data and research. This should commence as soon as practicable after its creation, continuing through the second stage of the reforms.

The Gateway would, over time and through the second stage of the reforms, set up a national information platform, and redundant services would be terminated. It would develop the new needs assessment service and tools, building on the current Aged Care Assessment Teams (ACATs), establish protocols with Centrelink for assessments of financial capacity and establish a care coordination function.

Both agencies — but particularly the Gateway which will be the key front end to the aged care system — would be responsible for implementing a significant education campaign to inform older Australians and their families of the new system and how it affects them, including the revised care co-contribution scheme. In addition, the Gateway would need to manage and coordinate a number of current programs and services, including the Commonwealth Carelink Centre, the seniors.gov.au website, the pilot Access Points program and HACC-funded information services.

### *Removing the distinction between high and low care and accommodation charges*

The removal of the distinctions between residential high and low care and between ordinary and extra service status is a necessary first step in the rationalisation of residential care regulation and in the promotion of continuity of care.

Presently the accommodation component of residential high care is funded via an accommodation charge, which the Commission has found to be unsustainably low. Residential low care and extra service high care is principally funded via accommodation bonds, many of which exceed the underlying cost of supply, including a reasonable return on investment.

Under the Commission's proposals, residential facilities would be required to set and publish an accommodation charge that is consistent with the value of the accommodation (rather than a resident's ability to pay), and optionally set and publish an accommodation bond. The Commission is also proposing that the removal of accommodation bond retention amounts would occur at the same time. During the implementation period, the AACC should monitor accommodation



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prices to minimise the risk of residential providers using their market power to exploit vulnerable older Australians. In undertaking the monitoring, the AACC should be given formal responsibility to recommend regulatory measures to the Government should the price monitoring indicate that a regulatory response is required to minimise such abuses.

Overall, the Commission's proposals should lead to accommodation payments (whether in the form of periodic payments or bonds) that are sufficiently high to meet the costs of providing the accommodation for all residents, including supported and those in high care.

### *Community care, including HACC*

While the Commission proposes that the increase in the number of residential places should occur from the second stage because of the exigencies and timing of construction, there is good reason to increase the number of community care places early to provide a pressure valve to the system and address — at least partially during the transition period — unmet demand. Accordingly, the Commission considers that the number of community care places should be increased as soon as practicable by 20 per cent (or some other significant amount above the baseline) above the ACAR baseline, increasing by a further 20 per cent until the end of the implementation period when the number of community places would be unlimited subject to an assessment of need and by the provision of the services by an approved provider.

The early opening of community care places would also assist residential providers who could expand their operations by offering community care services. The early increase in the number of community places was supported by a number of participants including the Council on the Ageing (COTA) Australia:

We would like to reiterate and even more strongly emphasise the importance of first dealing with community care, freeing it up and providing additional resources to allow it to support more people with higher care needs in the community. This would respond to a high priority need for consumers in which there are currently major blocks. (sub. DR565, p. 16)

Alzheimer's Australia stated that a smooth transition should:

Increase access to community care packages (including through the introduction of a mid level community care package), budget-holding for new packages, expanded respite care and strengthened assessment and information in the first stage of the reform. (sub. DR656, p. 28)

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The inquiry has also highlighted a number of gaps between various community care packages, which will be addressed by the Commission's continuum of care. In the first stage of the transition, however, there would be merit in temporarily adding another level of packaged community care. Anna Howe considered that an intermediate level of community care package between Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) would address the principal gap in the present community care system. Howe considered that the aims of the intermediate level would be:

- to give a clear signal of the Government's commitment to expanding aged care, particularly community care
- to respond to the call for restructuring Care Packages and give an additional step in package funding over the period until recommendations from the Productivity Commission Inquiry are implemented
- to contribute to maintaining overall provision and address the persisting and potentially increasing shortfall between approved and operational places for residential care. (sub. DR904, p. 1)

The desirability of an intermediate package between CACP and EACH as part of the transitional arrangements was argued also by COTA:

Introducing new levels of packages between CACP and EACH at regular intervals while the longer term pricing study is undertaken and new legislation prepared. This would require additional packages to be made available at the new levels. (sub. DR565, p. 31)

The temporary intermediate community care package would be aimed at reducing the pressure on EACH from those CACP clients who have needs above CACP but below that of EACH. Subject to an assessment, existing CACP clients that are accessing additional HACC services for nursing needs could move to the intermediate package. Similarly to relieve pressure on HACC, those clients receiving services from HACC above the CACP level would migrate to the intermediate package.

As noted in chapter 9, the HACC program has been very successful at providing low level care and support for older Australians. The Australian, state and territory governments (with the present exception of Victoria and Western Australia) have decided to split the funding responsibility for HACC between the Commonwealth (for aged care) and the states and territories (for disability care). Under the Commission's proposals, a significant proportion of existing HACC services would move to the continuum of care under an entitlement system subject to the assessment of need by the Gateway. The residual parts of the existing HACC would include:

- social activity programs

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- wellness programs
  - day therapy programs
  - community transport
  - meals delivery
  - information and general advocacy
  - other support services such as home maintenance and low level aids.

These programs would be able to be accessed directly or via an assessed referral from the Gateway. The existing HACC program would continue until the second stage of the transition when it would be rolled into the Commission's care continuum as separate community support services such as those highlighted by the Victorian Minister for Ageing (sub. DR901). It is likely that residual HACC services would also be required for people below normal aged care age with a level of disability which might not be covered under the proposed National Disability Insurance Scheme.<sup>2</sup>

As noted also by COTA (sub. DR565, p. 30), the implications of the changes are to move from block funding of HACC services (in first stage of the transition) to entitlement funding (for the formal aged care services) and block funding (for community support services) during the second stage. This will reduce block funding to existing HACC providers, which would then compete for consumers of entitlement based services. It may be desirable to introduce an 'entitlement pool' to successfully manage this transition.

RECOMMENDATION 17.5

***The Australian Government should introduce at the earliest opportunity a temporary intermediate community care package level to reduce the gap between Community Aged Care Packages and Extended Aged Care at Home during the first stage of the transition period.***

***Supported residents***

With the continuation of the supported resident ratio, it is also necessary to increase the accommodation supplement paid by the Government for supported residents — this should be increased as soon as practicable, perhaps in graduated steps, to a level that is sufficient to reflect the cost of the approved basic standard of

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<sup>2</sup> See the separate Productivity Commission Inquiry into Disability Care and Support that is scheduled to present its final report to the Government by 31 July 2011. The Commission released its draft report for that inquiry on 28 February 2011.

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accommodation. Ultimately this supplement, along with subsidies for care services discussed below, will be set by the Government based on the transparent advice and recommendations of the proposed AACC.

To improve the scope for providers to tailor services to different client groups, facilities should be able to trade supported resident ratio obligations with others in the same region (or subregion) so that some facilities could operate below their target and others could provide more specialised services. To test the merits of a supported resident ratio obligation trading arrangement, the Government should introduce a pilot scheme in the first stage of the reforms, followed by a review during the second stage. The review would assess the performance of the pilot scheme and the desirability of permitting trades in the supported resident ratio obligation between providers in the same region (or subregion) more generally. During the pilot, it may be useful to limit trades to 50 per cent of supported resident ratios.

#### RECOMMENDATION 17.6

***The Australian Government should conduct a pilot whereby providers could transfer (subject to approval by the Australian Aged Care Commission) up to 50 per cent of their supported resident ratio obligation per facility with other providers within the same region (or subregion).***

***This arrangement should be reviewed within five years with a view to assessing its widespread applicability and to consider the option of introducing a competitive tendering arrangement, or entitlement funding, for the ongoing provision of accommodation to supported residents as an alternative.***

#### *Other first stage reforms*

These first stage reforms, including the setting of a charge for standard accommodation, will lead to a reduction in the average value of accommodation bonds. As a consequence, there will be a need for an alternative means for age pensioners to deposit any excess funds from the sale of their home in a form that is exempt from the Age Pension assets test so that these individuals could (if they wished) remain eligible for the Age Pension. The proposed Australian Age Pensioners Savings Account would therefore need to be established in parallel with the accommodation payment reforms.

