FAIR WORK COMMISSION

Title of Matter:	Four yearly review of modern awards
Section:	s.156 -4 yearly review of modern awards
Subject:	Aged Care Award 2010–substantive issues
Matter Number:	AM2018/13

SUPPLEMENTARY SUBMISSIONS BY AGED CARE EMPLOYERS

1. These supplementary submissions address matters raised by the Full Bench during the hearing on 10 April 2019.

A. AGED CARE INDUSTRY PROFILE

2. In answer to a question from the bench concerning the proportion of Personal Care Workers who are known to have a certificate III, Aged Care Employers identified that the 2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce ("Aged Care Workforce Report") would provide useful information to the Commission and have provide a link to that report.

3. The report distinguishes between residential facilities which are covered by the Aged Care Award and home care and home support outlets, which are largely covered by the Social, Community, Home Care and Disability Services Industry Award (SCHADS Award). The report also includes nurses who are covered by the Nurses Award and Allied Health professionals & assistants who are covered by the Health Professionals and Support Services Award.

4. Thus employees covered by the Aged Care Award are the Personal Care Workers providing direct care, referred to in the report as Personal Care Attendants, and non-direct care employees who are in the other classifications covered by the Award.

5. The report deliberately focuses on those providing direct care. For this reason while some data is consistent with that identified by the Commission in the Aged Care Industry Profile, there are some variations.

Aged care industry profile	Aged Care Workforce Report
Aged care industry employees are predominately female (84.0%, compared with 50.0% of all employees);	86.2% of Personal Care Workers are female – Figure 3.4 page 17
almost six in ten (59.0%) Aged care industry employees are employed on a part-time or casual basis (i.e. less than 35 hours per week), compared with only 34.2% of all employees;	For Personal Care Workers, eight in ten (80.3%) are employed on a part-time basis and one in ten (10.8%) are employed on a casual or contract basis. There has been a small increase in full-time employment since 2012 and a significant decrease in casual or contract employment since 2012.
almost half (48.0%) of Aged care industry employees work 16–34 hours per week compared with only 22.5% of all employees;	For Personal Care Workers, more than half (57.2%) work 16–34 hours per week – Table 3.18 page 26. For Personal Care Workers over half (55.8%) are happy with their current hours of work, fewer than two in ten (14.0%) would like to decrease their hours and three in ten (30.2%) would like to increase their hours.
over half (54.6%) of Aged care industry employees are aged 45 years and over compared with only 36.9% of all employees; and	Over half (55.2%) of direct care employees (including nurses & allied health employees) are aged 45 years and over – Table 3.5 page 16
fewer than six in ten (58.1%) of Aged care industry employees completed Year 12 or equivalent compared with 68.1% of all employees.	The report only considers post school qualifications. Only 12.6% of Personal Care Workers do not have any post school qualification. The report notes that workers can hold more than one qualification type. 67.4% of Personal Care Workers hold a certificate III in Aged Care and 22.9% hold a certificate IV, although those numbers may overlap - Table 3.12 page 22.

B. LEGISLATION AND FUNDING

6. The major legislative instrument is the *Aged Care Act* 1997, the objects of which are set out in section 2.1, including funding arrangements for aged care, the provision of a high quality of care having regard for the needs of individuals and the allocation of limited resources.

7. The aged care industry is currently the subject of a Royal Commission whose terms of reference are:

   a. *the quality of aged care services provided to Australians, the extent to which those services meet the needs of the people accessing them, the extent of substandard care being provided, including mistreatment and all forms of abuse, the causes of any systemic failures, and any actions that should be taken in response;*

   b. *how best to deliver aged care services to:*

      i. *people with disabilities residing in aged care facilities, including younger people; and*

      ii. *the increasing number of Australians living with dementia, having regard to the importance of dementia care for the future of aged care services;*

   c. *the future challenges and opportunities for delivering accessible, affordable and high quality aged care services in Australia, including:*

