

Reforming aged care

A practical plan for a rights-based system

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Overview

Australia has let older Australians down – our aged care system is a mess and is not fit for purpose. The current system supported 1.3 million older Australians and cost government nearly \$20 billion in 2018-19. But it is conceptually fraught and badly funded. Capped funding results in unacceptably long wait times for home care, and evidence of poor-quality residential care abounds.

Australia needs a new aged care system. This report identifies three key changes needed to create a rights-based system that would ensure older Australians can get the support they need to stay active, independent, and engaged in the community for as long as possible.

Firstly, older Australians who need support should have universal access to care. Rather than rationing care and classifying people into broad groups, a new funding model should require that reasonable and necessary funding matches a person's individual care needs. This should be documented in individual support plans, which are portable between settings, and which then form a contract about what care they should receive.

Secondly, older Australians should have face-to-face help to obtain a range of diverse and high-quality service options. Rather than a poorly-regulated and fragmented system far away in Canberra, 30 regionally-based 'system managers' across the country should be made responsible for the care of older Australians in a defined geographic area. They should manage the local service system and only accredit providers dedicated to the rights of older Australians.

Thirdly, rather than viewing older Australians as passive recipients of care, regional system managers and their community representative committees should enhance the independence of older people through

social participation programs, promoting healthy ageing, and better integrating the aged care system with health care.

But the current aged care system is so broken that these measures alone won't fix it. Nothing will improve unless the federal government spends more on aged care. We estimate our proposed changes will increase government spending by an additional \$7 billion per year – a 35 per cent increase on current spending. And even more will be needed as the population continues to age.

Care will only improve if carers are adequately supported. Rather than having underpaid, under-trained and under-resourced staff, a national registration scheme should be introduced to improve the training of carer staff and provide better pay. Regulation should also mandate minimum staffing ratios and 24-hour nursing supervision in residential care.

The system should have competent national stewardship to ensure efficient and equitable care. Rather than having limited accountability and transparency, a comprehensive public reporting system should be established to monitor the quality of aged care.

Creating a new aged care system will take time. We recommend these changes should be phased over three years, starting next year with a trial of the new system in South Australia and Tasmania – the two smallest states. But before then, the federal government should immediately create a \$1 billion rescue fund to lift the quality of residential care.

Australia must learn the lessons from the Royal Commission into Aged Care Quality and Safety by building a new, high-quality aged care and support system that respects the rights of all older Australians.

Recommendations

The federal government should create a new Aged Care Act to enshrine a rights-based system that will require an additional \$7 billion of government spending per year. The new system should:

1. Tailor services to people's needs through care planning

- Introduce individualised care planning for assessment, planning and funding of services, whether home care or residential, beginning with a trial in 2021, and rolled out nationally in 2023, at an estimated cost of \$600 million per year.

2. Improve access through universal funding for care

- Provide a universal entitlement to funding of 'reasonable and necessary' care outlined in individualised support plans, at an additional estimated cost of \$4.6 billion per year, to cut the home care waiting list and provide higher-level support at home. The maximum amount payable for home care should be capped at the maximum the government would pay for residential care.

3. Means-test everyday living and accommodation

- Means-test non-care services in home care and residential care. In residential care, means-tested everyday accommodation costs should be paid by individuals through rental payments. Where government contributes to board and lodging, it should take account of economies of scale.

4. Improve system management through decentralised governance

- Establish a new statutory agency, the 'Australian Aged Care Commission', to act as a national system steward of overall performance and equity by 2023.

- Establish 30 new independent bodies across Australia for defined geographic areas that act as regional 'system managers' of the local service system, monitor quality, and enhance social participation and healthy ageing by 2023, at an estimated cost of \$150 million per year.

5. Lift quality through standards and workforce reform

- Introduce comprehensive rights-based quality standards, and a national registration scheme to ensure carer staff are sufficiently trained and supported (with minimum staffing ratios and 24-hour nursing supervision for residential care) by 2023, at an increased estimated cost of \$1.5 billion per year for residential care.
- Create a new public reporting system that better monitors and provides information on the quality of service providers, to maximise people's choice.

6. Improve system coordination

- Sign Commonwealth-state agreements and regional agreements with system managers to better integrate healthcare, housing, and related welfare services, by 2022.

The federal government should immediately introduce a temporary \$1 billion rescue fund (additional to the new system costs), to lift quality of the worst providers of residential care.

The new system should be phased-in over three years from 2021, starting with a trial in South Australia and Tasmania, overseen by an Aged Care Transition Authority. The new system should be independently reviewed in 2025.

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1 Reform is urgent

Australia's aged care system is a mess. Disgrace after disgrace has been uncovered by the Royal Commission into Aged Care Quality and Safety.

The system needs fundamental reform. The current policy settings have let abuse and neglect go unchecked, and left many older Australians without adequate support. There have been dozens of government-commissioned reports calling for change over recent decades.¹ The Australian Government must now take action.

Grattan's first report on aged care, *Rethinking aged care: emphasising the rights of older Australians*,² published in October 2020, showed that the current provider-centric system has failed older Australians and should be replaced by a system based on human rights. This report sets out what a rights-based aged support system looks like.

This chapter identifies the structural and regulatory failures of the current system: it is fragmented, complex, and centralised. Money is wasted on administrative costs and overheads, while there is insufficient funding to meet the needs of older Australians.

While the Commonwealth Home Support Program supports over 800,000 people, it lacks transparency. The Home Care Packages Program leaves thousands of people – independently assessed as being in need – without support. And the residential care predicament is even worse. The current policy settings encourage the building of ever larger facilities, where older Australians' care is sometimes trumped by providers' profits. This can't go on.

1. Royal Commission into Aged Care Quality and Safety (2019a).

2. Duckett et al (2020).

1.1 Access failures

The aged care system is hard to access. Older Australians and their families often find it hard to get good information about their options.³ Getting processed through the system can be cumbersome and slow.⁴ Older Australians often have to tell their story 'over and over' to different people to prove their eligibility and get assessed.⁵

Assessment, service planning, negotiation, and coordination are not well linked. Older Australians and their families often struggle to find the right provider for their specific needs.⁶ There is limited information about locally available services, and the quality of care they provide.⁷

No one seems to own the problem of poor information and way-finding. At the height of the pandemic, the Federal Government appeared to be seeking to protect the reputation of providers rather than give older Australians detailed information about which residential care facilities had high rates of COVID-19 infection.⁸

Older Australians, especially those in regional or rural areas, often have limited provider options.⁹ Research shows that people find it difficult to find 'appropriate, affordable, and appealing care'.¹⁰ Exercising informed choice can be difficult and costly.¹¹

3. Royal Commission into Aged Care Quality and Safety (Volume 1 2019b, pp. 2–3).

4. Royal Commission into Aged Care Quality and Safety (Volume 1 *ibid*, pp. 2–3).

5. *Ibid* (p. 2).

6. Ipsos (2020, p. 8).

7. Royal Commission into Aged Care Quality and Safety (Volume 1 2019b, pp. 2–3).

8. Grattan (2020). This information has since been released by state health authorities.

9. Royal Commission into Aged Care Quality and Safety (Volume 1 2019b, p. 184).

10. Ipsos (2020, p. 8).

11. Care finders charge people for help to navigate the system, and favour certain service providers: Egan (2020).

Box 1: Overview of Australia's current aged care system

Australia has three main aged care programs, ranging from low-level at-home care to high-level residential care.^a A range of smaller programs cater for specific needs such as respite care and 'flexible care'.^b The system is capped, meaning the government supports only a certain number of people at a given time, regardless of how many have been independently assessed as needing care.^c

The **Commonwealth Home Support Program** is generally considered 'entry-level' – it is for people who need minor to moderate support, including personal care, nursing, meals and other food services, domestic assistance, and some equipment and assistive technologies.

Just over half the people in this program receive only one type of service – while a small minority receive five or more services. Service providers must meet eligibility criteria and are allocated funds through a grants process. People seeking services are assessed by Regional Assessment Services. Providers determine the extent of consumer co-payments. The **Home Care Packages Program** is designed as a substitute for residential aged care. The program helps people with more complex needs to live independently at home. In general, packages go to people who need more support than the Commonwealth Home Support Program provides, although some packages provide the same support. There are four levels of home care packages, ranging from the lowest level of support (Level 1) to the highest (Level 4):^d

Package level	Weekly subsidy	Average care hrs/wk
Level 1	\$171.22	1.4
Level 2	\$301.21	2.4
Level 3	\$655.41	5.2
Level 4	\$993.58	7.9

Providers must be approved by the Commonwealth Government and regulated under the *Aged Care Act 1997*.

Consumer co-payments may include a basic fee and an income-tested amount. Providers can waive the basic fees, and many tend to do so.

Residential aged care provides accommodation and personal care to people who no longer can or want to live at home. Residents receive on average 3.23 hours of personal care per day.^e Residents pay a basic daily fee for cleaning, maintenance, and laundry, and a means-tested care fee for personal and clinical care and supplements, such as oxygen. Residents also pay means-tested accommodation costs, either through rental-like payments or by a Refundable Accommodation Deposit, or a combination of both.

Residential aged care providers are approved by the Commonwealth Government and regulated under the *Aged Care Act 1997* against quality standards.

a. Note that state and local governments also deliver aged care and provide additional services to older Australians.

b. Flexible care includes transition care, short-term restorative care, and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

c. As at 30 June 2019, the overall target is 79.6 aged care places for every 1,000 people aged 70 and older: Department of Health (2019, p. 4).

d. The weekly subsidy is based on the standard daily payment as at September 2020. Various supplements can increase the payment. Weekly care hours are sourced from the March 2020 survey of providers by StewartBrown (2020). The average was scaled as a proportion of each package level subsidy. Care hours do not include non-care services such as cleaning and allied health.

e. Ibid (p. 16).

The online ‘My Aged Care’ portal has failed to make access simple and easy. It is impersonal, bureaucratic, and hard to use.¹² And not all Australians have access to the internet. For example, Indigenous Australians living in remote areas sometimes don’t have phone or internet reception.¹³

Pressure to manage costs means formal assessment of home care and residential care focuses on eligibility and funding rather than the services that are needed. Formal assessment methods vary for home support, home care, and residential care. There are often delays in getting assessed, and between getting assessed and starting to receive the needed services.

1.2 A failing funding and service model

Funding for each service type described in Box 1 – home support, home care, and residential care – is not well aligned. Funding models are inconsistent across service types: block-grant funding for home support; broad funding classifications for home care; and detailed funding classifications for residential care.

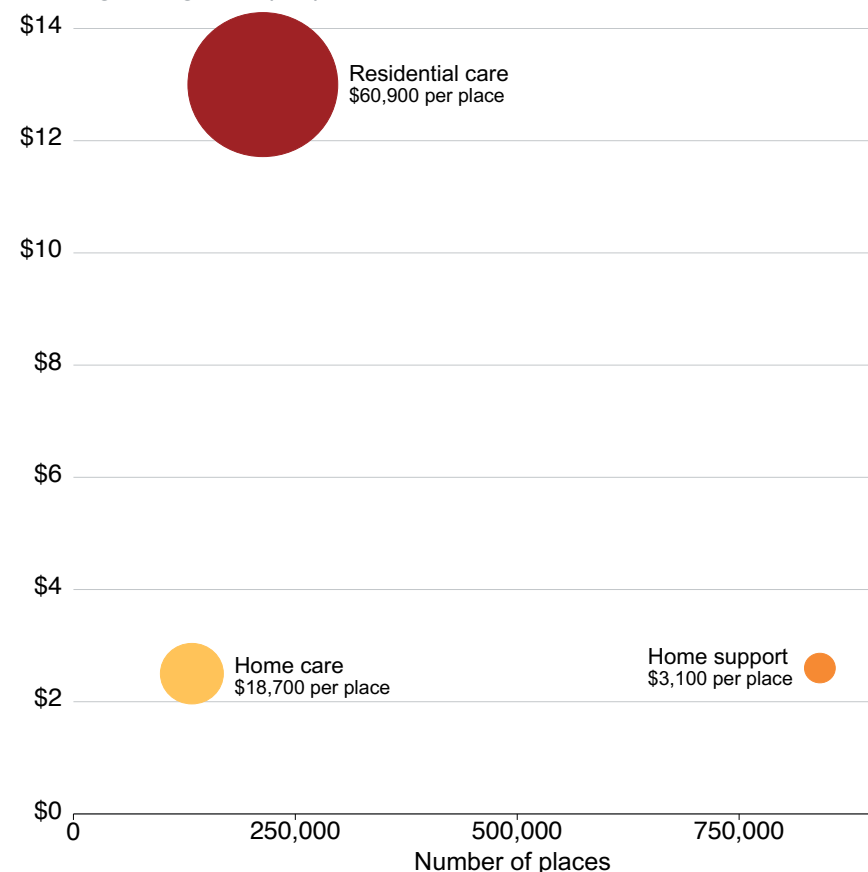
Home support, home care, and residential care combine funding for accommodation services, everyday living expenses, personal care, health care, and planning and coordination. What is paid for by governments and taxpayers, and what is paid for by the care recipient, is incoherent and illogical. In all three service types, care funding – money for care and support – is combined with funding for other needs – such as meals and accommodation – into a single budget. This is a particular problem in residential care, where unscrupulous providers can divert money supposedly allocated to provide care into private profit.

12. Royal Commission into Aged Care Quality and Safety (Volume 1 2019b, pp. 167–168); Ipsos (2020, p. 8).

13. Royal Commission into Aged Care Quality and Safety (Volume 1 2019b, p. 168).

Figure 1.1: Most of the nearly \$20 billion spent on aged care in 2018-19 went to residential care

Billions of Commonwealth expenditure per program in 2018-19, bubble size showing average cost per place



Notes: Cost per place is the average cost per operational place in residential care and per person in home care and home support. Note that there is a distribution of costs within each program. Smaller aged care programs, including flexible care and transition care, are not included in this chart.

Source: Aged Care Funding Authority (2020).

Bundling funding around two main accommodation settings (home or residential facilities) constrains older people's choices and makes it more difficult for people to maintain their independence. It hinders service innovation and the development of a broader range of accommodation options for older people.

Care funding is not portable, and forces people to move into residential care when they don't want to. Care funding is tied to the setting – home or residential care – rather than being based on the individual's care needs. When home-based service needs and costs increase significantly beyond maximum home care funding, people have to move to residential care, even if the services could be provided at home for the same cost as residential care.

1.3 Failures to provide support at home

Demand for support at home is increasing every year, yet the government programs cannot meet the needs of older Australians. Many people fall through gaping holes or end up in institutional care when they could be supported at home and in the community.

There is very limited provision of home modifications and assistive technologies for people with disabilities which are vital to supporting people live at home for as long as possible.

1.3.1 Problems with 'entry-level' services

The Commonwealth Home Support Program generally works well. But because it is governed by a program manual rather than under the *Aged Care Act 1997*, it is not transparent. Waiting times are not reported, so no one knows the extent of unmet demand. A further problem with the program is the transition to the next level of care, home care packages. For some people, moving from home support to a lower-level home care package would mean they would get

less support and have less flexibility and may end up paying more in out-of-pocket payments.

1.3.2 Shortages of home care places cause long wait-times

People assessed as eligible for a home care package by an Aged Care Assessment Team (ACAT) are placed on the waiting list – called the National Prioritisation System – until a package becomes available. In total, 103,599 people were on the waiting list for a package at their approved level as at March 2020.¹⁴ Of these, about 75,000 people did not even have an interim package while they waited.¹⁵

Another 28,000 people had been allocated an interim package while they waited for their allocated package. But the interim package didn't fully meet their needs.

The shortage of packages has resulted in unacceptably long wait times, with many people waiting more than a year. People with the highest needs – those assessed as eligible for a Level 4 package – have to wait on average nearly two years to receive support.¹⁶ Unlike the waiting list for public hospital elective procedures, the relative priority of people on the waiting list is not published.

The Royal Commission into Aged Care Quality and Safety used excoriating language to flag the urgent need for more home care packages:¹⁷

There is a clear and present danger of declining function, inappropriate hospitalisation, carer burnout, and premature institutionalisation because necessary services are not provided. We have been alarmed to find that many people die while waiting for a Home Care

14. Department of Health (2020a, p. 12).

15. Ibid (pp. 10–11).

16. Royal Commission into Aged Care Quality and Safety (2019c, p. 36).

17. Royal Commission into Aged Care Quality and Safety (2019b, p. 3).

Package. Others prematurely move into residential care. By any measure, this is a cruel and discriminatory system, which places great strain on older Australians and their relatives. It is unfair.

Because there are too few home care packages, some people end up in residential care when they could have been supported at home.¹⁸ About 65 per cent of people on the waiting list also have an approval for permanent residential care.¹⁹ These people with complex care needs may prefer home care, but the long wait-times may mean they end up in residential care.

1.3.3 Lower-level packages pointlessly overlap with Home Support

Almost everyone applying for a home care package already has approval for support under the Commonwealth Home Support Program.²⁰ People applying for home care packages are therefore seeking higher-level support than provided under the Commonwealth Home Support Program. Barely anyone actually gets assessed as needing a Level 1 package (see Figure 1.2). And some Home Support recipients receive more than what is available under a low-level home care package, yet are governed by a completely different program and fee system.

About 20 per cent of the 75,000 people waiting were offered an interim package at a lower level but decided not to take it.²¹ This may be because they are already receiving an equivalent service under the Commonwealth Home Support Program.

18. This is also driven by the limited funding for home modifications and assistive technologies at home.

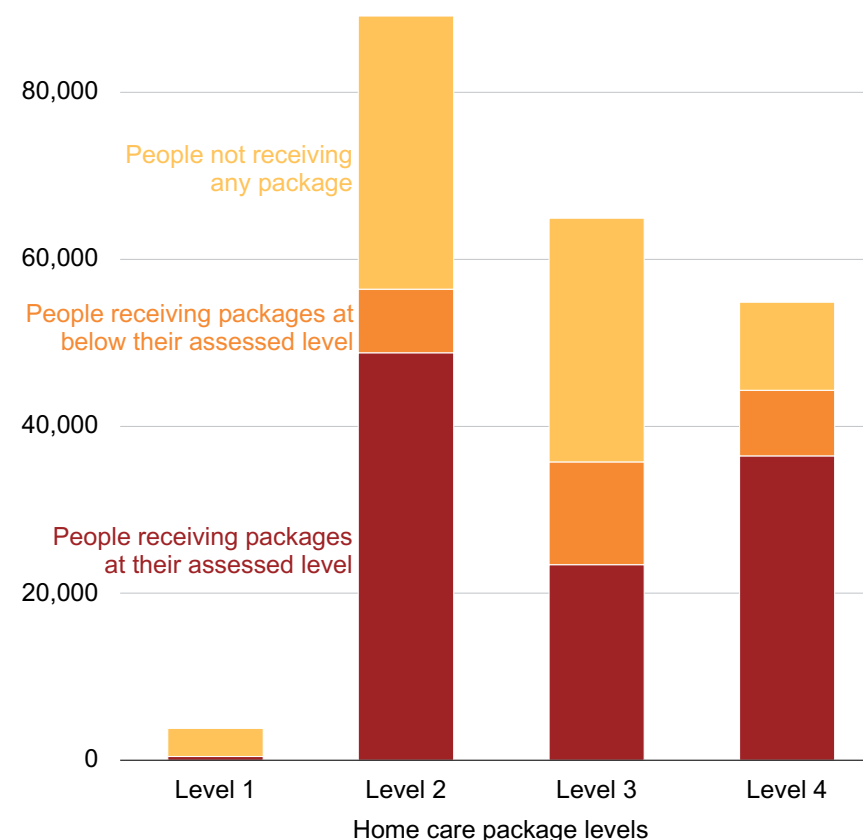
19. Department of Health (2020a, p. 12).

20. Ibid (pp. 10–11).

21. Department of Health (ibid, p. 11). This includes people who had been offered an interim package and had not yet accepted their offer.

Figure 1.2: Nearly half of older Australians assessed as eligible for home care are receiving no funding or less than they need

The number of people assessed as being eligible for home care at each level, and whether they are receiving care at that level, receiving an interim package at a lower level, or receiving no home care, as at March 2020



Notes: The number of people receiving packages at their assessed level is an estimate only, because the assessed level of people on interim packages is not reported.

Source: Department of Health (2020a).

1.3.4 Poor funding design

Costing and classification models for Home Care Packages are too broad. Aged Care Assessment Teams use a hierarchical, four-level needs classification on each of five domains to guide care classification to care packages.²²

Service types, levels, and costs are not formally considered as part of the classification process. Recipients are merely assigned to one of four funding levels. Such broad funding classifications will inevitably include recipients with a broad variety of needs and associated service costs.

Because funding bands for home care are broad and imprecisely related to the support need, and funding is tied to individuals, a significant proportion of package funds is left unspent. About \$1 billion of unallocated funds will be floating around the system in 2020-21.²³ A better system design would allocate only what is needed.

Another problem is that people are allocated to package levels which are insufficient to meet their needs. Similarly, funding announcements by the Commonwealth Government for more home care packages also fail to reflect demand. The October 2020 federal Budget allocated 22 per cent of new packages at Level 1, even though people assessed as needing a Level 1 package make up only 3 per cent of those currently waiting for a package at their level.²⁴

1.3.5 Gaming

Although home care assessment allocates a package with a maximum cost, there is still potential for providers to game the system by padding

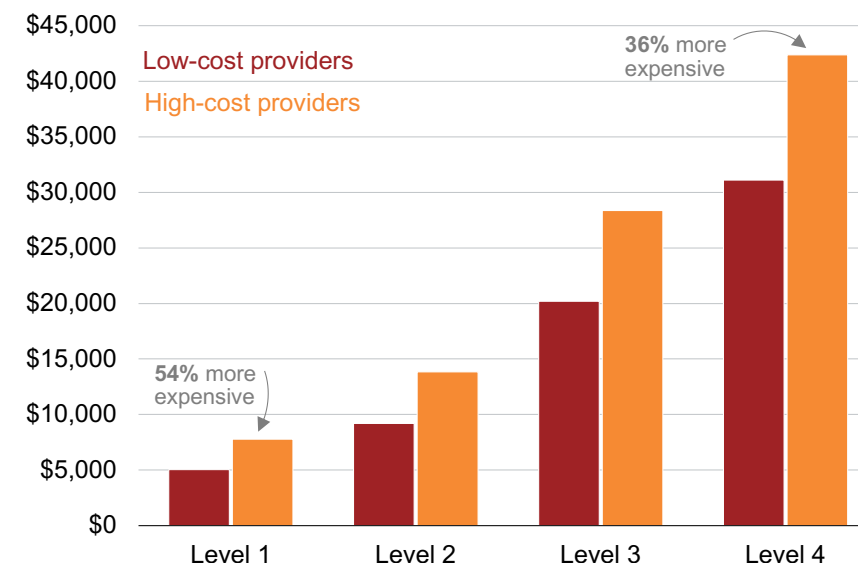
22. The five domains cover social, physical, medical, psychological, and vulnerability needs.

23. StewartBrown (2020, p. 33).

24. Department of Health (2020b, p. 4).

Figure 1.3: High-cost providers charge a lot more for the same care

The annual cost of a standard package of care at home, per package level, 2018-19



Source: Grattan analysis of home care data 2018-19.

out administrative and coordination costs, setting high prices for individual service types, and over-servicing.

Our research on a stratified random sample found some providers were much more expensive than others. High-cost providers were between 36 per cent and 54 per cent more expensive than low-cost providers for the same package of care (see Figure 1.3).²⁵

25. The average cost of a standard package was higher in regional and remote settings because provider management costs are higher. But the variation in costs between providers was similar across metropolitan, regional, and remote settings.