A number of participants argued that the present indexation of government payments to the industry is insufficient, causing financial pressure on some operators. Unfortunately, there has been insufficient information available to test this claim. Accordingly, the Commission proposes that the AACC collect and

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analyse costing data and recommend to the Government a scheduled set of care prices and a rate of indexation for subsidised aged care services. Initially, however, the AACC in conjunction with DoHA should conduct a public benchmarking study of aged care costs to initially set the required scheduled prices, thus providing some funding certainty for the next couple of years. Subject to the benchmarking study, the Government could increase subsidy levels for CACPs, EACH and EACH-D and as appropriate Aged Care Funding Instrument (ACFI) payments in residential care.

The Commission has also argued that there is a strong case for greater transparency in the provision of data and information generally, to generate opportunities for more effective research and evaluation (chapter 16). The Commission proposes that the AACC be given a mandate and responsibility for the collection and dissemination of data and information (including, for example, future demand trends and ways for providers to improve the quality of their services in line with best practice). This will greatly assist in building up a body of knowledge to aid the proposed five year review. The release and dissemination of such data (and research findings) would assist existing and potential providers to respond to the changing market environment. It would also enable non-provider organisations, such as in the financial sector, to develop products that could assist older Australians.

The Government should also harness the existing research organisations to conduct an examination of the public and private costs and benefits of residential and community based care.

## **Second stage reforms (within two to five years)**

Most of the Commission's proposals will require substantial legislative changes, especially to the *Aged Care Act 1997*, which could take at least two years to effect because of the complexity of the aged care legislative environment. That said, the early announcement of the Government's intentions would enable existing and potential providers to commence their planning. The Commission considers that the following proposals would comprise the second stage of the reform process and that they could be implemented within two to five years of announcement.

### ***Care services and subsidies***

A central reform is the provision of an entitlement based continuous range of care services, using a fully-integrated building block approach across both community and residential care. This would replace the current discrete home and community care programs and packages, and also give the Gateway assessors responsibility for specifying (initially) the care entitlements for those entering residential facilities.

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In addition, the Commission's proposed new care co-contribution regime should be implemented (with protection for those with limited means) and the lifetime stop-loss limit should also be introduced at this stage, with funding via entitlement and via the individual rather than directly to the provider.

The proposed government-backed Australian Aged Care Home Credit scheme would be set up at this time to enable older people, whose financial capacity largely consists of equity in their homes, to contribute to their aged care costs and to allow the Government to fully inform older Australians and their families of the scheme and its implications and efficacy.

As discussed above, prices for the approved services provided under the aged care system should continue to be set by the Government on the transparent advice and recommendations of the AACC. The AACC would benchmark the costs of care in both community and residential settings as soon as practicable and make transparent recommendations to the Government on a set of scheduled prices, indexation rates and the price to be paid for the basic standard of accommodation for supported residents.

Older people with entitlements to care would pay their care co-contributions directly to their chosen provider and would, for administrative efficiency, sign over their subsidy.

#### *Supply restrictions — bed licenses*

It would be disruptive to remove the supply restrictions in residential settings immediately, with some regions having excess supply and others excess demand at current price levels. The Commission has been advised that the value of residential care bed licenses varies significantly by region. In some areas, licenses have been handed back to DoHA, implying a zero valuation (or a very low valuation reflecting timing considerations if waiting for a new ACAR allocation).

In order to ensure a smooth adjustment, it would be preferable to liberalise supply gradually, allowing time for providers to assess emerging market opportunities and to build their capacity to provide additional services. During this time, prices for care and standard accommodation should remain regulated, to minimise the fiscal risk to the taxpayer and care co-contributions by users.

Even under a fully competitive market in metropolitan areas, there may remain a need for some form of residual service planning, which the AACC should conduct in consultation with DoHA. As Greg Mundy noted:

The [draft] Report acknowledges that market forces alone will not suffice in eg rural or remote areas. I am suggesting that there is also a *risk* in metropolitan regions that may

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need to be managed. Service planning may well be a background activity and a transitional need. (sub. DR525, p. 7)

Options to achieve a smooth adjustment of supply include:

- abolishing all bed licenses immediately on implementation of the new aged care system. This option could particularly affect some providers who rely on the asset value of their licenses
- continuing with the ACAR to set the number of licenses for a fixed period via its existing methodology, but with an additional percentage (perhaps 10 to 20 per cent) of licenses provided progressively above that baseline. This would gradually increase supply until it is effectively fully liberalised in both residential and community settings. Entitlements to subsidised care would still be dependent on an assessment of need by the Gateway.

The Commission favours the latter, with a period of five years from the announcement of the Government's policy being sufficient to allow a smooth adjustment by the industry, with the removal of all quantity restrictions at the commencement of stage three. Consistent with increasing the continuity of care services, the removal of quantity restrictions in residential care would be mirrored in community care, although the increase in the latter would occur earlier and the expansion would be more rapid.

The Commission's proposed reforms could affect some providers who rely on the asset value of bed licenses as collateral for borrowings. Participants suggested that a three to five year phase out of bed licenses would address the most significant of these concerns. The Commission also notes that new licences are issued without charge and that there will be new opportunities for providers, such as the opportunity to compete for sub-acute services, and to expand both residential and community offerings.

### *Improving the quality of aged care*

To further improve the quality of care services provided to the community, the quality assurance framework for aged care should be expanded to include published quality indicators at the service provider level to help older Australians and their carers to make more informed decisions and to promote the transparency and accountability of the aged care system.

The AACC should develop a Quality and Outcomes Data Set for care recipients to bring together evidence on best practice care.

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### *Supported and concessional residents*

The second stage of the reforms would be the appropriate opportunity to review the pilot scheme for trading supported resident ratio obligations. Subject to the review, the trading scheme could be expanded, or be replaced by an alternative such as a competitive tendering scheme or the redirection of the supported resident accommodation supplement from providers to residents.

At this stage, it would also be useful for the Government to undertake an assessment of the appropriate total assets test thresholds for the supported resident accommodation supplement (the current minimum threshold is \$39 000).

### *Other second stage reforms*

In the Commission's assessment, the second stage of the implementation plan would be the appropriate time to introduce and bed down the remaining recommendations relating to the care and quality (chapters 9 and 10), catering for diversity (chapter 11), age-friendly housing and retirement villages (chapter 12), carers (chapter 13), the workforce (chapter 14), and regulation (chapter 15).

### **Third stage reforms (five years and beyond)**

Over the first five years of its implementation plan, the Commission has proposed a gradual increase in the number of places in both community and residential settings. At the commencement of the third stage of the reform process, the remaining supply restrictions should be removed. That is, approved providers in both community and residential settings would be free to supply the number of care services and residential places that they wish. Demand would continue to be limited, amongst other things, by the number of older people who had assessed entitlements to approved care.

Following the removal of these restrictions, the Government should commission an extensive public study into the implementation of its reforms and the state of the aged care system. Such a review would be informed by the increased availability of data and information under the mandate provided to the AACC. Among other things, the review should analyse and recommend:

- whether the consumer-directed system had developed sufficiently so that care and supported accommodation prices could be liberalised in certain markets



- 
- any changes to the Accreditation Grant Principles, the Quality of Care Principles, and the Community Care Common Standards and other quality related arrangements
  - any changes that may be needed to maintain fiscal sustainability
  - any changes that may be needed to ensure access for special needs groups
  - whether supported residents should receive funding directly from an entitlement rather than through a mandatory ratio applying to residential facilities
  - the efficacy and cost of the proposed reablement service component
  - any changes to the financing arrangements, including a thorough examination of the operation of the new financial arrangements.

The Commission further considers that the Government should announce a timetable for subsequent public review of the aged care system.

RECOMMENDATION 17.7

*In implementing reform, the Australian Government should announce a detailed timetable for changes and how the changes are expected to affect consumers (including carers), providers, workers, and the sector in general. In particular, the Australian Government should:*

- *carefully and fully communicate the design, objectives and implications of the reform measures*
- *be guided by the three-stage implementation plan listed in schedule A.*

## **17.5 What do the reforms mean for older Australians, their carers and service providers?**

The recommendations in this report will introduce significant changes to the aged care sector. This section discusses the major implications for older Australians, their carers and for aged care providers.