      i. *in the context of changing demographics and preferences, in particular people's desire to remain living at home as they age; and*

      ii. *in remote, rural and regional Australia;*

   d. *what the Australian Government, aged care industry, Australian families and the wider community can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe;*

   e. *how to ensure that aged care services are person-centred, including through allowing people to exercise greater choice, control and independence in relation to their care, and improving engagement with families and carers on care-related matters;*

   f. *how best to deliver aged care services in a sustainable way, including through innovative models of care, increased use of technology, and investment in the aged care workforce and capital infrastructure;*

   g. *any matter reasonably incidental to a matter referred to in paragraphs (a) to (f) or that [the Commissioners] believe is reasonably relevant to the inquiry.*

8. In February 2019 the Royal Commission published a background paper, "Navigating the maze: An overview of Australia's current Aged care system", which usefully summarises

   a. How aged care is regulated from page 38; and

   b. How aged care is funded, from page 29 to 33.

9. Key points arising from the background paper are:

   a. There have been longstanding concerns around workforce numbers and skills mix, attraction, retention and career paths, remuneration and the levels of skills and qualifications. It is also recognised that the aged care workforce will need to expand considerably as the population ages and adopt new models of care and scopes of practice to meet changing expectations – Background Paper page 27;

   b. In September 2018, the Australian Government released A Matter of Care: Australia's aged care workforce strategy, which identifies those challenges as including

      3. Reframing the qualification and skills framework—addressing current and future competencies and skills requirements

      4. Defining new career pathways including accreditation

      Background Paper page 28;

   c. The existing quality standards and guidelines will be replaced from 1 July 2019 with the Aged Care Quality Standards, which include a greater focus on outcomes for consumers instead of provider processes – Background Paper page 43.

   d. Around three-quarters of funding comes from the Australian Government-Background Paper page 30;

   e. The funding allocation considers both the provision of accommodation and the care needs of the resident, including activities of daily living, behaviour and complex health care – Background Paper page 32;

   f. The funding assessment challenges highlighted by the StewartBrown June 2018 Aged Care Financial Performance Survey (tendered separately by

ABI) at page 4 that the 2017-2018 financial results for the residential care sector showed a significant deterioration from the previous year – Background Paper page 33.

10. The funding issues highlighted by the StewartBrown report for the Financial year 2018 tendered by ABI include at page 4 that :

    a. 45.1% of residential facilities recorded a negative Operating Result (EBT); and

    b. 63.5% of outer regional, rural and remote facilities recorded an EBT loss and 37% are operating at a cash deficiency.

11. One aspect that is not covered by the Background Paper is that each State and Territory has its own legislation that determine the circumstances under which a person, including a recipient of aged care, may be provided with a particular medicine, legislation that also governs matters such as storage, access and supply of those medicines.

C. AGED CARE EMPLOYEE LEVEL 4

12. The Commission asked about the differences between the dot points at the first 3 grades of aged care employees.

13. Grade 1 to Grade 2 the second dot point changes from a limited level of accountability to a medium level. The fourth dot point adds arithmetic skills for those outside the admin/clerical area.

14. Grade 2 to Grade 3 the requirement for communication and arithmetic skills changes from sound to good. The major change from the perspective of Aged Care Employers is the addition of the requirement in dot point 5 of Grade 3 of the requirement to have good interpersonal skills.

Number of personal care workers with a Certificate III

15. The Aged Care Workforce Report at Table 3.12 page 22 indicates that 67.4% of Personal Care Workers hold a certificate III in Aged Care and 22.9% hold a certificate IV, although those numbers may overlap.

16. The report indicates that only 12.6% of Personal Care Workers do not have any post school qualification. It is difficult to draw any meaningful conclusions beyond the certificate III, because workers can hold more than one qualification type and there is a wide variety of other post school qualifications, which may not be related to the work being performed.