1.3.6 Poor navigation support

Home care packages are labelled ‘consumer-directed care’. In theory, individuals can choose their own provider, switch between providers if they wish, and choose what services to purchase with their allocated budget. But this is not the reality. Consumers are not supported to negotiate services or solve problems. When things go wrong consumers can’t withhold payment, but have to resort to complaining through a cumbersome, slow, and distant bureaucracy.

The program assumes a market exists and that consumers have sufficient information to exercise choice of provider. But without good information there is no effective market, and this problem is worse for people in rural or remote areas and/or where there are few trusted services.²⁶

1.3.7 High administrative costs

Provider’s management and administration costs are split between care management and package management. Care management is the coordination of care and services identified in the older person’s care plan. Package management covers the cost of administration.

Providers charge about 30 per cent of funding per person for administration and management costs.²⁷ This means only about 70 per cent of funding actually gets spent on care and support for older Australians. The Commonwealth Government does not regulate these administrative fees.

And although most consumers do not use the full allocation provided for their package, many providers can nevertheless charge their full management and administration fees.

26. Royal Commission into Aged Care Quality and Safety (2019b, pp. 173–174).

27. Aged Care Funding Authority (2020, p. 48).

These fees also vary depending on the type and location of the provider. Not-for-profits charge consumers nearly 20 per cent less for expenses than for-profits.²⁸ On average, provider management costs are also lower in metropolitan areas than in regional and remote areas.

Provider management costs also vary significantly depending on whether consumers elect to manage their own package or have providers do it for them. High-cost providers charge up to 200 per cent more for provider management costs for packages managed by providers than low cost providers. Provider management costs are up to 400 per cent higher for self-managed packages.²⁹

1.4 Problems with residential care funding

Funding for residential care is no longer fit for purpose. There are technical concerns about the Aged Care Funding Instrument (ACFI) – used for determining payments for residential aged care – and its relationship to costing and care planning.³⁰ The funding system does not incorporate elements of best practice – such as funding at marginal costs³¹ – nor does the ACFI recognise the different fixed costs of delivering care services across providers with different numbers of residents.

1.4.1 Gaming and classification creep

Perversely, the assessment under the ACFI is done by the provider soon after a resident arrives at the facility. The assessment looks at

28. Expenses include care-related salaries, administration and management fees, and other care and non-care related expenses: Aged Care Funding Authority (ibid, p. 49).

29. This is based on Grattan analysis of home care data.

30. The October 2020 federal Budget provided the start of a transition to a new instrument, the Australian National Aged Care Classification. McNamee et al (2019).

31. Laffont and Tirole (1993).

three health and behavioural categories and gives the resident a high, medium, low, or no score on each. The resident's needs determines the score on the ACFI which in turn determines the level of subsidy to the provider.

But because providers do their own assessments, there are concerns about 'gaming' and 'classification creep'. The assessment determines the level of subsidy the provider receives for the resident, so the game is to over-classify and under-service. Providers have an incentive to score 'needs' higher. Nearly 30 per cent of audit reviews of ACFI scores result in reduced subsidies.³²

1.4.2 The residential funding model does not encourage quality care

There are no accountability measures that trace the expenditure of the Commonwealth Government care subsidy.³³ And facilities can use the funding for non-care purposes, potentially leaving people without the care they need.

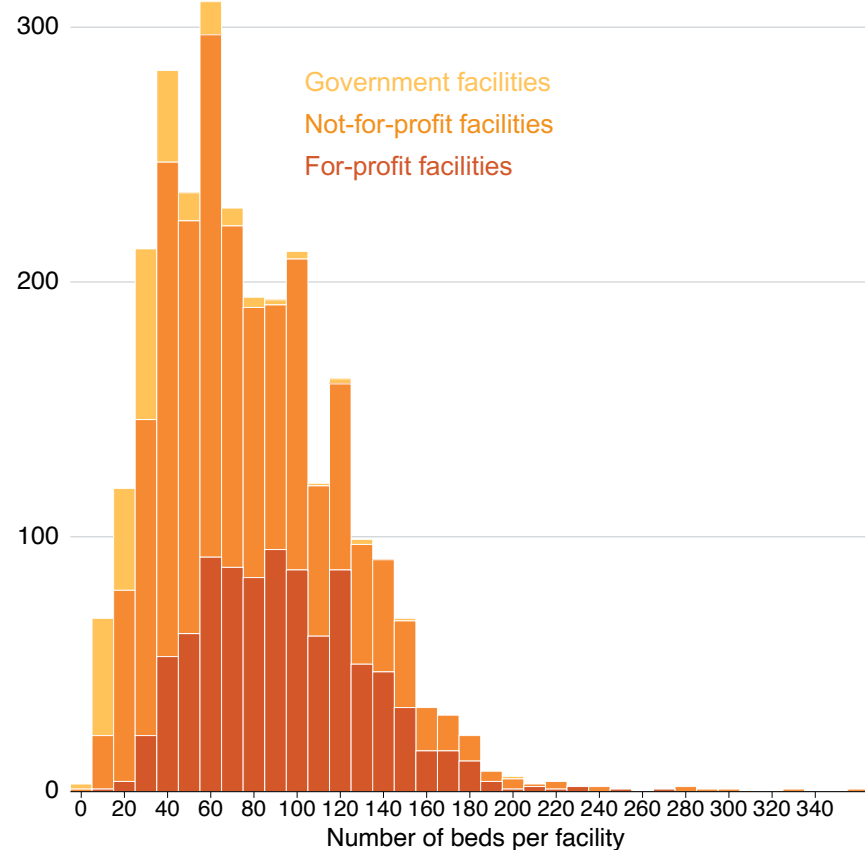
The ACFI also does not provide incentives for residential aged care facilities to rehabilitate a person over time. If a person improves, the provider's funding gets reduced. It also doesn't provide incentives for spending on quality-of-life factors such as good food.³⁴

32. As at 2017, see Rosewarne et al (2017, p. 215). It was lower in previous years, and some of this over-scoring may be due to inaccurately interpreting the ACFI classifications. Yet very few are upgraded: only 1.5 per cent in 2017.

33. See for example: Butler and Davey (2020).

34. On average, facilities allocate only \$6.08 per day per person to food; less than in prisons (\$8.25 per prisoner per day). Hugo et al (2017).

Figure 1.4: Most residential aged care facilities have more than 60 beds
Number of residential aged care facilities of each size, June 2019



Note: 'Beds' refer to operational places.

Source: Grattan analysis of Australian Institute of Health and Welfare (2020a).

While there are some exemplary providers, too many provide poor-quality care. Research for the Royal Commission found that 11 per cent of aged care facilities are of really poor standard – they are the subject of many complaints, they fail to meet standards more often, and the clinical outcomes for their residents are poorer.³⁵ And another 78 per cent of aged care facilities are of poor standard – with only a moderate level of service and sometimes with poor use of medication. Residents in all these facilities – which make up most of the industry – deserve better.

1.4.3 The residential funding model encourages bigger facilities

The current funding model encourages the building of larger facilities. The assessment under the ACFI does not take account of economies of scale – that the cost per person goes down as the number of people in the facility goes up – but allocates a constant subsidy amount regardless of the size of the facility. This means providers get a greater return the more residents in a facility.

Yet there is no evidence that larger facilities provide better care. In fact the evidence shows the opposite – that older people prefer smaller, home-like supported accommodation facilities and that those facilities provide better care.³⁶ Nor is there evidence that efficiencies through economies of scale are passed on to residents in reduced fees.

Coupled with capital financing incentives that also encourage the building of larger facilities (see Section 1.6.3), these incentives have resulted in a steady increase in large aged care facilities. Over the past 10 years, the proportion of aged care facilities with more than 60 beds has risen from less than 40 per cent to 60 per cent.³⁷ Today, about 30

per cent of facilities have more than 100 beds (see Figure 1.4). The trend to larger facilities is particularly driven by the for-profit sector, responding to financial incentives in the funding arrangements.³⁸

1.4.4 The proposed new funding model also has problems

The new proposed funding model – the Australian National Aged Care Classification, or AN-ACC – is a significant improvement on the current ACFI model for technical reasons, including that it has better explanations of the difference between classes, and its categories are much more clinically relevant.

But, like ACFI, AN-ACC is a type of activity-based funding.³⁹ Activity-based funding is not ideal for aged care, where relatively simple care functions and costs are nearly all determined by the number of staff hours required for different types of functions.⁴⁰ Activity-based funding is not a desirable way to determine cost for an individual support plan. Activity-based funding is appropriate for acute healthcare settings, but in aged care it is an opaque and overly-complicated

38. For-profit providers have on average 20 more beds per facility than not-for-profits: Aged Care Funding Authority (ibid, pp. 61–62). Note that this difference may also be due to not-for-profits having a bigger presence in regional areas, where facilities are usually smaller. For-profit providers have on average 95 beds per facility, whereas not-for-profits have on average 75 beds per facility: Aged Care Funding Authority (ibid, p. 61). Government facilities have on average 30 beds per facility. About 10 per cent of residents still live in ‘ward-style’ shared rooms with shared bathrooms: Aged Care Funding Authority (ibid, p. 63).

39. Activity-based funding involves classifying a person into a category and paying the service provider for ‘activity’ on the basis of the number of people being looked after or treated who are in the relevant category. It has been widely used for residential care for decades, using the ACFI to assign people to categories.

40. Activity-based funding is efficient and effective when providers have many high-cost users. To manage costs efficiently, providers spread the risk of individual variations within a group across a number of service users. Activity-based funding is much more difficult to apply for consumer-directed funding where funding is tied to specific individuals, particularly when funding can be spread across a range of providers.

35. University of Queensland (2020).

36. Ausserhofer et al (2016); Afendulis et al (2016); and University of Queensland (2020).

37. Aged Care Funding Authority (2020, p. 62).

method for allocating individual funds. It can lead to gaming, cost cutting, and the undermining of residents' rights. It is also problematic for small providers, who cannot spread risk across a large group of users.⁴¹

1.5 Carer workforce failures

Poor regulation and a badly-designed funding system have resulted in a poorly-trained, low-paid, and partly casualised workforce. Although staff are highly motivated, staffing models don't allow them to do their best, because owners often give priority to getting costs down and profits up rather than raising the quality of services and care.⁴²

The latest aged care workforce census, in 2016, found aged care services were provided by more than 366,000 paid workers and 68,000 volunteers.⁴³ Most worked in residential care facilities, where there were about 235,800 paid workers, about 153,900 of whom were direct carers.⁴⁴ Of these, about 70,000 were personal care attendants, and only about 14,600 were registered nurses.⁴⁵ The nursing has been taken out of 'nursing' homes.

About 10 per cent of the workforce is casualised.⁴⁶ Most carers are women; they make up nearly 90 per cent of the direct care workforce.⁴⁷

Many are also new migrants,⁴⁸ or people with low socio-economic status who can more easily be exploited.

Australia has poor aged care staffing levels compared to other countries. Research found that more than half of Australia's aged care facilities have unacceptable levels of staffing, and only 1.3 per cent have staffing levels that are considered best practice.⁴⁹ A 2019 survey of 2,775 aged care staff found that the greatest concern for 91 per cent of them in Australia is having sufficient staff to meet residents' basic needs.⁵⁰ The survey also found that 89 per cent of aged care workers noted inadequate staffing.

They are dedicated and work hard, but care staff are often overstretched and generally low paid.⁵¹ The low pay may reflect the female-dominated nature of the 'care' workforce.⁵² The Counsel Assisting the Royal Commission noted that:

The low pay they receive is nothing less than the aged care system exploiting the goodness of their hearts.⁵³

The quality of care and support received by older Australians depends critically on the quality of staff. Although there are many, many dedicated and well-trained staff working in home and residential care,

41. Activity-based funding is also inappropriate for smaller facilities because their costs are determined by minimum staffing requirements such as the need to have two care staff on duty at all times. This makes activity-based funding problematic for the 12 per cent of facilities with fewer than 30 beds, and potentially inappropriate for some larger facilities depending on the staffing model.

42. Some providers have been reducing labour costs by relying on lower-paid personal-care workers rather than nurses, who are paid more. See Royal Commission into Aged Care Quality and Safety (2020a, pp. 34–35).

43. Aged Care Funding Authority (2020, p. 14).

44. Ibid (p. 15).

45. Aged Care Funding Authority (ibid, p. 127).

46. Mavromaras et al (2017, p. 10).

47. Ibid (p. 17).

48. About 30 per cent of the direct care workforce in residential aged care were born overseas, and 40 per cent of recent hires in 2016 were migrant workers: Mavromaras et al (ibid).

49. This study compared Australia against a US star rating model for staffing levels. 57.6 per cent of Australian facilities had a star rating of 1 or 2 (considered unacceptable) and only 1.3 per cent had a 5 star rating: Eagar et al (2019).

50. Australian Nursing and Midwifery Federation (2019, p. 9); and Royal Commission into Aged Care Quality and Safety (2020b, p. 19).

51. Royal Commission into Aged Care Quality and Safety (2020b, p. 124).

52. In our *Rethinking aged care: emphasising the rights of older Australians* report, we noted that the under-payment of aged care workers was probably a reflection of society's under-valuing of roles and functions dominated by women. See Duckett et al (2020, p. 15).

53. Royal Commission into Aged Care Quality and Safety (2020a, p. 191).

there are also many who have inadequate training to look after people with complex needs.⁵⁴ About 50 per cent of people in residential care have dementia. Their care requires staff with specialist training.⁵⁵ The number of residents with high-care needs has also increased over time,⁵⁶ yet staffing profiles have gone in the opposite direction – with an increasing reliance on personal care attendants.⁵⁷ Staff also often do not have enough time to build meaningful relationships with residents. And the current system does not mandate minimum staffing levels.

The *Aged Care Act 1997* has an imprecise requirement that providers ‘maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met’.⁵⁸ The Aged Care Quality Standards are similarly vague and only require that the facility ‘has a workforce that is sufficient, and is skilled and qualified to provide safe, respectful, and quality care and services’.⁵⁹ Failure to specify what ‘adequate’ or ‘sufficient’ means renders these standards useless – as a guide to providers, as a check for consumers to compare quality, or as a mechanism of enforcement.

Victoria’s public sector aged care facilities are the only ones in Australia that have mandated minimum staffing levels. Victoria’s *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* stipulates minimum staff numbers, and requires at least one nurse to be on-shift 24 hours a day.⁶⁰

54. Royal Commission into Aged Care Quality and Safety (Volume 1 2019b, pp. 221–222).

55. Australian Institute of Health and Welfare (2020b); Australian Institute of Health and Welfare (2019a, p. 146); Royal Commission into Aged Care Quality and Safety (Volume 1 2019b, p. 205).

56. Australian Institute of Health and Welfare (2020c).

57. Royal Commission into Aged Care Quality and Safety (2020a, pp. 34–35); and Mavromaras et al (2017, p. 12).

58. *Aged Care Act 1997*, section 54(1)(b).

59. Standard 7: Human resources.

60. Note that the Victorian Government also contributes to funding public sector aged care services.

The COVID-19 crisis demonstrated the importance of adequate staffing, with the evidence speaking for itself: despite Victorian public sector facilities making up 10 per cent of facilities in the state, barely any government-run facilities had COVID-19 infections.⁶¹

1.6 Funding of land and buildings is inequitable and inefficient

The current funding and financing model for capital costs – land and buildings – is riddled with perverse incentives, inequitable to residents, and inefficient. There are three major problems with the system that undermine access and choice for aged care residents.

1.6.1 Limited choice

Older Australians are in a vulnerable position when entering residential aged care and negotiating the terms of payment. Incoming residents are often frail and dealing with major health issues or impairments. The decision to enter residential care may have been made quickly as a result of a health problem, leaving little time to plan and choose a facility.

There is a power imbalance during payment negotiations between providers and incoming residents. The current financing model encourages providers to seek a Refundable Accommodation Deposit (RAD) from the new resident. However, the provider receives a greater financial benefit than residents from the RAD (see next section).

Although incoming residents ostensibly have a choice between paying a RAD, a daily accommodation payment (DAP), or a combination of both, providers may pressure them to select the RAD payment method.⁶²

61. Although this was also partly due to many of Victoria’s public facilities being located in regional areas where there were few COVID-19 cases: Handley (2020).

62. It is, however, promising that the proportion of people opting for the DAP is increasing.

The financial status of some residents may leave them no option but to pay the RAD. These residents have low income but high assets. They do not have the cash available to pay the DAP, but their high assets mean they do not qualify for government support. These incoming residents then unavoidably face the often-stressful process of selling their home quickly to pay the RAD.⁶³

The RADs represent an implicit subsidy from residents to providers, yet the extent of the subsidy is neither transparent nor equitable.

1.6.2 Interest-free RADs are not fair for all residents

The RAD is, as its name implies, refundable to the resident or their estate. However, what is refunded is only what was deposited. Unlike any other use of capital, there is no capital growth and no interest payment. In return for this interest-free deposit, the resident gets a discount on their rental charge. But the discount is calculated at the 'Maximum Permissible Interest Rate' (MPIR), which is currently set at 4.1 per cent,⁶⁴ below what the resident might have earned on their deposit if they had maintained it in their superannuation fund or as a private investment.

Access to interest-free financing is an out-sized benefit to residential aged care providers, who would otherwise have to pay borrowing costs at the market rate, estimated as 5.9 per cent.⁶⁵

For the average RAD of \$318,000,⁶⁶ providers save \$18,762 per year in interest.⁶⁷ Residents forgo the benefits of investing this money

themselves when they enter into a RAD, but get a partial off-setting rental saving of \$13,038.⁶⁸ The considerable saving that providers enjoy through this unique, off-market financing facility is inequitable.

1.6.3 RADs encourage undesirable investment

The vast majority of older Australians want to receive care at home, rather than in a residential care facility. Currently, less than 1 per cent of people aged 65 are living in a residential facility (see Figure 1.5).⁶⁹ For people between the ages of 80 and 85, that rises to 5-to-10 per cent, and for those older than 90 it is 20-to-40 per cent. About 50 per cent of older Australians go into a residential care facility at some point, and about 80 per cent die there or in hospital.⁷⁰ But the proportion of older people in residential care in every age group is declining (see Figure 1.5).⁷¹

Yet the current financing model encourages a growing residential aged care sector. The interest-free financing for residential care providers may encourage reinvestment of these funds into yet more residential care infrastructure – both for maintenance and expansion.

As home-based care increases, the rate of demand for residential care will slow.⁷² The upshot is more investment in residential aged care than the community needs. Some of this will be wasteful investment in under-utilised facilities. The over-investment in residential care, driven by low-interest RADs, is thus an economically inefficient use of resources.

63. This also means that the resident loses the option of returning to home care, which is particularly problematic for younger residents.

64. Royal Commission into Aged Care Quality and Safety (2020c, p. 11).

65. This is based on a 10-year trailing average yield on 10-year BBB-rate corporate bonds. See Frontier Economics (2020, p. 34).

66. Royal Commission into Aged Care Quality and Safety (2020c, p. 11).

67. Calculated as the interest cost on an average RAD of \$318,000 at an interest rate of 5.9 per cent.

68. Calculated as the annual rental payment on \$318,000 at an MPIR of 4.1 per cent.

69. Gibson (2020).

70. Royal Commission into Aged Care Quality and Safety (2019d, p. 21); Australian Institute of Health and Welfare (2018a).

71. Gibson (2020).

72. Although the net number of people going to residential care will continue to go up due to the ageing population.

1.6.4 RADs discourage sensible draw-down of retirement savings

Many retirees do not draw down on their savings, even though retirement income policy is set on the assumption that savings will be consumed.⁷³ As a result many retirees are consuming much less than they should, lowering their living standards during retirement.

While it is difficult to disentangle the many reasons retirees don't spend down their savings, concern about potential future health and aged care costs appear to be important.⁷⁴ The large sums involved in RADs are likely to be particularly salient to retirees, and often act as a de-facto guaranteed bequest for their children, since aged care facilities typically return the value of the bond to the estate when the aged care resident dies.⁷⁵ Shifting away from RADs would therefore reduce retirees' motives to save in retirement in future.

1.7 Market failure

The current aged care system uses the language of the market and choice. But in practice, providers have much more information, control, and influence than consumers. In residential care, a veil of secrecy makes it very difficult for consumers to make judgments about issues such as staffing levels.

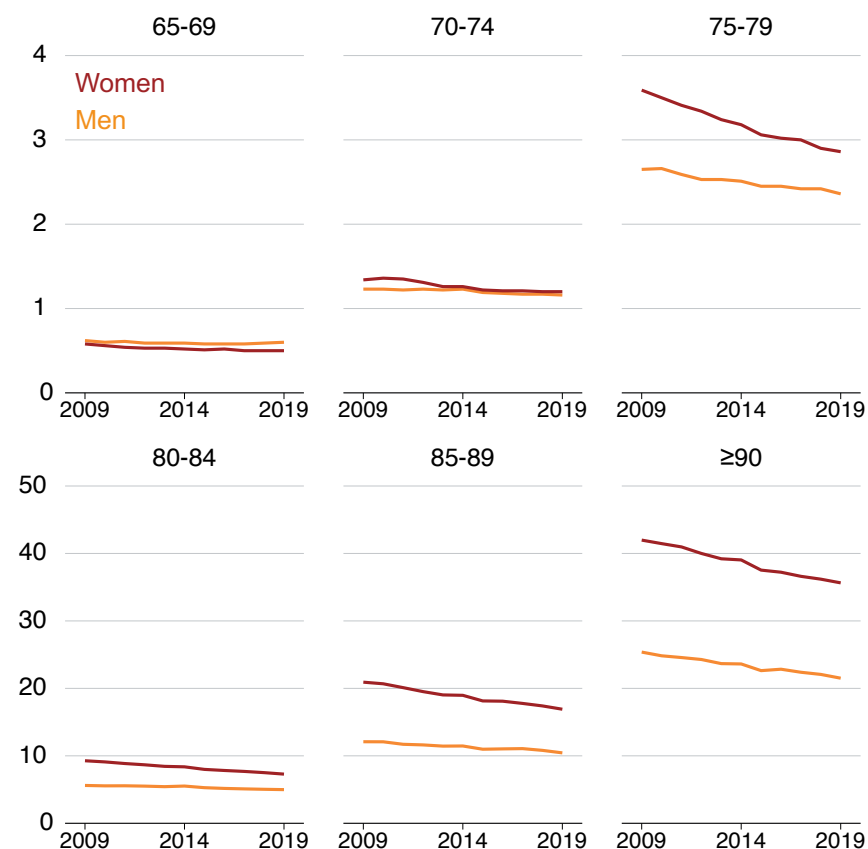
73. Australian government data show that less than half of all pensioners draw down on their assets, and more than 40 per cent are net savers. A recent study found that at death the median pensioner still had 90 per cent of their wealth as first observed: see Daley and Coates (2018, p. 32).

74. In the US and UK, where many must fund their own aged care, retirees do not draw down much on their wealth. In contrast, retirees draw down on retirement savings much faster in countries with low out-of-pocket medical and aged care costs, such as Sweden, Norway, Denmark, Germany, and Austria, where the median person aged 86-90 has only 21 per cent of the net wealth of younger retirees. See Daley and Coates (ibid, p. 33).

75. Ibid (p. 33).

Figure 1.5: The proportion of people going into residential aged care is falling across all age groups

Percent of women and men in each age group in residential aged care



Source: Grattan adaptation of analysis by Gibson (2020).

Box 2: The COVID-19 crisis exposed systemic problems

The Australian Government's failure to adequately prepare residential care facilities for the threat of COVID-19 has contributed to an unacceptably high death toll in aged care. By the end of the second wave in October 2020, there had been about 2,000 COVID-19 cases and 680 deaths in residential aged care – mostly in Victoria – accounting for about 75 per cent of Australia's COVID-19 death toll. In a pandemic, vulnerable people are of course sadly more likely to die, but the proportion of Victoria's death toll in residential care is still higher than many comparable countries, where about half of all COVID-19 deaths have been in aged care homes.^a

The Newmarch House disaster in NSW during the first wave highlighted all the immediate problems: not enough trained staff, lack of personal protective equipment, inadequate infection control, failure to adequately compensate staff to stay home if they had symptoms, lack of information and support for families and friends of residents, and poor coordination and accountability between the state and federal governments.^b Nineteen people died in just one home.