### **Older Australians and their carers**

The Commission's recommendations will significantly improve the quality and quantity of aged care services for older Australians. As a result of the reforms, older Australians would:

- have ready access to general advice on ageing issues, as well as specific information about their local aged care services. This advice and information

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would be available from a range of sources that all draw from a national information platform run by the Australian Seniors Gateway Agency (the Gateway)

- be assessed for their care and support needs by the Gateway. They could also go directly to community-support services (such as meals delivery and community transport) which would continue to be block funded (or receive a Gateway referral to them)
- receive an entitlement to services that matched their needs, and be advised of the price of those services and the details of approved providers in their local area
- be offered a care coordination service run by the Gateway and a case management service when needed
- have a single, updated, aged care electronic record that means that they do not have to keep repeating their history and personal circumstances
- benefit from a new intermediate community care package between CACP and EACH as part of the transitional arrangements
- choose their preferred provider (quantity limits on providers having been lifted), having regard to the quality of services being offered, including the professional and relationship skills of the personal carers, the cultural awareness and languages spoken and the ability to negotiate timing of service delivery
- seek a reassessment of their needs if there is a material change in their circumstances
- be subject to a fair and comprehensive financial means test — based on income and assets — to determine their level of co-contribution for approved care and support services (whether in their home or in residential care), with a safety net for those of limited means and with a lifetime stop-loss for care co-contributions
- have access to a government-backed Australian Aged Care Home Credit scheme with a no negative equity guarantee to meet their care and accommodation costs if their wealth is held mostly in the form of their house while protecting the share of the equity held by a spouse/partner
- be able to retain their house and be confident that their spouse, dependent child or other ‘protected persons’ would continue to be able to live in that house, rather than be forced to sell their home in order to go into residential care, as is the case for some at present
- if in residential care, pay a basic daily fee (currently set at 84 per cent of the single age pension), pay their care co-contribution, and pay a daily periodic accommodation charge or equivalent bond, with a safety net for those of limited means

- 
- retain their Age Pension if they sell their home to move to alternative accommodation (such as a retirement village, serviced apartment, or a residential care facility) and pay a lower capital sum or daily charge by investing the excess proceeds from the sale in a Government-guaranteed Australian Age Pensioners Savings Account scheme
  - benefit from measures to improve the quality of aged care services, including through a quality assurance framework, better evidence and information, and a more competitive environment facing approved providers
  - receive enhanced access to general practitioners at residential aged care facilities through an increased Medicare rebate
  - be given every opportunity to maintain or regain functional independence (including reablement)
  - be free to choose whether to purchase additional aged care services (including accommodation) beyond the minimum approved entitlement and meet the associated costs themselves
  - be confident that the AACC is monitoring the quality of care by providers and the price of residential accommodation during the transition period to protect against providers exploiting supply shortages and is an independent avenue for examining consumer complaints
  - receive improved access to information about advanced care directives, with a link to the proposed electronic records
  - get better palliative and end-of-life care through an assessed entitlement from the Gateway.

### **Aged care providers**

The Commission's reforms will involve significant changes for community and residential aged care providers, overcome current financial pressure points and create scope for individual providers to grow within an emerging competitive market. Good managers who meet the needs of empowered older people will have significantly more opportunities to be successful contributors to the caring of older Australians. Providers would:

- be subject to quality accreditation, but be free of any quantity limitations such as bed licences and numbers of care packages (with a five year transition to an open market)
- compete with other providers for clients who had entitlements to care and support services, subject to being approved providers of those services

- 
- receive a price set by the Government for those approved care and support services determined through the assessment process by the Gateway (comprising a care co-contribution from the client and a subsidy from the Government)
  - while meeting the approved quality and safety standards, and operating within the price set for the entitlement, compete on a range of dimensions such as the professional and relationship skills of their workforce, the cultural awareness and languages on offer, the quality of food and other services and their responsiveness to the particular requests of individual clients
  - offer a range of additional services, at a quality and price set by the provider
  - liaise with the Gateway on matters of initial assessments of client needs and entitlements, and be able to undertake subsequent assessments in response to a material change in a client's needs, subject to a risk management audit process
  - liaise with the AACC on matters of quality standards and assessments, complaints handling and costs of service delivery
  - be able to access information from the proposed AACC regarding projections of future demand trends and ways to improve the quality of services.

In addition, providers of residential care would:

- be able to seek approved provider status for all levels of care and support delivered in a residential setting (with inability to meet the demands of specific residents being dealt with on a strict exception basis), with the distinction between low, high and extra service care being removed
- receive care payments for community and residential care set by the Government on the transparent advice and recommendation of the Australian Aged Care Commission
- charge all residents for their everyday living costs by way of a basic daily fee (currently set at 84 per cent of the single age pension)
- set their own periodic accommodation charge for all new residents and, if desired, offer an accommodation bond of up to the equivalent amount, and publish those charges and bonds (with current bonds being grandfathered)
- receive a set daily accommodation fee for supported residents, based on the average cost of 1.5 beds per room per facility at a level designed to meet the value of that standard of accommodation
- be required to provide for a minimum quota of supported residents with a pilot scheme on a tradeable ratio obligation within the relevant region

- 
- be able to offer a range of other services in their facilities, such as respite care, transition care, reablement, sub-acute care, rehabilitative and restorative care, behaviour management stabilisation, palliative pain management and end-of-life care, subject to meeting the relevant quality and safety requirements, and reaching agreement on prices and other terms and conditions
  - access a transitional assistance package for small residential providers.

## Schedule A Implementation Plan

<i>Stage 1: expedited measures within two years</i>	<i>Stage 2: within two to five years</i>	<i>Stage 3: five years and beyond</i>
<ul style="list-style-type: none"> <li>Establish the Aged Care Implementation Taskforce and Aged Care Advisory Group</li> <li>Establish the Australian Aged Care Commission (AAC) and Australian Seniors Gateway Agency (the Gateway)</li> <li>Transfer the Aged Care Standards and Accreditation Agency to a statutory office in the AAC</li> <li>Remove the distinctions between low and high care, and between ordinary and extra service</li> <li>Require residential aged care facilities to offer and publish periodic accommodation charges and, optionally, equivalent (or discounted) accommodation bonds. Remove regulated accommodation bond retention amounts</li> <li>Introduce price monitoring for residential accommodation</li> <li>Increase the number of community care places by 20 per cent above the baseline established by the Aged Care Approvals Round, including the introduction of a temporary intermediate community care level between Community Aged Care Packages and Extended Aged Care at Home</li> </ul>	<ul style="list-style-type: none"> <li>Introduce the new model of care assessments and services entitlements</li> <li>Create the formal entitlement based aged care system, together with the block funded community support services</li> <li>Finalise the major regulatory changes</li> <li>Introduce the new co-contribution and lifetime stop-loss funding arrangements</li> <li>Introduce the Australian Aged Care Home Credit scheme</li> <li>Set care prices and the accommodation charge for supported residents based on transparent advice and recommendations from the AAC</li> <li>Review the pilot scheme for trading the supported residents ratio obligations</li> <li>Undertake an assessment of the appropriate total assets test thresholds for the supported resident accommodation supplement</li> <li>Gradually increase the quantity of residential places by 10 to 20 per cent above the baseline established by the Aged Care Approvals Round</li> <li>Introduce measures to improve the quality of aged care services, including the promotion of transparency and accountability</li> </ul>	<ul style="list-style-type: none"> <li>After five years, remove supply restrictions in both residential and community care</li> <li>Commission a public review which would analyse and recommend: <ul style="list-style-type: none"> <li>whether the consumer-directed system had developed sufficiently so that care and supported accommodation prices could be liberalised in certain markets</li> <li>whether any changes to the Accreditation Grant Principles, the Quality of Care Standards, and the Community Care Common Standards were required</li> <li>any changes that may be needed to maintain fiscal sustainability</li> <li>any changes that may be needed to ensure access for special needs groups</li> <li>whether supported residents should receive funding directly from an entitlement and the need for a mandatory ratio applying to residential facilities</li> <li>the efficacy and cost of the reablement service</li> <li>any changes to the financing arrangements, arising from a thorough examination of the operation of the new financial arrangements</li> </ul> </li> </ul>

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## Schedule A (continued)