17. Aged Care Employers are not aware of any detailed information that gives a representative picture as to the number of Personal Care Workers who are classified as Aged care employees level 3 or level 4.

SCHADS Award E.3.5 Qualifications and experience

18. The Commission has asked Aged Care Employers to consider whether the sixth dot point for Grade 3 may be replaced with wording similar to the SCHADS Award which provides :

> *Indicative but not exclusive of the qualifications required in this level is an accredited qualification to the position at the level of Certificate 3 and/or knowledge and skills gained through on-the-job training commensurate with the requirements of the work in this level.*

19. The Background Paper notes the aged care workforce strategy as including reframing the qualifications and skills framework to ensure that Aged Care workers have the skills and competencies to meet current and future requirements of aged care consumers in a safe, high quality manner. To that end the Australian Government has recently established the Aged Services Industry Reference Committee (ASIRC).

20. Aged Care Employers note that a key focus of the ASIRC is to review the current Certificate III qualification to ensure that it is fit for purpose and make any necessary improvements to enable a high performing, agile workforce that is responsive to consumer care needs and desires.

21. One of the key constraints and challenges for aged care providers will be the shift towards consumer directed care, including the new Aged Care Quality Standards, which, as noted above, include a greater focus on outcomes for consumers instead of provider processes.

22. The proposed introduction of the wording from E.3.5 of the SCHADS Award is consistent with :

    a. The skills and knowledge commensurate with the requirements of the work at this level;

    b. The Aged Care Workforce Report which notes that two out of three (67.4%) of Personal Care Workers have a Certificate II in Aged Care, supplemented with a diversity of other qualifications, the relevance of which may vary; and

    c. The ASIRC review of the current certificate III in the context of the need to reframe the qualifications and skills framework.

23. For these reasons the Aged Care Employers including the wording from E.3.5 of the SCHADS Award as indicative of the qualifications for a Personal Care Worker Level 4.

D. <u>BROKEN SHIFTS</u>

24. Aged Care Employers notes that broken shifts can only be worked by part time and casual employees pursuant to clause 22.8(a) of the Award. In this respect it should be noted that the majority of employees in the Aged Care Industry are part time or casual, whether that is the 59.0% noted in the Aged Care Industry Profile provide by the Commission on 5 April 2019 or the much higher percentage in relation to the residential direct care workforce for Personal Care workers where 80.3% are permanent part time and 10.8% casual or contract. (Aged Care Workforce Report table 3.16 page 25)

25. The Award contains specific requirements with respect to part time employees, including in clause 10.3. Which provides:

    (b) Before commencing employment, the employer and employee will agree in writing on a regular pattern of work including the number of hours to be worked each week, the days of the week the employee will work and the starting and finishing times each day.

    (c) Any agreed variation to the hours of work will be in writing.

26. Outside of these specific requirements, Aged Care Employers are not aware of any situation where an employee is required to consent to work broken shifts

at the commencement of their employment and that operates as some form of standing consent to work broken shifts as required.

27. Aged Care Employers confirm that their understanding is that the question of agreement is approached informally and for casual employees it is not necessarily recorded in writing.

28. During the hearing on 10 April the Commission raised concerns as to the interaction between the broken shift provision in clause 22.8, the span of hours in clause 22.2 and the shift penalties in clause 26.

29. The concern appears to be that an employee may, by agreeing to work a broken shift that takes their hours outside of 6.00 am to 6.00 pm on Monday to Friday without receiving the shift penalty that would otherwise apply to that work. It would be surprising if a modern Award made such a provision.

30. Aged Care Employers submit that this is not the proper construction of the Aged Care Award.

31. The span of hours provision in clause 22.2 is for the purpose of distinguishing between a day worker and a shiftworker. The distinction assumes importance only in relation the application of shift penalties under clause 26 and for annual leave purposes, both the quantum of leave under the NES and the annual leave loading.