None of these issues were addressed before the second wave hit Victoria in July 2020. Instead, the same problems emerged in many residential facilities with COVID-19 infections in Victoria over the next few months – killing hundreds and infecting thousands. The Royal Commission described the lack of personal protective equipment as 'deplorable'.^c

- a. This is based on a June 2020 review of 26 countries including the UK and the US: Comas-Herrera et al (2020, p. 2).
- b. Gilbert and Lilly (2020).
- c. Royal Commission into Aged Care Quality and Safety (2020d, p. 25).
- d. Mills (2020).
- e. Royal Commission into Aged Care Quality and Safety (2020d, p. 11).
- f. Colbeck (2020) and Davey (2020). This on-the-ground response brought together 150 staff from 28 agencies.

The Commonwealth Government provided additional funds for aged care to address COVID-19: in May, \$205 million to cover COVID-19 costs; in March, \$340 million and then \$100 million for training, extra staff, pathology services, and improved infection control. But money alone hasn't been enough.

COVID-19 exposed workforce problems. The virus primarily spread to aged care facilities through aged care workers. Staff are often casual, poorly paid, unskilled, and work in more than one facility. Many workers have no or insufficient sick leave entitlements. Some aged care workers spread COVID-19 to facilities while sick or waiting for test results.^d

No one body – whether that be the Commonwealth, responsible for aged care; the state, responsible for public health; or providers, responsible for residents – took responsibility. The Commonwealth's lack of capacity to effectively monitor, coordinate, and manage services on the ground was laid bare. The Royal Commission found that 'all too often, providers, care recipients and their families, and health workers did not have an answer to the critical question: who is in charge?'.^e In particular, surge workforce planning fell through these cracks – leaving some residential facilities with barely any staff, and residents with little or no care. Belatedly, the Commonwealth established a Victorian Aged Care Response Centre in late July to beef-up the response and create 'one point of truth'.^f

When consumers have poor information, markets can't prevent unscrupulous providers skimping on quality. In the absence of market signals, protecting the safety of some of the most vulnerable people in our community requires tough regulation.⁷⁶ But regulation has been progressively weakened over time, with language becoming softer and regulatory requirements less specific. This regulatory model was shown to be ineffective in evidence before the Royal Commission, even before the tragedies of the pandemic.⁷⁷

A combination of poor market signals and weak regulation creates an environment where for-profits can make large profits, and some do.⁷⁸ For example, a September 2020 report commissioned by the Royal Commission found that in 2017/18, approved aged care providers for home care and residential care made a total profit of \$1.1 billion (on a total income of \$25 billion), and most of these profits were earned by the largest 60 providers.⁷⁹

In particular, the home care program is designed on the basis of a fully-functioning market where consumers have information and access to exercise choice. But the consumer-directed care approach has not worked, because there is nothing to ensure the market is able to deliver.

The Royal Commission's interim report in 2019 said 'the notion that most care is consumer-directed is just not true', and that 'it is a myth that aged care is an effective consumer-driven market'.⁸⁰ For-profits

saw this model of care as an opportunity – jumping into the aged care sector to get their share. Over the past three years, the proportion of for-profit home care providers has almost tripled, from 13 per cent in 2016 to 36 per cent in 2019 (see Figure 1.6).⁸¹

1.8 Poor regulation

Australia's aged care system is not properly regulated or governed. Despite so-called aged care standards, poor care slips through gaping holes in the accountability system. This is partly due to poor standards and lax compliance efforts, but also to the centralisation of accountability. With the checks and balances effected through accountability to bureaucrats in Canberra, there are limited boots on the ground to provide real oversight. During the COVID-19 pandemic, almost every one of the internationally-identified risks of the impact on residential care was present. Yet, when measures were taken to address risks, they were too slow. Delays were caused by denial and attempts to shift responsibility (see Box 2).⁸²

1.8.1 Overly centralised and fragmented

As the Commonwealth Government has assumed responsibility for aged care, the states and territories and local government have withdrawn from planning, funding, and system coordination. The Commonwealth has centralised administration and regulation.

Stewardship and governance are concentrated nationally and fragmented across the Aged Care Quality and Safety Commission, the Aged Care Financing Authority, and the Department of Health.

76. In contrast, government-run facilities that are more heavily regulated have been demonstrated to provide better quality care than not-for-profits and for-profits. See University of Queensland (2020).

77. Royal Commission into Aged Care Quality and Safety (2019b, p. 8).

78. See for example Royal Commission into Aged Care Quality (2020) and Butler and Davey (2020), noting that there is considerable variation between providers, with some struggling to be viable, while others are making large profits.

79. Royal Commission into Aged Care Quality (2020, pp. 22–23).

80. Royal Commission into Aged Care Quality and Safety (Volume 1 2019b, p. 10).

81. This has coincided with a rapid expansion in the number of aged care providers between 2016 and 2019, following the introduction of consumer-directed care in 2017 where packages are assigned to the individual rather than the provider: Aged Care Funding Authority (2020, p. 43).

82. Langins et al (2020).

Centralisation through government and government agencies means governance functions are distant from the interests of individual users, and transactional rather than relationship-focused. High-functioning aged care systems, such as those in Denmark, Sweden and the Netherlands, are much more decentralised than Australia's.⁸³

The Commonwealth has not introduced organisational arrangements for localised system management to replace the local system management role of the states and local government.⁸⁴ This has led to a weakening of local area-based service planning, development, and management.

Similarly, the absence of local organisational support for older people has made it more complex for them to get information and assessment. There is no systematic organisational structure of local, integrated points of access and navigation for people who need care. Conflicts of interest emerge when service providers are the principal advisers on service options.

As funding for home care packages has increased, the number of home care providers has expanded significantly – increasing by nearly 90 per cent between 2016 and 2019.⁸⁵ Unmanaged competition, ineffective regulation, and limited consumer information have increased the risk of poor-quality services.

Neither home care nor residential care for older people is well integrated with health care services and services for people with disabilities. Health care services for older people with chronic disease, including dementia and mental health problems, are inconsistent, poorly planned, and fragmented. End-of-life care is inadequately funded, and access to services and their quality is variable. People

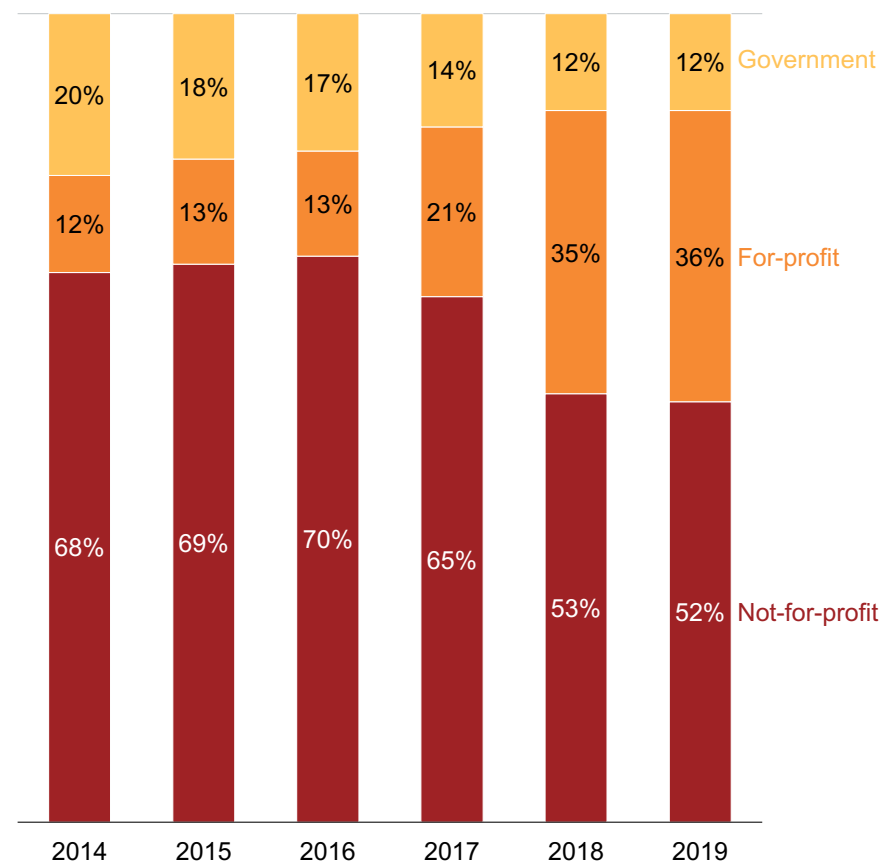
83. S. Dyer et al (2020, p. 63).

84. The Commonwealth Department of Health has state offices with roles in aged care oversight, but they do not perform a locally accountable role.

85. Aged Care Funding Authority (2020, p. 43).

Figure 1.6: Since consumer-directed care was introduced in 2017, the proportion of for-profit home care providers has tripled

The proportion of aged care providers in the Home Care Packages program



Note: This is a proportion of the number of providers, not the proportion of places run by each provider type.

Source: Aged Care Funding Authority (2020).

end up living and dying in residential care or hospital, when they would much rather be supported at home.⁸⁶

At the extreme, the recent inability of a number of residential aged care providers to prevent and manage the spread of COVID-19 in New South Wales and Victoria demonstrated the poor integration of health and aged care services. Operational management, communication and coordination between aged care and state-run health services were unable to ensure appropriate infection control, hospital transfers, emergency staffing levels and treatment within residential facilities. Resolution required special emergency management and coordination arrangements to be put in place. In practice, the Commonwealth has little regional system management capacity to address these issues.

The long-term care needs for older people and people with disabilities are similar. Yet there are considerable differences between the national schemes for these two populations. Legislative and policy objectives, eligibility and entitlements, models of service delivery, funding, and governance arrangements across the two schemes are fundamentally different.

The National Disability Insurance Scheme is a rights-based scheme that provides individualised, universal access to reasonable and necessary services for all eligible people with a disability. The aged care system is a capped, provider-driven scheme heavily focused on promoting efficiency and constraining costs to government.

1.8.2 Lack of accountability

When things go wrong in aged care, there is too little accountability and transparency. The Royal Commission reported that the complaints system is difficult to access and can be unresponsive to

complainants.⁸⁷ Some people fear being neglected or mistreated if they make a complaint.⁸⁸ This means bad care can continue unchecked.

Recent changes to standards are not enough. The assessment is too heavily based on process, with there is no clear guidance on how to improve residents' well-being.⁸⁹ And merely having tick-box quality assessments from Canberra to ensure compliance with standards does not provide meaningful support to providers on how to lift quality.

1.8.3 Lack of transparency

The aged care system is nowhere near transparent enough – to the point where the government does not have good knowledge of services provided to older Australians, and whether taxpayer funds are actually spent on care.⁹⁰

Although providers are asked to report against quality standards and some other requirements to the regulator, very little of this information is passed on to the consumer.

There is very little information available to older Australians looking for care options. There is no information about the number of complaints and assaults at facilities, or about staffing numbers or ratios.⁹¹ Only since July 2019 has it been mandatory to report against a limited set of quality indicators.⁹²

87. Royal Commission into Aged Care Quality and Safety (Volume 1 2019b, p. 65).

88. Royal Commission into Aged Care Quality and Safety (Volume 1 *ibid*, p. 65).

89. Sturmberg (2019).

90. For example, the Royal Commission exposed that the Department of Health did not know much about how the Home Care Packages Program operated, who received packages, and the types services that older Australians use, nor whether services were sufficient to make a difference. See Royal Commission into Aged Care Quality and Safety (2019c, p. 42).

91. Royal Commission into Aged Care Quality and Safety (2019b, p. 8).

92. Under the National Aged Care Mandatory Quality Indicator Program.

86. Swerissen and Duckett (2014).

Australia is lagging behind other countries.⁹³ Research for the Royal Commission applied a United States' ranking system to Australian residential aged care facilities and showed only a minority of providers have staffing levels at three stars or above in a five-star rating system.⁹⁴ Australia does not have such a ranking system, so potential consumers are not let into the secret of who is good and who is not. Nor does high profit necessarily equate to high quality.

The issue of transparency also extends to the financial practices of providers, who receive a significant amount of taxpayer funds. A 2018 Senate committee review of the financial and tax practices of for-profit aged care providers noted that the committee 'cannot with any certainty conclude that for-profit providers are engaging in improper tax or financial practices. The problem, however, is that the committee is also unable to conclude that they are not'. The committee concluded that:

The industry may have difficulty convincing the community that financial opacity is appropriate from companies that are in receipt of large sums of public money, and are actively campaigning to receive more on the basis that current expenditure is insufficient. The committee believes that both the industry and the public would be best served by strengthening the framework for transparency and accountability.⁹⁵

Recent efforts to improve transparency are welcome, but much more needs to be done.⁹⁶

93. Royal Commission into Aged Care Quality and Safety (2019b, p. 132).

94. Eagar et al (2019).

95. Senate Economics References Committee (2018).

96. For example, the *Aged Care Legislation Amendment (Financial Transparency) Bill 2020* – referred to the Senate Community Affairs Legislation Committee for inquiry and report in March 2021 – seeks to introduce financial transparency of approved providers by requiring they report on their income, spending, the total cost of direct and indirect care expenditure such as food, medical products, salaries and wages of staff, and so on.

1.9 Insufficient funding

Australia spends less on aged care than similar countries with high-functioning aged care systems. Netherlands, Japan, Denmark, and Sweden spend between 3 per cent and 5 per cent of their GDP on long term care.⁹⁷ The Australian Government spends 1.2 per cent.⁹⁸ Demand for services will increase as the Australian population ages over the next three decades. This means fiscal pressure on aged care services will only increase (See Section 3.9).

In 2018-19, the Commonwealth Government spent \$19.9 billion on aged care services (see Figure 1.1).⁹⁹ Most funding – \$13 billion in 2018-19 – was for residential care (see Figure 1.1).¹⁰⁰ Total expenditure, including consumer contributions for care and accommodation (but not capital), was \$25 billion.¹⁰¹ Out-of-pocket expenditure by older Australians on aged care was \$5.1 billion.¹⁰²

1.10 The loudest voices

As would be expected in an industry dependent on government funding and regulation, aged care providers have mobilised to protect their

97. S. Dyer et al (2020, p. 43).

98. S. Dyer et al (ibid, p. 43). Note that there are some acknowledged difficulties with comparing international expenditure on aged care.

99. Aged Care Funding Authority (2020, p. xi). Although the Commonwealth had provided most of the funding and provision since the introduction of the *Aged Care Act 1997*, it assumed full responsibility for aged care funding in 2018. Initially Western Australia and Victoria retained responsibility for home and community care services. In July 2015, the Home Support Program was created from a combination of former programs including the Home and Community Care Program for older people, which had been managed by state and territory governments. Victoria joined the Home Support Program in July 2016 and Western Australia in July 2018.

100. Ibid (p. xii).

101. Ibid (p. xi).

102. Excluding accommodation deposits. Aged Care Funding Authority (ibid, p. xi).

interests. An array of euphemistically-titled agencies ensures that the aged care system works in their interests. They have legitimate interests. But they have also lobbied against changes designed to increase information for consumers. There are examples of such changes being voted down in parliament at the industry's behest.¹⁰³

Consumer-oriented organisations are the poor cousins in this jungle, often with their political advocacy functions severely curtailed by government funding conditions. There is no consumer organisation specifically for the most vulnerable – those in residential care.¹⁰⁴ Their interests are swamped by the general concerns of older Australians.

1.11 A way forward

The structural and systemic problems in Australia's aged care system can be fixed. It is not inevitable that some care will be substandard – it is unacceptable. The necessary radical overhaul will require political will, more money, and a clear plan forward.

This report proposes a new funding (outlined in Chapter 3) and governance model (outlined in Chapter 4), and identifies some major structural reforms. But because the problems are so numerous and the industry so big, we cannot cover all the changes that are needed. We do not, for example, cover the smaller aged care programs such as respite, transition care, and care programs for Indigenous and Torres Strait Islanders. We also do not look at issues and policies outside of aged care, such as education and disability, that may impact on outcomes in aged care.

The next chapter sets out what a rights-based aged care system should look like. And Chapter 5 shows how Australia should gradually move to the new system.

¹⁰³.Connolly (2020).

¹⁰⁴.Although the Older Persons Advocacy Network (OPAN) provides advocacy, information and education for people living in residential care.

2 A new rights-based system

Australians should demand an aged support system which provides high-quality services that emphasise people's independence, self-fulfilment, and participation in the community. A rights-based approach, as proposed in our previous report,¹⁰⁵ means the system must take a bottom-up approach – first asking what individuals want and need, and then providing services that help them achieve that. The system should enable older Australians to choose to live at home, or in a residential facility if they need to.

A rights-based system should involve individual support plans that set out the services a person needs. The plan should then determine their funding. This should give older Australians greater choice and control over their care and support. And the care and support they receive would be tailored to their personal needs. Regional system managers should help older Australians develop support plans, navigate the system, and find the right care for their needs.

Providing support at home – even if they have complex needs – is key to older Australians' independence. Many more older Australians should get support. And if a person chooses to live in supported accommodation, there should be many more diverse options available – whether it be a more home-like setting or with more short-term clinical or restorative care.

The regional managers should also help ensure older Australians can continue to live meaningful lives connected to the community.

2.1 Principles for designing a better system

Australia's current approach to aged care, especially residential aged care, emphasises rationing, not rights. The current *Aged Care Act 1997* is based on that premise. A Cabinet memorandum from 1997 said:

Residential care is not a demand-driven program. Outlays are controlled by capping service provision – controlling the number of nursing home and hostel places to be funded.¹⁰⁶

The *Aged Care Act 1997* is focused on cost-control and the transactional relationships between the government and providers – rather than on what outcomes its trying to achieve for older Australians.

The new service system needs to shift away from this rationed, provider-centric approach, to a rights-based approach that supports older Australians to continue living meaningful lives.¹⁰⁷ To enable this, the new system should be based on rights that support older Australians, and principles that ensure the system functions efficiently.

2.1.1 Rights-based principles

The rights-based principles on which Australia's aged care system should be based are set out in Grattan Institute's October 2020 report, *Rethinking aged care: emphasising the rights of older Australians*:¹⁰⁸

- Universal access: All older Australians who need care and support should have access to adequate services, regardless of where they live, their financial position, or other factors.

105. Duckett et al (2020).

106. Departments of Health and Family Services and of Finance (1997).

107. Duckett et al (2020).

108. Ibid.

- Independence, self-fulfilment and participation in community: Older Australians should be supported to continue living meaningful lives as they age, and receive supports that enable them to fulfil their goals and aspirations.
- Equity and non-discrimination: Equal access extends to all groups, including minorities and those with special needs.
- Informed and supported choice and control: Older Australians should be able to make informed decisions about their own lives, health care, and aged care setting; whether that be at-home care or in residential accommodation. And independent support should be available to help them get services they need.
- Dignity, including dignity in death: Older people who need long-term support have the same right as other Australians to respect for their worth and dignity, and to live free from abuse, neglect, and exploitation.

2.1.2 System-level design principles

The second set of principles reflect broader community interests and include:

- Accountability: Transparency and accountability are necessary to ensure that taxpayer and consumer funds given to providers are used effectively and in the interest of the community.
- Efficiency: The service system model must make efficient use of taxpayers' funds to ensure quality and service standards are met.
- Feasibility: The model must be sustainable and practical to ensure that it is implemented effectively and for the long term. This means aged care should be better integrated with health and disability programs.

2.2 Individual care planning

As discussed in the previous chapter, the current assessment process assigns people to four broad payment categories in home care and one of 64 payment categories in residential care.

This is wrong on many levels. The new system should focus on the individual and work with them to identify and meet their needs.

The aged care system should provide older Australians with full choice and control over their care through the development of individual support plans – regardless of the setting. An individual support plan is the contract between the provider and an older person to make sure they get the services they need to live the way they want to – even when they are very frail, ill, or disabled. These plans will help protect older Australians' rights to independence, self-fulfilment, and participation in the community. Individualised care planning fundamentally shifts the provision of aged care from a provider-led system to an individual-based system, where care is allocated according to an individual's needs.

Consistent with the principle of universal access, a person's eligibility to receive support should be determined on the basis of their needs. This is best achieved through the care planning process, not as a separate and prior step.

Support plans should bring together different elements of the current aged care system. The care planning process should involve mapping goals and aspirations, and assessing needs. Funding for services that support those needs should follow automatically (see Section 3.3).

Individual support plans should be central to planning, budgeting, delivering, monitoring, reviewing, and adjusting all aged care services, whether people receive care in community or in supported accommodation.

The first step in a support plan is to determine a person's goals and aspirations (see Figure 2.1). Care planning should be holistic – it should not merely state what a person's care and support needs are, but take a whole-of-life approach that enhances the person's mental health and well-being. It cannot take a narrowly focused clinical approach. A person's goals may include being able to live at home, attend a weekly choir, or go for regular walks.

These goals then guide the funding and set of services the person needs to achieve their goals. The plan should set out in detail the type of services and hours and types of care needed. It should outline a person's requirements in the morning, midday, afternoon, and evening,¹⁰⁹ and it should take account of support available through family or friends.

Importantly, the services paid for under a support plan should be limited to what is reasonable and necessary (see more in Section 3.3.1) and only cover care requirements – not pay for ordinary things people would pay for in their lives (see more in Chapter 3). These services should be linked to price schedules that then provide a total sum of costs for the services (see more in Section 3.3).

Once individual support plans are developed, and home-based or supported accommodation services are provided, individuals or assessment officers should regularly monitor the quality, efficiency, and continuing appropriateness of the services that are delivered (see more in Chapter 5).

2.2.1 More support to live at home

Older people must have choice and control over their care, including whether they want to receive support at home or in supported accommodation.

109. Aged Care Workforce Strategy Taskforce (2018, p. 51).

Figure 2.1: How individual support plans work



Most older people live at home.¹¹⁰ Even for people in their 90s, only up to 40 per cent are in residential care (see Figure 1.5).

Regardless of their age, when older people need care and support, they have a strong preference for home care.¹¹¹ More and more Australians are choosing home care over residential care. A rights-based approach means that people should receive home care when they need it. They should not have to wait 12 or more months to receive support, by which time it may be too late.

Residential care should not be the only choice for older people the moment their needs become more difficult. Older people tend to have a strong aversion to living in residential care institutions. Even when

110. Productivity Commission (2015, p. 86).

111. Roy Morgan (2020, p. 47); Ipsos (2020, p. 9).

Table 2.1: The new rights-based system design draws on aspects of the NDIS, although there are a number of key differences

Features	Similarities	NDIS	Aged care reform proposal
Rights-based approach	Rights-based principles support independence and participation in society	Primarily drawn from CRPD and international conventions	Drawn from international conventions and 'soft law' rights for older people
Care planning and assessment	Individualised support plans	Care planning in multiple steps: developed by NDIA or intermediary (LAC); assessed independently or by NDIA; approved by NDIA	Care planning integrated and streamlined: drafted, assessed, approved, and reviewed by regional bodies, overseen by national steward
Funding model	Care funding tied to plans and covers all reasonable and necessary support	Uncapped and demand-driven (no means-testing); everyday living and accommodation not covered	Needs-driven (limit on home care); means-testing for everyday living and accommodation costs
Market management	Intermediary bodies can recommend best-performing providers	Minimal market management, and not at local level (done by NDIA)	Government-established regional system managers can commission and manage the local service system
Regulation	Central body sets accreditation requirements and quality standards	Central compliance	Regional compliance with provider performance standards publicly released
Cost	More expenditure required	Funding increased by 50 per cent	Funding needs to increase by 35 per cent
System capacity	Independent statutory body to oversee whole system	Staffing cap on NDIA (long wait times for plans)	Regional bodies carry out regional-level management

Notes: NDIS = National Disability Insurance Scheme. CRPD = The Convention on the Rights of Persons with Disabilities. NDIA = National Disability Insurance Agency. LAC = Local Area Coordinator.

their care needs are high and they don't have an able-bodied partner, a significant minority of older people want to be cared for at home rather than in a residential care facility. Home care support should be a genuine alternative to residential care, even for people with high and complex needs.