<i>Stage 1: expedited measures within two years</i>	<i>Stage 2: within two to five years</i>	<i>Stage 3: five years and beyond</i>
<ul style="list-style-type: none"><li>• Set region specific supported resident ratios for all new and existing residential providers (except those subject to explicit grandfathering arrangements) and introduce a pilot scheme for trading supported resident ratio obligations</li><li>• Increase the supported resident accommodation supplement progressively to a level commensurate with the cost of an approved supported resident place</li><li>• Introduce the Australian Age Pensioners Savings Account scheme</li><li>• Conduct a public benchmarking study of aged care costs to initially set the scheduled prices</li><li>• Provide protection to existing recipients of aged care services through appropriate grandfathering</li><li>• Increase the release of data, information and research findings with the AACCC having the responsibility for the dissemination of data as a national clearing house</li><li>• Introduce a temporary assistance package for small residential providers.</li></ul>	<ul style="list-style-type: none"><li>• Continuing the increase in the number of community care places that commenced in stage 1</li><li>• Implement the Commission's remaining recommendations relating to care, quality, catering for diversity, age-friendly housing and retirement villages, carers, the workforce and regulation.</li></ul>	<ul style="list-style-type: none"><li>– an appropriate timeframe for a subsequent public review of the aged care system</li><li>– re-evaluate workforce sustainability.</li></ul>





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## A Conduct of the inquiry

The Commission received the Terms of Reference for this inquiry on 27 April 2010. The final reporting date was subsequently extended from April to June 2011 (chapter 1).

As required by the Terms of Reference, and in line with its normal inquiry procedures, the Commission has encouraged maximum public participation in the inquiry.

- Soon after receipt of the Terms of Reference, the Commission advertised the inquiry in national and metropolitan newspapers and sent a circular to people and organisations thought likely to have an interest in the inquiry.
- In May 2010 an issues paper was released, inviting submissions (see below) from interested parties and indicating some particular matters on which information was sought.
- From August to October 2010, the Commission held six workshops covering finance and funding, the workforce, care needs and the provision of care, accommodation, technology, and cost projections/modelling (table A.2). The Commission also held an informal forum on rural and remote area issues.
- In January 2011, a draft report (PC 2011) was released. The report set out the Commission's views and draft recommendations on the matters under reference and sought responses from interested parties via further submissions and hearings.
- During February and March 2011, the Commission held public hearings in all state and territory capital cities to elicit feedback on the draft report (tables A.3).
- Over the course of the inquiry informal discussions were held in Australia with a broad cross-section of interested parties, including Australian, state and territory and local government agencies (table A.4).

The information gathered through these channels was complemented and augmented by around 925 written submissions from a wide range of interested parties (table A.1). Of these, around 440 submissions were received in response to the draft report. The public parts of these submissions are available on the Commission's website <http://www.pc.gov.au/projects/inquiry/aged-care>.

In addition:

- Commissioners and senior staff attended and presented at many aged care related conferences and conventions
- the Commission engaged Applied Aged Care Solutions Pty Ltd to undertake a study into a new care model, which is published at appendix C.

**Table A.1 Submissions received**

<i>Participants</i>	<i>Participants</i>
<b>A</b>	
Abbeyfield Australia	Aggar, Christina, Ronaldson, Susan and Cameron, Ian D
Ability Options	AIDS Council of South Australia
Able Community Care	Alcock, W G
ACH Group	Alkira Aged Care
ACON	Allergy and Environmental Sensitivity Support and Research Association
ACT Chinese Aged Care Info Service	Alliance for Forgotten Australians
ACT Disability, Aged & Carer Advocacy Service	Alzheimer's Australia
ACT Government	Alzheimer's Australia – WA
ACT Retirement Village Residents Association	Alzheimer's Australia NSW
Adams, Charles	Amana Living
Addicot, Glenda	Amaroo Care Services
Advantaged Care	AMP Capital Investors
Aegis Aged Care Group	Anderson, Shirley
Aged & Community Care Victoria	Andrew, Lorraine
Aged & Community Services – WA	Anglican Care
Aged & Community Services Australia	Anglicare Australia
Aged & Community Services of NSW & ACT	Anglicare Sydney
Aged & Disability Services, Mosman Municipal Council	Annecto
Aged Care Assessment Service – Vic	Ansell, Cam and Toohey, Jim
Aged Care Association Australia	Antioch, Kathryn
Aged Care Association Australia – SA	Arcare
Aged Care Association of Australia and Deloitte Touche Tohmatsu	Archibald, Mary T
Aged Care Crisis	Association for the Blind of WA
Aged Care Industry Council (NSW & ACT) Building Committee	Association of Independent Retirees
Aged Care IT Vendor Association	Association of Independent Retirees – NSW
Aged Care Lobby Group	Association of Independent Retirees – Qld
Aged Care Psychiatry Services – Prince of Wales Hospital	Association of Independent Retirees – SA
Aged Care Queensland	Association of Independent Retirees – Tas
Aged Care Standards & Accreditation Agency	Association of Residents of Queensland Retirement Villages
Aged Care Support Service	Association of Taxation & Management Accountants
Aged Rights Advocacy Service	Atkinson, Sallyanne
Aggar, Christina	Attendant Care Industry Association of NSW

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Table A.1 (continued)

<i>Participants</i>	<i>Participants</i>
Australian & New Zealand Society for Geriatric Medicine	Australian Institute of Health and Welfare
Australian Academy of Technological Sciences & Engineering	Australian Institute of Management Research & Policy Office
Australian Asian Association – WA	Australian Lawyers Alliance
Australian Blindness Forum	Australian Local Government Association
Australian Council of Trade Unions	Australian Meals on Wheels Association
Australian Dental Association	Australian Medical Association
Australian Federation of AIDS Organisations and National Association of People Living with HIV/AIDS	Australian Nursing Federation
Australian Federation of Totally & Permanently Incapacitated Ex Service Men & Women	Australian Nursing Federation – NT
Australian General Practice Network	Australian Nursing Federation – VIC
Australian Greek Welfare Society	Australian Osteopathic Association
Australian Health Insurance Association	Australian Physiotherapy Association
Australian Healthcare & Hospitals Association	Australian Physiotherapy Association
Australian Home Care	Australian Polish Community Services
Australian Institute for Primary Care & Ageing	Australian Psychological Society
	Australian Services Union – Vic Authorities and Services Branch
	Australian Unity
	Australian Unity Wellbeing Index
<b>B</b>	
Baker, D T	Bithell, Barbara
Baker, Noline	Blackall Range Care Group
Ballarat District Nursing & Healthcare	Blackwell, Peter
Ballina District Community Services Association	Blake Dawson
Banksia Villages	Blue Care
Banksia Villages Residents' Committee	Blue Cross Community & Residential Services
Baptcare	Boandik Lodge Incorporated
Baptcare – Community Aged Care	Bourne & Associates
Baptist Community Services – NSW/ACT	Boyer, Kim and Peter Orpin
Baptist Village Baxter	Brain Injury Australia
Baptistcare (WA Baptist Hospitals and Homes Trust)	Braithwaite, Valerie and John
Baptistcare WA and Shire of Brookton WA joint submission	Brennan, Ngaire
Beatty, Dianne	Briggs, Jenny
Bega Valley Meals on Wheels Plus	Brodady, Henry
Belcher, Wayne	Bromilow Home Support Services
Bell, Pamela	Brooke, Libby
Bellchamers, Joyce	Brooks, Nicole
Bendigo & Adelaide Bank	Brotherhood of St Laurence
Benetas	Brown, Douglas
Benevolent Society	Brown, R, Allen, C and Medley, D
Bernoth, Maree	Brucker, B
beyondblue	Bryant, Joanne
	Bupa Care Australia
	Burrows, Christine
	Business Council of Australia

(Continued next page)

Table A.1 (continued)