32. There is nothing in the Award that prohibits an employee from working outside the span of hours in clause 22.2(a). Instead the Award provides various consequences that arise from such work.

33. The span of hours in clause 22.2(2) is replicated in clause 26.1. In the case of part time or casual employees, being people who work less than 38 hours per week, are only entitled to penalty rates where some part of their hours falls outside the span of 6.00 am to 6.00 pm.

34. Thus a part time employee who works from 10.00 am until 1.00 pm is not entitled to a shift penalty, even though their shift starts at 10.00 am and thus 26.1(a) would otherwise apply. An Aged care employee—level 3 working this shift would receive $65.34 for that shift.

35. If that part-time employee agreed, in writing pursuant to clause 10.3(c), to work a broken shift, starting at 10.00 am until 1.00 pm, and then from 4.00 pm until 6.00 pm, that employee would not receive any shift penalty. An Aged care employee—level 3 working this broken shift would receive $108.80, an additional $43.56, reflecting the 2 hours additional work.

36. In contrast if that part-time employee agreed to work a broken shift starting at 10.00 am until 1.00 pm and then from 5.00 pm until 7.00 pm, the employee would be paid the shift allowance of 10%. In accordance with clause 26.2 that penalty would be paid for the entire shift. An Aged care employee—level 3 working this broken shift would receive $119.78, being both the additional $43.56 for the 2 hours additional work and a shift allowance of $10.89.

37. It is true that some modern awards, such as the Restaurant Industry Award, include an additional payment, in that case a split shift allowance of 0.5% of the weekly standard rate, $837.40, thus giving a split shift allowance of $4.19. That however is in the context of an industry that provides very different terms, relevantly that there is no shift penalty for work after 6.00 am and prior to 10.00 pm and that a loading of 10% is payable for any work between 10.00 pm and midnight and 15% between midnight and 6.00 am.

38. There is no disagreement that employees covered by the Aged Care Award are relatively low paid. Both the aged care industry profile and the Aged Care Workforce Report highlight that the majority of employees are part time or casual and that around half of employees work 16–34 hours per week.

39. The Aged Care Workforce Report shows that for Personal Care Workers, three in ten (30.2%) would like to increase their working hours.

40. In this way the ability for part time and casual employees to agree to work broken shifts can be seen as providing an opportunity for employees to increase their working hours. The existing qualification that it can only done by agreement remains an important safeguard.

BRUCE MILES

Frederick Jordan Chambers

12 April 2019

Royal Commission
into Aged Care Quality and Safety

Navigating the maze: an overview of Australia's current aged care system

Background Paper 1

February 2019

The Royal Commission into Aged Care Quality and Safety was established on 8 October 2018 by the Governor-General of the Commonwealth of Australia, His Excellency General the Honourable Sir Peter Cosgrove AK MC (Retd). Replacement Letters Patent were issued on 6 December 2018.

The Honourable Richard Tracey AM RFD QC and Ms Lynelle Briggs AO have been appointed as Royal Commissioners. They are required to provide an interim report by 31 October 2019, and a final report by 30 April 2020.

The Royal Commission intends to release consultation, research and background papers. This background paper has been prepared by Ms Carolyn Smith, with the assistance of staff of the Office of the Royal Commission, for the information of Commissioners and the public. The views expressed in this paper are not necessarily the views of the Commissioners.

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Introduction

Australia's population is ageing. On average, we are living longer in greater numbers than ever before. Older Australians represent a steadily increasing proportion of our total population and we continue to have one of the longest life expectancies in the world. The proportion of people aged 65 years or over in the total population is projected to increase from 15% at 30 June 2017 to between 21% and 23% in 2066.[1]

More older Australians will mean a greater demand for aged care and greater pressure on government budgets. In addition to the sheer increase in the demand for aged care, we can also expect changes in the needs of people requiring care, with changing patterns of disease, more diverse preferences for and expectations of care, changing wealth levels and developments in technology.[2]

Higher demand will see further pressures to increase the aged care workforce. This will occur as our working age population declines and we experience a likely reduction in informal carers and family support and greater competition from related sectors such as health and disability.[3]

Given the questions these factors raise about the sustainability of the aged care system and its capacity to grow and meet changing demand, successive governments have initiated various processes to look at aspects of the aged care system. Reviews have examined broad questions of accessibility, affordability and sustainability and whether the current aged care system is still fit for purpose.