Creating a right to home care – and effectively eliminating home care waiting times – will drive further change in the system, including reducing dependence on residential care.

People on Level 4 – the highest level of home care package – on average get about eight hours of care per week. In contrast, some people in residential care get 15 hours of care per week. Not everybody in residential care receiving low hours of care could be supported at home, but increasing the amount of home care would save money as well as provide better support for older Australians (see Chapter 3).

Merely adding another level to the already failing Home Care Packages Program would not be enough. We propose a new home support program with a new funding model (outlined in Chapter 3). The Grattan model would include:

- Sufficient funding to ensure everyone assessed as needing home support could receive care within 90 days, and within 30 days if care is urgently needed to prevent a person having to be admitted to residential care.
- A light touch assessment and care planning process for people needing up to 5 hours home support each week, with a standardised multi-disciplinary assessment and care planning for people needing more support. Each person would get an individual support plan outlining the services they reasonably need to achieve their goals. The assessment service should also link the person to local services, giving options where that is available.
- Services paid for according to a regional pricing schedule.

- Care services, such as nursing, assistive technologies, and allied health, available to everyone, with no means-test. Services which would normally be paid for out of household budgets such as meals, cleaning, and transport, would be means-tested.
- Individuals receiving home support up to the funding amount they would have been allocated in residential care.

The existing Commonwealth Home Support Program and Home Care Packages Program would be abolished and replaced by this new scheme.

Older people would be able to choose to live in a 'retirement village',¹¹² or other types of supported housing. The Grattan home care model outlined here would facilitate this option by enabling residents to receive home care where necessary.

2.2.2 More diverse and smaller options for supported accommodation

Once a person has completed the care planning process, they should be provided with options about whether they would prefer to receive support at home or in supported accommodation. This key choice should be made by the individual, not an external assessor.

Many people would not want to choose residential care. Residential care facilities are increasingly becoming a place of last resort for many people. Over the past 20 years, residential care facilities have increasingly moved away from being a lifestyle choice in a retirement living home to more high-level care facilities in larger-scale settings. The proportion of people going into residential care is declining across all age groups (see Figure 1.5).¹¹³

¹¹² These are state government rather than Commonwealth regulated services and not funded as residential aged care.

¹¹³ Gibson (2020).

Compared to the past, residents today tend to have more disabilities and complex care needs, and are more frail (see Figure 2.2).¹¹⁴ Today, nearly a quarter of permanent residents stay for only six months or less before they die (See Figure 2.3).¹¹⁵

But there are also many reasons why people may opt to go into residential care. This is very dependent on whether a person has family or friend support at home, and whether they need someone available 24 hours a day. With better access to higher-quality home care, more people would be able to stay at home (see Chapter 3). But for others, residential care will be needed.

In the past, the mantra about residential aged care was that it should provide a home-like environment. But today, more than half the residents have complex health needs such as severe dementia. As a consequence, contemporary residential care looks less and less like a home and more and more like some aspects of sub-acute hospital care such as rehabilitation and geriatric assessment wards.

Although the complexity of residents is increasing (see Figure 2.2), and is likely to continue increasing as home care is expanded and people delay going into residential care even further, older Australians should still have more choice about how they receive higher level support.

Residential care funding policy should reflect the growing diversity of types of supported accommodation. Some people need supported accommodation for the long term, others only for a short term. We suggest there should be five specific categories of supported accommodation:

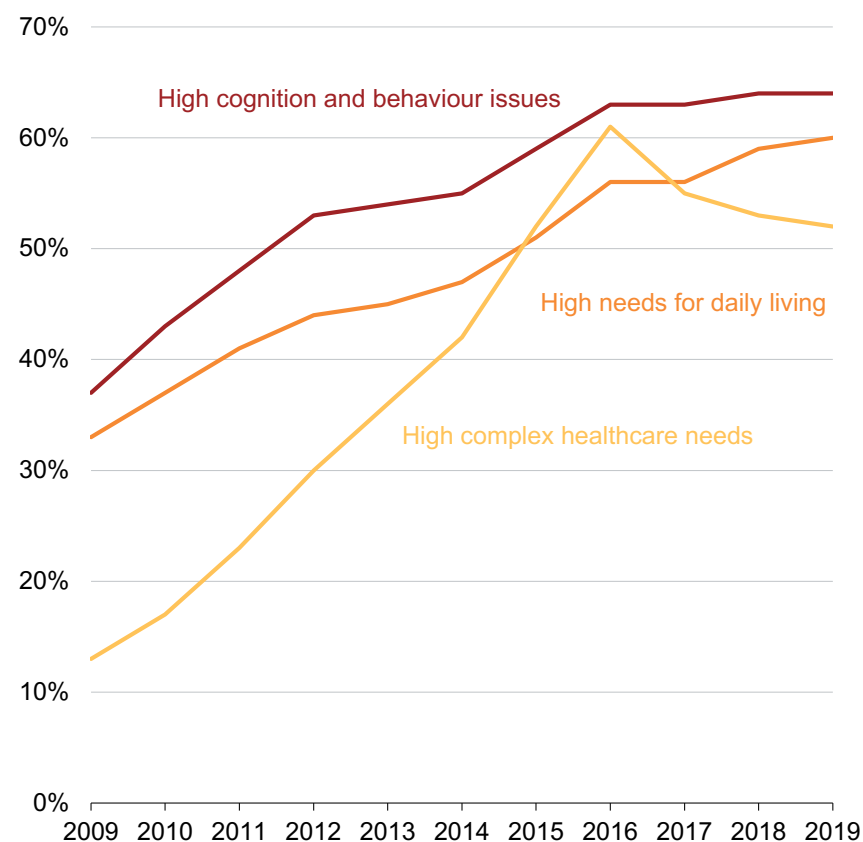
- Longer-term specialised support for people with severe dementia

114. Ibid.

115. Based on Grattan analysis of data from the Australian Institute of Health and Welfare (2020d).

Figure 2.2: Over the past 10 years, the proportion of aged care residents with high care needs has increased significantly

Proportion of residents rated in the 'high' ACFI category for each domain.



Notes: The Aged Care Funding Instrument (ACFI) classifications have low, medium, and high categories. This chart includes only those rated as 'high'. The Classification Amendment (Complex Health Care Domain Scores) Principles 2016 reduced some scores for components of complex care, contributing to the observed reduction in the percentage of residents with high scores for complex health care between 2016 and 2017.

Source: Gibson (2020).

- Longer-term support for people with severe disabilities and/or complex clinical care needs
- Short-term respite to support family and friend carers
- Short-term restorative and transition care for people coming out of hospital or who have had a major incident
- Longer-term lifestyle and community living

A one-size-fits-all residential care facility that ends up falling somewhere in the middle – not being home-like, but not having sufficient clinical expertise or adequate specialised support for dementia – means everyone loses. Instead, diversity of needs should have a diversity of responses.¹¹⁶

For example, larger facilities cannot provide a home-like setting, but they could more suitably provide hotel-like arrangements for respite care or transition care. By contrast, smaller facilities are better able to provide a home-like setting, and can be more integrated into the local community.

Under a human rights-based approach, supported accommodation facilities should also foster new models of care-giving and support. Contemporary examples include the Eden Alternative and the Green House models, which use a collaborative, whole-of-facility management system, with lower average sizes of facilities that we see in Australia.¹¹⁷ These models empower the staff through ‘flattened’ management

116. Larger facilities might have different zones in the building for the different types of residents.

117. The Eden Alternative model seeks to create culture change in aged care to enrich the lives of residents and staff by creating a home-like environment, with children, animals, and plants: Brownie (2011). The Green House model has small, self-contained, family style communal houses with private rooms and bathrooms. Trained staff are not categorised into roles, but are considered ‘universal workers’ who carry out a range of functions. Bitner and Franz (2017, p. 18).

structures that put the resident at the centre and involve residents and staff in decision-making.¹¹⁸

Smaller home-care settings can also lead to better health outcomes for residents.¹¹⁹ Smaller home-like residences need to be carefully designed. They need to have residents that are suitable together and they need to cater for the different care needs of each individual.

Regardless of the model, the most important factor is that older Australians, including those with very significant disabilities and limited means, should have choice – and not just be faced with one option of having to go into a large-scale residential facility.

The funding model for residential care is discussed in more detail in Chapter 3. The key elements are:

- Funding for care and everyday living and accommodation costs should be split, with clear accountability to ensure that care funding is spent on care.
- There should be no means-test for care funding.
- Everyday living and accommodation costs – the equivalent of rent and meals – should be income- and assets-tested.
- Payments to providers should be based on the characteristics of the resident according to their support plan.
- Payment arrangements for both care and, when subsidised by government, everyday living and accommodation should take account of economies of scale.

118. Brownie and Nancarrow (2013).

119. Afendulis et al (2016).

2.3 Coordination and integration with health care

Consistent with the principle that aged care should be multi-disciplinary, health care should be integrated into individual support plans. In Australia, health and social care is not well integrated. For example, people in a residential care facility find it difficult to get access to medical specialists.¹²⁰

A rights-based approach means that people in aged care should receive health care and disability support just like any other Australian. Health care integration means that a person should continue to be able to see their regular GP or specialist in an at-home or residential care setting, or elect to have their care managed by a new provider who will visit and care for them when needed.

The health system, through the Medicare Benefits Schedule (MBS), should make it easy for GPs, nurse practitioners, and specialists (such as mental health specialists) to give at-home care. It should be standard practice – supported by appropriate funding – that GPs and other health professionals visit residential facilities, including by tele-health where appropriate.

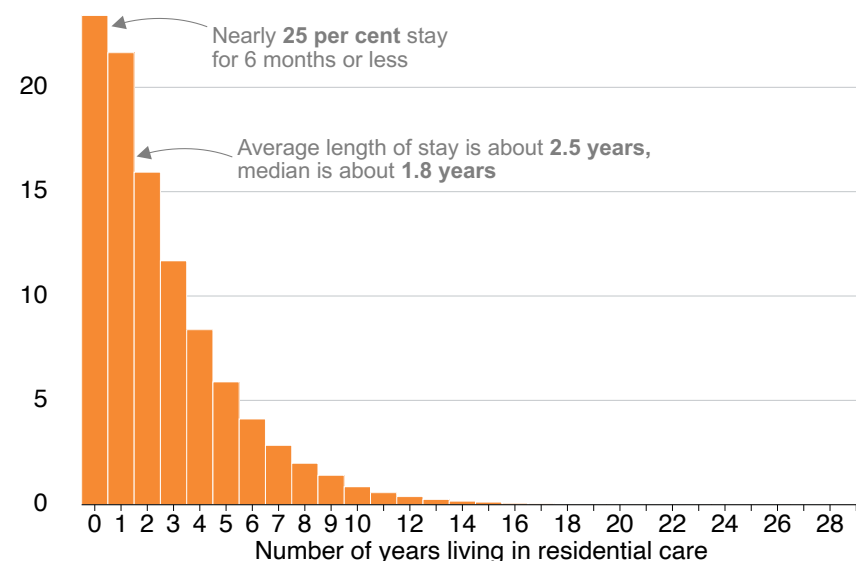
Residents should be able to choose and have ongoing relationships with their GPs.¹²¹ Where an older person has no regular GP, their support manager should help them choose a GP or primary care service, independent of the residential setting. Primary Health Networks (PHNs) could have a role in facilitating services which specialise in meeting the primary care needs of people living in residential care.

Support plans could identify funding needs for more intensive or specialised health needs, including chronic illness, end-of-life care,

¹²⁰.Dyer SM et al (2019).

¹²¹.The Public Advocate made a similar recommendation in a submission to the Royal Commission on Aged Care Quality and Safety.

Figure 2.3: Although many residents die within months of being admitted to residential care, others stay for many years
Percent of residents that died in 2018-19



Notes: This chart includes only residents who were admitted after the age of 65 years on a permanent basis. Although not clearly visible, 32 residents died in 2018-19 after living in residential care for between 20 and 30 years.

Source: Grattan analysis of Australian Institute of Health and Welfare (2020d).

and dementia. GPs are already able to claim for older people's health assessments, care planning, and review. And the 2019 federal Budget introduced a payment to GPs for patients older than 70 who are enrolled with their practice. The design of any benefit should encourage best-practice care for older Australians. These new arrangements could be extended to develop integrated payments for GPs, nurses, and allied health staff to provide team-based specialist support for older people.

2.4 Independent navigation and advocacy on a regional level

Older people need more consistent, accessible, and localised information and support to complement the My Aged Care portal. Entering the aged care system should be easy and simple. When the time comes that an older person needs extra support and care, they should be able to clearly understand what options are available that suit their needs. There should be a trusted and independent support-person available to help them navigate the system, preferably face-to-face.

A review of the NDIS found that when people have support to navigate their way through the system, they tend to get better results.¹²²

To provide structured and independent support, regional system managers should be established across Australia to be the local gateway for older people into the aged care system (see more in Chapter 4). They should provide an integrated, 'one stop shop' for all older people needing care, including for people in hospital who are likely to require long-term care. Regional system managers should employ 'support managers' who work one-on-one with older Australians and help them through the aged care system. They should not provide direct services.

122. Tune (2019, p. 44).

Care planning and assessment should be integrated and managed through regional system managers. An appropriately trained 'assessment officer' employed by the regional system manager should assess the older person's need, and help the person put together a support plan (see the care planning process in Figure 2.1).¹²³ The assessment officer should place an emphasis on explaining that older Australians have rights, including right to choice. Having assessment officers be independent, rather than employed by the provider, will help ensure older Australians are well informed and supported in planning and negotiating services. If consumers were better informed, poor-quality providers would be forced out of the marketplace.

Once the support plan is developed and agreed by the system manager, older people should have the option of appointing a support manager to help them negotiate and manage service agreements with providers to get the services agreed to in their plan. Support managers should be agents for older people, not for government. They should be employed by regional system managers, who would have a pool of diverse people that older people could choose from.¹²⁴ Importantly, support managers should train older Australians and their families in human rights and what it means for their care – including why supported decision-making, not substituted decision-making is important.¹²⁵

123. Giving professionally qualified and trained assessors responsibility for determining eligibility would reduce the administrative burden on applicants. Protocols, training, monitoring, and review processes could be used to ensure eligibility criteria are met, rather than forcing administrative separation of assessment and planning.

124. Separating this function from the assessment officer function would enable the support manager to act as an independent advocate for the older person and ensure they get the services they need.

125. Families must be involved in this process as they can undermine rights when making decisions *on their behalf*, which is not always consistent with the older person's wishes and preferences.

Regional system managers should have local knowledge of providers and be able to recommend the best support available for the specific needs of the older person. The support manager should provide information on local accommodation options and home-care services, costs, and quality. Support managers should help older people to manage administrative and co-payment requirements for services.

There may also be a need to refine the support plan in partnership with the chosen provider and the recipient and support manager for either home care or residential care and then approved by the assessment officer.¹²⁶

Although support managers would provide assistance with finding services, providers delivering services under the support plan would be ultimately responsible for delivering the support plan. This would include the actual service management, supervision, and coordination.¹²⁷ Regional system managers would regularly check-in with the older person, to ensure appropriate arrangements were in place and the support plan was being delivered.

The regional system manager should also assist with amending the support plan when the type and level of needs changed, and help review and monitor implementation of the plan when there had been significant over-spending or under-spending.

For entry-level services, relatively straightforward individual plans could be managed by older people or their carers. More complex plans would

require greater levels of coordination. Consistent with the principles of person-directed care, older people could choose the extent to which they wanted assistance with coordination.

Providers should be required to report to regional system managers on the hours and types of care delivered to individual users, satisfaction levels, and results (see more in Chapter 3 and Chapter 4).¹²⁸

2.5 Diversity of needs

Care planning and service provision should take account of people's diverse needs and preferences. This includes people who may have specific preferences and needs that reflect their identity and culture, such as people from culturally or linguistically diverse backgrounds.

Respecting diversity also means that the system should support people who place a high value on family and community involvement.¹²⁹ In particular, Indigenous Australians often favour assessment and service provision by organisations controlled by Indigenous people within their local communities.¹³⁰ To support these preferences, Aboriginal Controlled Community Health Organisations should partner with regional system managers to ensure that care planning and provision takes account of the cultural needs of Indigenous people.

2.6 Supported participation in community life

A rights-based model includes the right to independence and participation in society. Yet many older Australians live alone and are

126. This will be particularly important for residential care.

127. As soon as personal care and nursing was required (these are higher risk activities) and supervision and coordination was required, clinical governance requirements should apply. In some circumstances, where there are multiple service providers, one of the service providers would need to be assigned lead responsibility for service coordination, management, and supervision for all the services in the support plan. This should be the agency providing the nursing and personal care services.

128. This will require specific powers under the Act to compel the reporting of information.

129. Australian Institute of Health and Welfare (2019a, p. 148).

130. Broe (2019).

lonely.¹³¹ Societal ageism has meant that many older Australians are pushed out of sight, rather than integrated into community.

Under the Grattan model, older Australians should have much more opportunity to participate in community life – regardless of whether they are in supported accommodation or receiving support at home. For older people with a disability, this might require access to assistive technologies and/or support for home modifications not currently available under aged care programs. Older Australians should be viewed as valuable contributing members to society, and much more integrated into community life.

The regional system manager – and supported by a representative community advisory group – would play a key role in supporting this function. For example, the NDIS Local Area Coordinators not only assist people with disability to go through the care planning process, they also have employees working to build community participation of people with disability (see more on the comparison between the NDIS and the Grattan model in Table 2.1).

Regional system managers should not just have a reactive role; they should promote and enhance ageing in place. The system managers should engage in co-design with the community. They should work with, for example, local government and help create environments in local neighbourhoods that are better adapted to supporting older people – through transport, housing, social participation, and so on.¹³² Section 3.5 explains how programs to enhance social participation could be funded and administered at the local level.

131. Australian Institute of Health and Welfare (2018b); and Australian Institute of Health and Welfare (2019b).

132. For indicators of age-friendly cities, see: Davern et al (2020).

2.7 Adequate workforce to meet needs

An adequate supply of stable, well-trained, and committed staff is central to providing the support older people with impairments or disabilities need to live with dignity, independence, and respect.

Ultimately, aged care comes down to what happens between the carer and the older person. Quality care requires a quality care relationship. This requires time, skill, and an ongoing and meaningful, rather than a transactional, relationship.¹³³ Relationship-centred approaches to care would help avoid the commonly reported problem of carers and older people finding it difficult to form meaningful relationships with each other.¹³⁴ At a minimum, this requires:

- An adequate number of workers.
- Adequately-paid workers.
- Adequately-trained and supervised workers.
- Diversely-skilled workers.

As the Counsel Assisting the Royal Commission said:

Aged care workers do not need to be told they are heroes. They need better wages and conditions and enough colleagues to be able to complete their work safely and to the standard that they consider is appropriate.¹³⁵

Efforts to address workforce issues, including through the 2018 Aged Care Workforce Strategy, have had little success to date.¹³⁶ Change

133. Continuity of care is an important component of quality care. Older Australians have reported dissatisfaction with the constant change-over of carers. See Martin-Matthews and Sims-Gould (2008), Roe et al (2001) and Thomas et al (2007).

134. Bradshaw et al (2012).

135. Royal Commission into Aged Care Quality and Safety (2020a, p. 191).

136. The industry-led Aged Care Workforce Industry Council has not yet implemented the recommendations of the 2018 strategy, which were meant to have been

must be driven through much more funding for care (see Chapter 3) and improved governance (see Chapter 4).

Not only should the system get the basics right – such as better pay, better training, better career structures, minimum staffing ratios, and 24-hour nursing supervision – but it should shift to rights-based care delivery.

A rights-based care system should require all providers to have a dedicated human rights framework embedded into their organisation. All staff, not just carer staff, should be specifically trained in rights-based care.

The workforce must move from low-skilled, low-paid, insecure labour to a respected profession where well-trained carers support some of the most vulnerable people in society. A national registration scheme for all carer staff, including personal care staff, should drive a culture of excellence and peer review.

Over time, better work conditions should help attract more people into carer roles. Australia needs more carer workers now, and demand is expected to increase in coming decades as the population continues to age (see Section 3.9). In 2017, it was estimated that 29.4 per cent more personal care workers would be needed by 2023.¹³⁷ The number of aged and disabled carers required was projected to increase by 39.3 per cent, and nursing support and personal care workers by 11.6 per cent. By contrast, overall growth of 7.1 per cent was projected for all occupations.¹³⁸ These demand pressures can also be eased by better coordination across sectors such as health care and disability care.

2.8 Funding and regulating a right-based system

Older Australians should be supported by a rights-based aged care system. The next chapter sets out a new funding model for such a system, and Chapter 4 describes the governance model required.

implemented within one-to-three years: Royal Commission into Aged Care Quality and Safety (2020a, p. 192).

137. Department of Jobs and Small Business (2017, p. 21).

138. Ibid (p. 21).

3 A new funding and capital financing model

A new funding model for aged care is urgently needed. The current wasteful and irrational system, outlined in Chapter 1, should be replaced with a bottom-up system that ensures older Australians get the care they need and want.

A rights-based aged care funding system would recognise that older people have a universal right to aged support. Just like Medicare and the NDIS, universal access should be achieved through universal provision: the government should fund care of all older Australians who need support.

Funding should cater for each older person's needs and preferences. It should allow for more care at home and more diverse supported accommodation options. The money should be targeted, and used in a transparent manner. Public money that supports vulnerable older Australians should go towards care, not profits.

We estimate the Grattan model of aged care outlined in this report would cost the Commonwealth Government \$27.4 billion per year – about 35 per cent more than the \$20.6 billion the Commonwealth spends on the current system (see Figure 3.1 and Table 3.1).¹³⁹ In particular, about \$4.6 billion more will be needed for home care, to end the rationing that leaves some people waiting more than two years for support, and allows more people with higher-level needs to stay at home rather than going into residential care.

Recommendations 1: New funding model

A new Aged Care Act should:

- Introduce individualised care planning for assessment, planning, and funding of services, whether home care or residential, beginning with a trial in 2021, and rolled out nationally in 2023, at an estimated cost of \$600 million per year.
- Provide a universal entitlement to funding of 'reasonable and necessary' care outlined in individualised support plans, at an additional estimated cost of \$4.6 billion per year to cut the home care waiting list and provide higher-level support at home. The maximum amount payable for home care should be capped at the maximum the government would pay for residential care.
- Means-test non-care services in home care and residential care. In residential care, means-tested everyday accommodation costs should be paid by individuals through rental payments. Where government contributes to board and lodging, it should take account of economies of scale.

¹³⁹. Note this figure is an estimate of current spending based on the latest program user and subsidy figures available. The latest Commonwealth Government report only covers the period of 2018/19: Aged Care Funding Authority (2020).

3.1 Separation of care and everyday living costs

Before the 1997 *Aged Care Act*, nursing home funding was in two main components: a Care Aggregate Module (CAM), covering costs such as nursing salaries; and a Services Aggregate Module (SAM), covering meals, cleaning, etc.. The funding streams were separate and involved separate accountability. Importantly, if funding provided under CAM was not spent on care salaries, it was returned. There could be no cross-subsidies from CAM to SAM, or to the proprietor's profits.