<i>Participants</i>	<i>Participants</i>
<b>C</b>	
Cameron, Anne	Chinese Community Social Services Centre
Cameron, Ian	CHOICE
Campaign for the Care of Older Australians	Christadelphian Aged Care
Canberra Multicultural Community Forum	Chua, Ben
Capital Cove	City of Boroondara
Care Assessment Consultants	City of Port Adelaide Enfield
Care Connect	City of Port Phillip's Older Persons Consultative Committee
Care Net Community Nursing	City of Salisbury
Carer Support	City of Sydney
Carers – Qld	City of West Torrens
Carers – SA	Clare Dewan & Associates
Carers – Tas	Clubs Australia, the RSL and Services Clubs Association and Richmond Club
Carers – WA	CO.AS.IT (SA)
Carers Australia	Coad, Jan
Carers NSW	Colonial First State
Carers Queensland – Camp Hill	Combined Pensioners & Superannuants Association of New South Wales
Carers Support Network SA	Comhouse Co-operative
Carers Victoria	Commonwealth Ombudsman
Carne Reidy Herd Lawyers	Community Based Support South
Carnegie, Neville	Community Care (Northern Beaches)
Casey, Christine	Community Transport NSW Future Directions Working Group
Catholic Community Services	Consumers' Health Forum of Australia
Catholic Community Services NSW/ACT	Cook Care Group
Catholic Health Australia	COTA Australia
Catholic Homes	Country Women's Association of NSW
Catholic Social Services Victoria	CPSA – Orana Branch
Centre for Ageing & Pastoral Studies	Croft, Garth
Centre for Cultural Diversity in Ageing	Cullen, John
Centre for Health Communications, University of Technology Sydney	Curnow, Venessa
Centre for Health Service Development, University of Wollongong	Cussen, Karen
Challenger	Cuttris, Sophie
Chamber of Commerce & Industry – WA	
Chandraratne, Donald	
<b>D</b>	
Dalby & District Aged Persons Homes Association	Department of the Premier and Cabinet – SA
Day Therapy Centres Network in Victoria	Dieticians Association of Australia
de Bellis, Anita	Diversional Therapy Australia
dela Rama, Maria, Edwards, Melissa and Dalton, Bronwen	Doutta Galla Aged Services
Deloitte Access Economics for Homesafe Solutions	Dow, Briony
Deloitte Touche Tohmatsu	DPS Publishing
Department of Health and Ageing	Drake, Mrs C
	Dutch Care
	Dutch Care

(Continued next page)

Table A.1 (continued)

<i>Participants</i>	<i>Participants</i>
<b>E</b>	
East Wimmera Health Service – Donald Campus	Eliza Purton
Eastern Palliative Care	Embracia
ECH, Eldercare and Resthaven	Ethnic Communities’ Council of NSW
Echuca Community for the Aged	Ethnic Communities’ Council of Victoria
Economic Security4Women (eS4W)	Ethnic Link Services Uniting Care Wesley Port Adelaide
Edeson, M J	Evans, K A G
Elder Rights Advocacy	
<b>F</b>	
Fairfield City Council	Foltyn, Peter
Falla, Leslie	Fortus
Federation of Ethnic Communities’ Councils of Australia	Fox, John K
Federation of Jewish Aged Care & Community Service Organisations	Freedom! Gender Identity Association
Ferrie, Margaret	Froniditha Care
Financial Planning Association of Australia	Froniditha Care and DutchCare
Findlay, Therese	Frontier Services
Fine, Michael	Frontline Aged Care Solutions
	Futures Alliance
<b>G</b>	
Garland, Steven	Golden Plains Shire
Gaudron, M	Gonski, Peter
Gavan, Joan and Fitzgerald, Hilda	Goodwin Aged Care Services
Gay & Lesbian Health Victoria	Graudenz, Pam
Gay Lesbian, Bisexual, Trans and Intersex Retirement Association	Gray, Margaret
General Practice – NSW	Grealish, Laurie and Kasia Bail
General Practice – Vic	Great Community Transport
General Practice South, Tasmania	Greek Welfare Centre NSW
Gillespie, Cathy	Greengate Care
GLBTI Retirement Association	Gross, Eva
Glenara Lakes Residents	Guild Accountants
Glenorchy Linkages Group, Glenorchy City Council	Gwynne, Robyn
	GyMEA Home and Community Care Projects
<b>H</b>	
HammondCare Group	Health Care Consumers Association – ACT
Hannan, Elizabeth	Hearing Care Industry Association Health Services Union – WA Hellenic Community Aged Care Health Services Union East
Harrison, Jo	Healthcare Chaplaincy Council of Victoria
Harvie, Rob	HealthCube Management
Hassett, Adrian	Helping Hand Aged Care
Havilah Hostel	Henderson, Jennifer
Health & Community Services Workforce Council	Herbertson, Thelma
Health and Community Services Union – Tas	

(Continued next page)

**Table A.1 (continued)**

<i>Participants</i>	<i>Participants</i>
Herdy, Wayne	Home Instead Senior Care
Hicks, Ronald	Homeshare Australia & New Zealand Alliance
Hills Positive Ageing Project	Howe, Anna L
Hixon, Laurel L	Hunt, Roger
Hobsons Bay City Council	Huntsman, Leone
Hoffman, Rob	Hurst, Carmel
<b>I</b>	
Illawarra Forum	Innovative Care
Illawarra Retirement Trust	Institute for Social Participation, La Trobe University
Independent Living Centre NSW	Institute of Policy Studies, Victoria University New Zealand
Independent Living Centre WA's Multicultural Aged Care Service	Italian Benevolent Foundation SA
Ingram, Lyn	
<b>J</b>	
J R Cumpston	Johnson, Andrew
Jacobs, Nancy	Johnstone, Iain
James Underwood & Associates	Jones, Clara
Jannali Neighbourhood Aid	Jones, Ellis
Japara Holdings	Julia Farr Association
Jeon, Yun-Hee	Just Better Care
Jewish Care Victoria	Just Better Care Brisbane South
John Barker & Associates	
<b>K</b>	
Kearney, Margaret	Kimberley Aged & Community Services
Kellock Lodge Alexandra	KinCare
Kendig, Hal	King, Debra
Kerrins, Jody	Kobold, Marjory
Kiama Municipal Council	Koppel, Pauline
Kieltyke, Anna	Kurec, Erica
<b>L</b>	
Laragy, Carmel	LHI Retirement Services
Latrobe Community Health Service	Lifetime Planning
Law Council of Australia	Light Residents & Ratepayers Progress Association Linburn Nursing Home
Law Institute of Victoria	Liquor, Hospitality and Miscellaneous Union
Law Society of NSW	Little Company of Mary Health Care
Legacy Australia Council	Little, Valerie
Legacy Australia Council – Vic	Living Care
Leichhardt Community Transport Group	Local Government Association of NSW and Shires Association of NSW
Lend Lease Primelife	Local Government Association of SA
Lend Lease Primelife – Retirement Living	London, Amanda
Lesbian & Gay Solidarity (Melbourne)	Londregan, Peter
Lewin, Gill	
Lewis, Barbara	

(Continued next page)

Table A.1 (continued)

<i>Participants</i>	<i>Participants</i>
Long, Marilyn	Luscombe, Guy
Lott, Barbara	Lutheran Community Care on behalf of Lutheran Aged Care Australia
Lower Mountains Neighbourhood Centre	
Lower North Shore Community Transport	
<b>M</b>	
Ma, Janet	Menzies Centre for Health Policy, The University of Sydney and the Australian National University
Macarthur Aged & Disability Forum	Mercy Aged Care Services – Brisbane
Macarthur/Wingecarribee HACC Forum	Mercy Health
MacDonald, David	Mercy Health Richmond
MacKinlay, Elizabeth	Mifsud, Christine
Macular Degeneration Foundation	Migrant Information Centre (Eastern Melbourne)
Management Consultants & Technology Services	Minister for Ageing – Vic
Manly Warringah Pittwater Community Aid Service	Mission Australia
Manningham Centre Association	Monash University Gippsland and the University of Tasmania’s Department of Rural Health
Manor Court Werribee Aged Care	Morcombe, Peter
Martindale Nursing Home, Valleyview Aged Care Facility and The Kensington Aged Care Facility	Morgan Stanley Australia
Mary MacKillop Care SA	Morrison, Lena
Maskell, Lucynda	Moses, Donna
Masonic Homes	Motor Neurone Disease Australia
Masso, Janine	Mullen, Lou
Matrix Guild (Vic) and Coalition of Activist Lesbians – Australia	Multicultural Access Projects in Cumberland/Prospect, Nepean, and Northern Sydney
Maxwell, Juliette	Multicultural Aged Care
McAuley, John P	Multicultural Communities Council of Illawarra
McCall Gardens Community	Multicultural Communities Council of SA
McClatchie, Gordon	Multicultural Disability Advocacy Association of NSW
McDonough, Don	Mundy, Greg
McPherson, M	Municipal Association of Vic
Medibank Private	Murphey, Shannon
Medical Device Partnering Program	Murphy, Irene
Medical Technology Association of Australia	My Longevity
Medicare Australia	
Melbourne City Mission	
Melbourne Medical Deputising Service	
Mental Health Council of Australia	
<b>N</b>	
National Aged Care Advocacy Program (NACAP) Members	National Disability Services
National Aged Care Alliance	National Foundation for Australian Women
National Ageing Research Institute	National Health, Aged & Community Care Forum
National Association of People Living With HIV/Aids	National LGBTI Health Alliance
National Council of Women of Australia	National Presbyterian Aged Care Network
	National Rural Health Alliance