The 1997 Act freed up staffing requirements and abolished the CAM-SAM distinction. But we argue that this distinction was a useful way to break-up funding for aged care.

We propose that aged care services should be defined into two categories:

- Care and support services: This covers services that support people with their frailty or impairment in old age. This includes necessary personal care, nursing, allied health, and supports for mobility, showering and bathing, dressing, social programs, assistance with shopping, and so on.
- Everyday living and accommodation: This covers supports that any other person regardless of their age would ordinarily pay for. This includes meals, gardening, cleaning, washing and ironing, basic home maintenance, accommodation, and so on.

3.1.1 Universal funding for care

The health and disability systems give Australians universal access to services on the basis of need.¹⁴⁰ For Australians to have this same

right in aged care, there should be universal access to independently-assessed, reasonable, and necessary care and support.

The government should commit to a goal that, when the new scheme is fully implemented, all people in those states who are at risk of being admitted to a residential aged care facility should have appropriate support within 30 days, and all other people should have reasonable and necessary support within 90 days.

Reasonable and necessary care costs should not be means-tested, in the same way that Medicare and the NDIS are not means-tested. Access to aged care should be based on need, not on people's capacity to pay. Applying means-testing to care costs could mean that vulnerable people, especially those just above income cut-offs, would miss out on needed care. Universal coverage for care has the advantage of spreading risk across the population.¹⁴¹

Importantly, our proposal covers only care services which are independently assessed as 'reasonable and necessary' – they cannot be unlimited. This puts an upper limit on services provided, to reflect community expectations that taxpayer money is efficiently targeted (see Section 3.3.1). And universal coverage should not extend to everyday living and accommodation costs, which should be means-tested (see Section 3.1.2).

There is public support for government paying the cost of care. A survey for the Royal Commission found that about half of respondents regarded the government as the most responsible for covering the costs of aged care services.¹⁴² The Counsel Assisting the Royal Commission in their final submission recommended that care costs

140. But note that universality under the NDIS is not provided to people aged 65 years and older.

141. Arrow (1963).

142. Roy Morgan (2020, p. 15). 28 per cent saw the older person responsible for paying.

should not be paid by older Australians, but by government, in both home care and residential care settings.¹⁴³

3.1.2 Means-testing of everyday living costs

Our proposal for universal coverage is not unlimited, and includes means-tested everyday living costs (see more at Section 3.7). Everyday living costs, such as cleaning and gardening, should normally be paid for by the older person receiving the service, just as they would have paid for it, or done it themselves, previously.¹⁴⁴

At present, means testing in home care is inequitable. The Commonwealth Government issues guidance, but in fact the level of consumer contributions is at the whim of the provider.¹⁴⁵

This should change to a consistent expectation of consumer contributions to everyday living and accommodation costs, and a standard means-testing policy. This more systematic approach to means-testing may increase consumer co-contributions for home care compared to today.

3.2 Financing options for universal coverage of aged care

Universal coverage for care services will require a significant boost to aged care spending. Under our model we estimate universal coverage

143. See recommendations 96 and 98, Royal Commission into Aged Care Quality and Safety (2020a).

144. Our proposal is likely to increase consumer contributions for home care and support, because the services which substitute for 'everyday living costs' become means-tested. We have not been able to estimate the size of this increase because of poor data on existing contribution arrangements.

145. For example, many home care providers are foregoing or reducing co-contribution costs. In 2018-19, co-contributions for home care amounted to only \$107 million – less than 5 per cent of the annual cost to government of \$2.5 billion: Aged Care Funding Authority (2020, p. 47). Similarly, co-contributions for the Home Support Program in 2018-19 were \$252 million, amounting to only 10 per cent of total government funding: Aged Care Funding Authority (ibid, p. 40).

coupled with better managed aged care would amount to a 35 per cent increase in government expenditure on aged care compared to today. And with an ageing population, there will be even more demand on the aged care system in the future (see Section 3.9).

Adequate financing for aged care presents a challenging situation. But, as we have demonstrated in this report, increased government spending on aged care is necessary to ensure older Australians have equitable access to care and to support vulnerable older people to continue living meaningful lives. We have indicated in our model some of the additional costs would be offset by users directly – through our more rational approach to means-testing.

In Australia universal provision is usually funded via taxation: this is how Medicare and the NDIS are funded. There are a range of options for expanding the tax base to raise the extra money needed for a high-quality aged care and support system, including the introduction of a hypothecated levy for aged care. Other options for financing aged care include the introduction of social insurance or private insurance for aged care, changes to income and assets tests, and changes to the treatment of tax concessions for superannuation.¹⁴⁶

We are not recommending any of these financing strategies, but endorse the principles that financing should be equitable, efficient and provide certainty and sustainability for the aged care system in the future. Financing for aged care should be considered as part of a broader Commonwealth Government consideration of taxation and retirement incomes.

3.3 Care funding should be linked to support plans

The amount of funding allocated to an individual should be determined by their individual support plan. The support plan should set out a

146. See Appendix B for a further discussion of funding options.

person's care and support needs that will help them achieve their goals (see more in Box 3 and Section 2.2). The plan should include both care services and everyday living and accommodation costs – with full coverage provided for the care component only, and means-testing for everyday living costs. This should apply in both home care and residential care settings.

3.3.1 Only reasonable and necessary services should be covered

A rights-based model requires that entitlement is defined not merely by clinical or health needs. 'Need' should be defined more broadly to consider what a person needs to live a meaningful life and pursue their goals.¹⁴⁷ This approach ensures that the concept of care and support is not narrowly viewed as warehousing older people to provide them with basic care to maintain their functioning. Care and support should allow them to live the life they want to live, as far as is possible.

A person's 'needs' should be 'reasonable and necessary'. This terminology is drawn from the NDIS, and is found in other compensation schemes in Australia.¹⁴⁸

147. This approach is similar to the NDIS, where people with disability receive supports that help them to pursue their goals, live independently if possible, and be included in the community as fully participating citizens: *NDIS Act 2013*, Section 3(d), Section 4(5), and Section 4(11).

148. For example, in state and territory motor accident lifetime care and support schemes: Tune (2019, p. 46).

Box 3: What should an individualised support plan look like?

The main purpose of support planning is to ensure that the older person has agency over their care, and that their care services meet their needs and preferences. The second purpose of a support plan is to determine the care services funded by the government. And the third purpose is to guide providers in their provision of accountable care.

Support plans should include:

- Personal information, including the person's daily life routine.
- A clear articulation of the person's goals and aspirations, and an outline of the physical and mental health supports needed to achieve each goal. Goals should not be limited to status quo statements such as 'maintaining physical health', but should promote rights-based goals that improve quality of life, such as to 'live independently'.
- List of family and friend supports.
- A list of community groups and non-aged care services (to help with coordination).
- A list of 'reasonable and necessary' services and care hours, categorised into groups such as 'Assistance with daily life', 'Assistance to participate in the community', and so on.
- A cost column referencing the regional pricing schedule and maximum allocation of costs per hour for each service type.

These plans should not be paper-based, but part of a secure software system so they can be stored and monitored by the regional system manager, and updated over time.

Reasonable and necessary services would be supports that address frailty, illness, and/or impairment that prevents older people exercising their rights to independence, self-fulfilment, and full participation in society.¹⁴⁹ The assessment should also take account of a person's needs based on their culture and identity.

3.3.2 Maximum service prices should be regulated

The cost of services in a person's support plan should be determined by the level (e.g. the number of hours of care) and the price (e.g. the cost per hour) of the service provided. Support plans should provide reasonable and necessary services at an efficient cost.

To ensure service prices are efficient, maximum prices for different service types should be regulated. Maximum prices should be set through an analysis of market conditions, regulatory requirements, and costs.

Maximum prices will therefore vary depending on the region and the type of service. For example, staffing and travel costs are likely to be higher in dispersed regional or rural areas than in cities. Similarly, home care will have significantly higher travel costs than residential care.

An appropriate schedule of service types should be developed, including travel and service coordination.¹⁵⁰ All fixed and variable service costs should be incorporated into the price.

149. According to the NDIS, reasonable and necessary services should represent value for money, be effective, and take account of family and friend carers and other government services provided to recipients and their families: NDIS (2019).

150. Travel time and costs will largely be relevant for home care services. Coordination time will be important for more complex care and support, particularly for home care where multiple service providers are involved.

This is not a simple or easy task, so the national system steward could provide a standard maximum fee schedule, and regions could then vary it according to their needs.

Providers should be permitted to compete on price and quality, to encourage high-quality, efficient service delivery.

Permitted reasonable and necessary service levels (i.e. hours of care) and fixed costs should be lower for larger, congregate care providers.

Maximum service prices should be permitted to vary between regions, with prices set by the relevant regional system manager.¹⁵¹ Where there is overlap with similar services provided under the NDIS, prices should be coordinated.

3.3.3 Service delivery and payment should be coordinated

Once an assessment and support plan has been completed, negotiations with available providers should lead to an agreement to provide the required types and levels of care.

The budget for the support plan should be determined by the level and type of services required, and the price agreed with providers within the maximum permitted prices.

Support plan funds should be held by the regional system managers and allocated through a budget which is paid prospectively and regularly reviewed.

151. Reasonable pricing schedules for hours can be set (as is the case under the NDIS). By including travel as a function, additional weighting for home care over residential care is not required (i.e. a travel time allowance can be included for home care). To ensure efficiency, any on-costs should be built into the hourly prices so that providers don't get a separate payment for administration and on-costs. Salary on-costs are usually 30-to-40 per cent, and administrative on-costs are usually 20-to-30 per cent. As a result, costs will range from \$40 per hour for cleaning to \$80 for nursing.

The delivery of services under the support plan could be managed solely by the older person (and their family), by a provider, or by the regional system manager,¹⁵² depending on the complexity of the services needed and the amount of support available from family and friends.¹⁵³

3.3.4 Service funding should be reviewed regularly

As a person's needs increase (or decrease), their support plan should change. Plans should be reviewed at least once a year, and more regularly if the older person and the provider agree. Reviews should be conducted by the regional system manager and the older person and their family. Budget variations of up to, say, 15 per cent should be permitted, to allow for temporary fluctuations in needs. Where greater variations occur, the regional system manager should update the support plan accordingly.

3.3.5 Managers should be accountable for expenditure

Regional system managers should oversee the delivery of and expenditure on support plans. An assessment officer should create the plan with the older person, and then a second assessment officer should review and approve it.

152. For simple support plans, the provider could be made responsible for coordination, with oversight from the regional system manager. These arrangements would have to be priced into the support plan.

153. For simple combinations of functions, there should be little need for coordination. For complicated plans, significant coordination and support may be required. When multiple providers are involved, it may be easier for the regional system manager to coordinate care.

To ensure national equity, the regional system manager must be accountable to the national system steward – discussed in the next chapter – for assessments and approvals.¹⁵⁴

To ensure equity and efficiency, support plans should be compared across regions. This could be done using activity-based funding methodologies. Although activity-based funding is not appropriate for determining the cost of an individual's support plan (see Section 1.4.4), the methodology should be used to monitor support plan costs across geographic populations and different levels of impairment and disability. Action should be taken where and when significant unexplained cost variations are detected.

Each person's support plan should be assigned to a category according to the person's attributes and needs.¹⁵⁵ This would enable the national system steward to compare the regional system managers in terms of:

- The distribution of support plans, to assess whether there is variation in the type of people receiving support; and
- The cost of support plans within each category, to assess whether people with similar needs are being provided with similar levels of support, regardless of where they live.

This analysis should enable the national system steward to assess whether variation is due to different pricing of services or different intensity of services provided.

To ensure services are delivered according to the support plan, providers should report regularly on the specific services and care

154. Regional system managers should record and submit data to the national system steward on their assessments and approvals.

155. The AN-ACC could be extended to include lower-intensity needs and potentially be used for this purpose, or another classification system could be developed.

hours delivered (see more in Section 4.6), and these reports should be monitored by the regional system manager.

3.3.6 Support plans should be portable across providers and care settings

Plan-based funding would allow for portability. Older Australians could more easily move between providers and, for example, between supported accommodation and their home.¹⁵⁶

More flexible accommodation funding combined with portable care funding should lead to the development of a broader range of accommodation options for older people. This could include social housing providers partnering with aged care providers to develop more community-based supported accommodation. It would also enable people to remain in settings such as retirement villages as they develop more complex care and support needs.

3.3.7 Home care funding should be capped at a higher level

With individual support plans, more older Australians would opt to receive care at home. But funding for home care should be equitable and efficient. A person's funding should be capped at the maximum funding allocated for residential care services. If a person needed more care than this maximum amount, they could still opt to stay at home if they had family or friends as support, or they could afford to pay out of their own pocket for carers.

3.4 Residential care funding

People who were being considered for residential care would have their needs assessed by the regional system manager. As part of

¹⁵⁶. If a person moved between home care and residential care, the relevant pricing schedule that applies would differ, to take account of economies of scale. See Section 3.3.2.

this process, the potential funding level would be identified. This independent assessment process would end the potential for gaming of classifications under the current system, where providers do the assessment.

Activity-based funding systems – such as the ACFI and the new AN-ACC – recognise that there is inherent variability in residents which cannot be explained by the classification system.¹⁵⁷ This variability doesn't matter if residents are allocated randomly to facilities and the facilities are large enough to absorb the random variation.

But as facilities start to specialise in particular groups, or the average size of facilities starts to reduce, it would be reasonable to replace the classification-based approach used in residential care with more personalised approaches based on individual support plans. This transition should be considered by the independent review we propose for 2025 (see Section 5.4).

3.5 A funding stream for social supports

Individual support plans for both home care and supported accommodation should specify the person's preferred social programs or activities. Providers would then be paid to facilitate the older person's participation in these activities. This might include helping the person to go to senior citizens centres, on recreational trips, and so on.

There should be a separate funding stream to foster social programs such as those outlined in Section 2.6 in each regional area. That funding stream should be administered by the regional system managers. The funding could provide grants to community organisations, local government, and businesses who run specific programs. It could pay for free programs for older Australians with limited means.

¹⁵⁷. Elissen et al (2020); and Commerford and Phelps (2018).

Regional system managers would specify grant criteria that suit their region's needs. Funded programs should demonstrate that they making people more independent and engaged, rather than just getting people together. The criteria should also specify that the organisation not only run the program, but facilitate transport and meals.

Grant money would cover costs of the program only, not fund the facility.

3.6 A funding stream for specialist care needs

In many cases, supporting a person's independence requires making sure they have access to assistive technologies and home modifications. New hospital-in-the-home and artificial intelligence technologies are likely to become a much larger part of aged care in future.

Older Australians should not have to pay for specialist facilities that they need because of their impairment, illness, or disability. A separate Commonwealth funding scheme should be available to cover the fixed, additional costs of specialist facilities required to meet needs beyond everyday accommodation and living expenses. This should include in-home equipment and facilities, and home modifications, including aids and appliances.¹⁵⁸ This should extend to specialist facility costs in supported accommodation settings.

Individuals or providers would seek funding for these specialist supports through the regional system manager, who could allocate grants provided the technology is reasonable and necessary according to a person's established support plan. Organisations currently

delivering aids and equipment through state-funded programs would instead be funded under this new national program.

3.7 Board and lodging in residential care

Although care services should be funded by government, everyday living and accommodation costs such as board and lodging should be paid by individuals. This is particularly relevant for supported accommodation settings, where accommodation and capital costs can be substantial. This section outlines how a new capital financing model could ensure accommodation costs are affordable for older Australians, while also ensuring the system is efficient and financially feasible for providers.

3.7.1 Residents should pay rent

When people choose residential care, they should pay for capital through rental-like payments.¹⁵⁹ The Refundable Accommodation Bonds (RADs) currently used may have previously been necessary to ensure access to capital – and it may still be the case that small or not-for-profit providers don't have a balance sheet which would support borrowing. But these capital market imperfections should be tackled directly rather than through opaque, complex, and inequitable subsidies from some residents to all providers.

Individuals should be required to make means-tested contributions for their everyday accommodation and living expenses. Means-testing should include both income and asset testing. Some or all of the value

158. This would include supports currently provided through the Commonwealth Home Support Program such as mobility aids, communication aids, reading aids, and car modifications. It would also supersede any state programs that currently deliver aids and equipment.

159. It may be appropriate to bundle rental and other 'lodging' payments, such as meals. The proportion of residents choosing to pay rental payments has increased over time. In 2018-19, 41 per cent of residents opted to pay Daily Accommodation Payments or Daily Accommodation Contributions. See Royal Commission into Aged Care Quality and Safety (2020c, p. 11).

of the home should be included in the assets means-test.¹⁶⁰ Funding for capital, facilities, and other fixed costs should be separated from funding for individual support plans.

Older people who need care services but are on low incomes and have few assets should have access to funding to provide them with appropriate housing options in addition to residential care. People on low incomes should be supported with means-tested government payments which should cover, in part or in full, the cost of a residential aged care room at a defined, 'acceptable quality' level. These Commonwealth accommodation subsidies for people on low incomes should be directed to individuals rather than providers, to help give older people choices about accommodation other than residential care.

People with low incomes but high assets should have the option to pay rent on an on-going basis or to have an equivalent value deducted from their estate after death (in which case the required payment would grow at the government's financing rate).¹⁶¹

Rental payments would vary according to the specific room and facility chosen. Rental costs for residents should be regulated so they meet the reasonable costs of capital financing as outlined in Section 3.7.2.

To avoid any supernormal profits being made on care funding of older people, there should be a regulated cap on the rate of return made on board and lodging.

160. For the case for including a greater portion of the home in the assets test for residential care, see Grattan's report 'Housing affordability: re-imagining the Australian dream': Daley et al (2018).

161. This follows Paul Keating's recently proposed 'HECS' model for aged care payments. Under his proposal, payments for aged care would be deducted from the resident's estate after departure from aged care. Payments would be paid up-front by the government to providers, and the balance would become a concessional loan made by the government to the resident. See Aged Care Quality and Safety (2020, P-9102).

3.7.2 Residential aged care is a social benefit, so government should support its capital financing

Phasing out RADs will require an alternative source of financing. Requiring providers to source their own financing at market rates would impose a significant interest burden on providers and compromise the viability of many, leading to a reduction in quality of care and accommodation across the sector. Some providers may be unable to refinance; the market has proved reluctant to finance residential aged care providers, especially smaller ones, who are often perceived as high-risk debtors.¹⁶²

In the absence of RADs, the financing problem may become too little capital rather than too much. Government should recognise this market failure with capital support through loan guarantees. The new capital financing model should recognise that residential aged care is part of the social infrastructure, and so government funding should be available to facilitate capital developments of both for-profit and not-for-profit providers.

Government should create a financing facility to fund capital investment in residential aged care – including land and buildings – through concessional loans, where the facility's funds are raised through government bonds. Providers should be able to apply to the facility for capital loans, which would finance new facilities, facility upgrades, and repayment of RADs (to enable a smooth transition to the new model).¹⁶³ As a loan facility, it is cost-neutral to government. And the risk-burden is unchanged, given the government already guarantees RADs.

162. Royal Commission into Aged Care Quality and Safety (2020c, p. 9).

163. A similar model is in place with the National Housing Finance and Investment Corporation (NHFIC), which serves as an instructive precedent. See the *National Housing Finance and Investment Corporation Investment Mandate Direction 2018, Part 3*.

Government financing should be based on normal prudential requirements and business cases – ideally assessed locally – to ensure the government's risk is minimised and the investment meets community needs and aged care policy goals.

To ensure viability, business cases should include realistic estimates of local demand for residential care. Government guarantees should be contingent on the proposed development meeting social obligations, including a specified minimum threshold of places being available for pension-eligible residents. They should also be weighted towards supporting diversity in supported accommodation types (see Section 2.2.2) and geographic spread, including lower-SES areas, regional and rural areas, and so on.

Residents' rental payments should be linked to the government's cost of financing, enabling the government to recover principal and interest costs of any financing facility grants over the course of the asset's life.

The proposed new arrangements are fair to both providers and consumers because capital costs are covered. However, they are not as generous to providers as the current arrangements, because the providers would no longer accrue all the benefits of the interest-free RADs.

If other policy initiatives were implemented – especially expanded home care – there would be reduced demand for residential care,¹⁶⁴ and so market pressure would reduce the ability of providers to pass on to consumers increased charges in an attempt to restore their previous position.

¹⁶⁴. Pattyn et al (2020).

3.7.3 Rental payments should take account of economies of scale

Many costs of providing residential aged care decrease with size of the facility, a phenomenon economists term 'economies of scale'.¹⁶⁵ However, payments by government and residents do not vary depending on the size of the institution, meaning that profits – or surpluses for not-for-profit organisations – increase with the size of the facility. To the extent there is information about quality, it appears that smaller facilities tend to provide better care.¹⁶⁶ The current policy is perverse, whereas the Grattan model would reduce the incentive for ever-increasing sizes of residential aged care facilities.

We propose splitting care funding and board and lodging funding for residential aged care (Section 3.1). The extent of economies of scale differ between the two types of services. There may be only limited economies of scale for care provision, because care needs are individual. Even where group services are provided, say for activities, groups are likely to be capped at 20-to-30 people.

On the other hand, there are likely to be significant economies of scale for board and lodging: although the kitchen for a facility of 100 residents is likely to be significantly larger than the kitchen for a facility with 30 residents, it is unlikely to be more than three times the size. The cost of building for 100 residents is likely to be lower per place than for 30 residents, and similarly cleaning costs, cooking costs, and so on.

At present all of the financial benefits of economies of scale accrue to the provider: neither government nor residents benefit from lower board and lodging payments.

¹⁶⁵. For example: McNamee et al (2019, pp. 12–13) shows that smaller facilities are associated with higher cost per occupied bed day.

¹⁶⁶. See for example: S. M. Dyer et al (2018).

Grattan's proposed new aged care system would change that. Where government contributes to the board and lodging payment because the resident has insufficient means, the government contribution should be reduced for larger facilities. Similarly, regional system managers should encourage and expect larger residential aged care facilities to pass on economies-of-scale benefits to residents.

3.8 Care planning and coordination costs

The costs of planning and coordination should be funded separately to care services. Regional system managers should be directly funded to provide information, assessment, planning, and care coordination (see Table 3.1).

Assuming about 30 regional system managers with 40 staff per region, system management and contracting of services would cost about \$150 million per year.¹⁶⁷

Each regional system manager would employ a large team of assessment officers and support managers to support older Australians to access and manage care.¹⁶⁸ This would cost about \$600 million per year.¹⁶⁹

Each region should have an aged care team of about 200-to-250 people, costing about \$25 million per year. This amounts to \$750 million per year nationally.

167. Assuming that 40 staff members on average receive \$90,000 per year, with 40 per cent additional funding to cover overheads. We also discount 30 per cent of the costs from the current National Aged Care Commission, because some of the national body's functions would be moved regionally.

168. Estimated to be about 180 people employed per region.

169. This is assuming that the number of support hours per year vary according to the complexity of care, with an average cost of \$50 per hour (with an additional 40 per cent on top to account for overheads). The total amount also takes account of the cost savings of abolishing the Aged Care Assessment Teams (ACATs). See Appendix A.

Each region would be monitoring about \$900 million in payments to providers. Therefore, these governance costs make up less than 5 per cent of total aged care costs, which is reasonable.

3.9 Future growth

Unlike earlier generations, today Australians have a reasonable expectation that they will live well into old age. Over the past 100 years, Australians' living standards have improved, public health measures have been introduced, and better health care, including immunisation, has been developed. Deaths from infectious disease have consequently declined dramatically.