(Continued next page)

**Table A.1 (continued)**

<i>Participants</i>	<i>Participants</i>
National Seniors Australia	NSW Aged Care Alliance
National Seniors Australia Knox Branch	NSW Community Transport Organisation
National Stroke Foundation	NSW Council for Intellectual Disability
Naughton, Margaret	NSW Government
New England HACC Development	NSW Government – Dept of Finance and Services (formerly NSW Dept of Services, Technology and Administration)
Nichols, Helen	NSW HACC Development Officers Network
Niemotko, Waldemar	NSW HMMS State Council
Nixon Hostel, Kingston City Council	NSW Home Modification and Maintenance Services State Council
North & West Region CACP/EACH/ACAS Network	NSW Neighbour Aid & Social Support Association
North and West Region CACP/EACH/D/ACAS Forum	NSW Ombudsman
Northern Rivers Social Development Council	NSW Transcultural Aged Care Service
Northern Sydney Volunteer Network	NSW Trustee & Guardian
Northside Community Forum Inc	
Noyce, Pat	
NSROC – Northern Sydney Regional Organisation of Councils	
<b>O</b>	
O'Donnell, Carol	Older People Speak Out
Occupational Therapy Australia	Older People's Reference Group
Office of the Aged Care Commissioner	Older Women's Network NSW
Office of the Australian Information Commissioner	Ottman, Goetz
Office of the Health Services Commissioner	Ottrey Homes, Cobram District Retirement Village
OIPC, Department of FaHCSIA	Ozcare
<b>P</b>	
Pakary, Yalding and Hahndorf Holdings	Pharmaceutical Society of Australia – ACT
Palliative Care Australia	Phillips, Joy
Palliative Care NSW and Palliative Care Advisory Group NSW	Physical Disability Australia Ltd
Palliative Care Victoria	Physical Disability Council of NSW
Papli, Rain	Pieters-Hawke, Sue
Parkinson's Australia	Pinevale Villas Lismore
Parry, Yvonne	Pinkas, Georgina
Pearce, Janet K	Polish Welfare Office
Peden, Maureen	Pontifex, Margaret J
Pendleton, Denise	Pratt, Kenneth
Penhall, R K	PricewaterhouseCooper
Peninsula Advisory Committee for Elders, Mornington Peninsular Shire	Probets, Jennifer
Peninsula Care Planning Group	Proprietors Networking Group
Peninsula Health	Psychogeriatric Care Expert Reference Group
Penrith City Council	Public Interest Advocacy Centre Ltd
Perth Home Care Services	Pugh, Deb
	Puttman, Margaret
	Psychogeriatric Care Expert Reference Group

(Continued next page)



Table A.1 (continued)

<i>Participants</i>	<i>Participants</i>
<b>Q</b>	
Quality Aged Care Action Group	Queensland Law Society
Quality Aged Care Action Group Inc – Blue Mountains	Queensland Nurses' Union
Queensland Action for Universal Housing Design	Queensland Shelter
Queensland Aged and Disability Advocacy	Queensland Smart Home Initiative
	Quirk, Lisa
<b>R</b>	
R M Begg Kyneton Aged Care	Retirement Village Residents Association
RDNS SA / Your Life	Returned & Services League of Australia
Real Animals Pets and People	Returned & Services League of Australia – ACT
Redfern & Inner City Home Support Service	Roberts, Lynne
Redleaf Training and Consultancy	Robinson, Andrew and See, Catherine
Regional Coordination Office of Community Transport, Northern Sydney	Robinson, Susanne
Regional Development Australia – Sydney	Rockdale Neighbour Aid
Regis Group	Roeder, Rob
Repatriation Commission	Royal College of Nursing, Australia
Respecting Patient Choices 'Making Health Choices' Project Steering Committee	Royal District Nursing Service
Retired Teachers Association – NSW	Royal District Nursing Service – Vic
Retirement & Aged Care Services, Manchester Unity Aust	Rudolph, Peter J
Retirement Village Association	Rural Doctors Association of Australia
	Ryder, Susan
<b>S</b>	
Sadler, George T	Smith, Angela
Salisbury Private Nursing Home	Smith, Christine MP – Member for Burleigh
Salvation Army (Vic) Community Aged Care Program	Smith, R T and D H
Samarinda Aged Services	Soroptimist International Australia
Sarre, Rick	South Asian Muslim Association of Aust
School of Nursing, Midwifery and Postgraduate Medicine – Edith Cowan University	South Australian Government
Seasons Living Australia	South Australian Government
SEQUAL	South Eastern Region Migrant Resource Centre
Seventh-Day Adventist Aged Care (South Qld)	South Sydney Community Transport
Shapemaster Australia / Easy Tone Tweed Coast	Southern Cross Care – Tas
Shaw, Rhonda, Sappey, Jennifer and Gullifer, Judith	Southern Cross Care – Vic
Shepparton Villages	Southern Cross Care – WA
Sherwood Respite Services	Spakia
Shire of Northam – WA	Spectyrum Migrant Resource Centre
Short, Leonie M	Speech Pathology Australia
Shortis, Stephen	Spies-Butcher, Ben
Silver Chain Nursing Association	Sridharan, Swarupa M
Sir Moses Montefiore Jewish Home	St Andrew's Village Canberra
	St Bartholomew's House
	St George Community Services
	St George Migrant Resource Centre

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**Table A.1 (continued)**

<i>Participants</i>	<i>Participants</i>
St Johns Village	Sunrise Supported Living (SSL Management)
St Laurence Community Services	Sunshine Coast and Wide Bay Health Service District
Stanley, Ingrid	Sutton, Gillian
Stann, Ian	Swan Hill Rural City Council
Stewart Brown & Co	Swarbrick, Dianne
Stewart Brown Business Solutions	Sydney Multicultural Community Services
Sukkar, Khalil	Sydney South West Area Health Service
Sundale Garden Village, Nambour	
<b>T</b>	
Tablelands Futures Corporation	The Royal Australasian College of Physicians
Tabulam and Templer Homes for the Aged	The Royal Australian & New Zealand College of Psychiatrists
Tandara Lodge Community Care	The Royal Australian College of General Practitioners
Tanunda Lutheran Home	The Royal Society for the Blind
Tasmanian Council of Social Service	The Rural City of Murray Bridge
Tasmanian Government	The Salvation Army (Vic) Property Trust Adult Services
Taylor, Jan	The Salvation Army Aged Care Plus
Tech4Life	The Salvation Army Aged Care Plus
Temple, Penny	The Visiting Dentist
Tender Living Care Australia	The Whiddon Group
Tender Loving Cuisine	The Wicking Dementia Research Network
Thacker, Wendy	Tickled Pink Aged Care
The Aged Care Channel	TLC Aged Care
The Aged-care Rights Service	Toohey, Jim
The Australian Academy of Technical Sciences & Engineering	Torbay Retirement Villages
The Australian Association of Gerontology	Totts
The Barossa Council	Travers, John
The Benevolent Society	TRI Community Exchange
The Bethanie Group	Trieu, Luan Ho
The College of Nursing	Trustee Corporations Association of Australia
The Country Women's Association of NSW	Tunney, Joy
The Futures Alliance	Tunstall Healthcare Asia Pacific
The Home Modification Information Clearinghouse	Turnham, Robin
The Home Nursing Group	Twitchin, Joe
The Pharmacy Guild of Australia	
The Repatriation Commission	
<b>U</b>	
U3A Online	Uniting Care Australia
Ukrainian Elderly People's Home	Uniting Care Community Options
Union of Australian Women – Darebin Group	UnitingCare East Burwood Centre
United Voice – NSW	UnitingCare Wesley Port Adelaide
Uniting Care Ageing NSW.ACT	