As a result, the population is ageing. In 1900 about 4 per cent of the population was 65 or older. By 1977 it was 9 per cent, and by 2017 it had grown to 15 per cent (3.8 million people).¹⁷⁰

It is important to recognise that most Australians will enjoy a healthy, active life into their 70s and 80s. Nonetheless, spending needs to significantly increase as Australia's population ages.¹⁷¹

Older Australians are expected to make up about 20 per cent of the population within the next two decades as the 'Baby Boomer' generation reaches older age.¹⁷² This means 2.5 million more Australians than today will be aged 65 and older.

Estimates suggest that if current spending per person is kept constant and adjusted for increased life expectancy, total spending on health and aged care will need to at least double by 2035 to keep up with population ageing.¹⁷³ This does not take account of any unmet need,

170. Australian Institute of Health and Welfare (2018b).

171. Australian Institute of Health and Welfare (2018c).

172. Ibid (Figure 1).

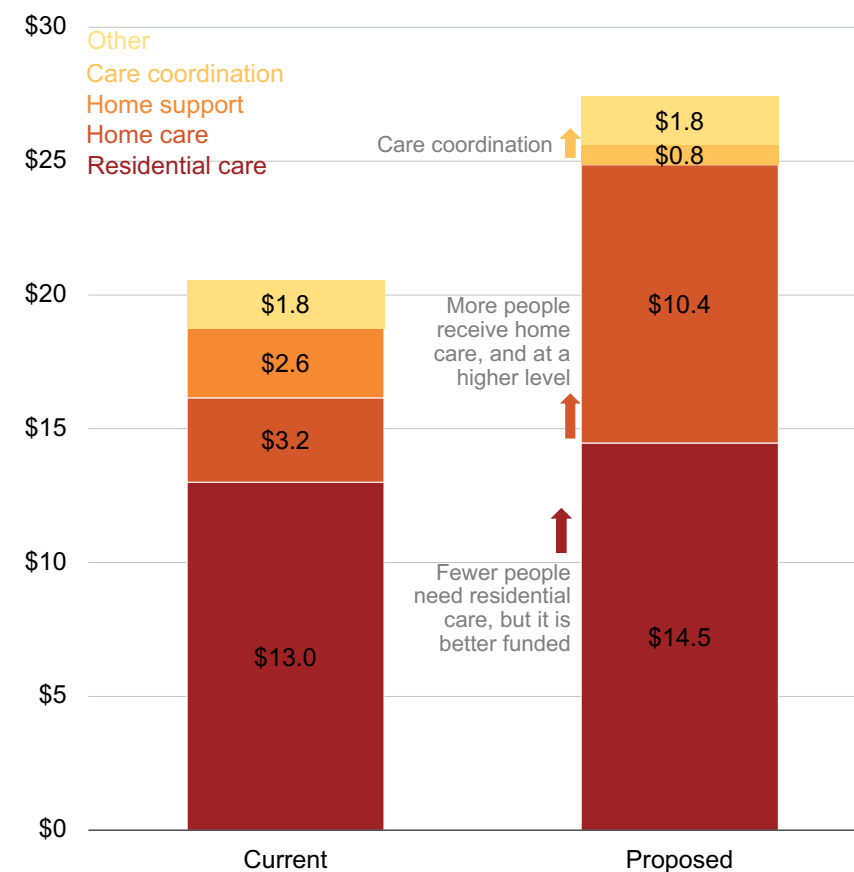
173. Harris and Sharma (2018).

Table 3.1: Estimated costs under our proposed new system

Category and assumptions	Annual cost
<i>Home care</i>	\$10.4b
<ul style="list-style-type: none"> Current users and everyone on the waiting list receives care at their assessed level <ul style="list-style-type: none"> CHSP users supported at the same level, but those on the home care waiting list receive home care Administrative costs are lower at 25 per cent More high-needs people receive home care <ul style="list-style-type: none"> 33 per cent needing less than 20 hours of residential care per week and 16 per cent needing between 20 and 25 hours receive home care 50 per cent increase in care hours for those that receive home care instead of residential care 	
<i>Residential care</i>	\$14.5b
<ul style="list-style-type: none"> Residential care funding is increased by 20 per cent for all ACFI levels to take account of improved care needs and more staffing (bring all facilities up to 3-star rating) Fewer people receive residential care as per the above home care assumptions 	
<i>Regional system managers</i>	
<ul style="list-style-type: none"> Service system management: 30 regional system managers employ 40 full-time staff each 	\$150m
<ul style="list-style-type: none"> Care planning: regional system managers undertake care planning for all recipients in each region, minus current cost of Aged Care Assessment Teams (ACATs) 	\$600m
<i>Other costs</i>	\$1.8b
<i>Total new system cost</i>	\$27.4b

Figure 3.1: Our proposed new system would cost more, but it would provide better care and support

Annual Commonwealth Government spending on aged care, billions



Notes: 'Other' includes flexible aged care and other smaller aged care programs and costs. Under the proposed model, home support is merged into one stream called 'home care'. The costs for both 'current' and 'proposed' reflect the latest spending data for each program. This is 2018/19 data for home support, March 2020 data for home care, 2019/20 ACFI subsidies for residential care.

Source: Grattan analysis, see Appendix A.

or increased community expectations, or reductions in the availability of informal support.

The Aged Care Financing Authority projects spending to increase to more than \$25.4 billion by 2022-23.¹⁷⁴ And the latest Treasury Inter-generational Report in 2015 projected that government spending on aged care was projected to increase to 1.7 per cent of GDP in 2055, which is up from 1.2 spent currently.¹⁷⁵ 1.7 per cent of GDP in 2054/55 is equivalent to \$80 billion (in 2014/15 dollar terms).

Under our proposed new system, funding needs will be even greater. As this report shows, a significant boost to spending on aged care is urgently needed today. However, some of this load will be eased by the stimulus effect of investing in aged care. Government spending in care industries creates jobs and helps reduce female economic disadvantage (see Section 5.2.2).¹⁷⁶

3.10 Regulating the new system

The new funding model outlined in this chapter will, over time, change Australia's aged care system for the better. But the funding model must be underpinned by a strong governance model, as outlined in the next chapter.

174. Aged Care Funding Authority (2020, p. xi).

175. The report noted that the dominant influence on aged care spending will be the growing number of people aged over 70, reflecting the government's commitment to provide 125 places per 1000 people aged over 70. See The Treasury (2015, p. 71).

176. Dixon and Hodgson (2020).

4 A new decentralised governance model

Aged care needs a new governance approach. The current governance system is overly centralised and has failed to ensure adequate accountability. It has failed to prevent the abuse and neglect of older Australians in the aged care system.¹⁷⁷

This chapter outlines a new governance model and accountability mechanisms that should be enshrined in a new Aged Care Act. We propose a national ‘system steward’ that sets the performance and regulatory framework for the whole system, with regional ‘system managers’ operating the system and advocating for older Australians.

Even with state offices, the existing Canberra-focused system is too remote to hold providers to account. Under the Grattan model, regional system managers would provide a much-needed personal touch. They would look providers in the eye and make them directly accountable for the provider’s recommendations about care.

Regional system managers would coordinate and negotiate access to services for older Australians. They would monitor the system in their region, overseeing providers and commissioning new services where there is a gap in the market. They would help coordinate and integrate non-aged care services, including health care.

This more decentralised governance structure should help uphold the rights of older Australians. National rights-based quality standards would be set and enforced, with additional focus on ensuring providers deliver services according to people’s individual support plans.

Recommendations 2: New governance model

The new Aged Care Act should:

- Establish a new statutory agency, the ‘Australian Aged Care Commission’, to act as a national system steward of overall performance and equity by 2023.
- Establish 30 new independent bodies across Australia for defined geographic areas that act as regional ‘system managers’ of the local service system, monitor quality, and enhance social participation and healthy ageing by 2023, at an estimated cost of \$150 million per year.
- Introduce comprehensive rights-based quality standards, and a national registration scheme to ensure carer staff are sufficiently trained and supported (with minimum staffing ratios and 24-hour nursing supervision for residential care) by 2023, at an increased estimated cost of \$1.5 billion per year for residential care.
- Create a new public reporting system that better monitors and provides information on the quality of service providers, to maximise people’s choice.
- Sign Commonwealth-state agreements and regional agreements with system managers to better integrate healthcare, housing, and related welfare services, by 2022.

177. Royal Commission into Aged Care Quality and Safety (2019b).

4.1 New governance model

A new governance model should be enshrined under a new Aged Care Act (see Section 5.1.5).¹⁷⁸ The governance model should split responsibilities to ensure checks and balances are in place. A national system steward should set the framework, and regional system managers should operate the system. Our proposed governance model is depicted in Figure 4.1.

The national system steward should be an independent statutory body. The regional system managers should be independent from government and providers. This would promote transparency, accountability, and efficiency in the delivery of aged care services, and enhance community trust. Independence will ensure regional system managers can appropriately advocate for and support the rights of older Australians in their region.

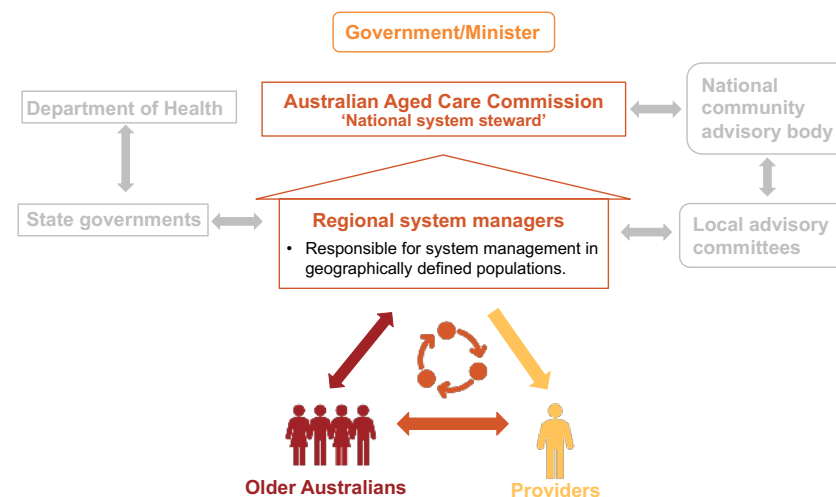
4.1.1 National system steward

The Australian Aged Care Commission,¹⁷⁹ or ‘national system steward’, should have responsibility for overall system functioning, and oversee regional system managers (see Section 4.1.2). The key responsibilities of the national system steward should be to:

- Manage overall system functioning according to the principles and rules under the Aged Care Act, including setting and/or varying quality standards and setting the rules for new entrants.¹⁸⁰

- Monitor compliance with national standards through the work of regional system managers, and publish comparative performance data.
- Oversee regional system managers, including their regulation of provider performance, equity of assessment processes, pricing of regional system services, and ensuring the effectiveness of service system management (see Section 4.1.2).
- Provide a second line of defence for accountability and enforcement.
- Be responsible for workforce planning, including setting of minimum workforce standards and training requirements under a new workforce register.

Figure 4.1: The Grattan governance model for aged care



178. See Grattan's previous report, which argued that system reform must start with a new Aged Care Act: Duckett et al (2020).

179. As proposed by the Counsel Assisting the Royal Commission in their final submission: Royal Commission into Aged Care Quality and Safety (2020a, p. 69).

180. The Aged Care Act would set the rights based-framework, rules, and quality standards.

The national system steward should be an independent statutory agency, with a governing board directly responsible to the relevant Minister. The governing board should have a diverse skills-base, including people with experience in aged care, regulation, and generic governance skills. Boards should include people with lived experience receiving aged care and support.¹⁸¹

The current Aged Care Financing Authority and the Aged Care Quality and Safety Commission should be incorporated into this new overarching governing agency. This should coincide with a shift in the culture, capability, and competency of the current national bodies. The national system steward should also be responsible for supporting any independent national oversight bodies representing the interests of older people.

The Department of Health should continue to have a role in providing policy advice to government and the national system steward. It should also oversee the whole system and ensure aged care policy is more integrated with disability and health care policy. This means the role of the Department would be more limited than now, because many operational functions would be devolved to regional system managers.

An independent and competent Australian Aged Care Commission would help restore community confidence in the aged care system. The Department does not have a good record of ensuring good governance or accountability (see Chapter 1).¹⁸² As well as providing a much more prominent point of accountability and stewardship for the aged care system, the Commission should be a trusted, non-partisan voice for older people who need aged care services.

181. Or caring for people who receives care and support.

182. The Counsel Assisting the Royal Commission in their final submission said that 'the Department of Health has been an ineffective system governor'. See Royal Commission into Aged Care Quality and Safety (2020a, p. 66).

Box 4: Defining 'stewardship' and 'system governance'

We use the term 'steward' to define the national body's role in setting the regulatory framework for the system, ensuring compliance, establishing the roles and functions of different actors, and adjusting the system in response to monitoring and feedback.^a **Stewardship** is 'an explicitly ethically based, outcome-oriented policy approach'.^b It is designed to prevent market failure and manage markets for social purposes. For vulnerable populations, stewardship ensures the rights of individual participants are protected. As with market models, individual agency and choice remain central, but stewardship manages markets to ensure they are more fully realised. Stewardship takes account of the need for the system to achieve broader social goals such as equity of access, quality of provision, and efficient service delivery.

System governance is the application of the regulatory framework and market interventions to ensure individual rights are protected and social goals are achieved. Within stewardship models, governance usually requires the establishment of intermediaries which act with and for individual users within the framework designed by the system steward. This is where regional governance should be established to ensure regional and local responsiveness, individual choice, and variations in provision in line with the different needs of different populations, as outlined in the next section.

a. Duckett and Willcox (2015).

b. Saltman and Ferroussier-Davis (2000).

4.1.2 Regional system managers

The new Aged Care Act should establish regional governance, by conferring responsibilities on independent ‘regional system managers’ (see Figure 4.1). Regional system managers should be given specific responsibilities by the national system steward to implement its framework. This would include planning, monitoring, and managing aged care services for specific geographically defined populations. The key responsibilities of the regional system managers should be to:

- Regulate, monitor, and maintain relationships with service providers (see Section 4.6).
- Pay providers and manage service expenditure by setting maximum pricing schedules, holding funds, and monitoring expenditure under support plans (see Section 3.3.5 and Section 5.1.3). This would include financial risk monitoring and prudential regulation, including approving capital loans for residential aged care (see Section 3.7.2).
- Provide older Australians with personalised help to navigate the system, including care planning and assessment (see Section 2.4).
- Support community and social programs to enhance participation of older Australians in the community and promote healthy ageing in place (see Section 2.6).
- Commission and manage the local service system, including issuing accreditation certificates (see Section 4.2).
- Coordinate the integration of services, including health care, housing and welfare services (see Section 4.4).

Regional governance is required to ensure a detailed understanding of community need and diversity, service delivery, referral patterns, and interactions between service providers. Regional system managers

should understand the diversity of different geographic populations, and develop and maintain relationships with providers to plan, commission, monitor, and manage service delivery on behalf of older people.

Regional system managers should cater for specific community needs in each region. This would involve engaging with the community and managing the service system in regional or remote settings, or partnering with Aboriginal Controlled Community Health Organisations, and other relevant organisations, to ensure care planning and provision takes account of different cultural needs.¹⁸³ Regional system managers should ensure that when needed, interpreters are involved in the care planning process.

Regional system managers should be big enough to ensure they can manage the system in their local area while still being able to maintain relationships with service providers and provide personalised support to local older people who need services.

Regional system manager governance should be responsive to their community, reflecting the region’s diversity. Regional system managers should be independent corporate bodies with a governing board. Board members should have a mix of skills and experiences relating to aged care, health care, and so on, older people with ‘lived experience’, as well as generic governance skills. To ensure independence, the board should include both Ministerially-appointed and directly-appointed members.

Government should consider enhancing Primary Health Networks (PHNs) for this purpose.¹⁸⁴ Australia has 31 PHNs. They have

¹⁸³ Indigenous Australians often favour assessment and service provision by organisations controlled by Indigenous Australians within their local communities: Broe (2019).

¹⁸⁴ Stephen Duckett, a co-author of this report, chairs the board of Eastern Melbourne Primary Health Network, and Hal Swerissen, another co-author, is a member of the board of Murray Primary Health Network.

responsibility for primary care service integration and have developed capability in population needs assessment, service planning, commissioning, service monitoring, contract management, and community engagement. If PHNs were designated as the new regional system managers, there should be a requirement that their boards be significantly reformed to include people with skills and experiences in understanding the needs of older Australians – and expanded capacity and emphasis on aged care.¹⁸⁵

Employees of the regional system managers should undergo a training program and be certified to deliver these functions with strong oversight by the national system steward. Training should ensure they are competent regulators, and a mix of employees should have strong commercial and management skills, and experience in aged care, health care, and social work. They should have to declare any conflicts of interest, and be held to a set of ethical principles that ensure their independence and integrity in carrying out their responsibilities. This would help mitigate the risk of regulatory capture. Importantly, those working face-to-face with older Australians should be good with people.

Competent assessment officers and support managers are absolutely essential to ensure people receive the high quality care they need. If the assessment and care planning is of poor quality, the older person should be able to raise issues with the local or national community advisory group to get support and hold the regional system to account.

Regional system managers should be accountable to the national system steward for the protection of older people's rights and the quality of the services provided to older people. Regional system managers should be monitored, and their costs reviewed, by the national system steward, using activity-based funding methodologies

185. A mixed model could also be considered where augmented PHNs are the regional system managers in some regions and new organisations have that responsibility in other regions.

to ensure equity in their approach to developing individual support plans (see Section 3.3.5). Their management of the service system and accreditation of providers should also be reviewed by the national system steward.

If a regional system manager continues to fall short, even after attempts by the national system steward to improve their performance, the system steward should have the ability to intervene including appointing an independent adviser to the board or transferring funding to another organisation.

4.2 Managing the service system

The current aged care service system is not functioning as an effective market (see Section 1.7). The rhetoric of rights to choice and control is useless if good-quality services are not available and there is no good information upon which to base choice. There is a crucial role for government to manage the service system to ensure older Australians' have diverse options of services available.

Service system planning and management requires:

- Commissioning or stimulating the creation of necessary services where they don't exist locally.
- Accrediting providers who operate in their local service system.

Individual older people and their carers cannot develop and manage the local service system to make sure it meets their needs. There are significant risks in leaving subsidised consumer choice and provider competition as the main mechanisms for ensuring needs are met, particularly for vulnerable consumers and in geographic areas where there are service shortages. There are now well-developed commissioning models for aged care services that include planning, priority setting, procurement, contract management, and evaluation. Commissioning models are designed to manage market relationships

between providers on behalf of older people so they have choice and their rights to high-quality, efficient, and equitable services are protected.¹⁸⁶

Regional system governance is needed for market management, to identify and rectify market failure. While regional system managers should be accountable to a national system steward for their performance, they should be required to develop and manage the service system on behalf of older people with an agreed national framework. They should be accountable to government for the quality and performance of the providers of services to older people in their region.

Regional system managers should have the capacity to intervene when markets don't work well. For example:

- Where there is insufficient demand for services (e.g. in geographically dispersed populations), viable services need to be developed.
- Where barriers to market entry are low (e.g. home care services), commissioning of new service agencies must be managed to prevent inappropriate or poor-quality service delivery.
- Where public-good service system capacity needs to be built, including workforce, infrastructure, and information technology that benefits all users and providers, market intervention is likely to be necessary.

The ability to intervene in the market, and the extent of any such intervention, should be governed by a national framework set and overseen by the national system steward. This framework should

set rules and guidelines on how regional system managers can intervene.¹⁸⁷

Service system management needs to be regionally-based because there are significant risks associated with market intervention and transactional contract management by national agencies far removed from individual users and providers. These include overly bureaucratic and slow decision-making. This can lead to inequity, poor quality, inefficiency, and a loss of independence, sovereignty, and choice for people who need aged care. Regional devolution of market intervention is likely to help mitigate these risks.

To ensure regional system managers have oversight of both the quality and type of service provision in their region, they should also be responsible for assessing and issuing audit certifications to all service providers in their region, including new entrants (see Section 4.6.1).¹⁸⁸ Although the audit requirements should be set nationally, they should be implemented regionally to take account of the service system needs.

4.3 Community representation

Any reform to aged care should involve much greater emphasis on listening to older Australians. This will help realise the rights of older Australians.

A national community advisory body on policy and funding reform should be established.¹⁸⁹ It should be made up of a diverse and representative group of older Australians. It would directly advise the Australian Aged Care Commission, the Department of Health, and

186. European Commission (2016); and Jasper et al (2019).

187. See for example the NDIS Market Enablement Framework: National Disability Insurance Scheme (2018).

188. This would replace the functions of the Aged Care Quality and Safety Commission.

189. J. Ibrahim (2020).

the Minister. It could also provide independent oversight of the system governance functions.

Each regional system manager should also establish an aged care community advisory group, made up of a diverse group of older Australians (both those receiving and not receiving aged care services).¹⁹⁰ They could advise on investment in social programs, advancement of healthy ageing in place, and act as another pathway for older Australians to make complaints. They could also organise participation activities and community visitation programs to reduce social isolation and increase connection in care facilities. These committees should then collectively report to a national advisory body.

These community advisory groups should help enhance the voice of older Australians, and work in collaboration with a better funded National Aged Care Advocacy Program that enhances advocacy support for older Australians, and helps train and support community representatives.

4.4 System coordination

As set out in Section 4.4, there must be much greater coordination of other non-aged care services in aged care, including health care, disability, and social work. Regional system managers should help coordinate these services within the local service system.

But the roles and responsibilities of state/territory and local government need to be clarified, particularly for area-based systems management and advocacy. This could be achieved through strengthened Commonwealth-state bilateral agreements on coordinated care. The states have responsibility for acute health care and a range of primary

care, housing, and welfare services that support older people. The Commonwealth has principal responsibility for primary care, aged care, and income support for older Australians.

Commonwealth-state bilateral agreements should enforce system integration across acute, primary, and long-term care services. This should involve development of area-based planning and coordination, and of service models, data and reporting systems, payment systems, and regulatory arrangements. A key focus should be reducing the number of avoidable hospital admissions from residential care.

System reform should include specific regional agreements between the Commonwealth Government, state/territory governments, and regional system managers to better coordinate and integrate aged care, health care, housing, and related welfare services to support older people to live independently and participate in their community.

4.5 A rights-trained and supported workforce

The national system steward should set much higher standards for a supported aged care workforce. This must go hand-in-hand with better funding for aged care.

A national registration scheme for carer staff should be established to mandate training and foster a culture of excellence and peer review. Registration should mandate minimum and ongoing training and development. A national training framework should be developed that individuals must be registered against. This could be a stand-alone statutory registration scheme for aged care workers, or be merged as part of existing registration systems for healthcare professionals. The registration should also include professional ethics standards and rights-based obligations. The scheme must include personal care attendants who do not fall under any existing registration program.

190. Diversity is particularly important to ensure that people from diverse backgrounds, identities, or sexual orientation can feel supported in raising issues or concerns with the group.

Importantly, there should be mandated training to develop competencies in human rights and its practical implications for all staff employed by a provider. For example, how to support the right to autonomy by allowing people to take reasonable personal risks,¹⁹¹ and the limited circumstances where restrictive practices can be used. It must also include mandatory training to develop competencies in culturally-appropriate care-giving.¹⁹²

Personal care attendants should have at least a Certificate III in personal care (ideally Certificate IV). Care staff supporting people with complex needs or providing care at home should at least have a diploma. And nursing and allied health staff should have degree-level qualifications.

These new training requirements would mean vocational education providers, including government and aged care service providers to work with TAFEs, and universities to enhance existing courses or develop new ones. The quality of the training is paramount. The existing oversight of vocational education by the Australian Skills Quality Authority should be supplemented to ensure that Certificate graduates actually have the certified competencies in practice and to ensure there is not unscrupulous expansion of certification programs that provide low-quality care.

191. J. E. Ibrahim and M.-C. Davis (2013). See also South Australia's *Ageing and Adult Safeguarding Act 1995*, Section 12(e) which says the right to autonomy should take preference over safety concerns to the extent that it is reasonable and doesn't harm others. This is the case even when others may regard it as wrong, reckless, or inappropriate.

192. Government should also specifically require that Aboriginal and Torres Strait Islander people are cared for by their own people. This means providers (both residential and home care) should have a specific focus on providing culturally appropriate care and living environment. See Counsel Assisting submissions that stressed the importance of culturally appropriate care: Royal Commission into Aged Care Quality and Safety (2020a, pp. 166–190).

Different levels of registration and opportunities to increase skills should embed a career structure for carer staff, and this should be adequately reflected in a higher pay scale.¹⁹³

To avoid barriers to entry, people with no training should be supported by the provider through on-the-job training to complete a Certificate III.¹⁹⁴ Providers should pay for any further training of care staff needed to meet the new standards under the new Aged Care Act.

Accreditation standards under the new Aged Care Act (see Section 4.6.1) should also embed stronger workforce requirements into the accountability system. Accreditation should require:

- Competent providers with an appropriate mix of skills and expertise, including demonstrated commercial and management skills, and a commitment to human rights (i.e. a probity test).
- Providers have a human rights framework with an organisational objective to uphold older Australians' rights through the provision of quality care.¹⁹⁵
- All carer staff be registered under a national registration system.
- Providers demonstrate appropriate supervision and support structures for carer staff, including 24-hour supervision by a registered nurse in residential care.¹⁹⁶
- Minimum staffing ratios, and mix of staff in residential care.¹⁹⁷

193. This may also require changes to Enterprise Bargaining Agreements.

194. Providers could be linked up with the educational institutions to deliver the formal training component, with care staff holding an interim registration before receiving full registration on completing the course.

195. The national system steward should develop a standard template for a human rights framework.

196. Xerri et al (2019).

197. See recommendations by the Counsel Assisting: Royal Commission into Aged Care Quality and Safety (2020a). Staffing ratios must be adequate to ensure quality and rights-based care: Harrington and Edelman (2018).

4.6 Rights-based accountability

Under a rights-based aged care system, the objective of the accountability mechanisms is to hold all actors to account for their role in fulfilling the rights of older Australians. Importantly, accountability needs to take account of the power imbalance between parties. Older Australians receiving care are particularly vulnerable, and their voices are often drowned out by the interests of providers and government. A rights-based approach can turn this dynamic around and ensure older Australians have voice and choice.

Our proposal requires accountability through accreditation to meet minimum standards, and to deliver services according to older Australians' individual support plans. This must be underpinned by enforcement – with much stronger consequences for providers that fail to meet their commitments. The regional system manager is responsible for both accrediting providers and monitoring support plans. Where the regional system manager fails to resolve issues with a provider within a specified time, the national system steward should step in to investigate and issue sanctions, including potential loss of accreditation. These sanctions should be embedded in the new Aged Care Act.

4.6.1 Accreditation of service providers

A set of quality standards should set out 'non-negotiable' requirements for service delivery, particularly rights-based standards that require providers to uphold older Australians' choice and dignity. These standards should not be vague statements – they should be underpinned by a data-driven approach to measuring quality care.¹⁹⁸ Comprehensive quality metrics should be measured and regularly reported (see Section 4.6.3).

198. Duckett and Jorm (2018).

Regional system managers should approve and regularly review service provider adherence to these standards. They should regularly check-in face-to-face with providers, including home care providers, to ensure they are upholding rights-based standards.¹⁹⁹ But compliance should not only be achieved by random inspections (important though these would be), but also through a partnership model. This means that regional system managers would have a relationship-based interaction with providers and work collaboratively with them to lift quality of care. In this sense, regional system managers would be a 'critical friend' to service providers.

4.6.2 Accountability to the support plan

Providers must not only be answerable for meeting quality standards, but also for delivering support plans. And there should be consequences for providers that fail to deliver.

An individual support plan would be the contract between the provider and an older person to make sure they get the services they need to live the way they want to – even when they are very frail, ill, or disabled, or in residential care.²⁰⁰

To ensure services are delivered according to the support plan, providers should report on the specific services and care hours delivered. For home care, this should be part of the payment schedule. There must be regular reporting against support plans, with appropriate monitoring and accountability by the regional system managers.

To prevent providers exploiting the support plan model, there must be rules for any variations to the support plan. Regular reviews of support plans would provide a mechanism for older Australians to say whether

199. Robertson (2020, pp. 7–8).

200. Note that older people must have control over who sees and accesses their plans and should have the ability to limit who can see certain information.

they are happy with the services being delivered according to their plan.

4.6.3 Data-driven monitoring and transparency

United States Supreme Court Justice Louis Brandeis famously said:

Publicity is justly commended as a remedy for social and industrial diseases. Sunlight is said to be the best of disinfectants; electric light the most efficient policeman.²⁰¹

Australia's aged care system is in sore need of such a disinfectant.

If choice is to be a key element of the aged care and support system then meaningful choice needs to be supported, and this means publishing much more information about the quality of care and support provided. Much more information should be available publicly that allows people to make better choices. Box 5 lists examples of the kinds of information people want – yet don't have readily available – when they are looking for supported accommodation options.

There should be a mandatory public reporting system released online that has information about each service provider. It should be managed by the national system steward and apply to all providers – both home care and residential.²⁰² The reportable information should be listed under regulation, with consequences for inaccurate reporting. The public reporting system should include the organisation's accreditation report – containing information about their rights-based governance policies and training requirements for staff. It should also have information about the provider's history on meeting quality standards,

and how any problems were rectified, and steps taken to enhance dignity and autonomy of older Australians.²⁰³

A star rating system for staffing should be introduced,²⁰⁴ with the star rating for each facility published on the public reporting system, and facilities which are not rated as four or five stars asked to show cause why they should continue to receive government funding.

Quality metrics should also be measured by user and carer staff surveys. High-level survey results should be publicly released, to provide information to the community about the performance of providers.²⁰⁵

But quality metrics should be more comprehensive.²⁰⁶ The current quality measures include only unplanned weight loss, pressure injuries, and physical restraint.²⁰⁷ An expanded set of metrics should focus more on quality-of-life and health outcomes, such as mental health measures, time spent in bed, and responsiveness of staff.²⁰⁸ Safety is crucial, but focusing on safety indicators can undermine older Australians' rights to make decisions for themselves.²⁰⁹

203. For example, demonstrated training of carer staff, and family and residents, about rights: J. E. Ibrahim and M.-C. Davis (2013). Training should make clear the legal responsibilities of care providers.

204. See US star rating system explained in Eagar et al (2019).

205. Monitoring quality metrics can also be useful for improving care practices: J. Ibrahim et al (2014).

206. J. Ibrahim et al (2014); and Inacio et al (2020).

207. Falls and major injury and medication management are set to be added in 2021 under Australia's National Mandatory Quality Indicator Program. Research conducted for the Royal Commission shows that Australia could report on more quality indicators in line with best practice in other countries: Caughey et al (2020).

208. See, for example, metrics used in nursing homes in the United States: US Agency for Healthcare Research and Quality (2019); US Centers for Medicare & Medicaid Services (2020).

209. Regional system managers should monitor the measurement against indicators, to ensure providers do not report inaccurately.

201. Brandeis (1914).

202. Not enough information is gathered about home care, so specific measures may be needed to address this: J. Davis et al (2017).

Box 5: Questions to ask when seeking supported accommodation

Ms Merle Mitchell AM, a resident living in a facility in Victoria, recommends asking these questions when choosing a residential care facility:^a

- What are the resident-staff ratios for morning, afternoon, and evening shift?
- Do you have a bank of casual staff?
- How often do you have to use agency staff?
- How well does your laundry service work? Are there always towels for people to use for their morning showers? When do the fresh towels get distributed?
- What are your two top priorities for the provision of residential care?
- Can I see a menu?
- Do you provide palliative care and, if so, how?
- Are all rooms private, or are some shared?
- What is your activities program?
- How well do you deal with individual needs?

a. Mitchell (2020).

Public reporting should also include reporting on complaints and serious incidents, and how they were managed or resolved.²¹⁰ Although a rights-based system should not rely on complaints to find poor practice, an effective complaints mechanism is still very important – not just for older Australians but also for carers, family, and friends. Regional system managers – as the regulators – should be the first port of call so they can follow-up on complaints and investigate where appropriate. The local community advisory or representative body of older Australians could provide another, and perhaps more trusted, pathway for making complaints. Non-compliance should be escalated to the national system steward if necessary.

The collection of data – whether publicly reportable or used by the regulator – could also be made easier through advances in technology, such as using QR (Quick Response) codes.

4.7 Phasing in new arrangements

This new governance model should shift the aged care system to a much more localised approach. Older Australians should feel empowered that they have an advocate supporting them in receiving care, and they have a diversity of choices available. Stronger accountability and transparency should ensure the market is properly regulated, so that vulnerable older Australians cannot be exploited.

Some of the changes can and should be made immediately – such as improved transparency. But other changes will take time to phase in, because the new model requires the establishment of regional bodies across Australia. The next chapter shows how the transition should work in detail.

210. See recommendation 4 of the National Legal Response to Elder Abuse: Australian Law Reform Commission (2017, p. 10).

5 A staged transition to a new system

This report shows that Australia's aged care system needs transformational change. But transformational change will not, indeed should not, occur overnight.

Aged care is a big industry, and big changes are needed. Introducing much better governance, a new rights-based approach to care planning and support, revised funding, and recruiting and training staff will all take time.

We recommend the new system be introduced in three stages between 2021 and 2023, with a fourth stage – of review – scheduled for 2025 (see Table 5.1).

Some changes can be introduced quickly, others will take longer to phase-in. The first priority must be older Australians who are waiting for care, and people in care who are at risk because of poor staffing and oversight. For them, urgent action is necessary.

We also recommend a big funding boost (see Figure 3.1 on page 48). Without this, any reform to aged care will fail – and the system will continue to fail older Australians. Research shows that nearly 90 per cent of Australians think the government should spend more to support quality aged care.²¹¹

5.1 Stage One: action in 2021

In 2021 the government should:

- Start phasing-in new home care arrangements.
- Urgently improve the quality of residential care where residents are at risk.

²¹¹ Ratcliffe et al (2020, p. 3).

- Establish independent price setting for residential care.
- Introduce new transparency requirements.
- Develop a new rights-based Aged Care Act and system. This should be overseen by a non-statutory Aged Care Transition Authority.
- Start workforce reform by developing more stringent staffing and training requirements and a better career structure.
- Develop a new funding model to pay for aged care reform.

5.1.1 Start the reform of home care and support

The proposed new aged care and support system requires a new framework for individual care planning, and uncapping access to necessary home care. Opening up home care access is the right place to start, not only because it is the compassionate thing to do, but because it will save money and enable more older Australians to stay at home longer.

Given the scale of change required, the new system should be trialled before being rolled out Australia-wide. We suggest implementing the new scheme in South Australia and Tasmania in the second half of 2021, with an assessment of progress and problems in the second half of 2022, and wider roll-out commencing in 2023. This timetable would provide the opportunity to systematically refine major changes to the governance, program, funding, and delivery of aged care. It would allow time to build capability in leadership, management, staffing, and administrative systems.

We suggest South Australia and Tasmania as the initial sites because they are small enough to be manageable, but large enough to have a

Table 5.1: Grattan's plan for a three-year transition to a new aged care system

Stage	Home care	Residential care	Governance
Stage One – 2021 'Urgent action'	<ul style="list-style-type: none"> • Merge home support and home care programs • Start phasing-in new home care arrangements, with trials in Tasmania and South Australia 	<ul style="list-style-type: none"> • Establish a temporary \$1 billion rescue fund to improve the worst-performing residential aged care facilities, contingent on recovery plans • Move residential care price setting to the Independent Hospital Pricing Authority 	<ul style="list-style-type: none"> • Develop a new rights-based Aged Care Act, overseen by a non-statutory Aged Care Transition Authority • Introduce a new era of transparency, with a compulsory public reporting system of provider quality • Start workforce reform, with new training programs • Develop the funding model to pay for aged care reform
Stage Two – 2022 'Phase-in'	<ul style="list-style-type: none"> • Review the trial phase of individual service planning for home care 	<ul style="list-style-type: none"> • Review rescue fund implementation 	<ul style="list-style-type: none"> • Introduce and pass new Aged Care Act • Implement new workforce reforms through the Aged Care Act, and establish a national workforce register • Sign Commonwealth-state bilateral agreements for system coordination, and make changes to Medicare
Stage Three – 2023 'Roll-out'	<ul style="list-style-type: none"> • Introduce a new system of individual service planning for home care, with national roll-out of regional system managers • Make funding portable across residential and home care 	<ul style="list-style-type: none"> • Separate care and everyday living expenses funding, with all new residents paying rent (not Refundable Accommodation Deposits, or RADs) • Establish a new government financing facility for capital investment 	<ul style="list-style-type: none"> • Establish the Australian Aged Care Commission as a statutory body • Establish 30 regional offices across Australia as 'system managers', and sign tripartite agreements for system coordination • Introduce new rights-based standards and explicit minimum staffing standards, and accredit providers against these
Stage Four – 2025 'Review'	<ul style="list-style-type: none"> • An efficiency audit by the Australian National Audit Office • An independent review of the new aged care system, drawing on the audit findings and other information 		

mix of urban, rural, and remote populations. They also have substantial Indigenous populations and people from culturally and linguistically diverse backgrounds.

Phasing in individual care planning

A key role for the regional system managers will be individual care planning. This will replace the purely assessment function of the existing Aged Care Assessment Teams (ACATs). As an interim step, the Regional Assessment Services/ACATs in South Australia and Tasmania should be augmented with additional assessment officers and support managers for home care and support.

Merging the Commonwealth Home Support Program and Home Care Packages

The existing Commonwealth Home Support Program has no statutory basis. It is governed by a Program Manual. So changes can be made to the Manual, in advance of a new Aged Care Act. We recommend individual support plans be developed with older Australians in South Australia or Tasmania who need home care or home support. The assessment teams should work with existing providers – including existing providers under the Commonwealth Home Support Program – to implement the support plans. If new providers are required, these could be contracted by the relevant ACAT (or its auspicing agency).

In this initial phase of roll-out, the fees previously charged by agencies funded under the Commonwealth Home Support program or who provided Home Care Package services would be rolled over and paid under the new program. There would be some harmonisation of fees – taking into account cost, quality, and accessibility – during implementation.

Uncapping home care and support

About 9,000 people in South Australia and Tasmania are waiting for Home Care Packages. The government should commit to a goal that all people in those states who are at risk of being admitted to a residential aged care facility should have appropriate support within 30 days, and all other people should have reasonable and necessary support within 90 days.

This should not involve new ‘packages’, because these are inefficient and no longer fit-for-purpose. Rather, the Commonwealth should commit sufficient funds, equivalent to what would have been required to clear the South Australian and Tasmanian waiting lists, and allocate those funds to the support of older Australians as specified in the individual support plans. Existing funds for the Commonwealth Home Support Program should be re-allocated to the assessment teams as people transition out of existing arrangements.

Moving on means-testing

The South Australian and Tasmanian phase-in should also involve rationalisation of means-testing for home care. As we have argued, care should not be means tested but everyday living expenses should be. This should be introduced as soon as possible, in a consistent way across the two states, not reliant on the whim of the service provider.

5.1.2 Improve the worst-performing residential care facilities

Urgent action is needed to lift quality in some residential facilities where residents are at risk. The federal government should set up a \$1 billion rescue fund to lift standards in the lowest-performing facilities.²¹²

212. This is based on lifting the 11 per cent of poor performers identified by University of Queensland research: University of Queensland (2020).

An upfront assessment should first determine whether a facility can transform (or is viable longer term), or whether it should be sold or closed. The government should then require approved facilities to receive rescue support to produce a recovery plan, outlining how they propose to meet the expected standards by the middle of 2021.

The rescue fund should be used to make sure the plans are implemented. Access to the fund should be tightly scrutinised, so the money goes to upgrading staffing, not to greater profits for owners.

The new funding and regulatory system should ensure facilities can't continue to operate if they provide risky, poor care. The rescue fund is therefore a temporary measure, to protect older Australian who are at risk right now. All facilities should operate under the new system from 2023.

5.1.3 Set service prices for residential care

Under the new system, regional system managers will be responsible for setting and managing pricing schedules for their region. The Australian National Aged Care Classification (AN-ACC) system is used for residential aged care funding, but prices need to be set independently of the regulator.²¹³

We propose that price setting under AN-ACC should be done by the existing Independent Hospitals Pricing Authority.²¹⁴ IHPA has the expertise to understand pricing methodologies, and is well placed to extend its functions to aged care. But it would need to establish a separate aged care stream or aged care advisory committee to incorporate specialist understanding of the aged care market, which

213. This function will be needed for at least three years while the regional system managers are established and plan-based price schedules are developed for residential aged care.

214. Stephen Duckett has been a consultant to IHPA and sits on several of its advisory committees.

is very different to the health care market. The make-up of the IHPA board would need to change, to incorporate aged care expertise.

5.1.4 Impose new transparency requirements

Starting in 2021, the federal government should publish information about the performance of both home and residential care providers. This should include information about complaints and the organisation's response, full accreditation reports, and quantitative information about care (see Section 4.6.3).

The information should be provided in a way which allows easy comparison between providers. It should be provided to home and residential care providers from March 2021 to enable services to make necessary changes. The information should be made public from September 2021 and updated every six months thereafter.

5.1.5 Develop a new Aged Care Act

The existing Aged Care Act is fundamentally flawed. A new Act is a necessary precursor to implementing a better aged care and support system.

Developing a new Aged Care Act should be a participatory process, especially engaging older people and their carers, and high-quality providers. Developing the new system, and the new legislative framework, will be a complex process. It should not simply be delegated to a new section within the Department of Health, but rather should be the responsibility of a new, higher-profile group, established under the auspices of the Department but functioning as a quasi-independent non-statutory Aged Care Transition Authority.

5.1.6 Start workforce reform

Workforce planning must start immediately to begin setting the expectations and frameworks for a higher-skilled and better-resourced aged care sector. Planners should consider workforce demands and standards in overlapping sectors, such as disability under the NDIS.

The timeline and the expectations for workforce reform should be outlined immediately, to allow vocational education and higher education providers time to develop new and improved training programs, and build their capacity to respond to increased demand.

Planning should then feed into the workforce specifications set down in the new Aged Care Act in 2022.

5.2 Stage Two: action in 2022

In 2022 the government should:

- Introduce and pass the new Aged Care Act.
- Implement workforce requirements under the new Act, and establish a national workforce register (see Section 4.6.1).
- Sign Commonwealth-state bilateral agreements for system coordination, and make changes to Medicare for better healthcare integration and at-home support (see Section 4.4).

5.2.1 A new Aged Care Act

The new Aged Care Act should be developed in 2021, for introduction and passage in the Autumn 2022 session of parliament.

The new Act will be crucial to authorise the phasing out of superseded arrangements and the introduction of new funding systems for a rights-based approach.

In our timeline, most changes that require different legislation are scheduled for 2023.

5.2.2 New workforce requirements

Addressing training needs will take time, as will phasing in a new career structure. As part of implementation of the new Aged Care Act, the government should specify the timetable for establishing the minimum staffing requirements, the new national workforce register, and the new staff training and certification expectations. The first priority will be to make it mandatory that all personal care workers have Certificate III training – with providers responsible for up-skilling existing staff who don't have that training.

A new career structure will need to be supported by increases in Commonwealth care subsidies. These should be phased in from the 2022 Budget. There should be audit and accreditation requirements, to ensure the money for better staffing is not diverted into the pockets of proprietors.

By the third year, more workers – both system managers and carer staff – will be needed to deliver the new service system. An increased investment of \$7 billion dollars per year in aged care will help drive this job creation. We estimate that this could amount to about 70,000 new jobs, with these jobs spread over more than 70,000 people, because most who work in aged care work part-time.²¹⁵

215. This is a generous estimate based on \$100,000 annual salary per person (including on-costs). Currently, personal care attendants get \$36,000 per year (although not necessarily full-time) and make up about half of the direct care workforce, and registered nurses get about \$70,000: Mavromaras et al (2017, p. 27).

5.3 Stage Three: action in 2023

By 2023 the new Aged Care Act should have been proclaimed, allowing more substantial changes to be implemented. In 2023 the government should:

- Implement a new system for national and regional governance (discussed in Chapter 4).
- Introduce new rights-based quality standards and explicit minimum staffing standards for residential care. The new registration and pay structure should be phased in from 2022. The second element of the staffing reform requires statutory authorisation and should be phased in from 2023. This should include requirements for all residential aged care facilities admitting residents with complex needs to have on-site registered nurse supervision at all times.
- Separate care and domestic support funding across both residential and home-care services (see Section 3.1).
- Start phasing-in the new residential care funding (capital and economies of scale). RADs should be phased out as residents die or move to a different facility.²¹⁶ The government financing pool should be made available so providers can begin making applications for financing where needed as RADs are phased out.²¹⁷ At the same time, all new residents to residential care facilities should make rental payments (see Section 3.7).

216. It may be appropriate to set a maximum phase-out, say five years, to simplify system covenants. At the end of this period existing RADs would be bought out.

217. The financing pool must be large enough to retire existing RADs as residents leave residential aged care. This sets the minimum size of the fund at \$30.2 billion (the current stock of RADs). This figure does not represent an increase in risk for the government, since RADs are already guaranteed by the Commonwealth. Nor does it represent an increased interest or long-term debt burden, because residents' rental payments will fully cover the government's costs.

- Introduce a new system of individual service planning for home care (see Section 3.3).
- Make funding portable across residential and home care (see Section 3.3.6).
- Introduce tripartite agreements between the Commonwealth (or the national system steward), regional system managers, and state governments on service system coordination and integration (see Section 4.4).

5.4 Stage Four: review in 2025

The proposed changes to the aged care system are transformational. They will require detailed consultation as part of their development, but also independent evaluation to ensure that the problems that have been identified by the Royal Commission have indeed been addressed.

We propose two forms of review in 2025: firstly an efficiency audit by the Australian National Audit Office to provide detailed and independent assessment of the processes of implementation against the goals that were established, and secondly an independent review of the new aged care system, drawing on the audit findings and other information.

5.5 Long-term cultural change

Transformational change of Australia's aged care and support system will take years. Establishing a new framework that empowers older Australians will require a cultural shift that will take even longer.

The goal should be that older Australians are not filled with dread when they need care – but instead they are filled with hope that they can get the support they need to continue living a meaningful life.

Appendix A: Methodology for estimating aged care reform costs

This report calls for several improvements to the current aged care system, including removing the cap on Home Care places, increasing the amount of care people in residential care facilities receive, and introducing personalised support plans for older Australians receiving care.

This appendix details the three-step method we use to estimate the cost of our reforms:

Step 1: Unitise care parameters

- Collect data on the current distribution of older Australians across the Commonwealth Home Support Program (CHSP), Home Care Packages Program, and residential care, including the level (home care package or ACFI level) of care they receive, and the subsidies applied to each level;
- For each home care package and ACFI level, estimate the average number of care hours delivered per week under the current system;
- For both home care and residential care, estimate the cost of delivering one hour of care.

Step 2: Estimate the new distribution of aged care users (and the care they receive) under Grattan's reforms

- Estimate the effect of clearing the current home care waiting list on the number of users in each package, and the secondary effects on CHSP uptake.
- Assume a subset of people in residential care will move to home care under the improved model, and these people may need

additional hours of care at home compared to in a residential care facility.

- Optimise home care expenditure to allow an increase in care hours delivered.

Step 3: Calculate the funding required to support Grattan's reforms

- Estimate the care cost of the reformed system;
- Estimate the cost of providing and maintaining support plans for all care recipients;
- Estimate the cost of system administration conducted at the local level;
- Calibrate costs to actual reported costs.