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Table A.1 (continued)

<i>Participants</i>	<i>Participants</i>
<b>V</b>	
van Dam, Tom	Victorian Government
Van Deventer, S	Victorian Healthcare Association
Van Kool, Joanna	Victorian National Respite for Carers Programs
Vasey RSL Care	Services Network
Victoria Manor Aged Care Facility (Better Aged Care)	Vignolo, Alba
Victorian Committee for Aboriginal Aged Care & Disability	Villa Maria Society
Victorian Council for Civil Liberties	Village Baxter
Victorian Day Therapy Centres Network	VincentCare Victoria
Victorian Deaf Society	Vision Australia
	Volunteer Home Visitors
<b>W</b>	
Walker, Robyn	Williams, Kerry
Walters, Art	Willoughby City Council
Warrigal Care	Wilson, Beryl
Waters, Anne	Wilson, Jill, Wright, Olivia, Ward, Liz, Capra
Watson, Vince	Sandra and Petersen, Maree
Watts, Geoffrey	Wilson, Robert
Webster, Pam	Winterton, Peter
Wesley Homeshare Advisory Committee	Wintringham
Wesley Mission Melbourne	Wintringham House
West, Julie	Woodville Nursing Home
West, Rosemary	Wortley, Jean
Western Australian Government	Wright, Clive
Western District Health Service	Wyanga Aboriginal Aged Care Program
Western Sydney Regional Community Care Forum	Wynne, J Michael
Williams, G, James, M, Buckby, B and Simpkins, W	
<b>Y</b>	
Yates,	
<b>Z</b>	
Zanghi, Margaret	Ziolkowski, F

**Table A.2 Attendees at workshops**

<i>Participants</i>	
<b><i>Financing and Funding – Canberra (31 August 2010)</i></b>	
Access Economics	Centre for Policy Development
Aged & Community Services Australia	Committee for Economic Development
Aged Care Association Australia (ACAA)	Grant Thornton Australia
Anna Howe	Henry Ergas
Bruce Chapman	Jim Toohey
Centre for Health Services Management, University of Technology, Sydney	KELLYresearch
<b><i>Workforce – Sydney (3 September 2010)</i></b>	
Aged & Community Services Australia	Frontier Services
Aged Care Association Australia	Hammond Care
Australian Nursing Federation	Liquor, Hospitality & Miscellaneous Union
Bupa Australia	National Rural Health Alliance
College of Nursing	Palliative Care Australia
DutchCare	Royal College of Nursing Association
<b><i>Care needs and the provision of care – Canberra (15 September 2010)</i></b>	
ACH Group	Centre for Research on Ageing, Curtin University of Technology
Age Care Mental Health, University of New South Wales	Council on the Ageing (COTA) Australia
Ageing, Work, and Health Research Unit, University of Sydney	Federation of Ethnic Communities' Councils of Australia
Alzheimer's Australia	National Seniors Australia
Anglican Retirement Villages	Palliative Care Australia
Anna Howe	St Ives Group
Australian Centre for Evidence Based Aged Care, LaTrobe University	The Benevolent Society
Catholic Health Australia	The Whiddon Group
<b><i>Accommodation – Canberra (29 September 2010)</i></b>	
Ageing, Work, and Health Research Unit, University of Sydney	Institute for Social Science Research, University of Queensland National Seniors Australia
Australian Unity Retirement Living	Office of Housing, Department of Families, Housing, Community Services and Indigenous Affairs
Caravan and Camping Industry Association	Queensland Housing and Urban Research Institute (AHURI), University of Queensland
CityFutures Research Centre, University of New South Wales	Retirement Village Association
Community Housing Federation of Australia	The Benevolent Society
Council on the Ageing	
ECH	

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Table A.2 (continued)

<i>Participants</i>	
<b>Technology – Melbourne (13 October 2010)</b>	
Aged & Community Services Australia	LeeCare
Aged Care Association Australia	Medical Technology Association of Australia
Australian Academy of Technological Sciences and Engineering	Royal District Nursing Society (SA)
Department of Broadband, Communications and Digital Economy	Samarinda
iCare	Silverchain
Independent Living Centre	Simavita
	Tunstall Healthcare
<b>Cost projections – Canberra (28 February 2011)</b>	
Australian Institute of Health and Welfare	Department of Prime Minister and Cabinet
Department of Finance	Department of the Treasury
Department of Health and Ageing	

Table A.3 Public Hearings

<i>Participants</i>	
<b>Melbourne – (21 March 2011)</b>	
Australian Nursing Federation	Ethnic Communities' Council of Victoria
Australian Unity	Lorraine Andrew
Benetas	Royal District Nursing Service
Carers Victoria	Saskia van Deventer
Connect Care	Villa Maria
<b>Melbourne – (22 March 2011)</b>	
Alzheimer's Australia Vic	Dutch Care
Anna Howe	Froniditha Care
Australian Nursing Federation (Vic)	Irene Murphy
Australian Psychological Society	Jody Kerrins
Australian Services Union	Peter Sherman
Blind Citizens Australia	Wintringham
COTA Australia	
<b>Melbourne – (23 March 2011)</b>	
Age and Community Care, Victoria	Doutta Galla Aged Services
Austin Health	Eastern Palliative Care
Australian Institute for Primary Care & Ageing	Erica Kurec
Brotherhood of St Laurence	Mary Archibald
Centre for Cultural Diversity in Ageing	Mary Owen
Centre for Research, Swinburne University	Robyn Brown
Debbie Medley	Ukranian Elderly Peoples Home
Deborah Knapp	VincentCare Victoria

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Table A.3 (continued)

*Participants*

**Hobart – (24 March 2011)**

Advocacy Tasmania	Health & Community Services Union (Tas)
Aged & Community Services (Tas)	Kim Boyer
Association of Independent Retirees (Tas)	Royal Guide Dogs Tasmania
Australian Nursing Federation (Tas)	School of Nursing & Midwifery & Wicking Dementia Research and Education Centre
Care Assess	Southern Cross Care Tasmania
Carers Association of Tasmania	
Faith Layton	

**Brisbane – (25 March 2011)**

Aged Care Qld	Kincare Community Services
Association of Independent Retirees (Qld)	Mercy Aged Care Services
Association of Independent Retirees, Brisbane South Branch	Queensland Aged and Disability Advocacy
Blue Care/UnitingCare Qld	Robert Jeremy
Carers Qld	Robin Gallen
Eileen M Byrne	United Voice Qld
John Kenneth Fox	Wayne Herdy

**Sydney – (28 March 2011)**

Australian Institute for Population Ageing Research	Medical Technology Association of Australia
Australian International Research Institute Inc	New England HACC Development
Australian Medical Association	NSW Health, Centre for Oral Health Strategy
Carers NSW	NSW Nurses Association
Combined Pensioners & Superannuants Association of NSW	Peter Foltyn
Ethnic Communities' Council of NSW	Presbyterian Aged Care NSW & ACT, PresCare Qld
Intel-Ge Care Innovations	Public Interest Advocacy Centre
Margaret Kearney	Robin Turnham

**Sydney – (29 March 2011)**

ACON	Deloitte Access Economics
Aged & Community Services Australia NSW & ACT	Gabrielle Meagher (Uni of Sydney)
Aged Care Association Australia (NSW)	Health Services Union East
Centre for Health Service Development	Maranatha House
Association of Independent Retirees	NSW Transcultural Aged Care Service
Ben Spies-Butcher	Quality Aged Care Action Group
Bob Davidson	The College of Nursing
Cameron Way	Voldis Care Ltd
Clara Jones	Willoughby Council
Community Transport Organisation of NSW	Younger Onset Dementia Association