A.1 Step 1: Unitise care parameters

A.1.1 Collecting distribution and subsidy data

To begin, we collected information on the number of people in home care and residential care.

For home care we used the Department of Health's Home Care Packages Program data report 1 January-31 March 2020 to extract the number of people currently in each package level, the number of people who are in interim packages (by their assessed level), the number of people waiting for a package, and the annual subsidies for each home care package.

For residential care we used *GEN data: People using aged care (March 2020)* to extract the number of people using residential aged care.

We then use the *GEN data: Care needs of people in residential care (March 2020)* to collect the number of people in each ACFI category.²¹⁸ The Aged Care Financing Authority's *Eighth Report on the Funding and Financing of the aged care industry (July 2020)* provides the data for ACFI subsidy by level for each of the three ACFI categories (BEH, ADL, and CHC). This report also provides information on the number of people using the CHSP and the average amount received. The data is manipulated into three categories to make a 'care distribution table' with the following items:

- Care Level (ACFI level or home care package)
- Care Type (residential, home care or CHSP)
- Number of Recipients

A.1.2 Converting care levels into care hours

We then converted home care package levels and ACFI levels into care hours to equilibrate the units for home care and residential care (see distribution in Figure A.1). This allows us to see the distribution of actual care provided across both programs and to easily 'move' people between the two.

To do this we use StewartBrown's determination of the average hours of care provided per week in both home care and residential care. We then scale the average hours of care within each program to find an estimate of the average hours of care provided for each package level. For home care, the StewartBrown average hours of care (A_{hc}) is scaled by the relative subsidy of each package. The formula for the average

hours, H , assigned to each package level 1 through 4, L , is:

$$H_L = \%S_L \cdot \lambda$$

where $\%S_L$ is the annual subsidy S_L for home care package level L as a proportion of subsidies for all home care package levels:

$$\%S_L = S_L / \sum_{L=1}^4 S_L$$

The scaling constant λ is the relative subsidy of each package, given by:

$$\lambda = A_{hc} \cdot \sum_{L=1}^4 (User_L) / \sum_{L=1}^4 (U_L \cdot \%S_L)$$

where $A_{hc} = 4.32$ hours per week²¹⁹ is the average number of care hours delivered per week to each home care recipient, and U_L is the number of people (users) receiving a home care package.

For residential care we scale StewartBrown's hours of care average (A_{res}), by the Relative Value Unit (RVU) assigned to each ACFI level.²²⁰ This yields the following expression:

$$H_{ACFI} = A_{res} \cdot RVU_{ACFI}$$

219. StewartBrown (2020, p. 35).

220. Relative Value Units developed by the University of Wollongong for the Royal Commission into Aged Care Quality and Safety, provided to Grattan by the Royal Commission. Because our data was more recent than what the RVU's were based on, the RVUs were scaled so that the average amounted to one, so that it matched the current data set.

218. Note that the latter spreadsheet contains 6,378 fewer entries than there are people in residential aged care. These people are treated as if they receive the mean ACFI subsidy and are manually added to the data.

where $A_{res} = 3.23$ hours per day²²¹ is the average number of care hours delivered per day to each residential care recipient, and RVU_{ACFI} is the Relative Value Unit (RVU) assigned to each the ACFI level, where ACFI is a combination of the resident's CHC, BEH, and ADL assessments under the ACFI methodology.²²²

The *care distribution table* is updated to include an additional category:

- Care Level (ACFI level / home care package) (L , $ACFI$)
- Care Type (residential / home care / CHSP) (hc , res , $CHSP$)
- Number of Recipients ($Users_L$, $Users_{ACFI}$)
- Hours of Care delivered ($Hours_L$, $Hours_{ACFI}$)

A.1.3 Calculating the cost per care hour delivered

Next, we find the dollar cost of delivering an hour of care in home care and residential care.

For home care, the cost per care hour, $CPCH_{hc}$, is calculated as:

$$CPCH_{hc} = \frac{S_L \cdot \%CE}{H_L}$$

where care expenditure $\%CE = 68\%$ is the percent of home care package funds that are spent on care (the remainder is spent on administration and coordination).²²³ Note that the choice of package, L , does not affect the calculation.

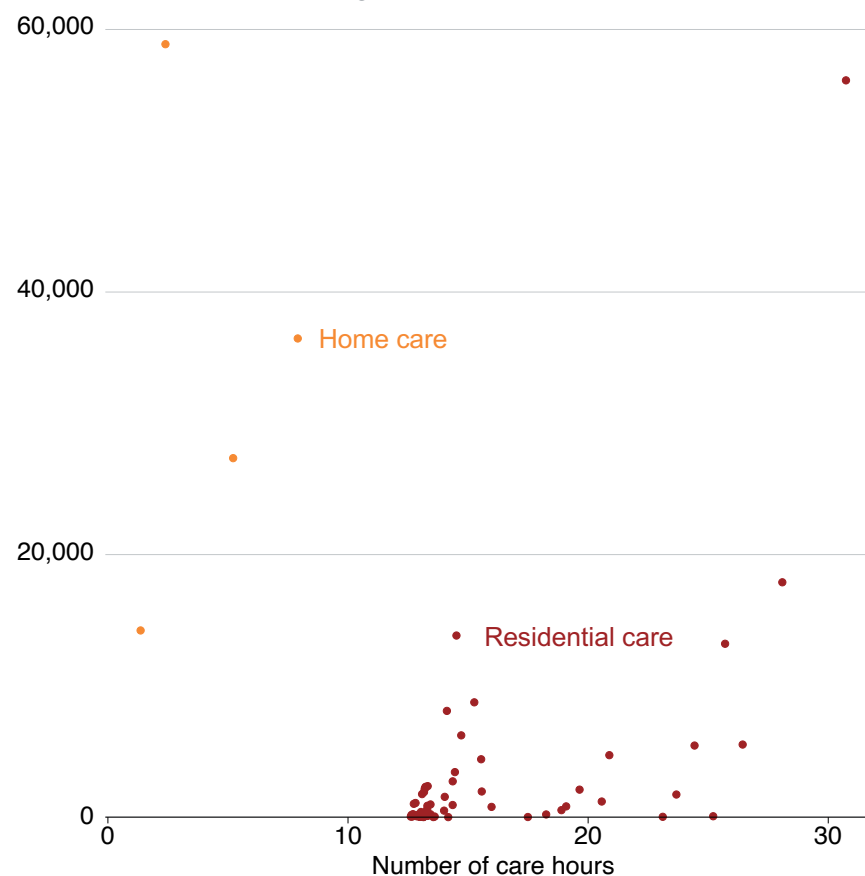
221. StewartBrown (2020, p. 16).

222. ADL = activities of daily living; BEH = behaviour (BEH); CHC = complex health care.

223. Aged Care Funding Authority (2020, p. 48).

Figure A.1: Distribution of care hours per week

The number of people receiving home care or residential care at different home care levels or ACFI ratings



Source: Grattan analysis of AIHW data and StewartBrown reporting of average care hours.

For residential care the cost per care hour, $CPCH_{res}$, is calculated as:

$$CPCH_{res} = \frac{ACFI}{U \cdot A_{res} \cdot (365/7)}$$

where Total ACFI expenditure $ACFI = \$11,286.2$ million, the 2018-19 government expenditure on ACFI;²²⁴ and the number of users is $U = 188,772$ is the number of people in residential care at June 2019.²²⁵

A.2 Step 2: Estimate the new distribution of aged care users (and the care they receive) under Grattan's reforms

A.2.1 Estimating the effect of uncapping home care places

We assumed that there is no unknown latent demand for home care; that is, all people who currently need home care are on the waiting list.

This is a conservative assumption because many people currently apply early for home care due to the long waiting list. We are also proposing means-testing everyday living expenses, which may decrease demand for government-funded home care.

We have costed clearing the waiting list as an ongoing cost, not once-off. There are about 140,000 users of home care packages today, and just over 100,000 people on the waiting list – which means we costed our model at a total of 240,000 person years of home care each year. This means that if the waiting list was cleared in 2020, based on the median length of 18 months that people stay in a package,²²⁶

224. Ibid (p. 71).

225. Australian Institute of Health and Welfare (2020e).

226. The median length of stay varies by package. For people entering in 2016-17, the median was 18 months for level 1, 21 months for level 2, 14 months for level 3, and 18 months for level 4. The average across the four levels is 18 months, and this may have increased since then, because a three-year trend from 2015-16 to 2017-2018 shows that median length of stay is increasing. See Aged Care Funding Authority (2020, p. 24).

there would be the equivalent of 120,000 person years of use in 2021. Each year, about 110,000 extra people are assessed as needing home care across the four levels.²²⁷ So, that means there would be about 230,000 person years of home care needed in 2021 – slightly less than the estimated 240,000 figure costed.

We determined the impact of uncapping home care on the number of people in each package level.

We start with the current number of users in each package, U_L .

We then take the number of people who have been approved for a package at level L , but have not received any package, $NoPackage_L$ – or are currently in an interim package, $Interim_L$.

Due to data constraints, we do not have exact information on which interim package users are receiving while they wait for a package at their approved level. To combat this, we assume that 50 per cent of those in an interim package are receiving a package one level below their approved package, and 50 per cent are receiving a package two levels below their approved package.²²⁸

227. This is based on the average number of people assessed each year for home care over the past 3 years, reported in quarterly reports. See for example: Department of Health (2020a).

228. 100 per cent of people who are in an interim package while waiting for a Level 2 package are assumed to be receiving a Level 1 package.

This gives the following expression for the uncapped estimate of users in each package level, $Uncapped_L$:

$$\begin{aligned} Uncapped_L &= Users_L \\ &+ NoPackage_L \\ &+ Interim_L \\ &- 0.5 \cdot Interim_{L+1} \\ &- 0.5 \cdot Interim_{L+2} \end{aligned}$$

Where $Interim_{L+1}$ and $Interim_{L+2}$ are the number of people on an interim package who are approved for a package 1 and 2 levels above. Note that in the case where $L + 1 > 4$ or $L + 2 > 4$, the value reverts to zero. In the case that $L = 1$, the coefficient on $Interim_{(L+1)}$ equals 1 instead of 0.5.

We also estimate the impact that uncapping home care will have on CHSP use. 97.3 per cent of people who have been approved for home care but have not received any package have CHSP approval. Of those who have rejected an interim package, 96.7 per cent have CHSP approval.²²⁹ We estimate the number of people to be removed from CHSP upon removal of the home care cap as follows:

$$\begin{aligned} CHSPReduction &= NoPackageOffered \cdot 0.973 \\ &+ InterimPackageNotAccepted \cdot 0.967 \end{aligned}$$

Where each variable is the corresponding number of home care users.²³⁰

229. We assumed this same percentage for those that had not yet accepted their offer of an interim package but whose offer was still open.

230. Department of Health (2020a).

The 'care distribution table' is updated to reflect the uncapped level of home care package users and the reduction in CHSP users.

We have not estimated the increased revenue, or reduced expenditure, from means-testing everyday living expenses, so our net cost of home care is an upper limit.

A.2.2 Allow an increase in care hours delivered in residential care

Following the University of Wollongong's report on staffing levels in aged care,²³¹ Grattan considered the effect of increasing the number of hours delivered in aged care by 20 per cent for all ACFI levels.

In this scenario, we assume all people in residential care (before any movement to home care) receive 20 per cent more hours of care.

The 'care distribution table' is updated by increasing the 'Hours of care' column by the appropriate percent for all people in residential care.

A.2.3 Allow movement of residents to home care

Our revisions to home care allow aged care users to receive more care at home. Due to this, we assume that some residential aged care users will decide to switch to home care.

We break it up as follows:

- Group 1: People currently receiving less than 15 hours of care
- Group 2: People currently received between 15 and 20 hours care.
- Group 3: People currently receiving more than 20 hours of care.

231. Eagar et al (2019).

Our costings assume that 33 per cent of people in Group 1 receive home care, 16 per cent of people in Group 2 receive home care, and no one in Group 3 receives home care – they all receive residential care.

For those that do move from residential to home care, we argue that they should be receiving more care at home than they would have in residential care due to the home care setting. This yields the following expression:

$$H_L = H_{ACFI} \cdot HomeCareHoursBoost$$

Where *Home Care Hours Boost* is a factor ≥ 1 representing any additional care hours provided in home care compared to equivalent residential care.

The ‘care distribution table’ is updated to reflect both the increased number of people using home care and any additional hours of care they receive. New home care levels are created during this process so that each unique ‘hours of care’ value is its own home care level for the purposes of the data table.

Note that L , the number of levels in home care, has now increased from 4 to an unspecified value to accommodate the care needs of people moving from residential care to home care. We define this new number of home care package levels as L_{upper} .

A.2.4 Optimising expenditure in home care

Under home care, currently 32 per cent of the funds that are spent go towards administration.²³² We investigate where home care expenditure becomes more efficient and fewer funds go towards administration.

²³² Aged Care Funding Authority (2020, p. 48).

We estimate the number of hours of care received under an improved system as:

$$H_L = OptimisedCareHours = CurrentCareHours \cdot \frac{New\%CareCost}{68\%}$$

In scenarios where home care expenditure is optimised, *Optimised Care Hours* replaces *Current Care Hours* in the ‘care distribution table’.

A.3 Calculate the funding required to support Grattan’s reforms

A.3.1 Estimate the cost of providing care under Grattan’s reforms

Now that we have determined the hours of care being provided to each need level and the number of people in each need level, we move to determine the cost of the system.

First, we need to account for the fact that some care costs are not covered under the ACFI subsidies and standard home care package subsidies. To resolve this issue, we find the additional sundry costs as a percent of the base care subsidies. We can use this as an add-on factor for system cost estimation.

These additional care costs are found as:

$$SundryCareFactor_{res} = \frac{S_{res}}{ACFI}$$

$$SundryCareFactor_{hc} = \frac{S_{hc}}{PackageExpense}$$

where²³³ S_{res} is the total government expenditure/subsidy on residential aged care; $ACFI$ is the expenditure derived from ACFI

²³³ Values used to calculate Sundry care factors are from: Aged Care Funding Authority (ibid).

payments; S_{hc} is the total government expenditure/subsidy on home care; and $PackageExpense$ is the total value of home care packages offered.

Next, we take the care distribution table, our cost per care hour estimates for home care and residential care, and our sundry care factors and calculate the total care cost:

$$SystemCC = CC_{hc} + CC_{res} + CC_{CHSP}$$

where care costs per hour for home care are given by²³⁴

$$CC_{hc} = \frac{1}{New\$CareCost} \sum_{L=1}^{L_{upper}} H_L \cdot U_L \cdot CPCH_{hc} \cdot SundryCareFactor_{hc}$$

Care costs per hour for residential care are given by

$$CC_{res} = \sum_{ACFI=1}^{ACFI_{upper}} Hours_{ACFI} \cdot Users_{ACFI} \cdot CPCH_{res} \cdot SundryCare_{res}$$

Care costs per hour for CHSP care are given by

$$CareCost_{CHSP} = Users_{CHSP} \cdot AverageCHSPFundingPerPerson$$

with H_L , H_{ACFI} , U_L , U_{ACFI} , U_{CHSP} as the updated values taken from the care distribution table to reflect the impact of our proposed reforms.

234. Note: The first term scales up the purely care component of home care expenditure to include the administration cost component.

A.4 Estimate the cost of providing and maintaining support plans for all care recipients

We model the cost of providing on-going care planning for every individual receiving age care.

Users are separated into 7 groups and assigned a certain number of annual on-going planning hours:

Grouping	Annual planning hours
Home support program	2
Home care Level 1	3
Home care Level 2	6
Home care Level 3	15
Home care Level 4	30
Residential care	6
Residential to home care movers ($L > 4$)	30

These care planning hours are based on the following reasoning:

- Home Support Program: 2 hours per person per year (mainly domestic support, initial planning amortised over a number of years and then basic contact, review, and administrative function, services are largely self managed – so following initial assessment and plan, reviews are largely administrative checking of provider reports against the support plan for payment purposes with the odd phone call to check all is going well with the recipient)
- Home care Level 1: 3 hours pp per year (similar to HSP, limited complexity and coordination, mainly domestic and community support, services largely self managed)
- Home care Level 2: 6 hours pp per year (similar to HSP, limited complexity and coordination, mainly domestic and community support with limited personal care, limited provider care/service management with regional oversight and review)

- Home care Level 3: 15 hours pp per year (personal and nursing services plus domestic support, more care/service coordination required from provider with oversight and review from region, more allowance for assessment as well)
- Home care Level 4: 30 hours pp per year (personal and nursing services, plus domestic support including palliative care and specialist medical, heavy care/service coordination required by provider with oversight and review from region, more allowance for assessment as well)
- Residential care: 6 hours pp per year. This will not require significant coordination support because there is only one service provider involved
- Residential to home care movers: 30 hours pp per year. These people will require similar support to those on Level 4 packages.

We estimate an hourly cost of to run such planning services:

$$HourlyPlanningRate = \$50_{perhour} \cdot 1.4$$

where \$50 per hour reflects the expected hourly wage of those undertaking the planning service; and 1.4 is a cost scaling factor to cover overhead costs – i.e. all costs not captured by *Salary Baseline*.

Total planning costs are then a function of the number of people in each grouping:

$$TotalPlanningCost = U_{res} \cdot P_{res} \cdot PRate + \sum_{L=1}^{L_{max}} U_L \cdot P_L \cdot PRate$$

where U_{res} is the total amount of users remaining in residential care under the current assumptions; P is the number of annual planning hours for the grouping; and $PRate$ is the hourly cost.

These costs are in addition to the Aged Care Assessment Team (ACAT) costs for home care and residential care,²³⁵ less 30 per cent funding for the Aged Care Quality and Safety Commission to account for movement of functions to the regional level.²³⁶

A.4.1 Estimate the cost of system administration conducted at the local level

To ensure the smooth running of our proposed system, coordination at the local level is required.

We estimate the cost of system coordination as follows:

$$CoordCost = Centres \cdot E \cdot ERate$$

where $Centres = 30$ is the number of centres, $E = 40$ is the number of staff per centre, and $ERate$ is the annual employment cost, assumed to be \$90,000 plus 40 per cent for overheads.

The system manager role includes relationship management, monitoring, payment, finance, IT, review, complaints, service development, etc.. So that would mean 8 people including a team leader. We also have the social program, accreditation and standards, complaints, system planning, healthy ageing, administration and team management, community information, training and development, workforce, and so on. This would require a team of about 40 people.

235. In 2018/19, the national average Australian Government expenditure per ACAT assessment was \$711.79: Productivity Commission (2020, p. 14.26).

236. Annual funding for the Commission in 2019/20 was \$83.4 million: Aged Care Quality and Safety Commission (2020, p. 99).

These people will have to coordinate with the national regulator, the pricing authority, and the Department. There should be offsets from reductions in functions for the Department as a result of regional devolution.

A.4.2 Calibrate costs to actual reported costs

To make sure that our model calibrates to the current system costs, we add a sum of \$1.8 billion.²³⁷ This sum accounts for the difference between total government aged care spending (in 2018/2019) of \$19.9 billion, and the amount spent on the sections we have modelled: home care (\$2.5 billion), residential care (\$13 billion), and CHSP (\$2.6 billion). These are other smaller government programs, including flexible and transition care.

$$\$19.9\text{billion} - \$2.5\text{billion} - \$2.6\text{billion} - \$13\text{billion} = \$1.8\text{billion}$$

A.4.3 Determine the total system cost

The total system cost is simply the sum of the parts we have discussed throughout. The additional government funding required is the difference between the cost estimate under Grattan's proposed reforms, and the cost where no changes to the system are introduced.

The estimated cost of the system with no reforms is \$20.56 billion. This is slightly higher than the \$19.9 reported in the most recent ACFA Report, reflecting the increased ACFI and home care subsidies, and the increased number of people receiving home care since ACFA's report was released.²³⁸

237. Aged Care Funding Authority (2020, pp. 12–13).

238. Note that entering data from mid-2019 into the model returns the \$19.9 billion reported by ACFA.

The system cost equation is:

$$TotalSystemCost = SystemCareCost + TotalPlanningCost + CoordCost + Calibration$$

A.5 Limitations of the model

The model is an estimation of costs for our proposed new system, but given the lack of available data in aged care, it is not comprehensive.

We have made no assumptions for our means-testing proposal. The estimated costs are based on existing expenditure for the current programs.

We have also not adjusted the costs to optimise it to account for unspent funds. The current and proposed system costs include unspent funds in the total expenditure. This means our model assumes that unspent funds are all fully spent. It is likely that under a better managed system, more funds would be spent – but it is unknown to what extent, given the lack of data. This means our model is potentially over-costed by up to \$1 billion – which is the estimated amount of unspent funds per year under the proposed system.²³⁹

239. This is based on an assumption that up to 20 per cent of home care funds are being unspent per year.

Appendix B: Aged care funding options

The Commonwealth Government can raise more money for aged care through various financing mechanisms, including increased taxation, greater user contributions, voluntary participation in private long-term care insurance, and mandatory participation in long-term care (social) insurance. Internationally, financing for aged care varies in its reliance on taxation and insurance, the extent to which individuals are expected to make out-of-pocket contributions, and the mechanisms used to ensure financing is consistent with people's ability to pay.²⁴⁰

Financing through general taxation is problematic when economic conditions change and force fiscal constraint. There are then risks that aged care services will be underfunded. Pay-as-you-go budget financing for aged care is also potentially inequitable because younger generations will increasingly pay for older people's care as the population ages.

Increasing user contributions, even when they are means tested, fails to pool risk across the population, and the cost burden inevitably falls most on those who need services more. Stop-loss schemes that place an upper limit on contribution costs for older people (after which the government meets costs) are a strategy for partially reducing this inequity and risk.

Private, voluntary insurance schemes can manage risks and finance services, but require appropriate market conditions, and they usually require favourable regulatory arrangements and government incentives.

240. Nordic countries, with higher overall rates of taxation, fund more long-term care from general taxation, see S. Dyer et al (2020); Germany, France, and the Netherlands rely more on social insurance models, see S. Dyer et al (ibid, p. 4); The UK has a residual model funded through general taxation and high levels of user contributions, see S. Dyer et al (ibid, p. 20); The US has a mixed model of government-financed schemes (especially Medicaid), private insurance, and user contributions, see S. Dyer et al (ibid, pp. 29–30).

In Australia, insurers have expressed an interest in developing appropriate products, but they have not yet done so. In Australia, private health insurance has demonstrated the difficulties in combining public financing and voluntary private insurance. Despite a range of inefficient subsidies, tax incentives, and regulation, private health insurance is unpopular and continues to spiral downward. It has also led to people with private insurance getting inequitable and advantaged access to necessary services.²⁴¹

Means-tested social insurance addresses generational and inter-generational equity, risk pooling, and funding adequacy. But it takes time to develop a sustainable funds pool. Alternative arrangements are required during the establishment phase. Depending on the design of the social insurance arrangements, they may weaken local service development and responsiveness.²⁴²

Australian aged care is financed through a universal taxation and means-tested contribution scheme. User contributions finance about a fifth of aged care.

The recent increased funding required to meet the reasonable and necessary costs of long-term care for people with disabilities was supported through a mix of specific tax measures (increased Medicare Levy) and general taxation.

Reductions in tax concessions for superannuation and wealth transfers could also provide savings for increased aged care expenditure.²⁴³

241. Duckett (2019).

242. Kim and Kwon (2020).

243. See for example the Treasury Retirement Income Review consultation paper: Treasury (2020).

It is also accepted that people with disabilities should meet their own everyday expenses and accommodation costs (board and lodging) through means-tested contributions when they need long-term care. We propose a similar strategy should be adopted to increase funding for aged care.

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