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Table A.3 (continued)

<i>Participants</i>	
<b>Adelaide – (31 March 2011)</b>	
Advocates for Seniors in Care	Ethnic Link Services
Aged and Community Services (SA & NT)	Jenny Briggs
Aged Care Association of Australia (SA)	Josephine Swiggs
Aged Care Lobby Group	Lyn Taylor
Association of Independent Retirees SA	Masonic Homes
Australian Nursing Federation (SA Branch)	Multicultural Aged Care
Betty O'Halloran	Padman Health Care
Carers South Australia	Royal Society for the Blind SA
ECH, Resthaven and Eldercare	United Voice (SA)
<b>Perth – (1 April 2011)</b>	
Aegis Aged Care Group	GLBTI Retirement Association Inc
Aged and Community Services WA	Silver Chain
Aged Care Association of Australia WA	St Bartholomew's House
Angela Smith	Tony Fowke
Baptistcare	United Voice (WA)
Carers WA	Volunteer Taskforce
Clive Rogers	Wayne Belcher
<b>Canberra – (5 April 2011)</b>	
ACT Disability, Aged and Carer Advocacy Service	Council on the Ageing (COTA) Australia
ACT Retirement Village Residents Association	Disability Advocacy Network Australia
Aged and Community Services Australia	Elizabeth Hannan
Aged Care Association Australia	Kasia Bail
Alzheimer's Australia	Maree Bernoth
Canberra Multicultural Community Forum	National Seniors Australia
Catholic Health Australia	Royal College of Nursing Australia
Challenger	Superannuated Commonwealth Officers' Association
<b>Canberra – (6 April 2011)</b>	
Anglicare ACT/Goulburn	Federation of Ethnic Communities' Councils of Australia
Anglicare Australia	National Stroke Foundation
Australian Nursing Federation (ACT)	Palliative Care Australia
Carers Australia	The Pharmacy Guild of Australia
<b>Brisbane – (7 April 2011)</b>	
Aged Care Qld	Guide Dogs Qld
Association of Residents of Qld Retirement Villages	James Underwood & Associates
Clark Phillips	Older People Speak Out
	Qld Nurses Union
<b>Darwin – (11 April 2011)</b>	
Australian Nurses Foundation	Council of the Ageing
Alzheimer's Australia	Masonic Homes

**Table A.4 Consultations**

<i>Interested parties</i>	
<b>Australian Capital Territory</b>	
Aged and Community Services Australia	Department of Prime Minister & Cabinet
Aged Care & Rehabilitation Service, ACT Health	Department of the Treasury
Aged Care Association Australia	Department of Veterans' Affairs
Aged Care Association Australia	Ginninderra Gardens
Aged Care Commissioner	Goodwin
Aged Care Standards & Accreditation Agency	Grant Thornton
Alzheimer's Australia	Hal Kendig
Ambassador for Ageing	Health Workforce Australia
ANZ Bank	Henry Ergas
Australia's Chief Commonwealth Nurse	Illawarra Retirement Trust
Australian Blindness Forum	Innovations in Health & Community Care Forum
Australian General Practice Network	L.E.K. Consulting
Australian Medical Association	Medibank Private
Australian National Audit Office	Morshead Home
Australian Nursing Federation	National Aged Care Alliance
AVEO Live Well	National Australia Bank
BCS Community Aged Care Services	National Consumer Advisory Committee
Beyondblue	National Rural Health Alliance
Board of the Aged Care Association of Australia	Nelson Partners
Carers Australia	Office of the Aged Care Commissioner
Catholic Health Australia	Palliative Care Australia
Council on the Ageing (COTA)	Realise Performance
Department of Defence	Retirement Village Association Australia
Department of Families, Housing, Community Services & Indigenous Affairs	Royal College of Nursing Australia
Department of Finance & Deregulation	St George Bank
Department of Health & Ageing	Uniting Care Aged Care Victoria
	Uniting Care Australia
<b>New South Wales</b>	
Aged Care Action Group	Charles Chambers Court
Aged Care Standards & Accreditation Agency	College of Nursing
Alkira Gunnedah	College of Nursing Professional
Alzheimer's NSW	Combined Pensioners and Superannuants
Anglicare Retirement Villages	Department of Human Services (NSW)
Armidale Home Nursing Group	Frontier Services (National Office)
Aspley Reiv	Guild Accountants
Aspley Riverview Walcha (PAC)	Hunter New England and Area Health Service
Australian Nursing Federation	Illawarra Retirement Trust
Australian Social Policy Association and The Benevolent Society	Liquor, Hospitality and Miscellaneous Union
Autumn Lodge Armidale	Magnolia Manor Aged Care
Caravan and Camping Industry Association	Maroba Aged Care
Carers NSW	McLean Village
	McMaugh Gardens

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Table A.4 (continued)

<i>Interested parties</i>	
<b>New South Wales</b> (continued)	
Merton Court	Sir Moses Montefiore Jewish Home, Randwick
Mission Australia	St Andrews, Ballina
NSW Health	Stewart Brown Business Solutions
Nurses in Management – Aged Care, New England	Stockland Group
Quality Aged Care Action Group	Summit Care
Quirindi Retirement Homes Ltd, Quirindi	The Aged-care Rights Service (TARS)
Realise Performance	The Benevolent Society
Residential Gardens for the Spanish Speaking Frail Aged, Rooty Hill	Thompson Health Care
Richardson House, Barraba	Touriandi Lodge
Simavita	Uniting Care Ageing
	Waverley Aged Care Assessment Team
	Westpac
<b>Northern Territory</b>	
Aboriginal Health Registration Board	Department of Health and Families
Frontier Services	Masonic Homes Tiwi Garden Lodge (NT)
<ul style="list-style-type: none"> <li>• The Juninga Centre</li> <li>• Rocky Ridge</li> <li>• Kalano/Katherine Hostel</li> </ul>	
<b>Queensland</b>	
Aged Care Queensland	Hillview House, Merrimac
Blue Care, Toowong	Queensland Nurses Union
Carers Queensland	
<b>South Australia</b>	
ACH Group	Eldercare
Aged Care Association of SA	Office for the Ageing, Department for Families & Communities (SA)
Anglicare	Padman Health Care
Department of Health (SA)	Resthaven
Department of Premier & Cabinet	
ECH	
<b>Tasmania</b>	
Aged and Community Services Tasmania	Huon Eldercare
Department of Health & Human Services (Tas)	The Gardens
<b>Victoria</b>	
Aged and Community Care Victoria (ACCV)	Caulfield General Medical Centre
Aged Care Association of Australia & Deloitte	<ul style="list-style-type: none"> <li>• Sub-acute Ambulatory Care Services</li> <li>• Hospital Admission Risk Program</li> <li>• Aged Persons Mental Health Service</li> <li>• Caulfield Community Health Service</li> <li>• Residential Care Services</li> <li>• Aged Care Assessment Services</li> </ul>
AlfredHealth	City of Greater Dandenong
Anna Howe (Consulting Gerontologist)	Clark Phillips Consultants
Australian Association of Gerontology	Council of the Ageing (COTA)
Australian Nursing Federation	
Bayview Waters Supported Residential Service	
Bendigo Health	
Benetas	
Brotherhood of St Laurence	

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Table A.4 (continued)

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*Interested parties*

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<b>Victoria</b> (continued)	
Department of Health (Vic)	Regis Group
Department of Health, (Vic) Loddon Mallee Region	Regis Waverley Gardens
Fermont Lodge Supported Residential Service	Retirement Village Association and Deloittes' Senior Living Group
Healthscope	Rural Health Workforce Australia
Maryborough District Health Service	Tender Loving Aged Care
Municipal Association of Victoria	The Bethanie Group
National Aged Care Alliance	Village Baxter
Public Sector Residential Aged Care Leadership Committee	West Wimmera Health Services
	Wintringham
<b>Western Australia</b>	
Aegis Aged Care Group	Aged & Community Services of WA
Aged Care Association Australia (WA)	Alzheimers Australia WA
Department of Health (WA)	Department of Premier and Cabinet (WA)
GLBTI Retirement Association (GRAI)	Perth Home Care Services
Silver Chain	The Bethanie Group
Western Australian Centre for Health & Ageing	

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