The aged care sector has also faced regular scandals about the quality of aged care services, particularly in residential aged care, prompting reviews and changes to assure the quality and safety of aged care services. Periodic public debate has centred on whether the community can have confidence in the quality of aged care being provided and the effectiveness of the regulatory framework. Reviews have also recognised that aged care sits within a broader system of health and human services and that older people experience complex journeys through disconnected systems to get their needs met.

All of these reviews have concluded that the aged care system is in need of substantial reform. The system is complex and fragmented, and reform has been difficult to implement. Since the mid-1990s, continual waves of change have attempted to address pressures and position the system to meet the needs of an ageing population. In 2011, the Productivity Commission, in its report entitled *Caring for older Australians*, concluded:

> The aged care system suffers key weaknesses. It is difficult to navigate. Services are limited, as is consumer choice. Quality is variable. Coverage of needs, pricing, subsidies and user co-contributions are inconsistent or inequitable. Workforce shortages are exacerbated by low wages and some workers have insufficient skills.[4]

The sector is part way through progressive implementation of reforms that commenced in 2013 in response to the findings of the Productivity Commission. The reforms had the aim of improving the affordability, sustainability and quality of aged care services, including by moving towards a more consumer-driven and market-based aged care industry where older

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1 Australian Bureau of Statistics, *Population projections in Australia, 2017 (base)—2066* (Catalogue 3222.0), www.abs.gov.au.

2 Productivity Commission, *Caring for older Australians*, Report No 53, 2011, Vol 1, p 2.

3 Ibid, p xxvii.

4 Ibid, p xxii.

people and their families have greater choice and control over the services they receive.[5] The 2017 review of those reforms found progress towards a more consumer driven and sustainable aged care system but also recognised that further reform was required in information, assessment, consumer choice, means testing and equity of access.[6] Significant changes to Australia's aged care quality regulatory processes and structures are underway as is the implementation of action to address longstanding workforce challenges.

An ageing Australia

A history of aged care as a Commonwealth responsibility

Overview

The funding and regulation of aged care services is predominantly the role of the Australian Government although all three levels of government in Australia—local, state and federal—are involved.

A 2003 monograph provides a comprehensive history of the evolution of the Australian Government's role in providing support for the needs of older people.[7] In that monograph, Cullen outlines the history of support for older people through mainstream strategies such as income support, subsidised health services and support with housing, and targeted strategies through support for aged care infrastructure, subsidised residential care, subsidised care at home and in the community, and support for carers.

The Australian Government has not always been as heavily involved in the support of older people as it is now. Until 1 July 1909, all responsibility for supporting the social security and welfare, health and housing needs of older people resided with the states. As the twentieth century progressed, successive Australian Governments expanded their role in this area and 'became increasingly engaged in funding, planning and regulating services for older people'.[8]

Care in a residential or institutional setting

For the first half of the twentieth century, state institutions such as asylums and hospitals were the main source of accommodation security for frail older people. The Australian Government moved in 1954 to assist older people in need of adequate hostel accommodation through the provision of capital grants to religious and charitable organisations.[9]

Over the last half of the twentieth century, the Australian Government provided substantial support for the development of aged care infrastructure, through capital grants as well as recurrent funding arrangements designed to encourage private investment in both nursing homes (high care) and hostels (low care). Residents also made substantial capital contributions to the establishment of these residential care services.[10]

Specific outcome standards and quality of care requirements were introduced for nursing homes in 1987 and for hostels in 1991. A process to monitor the quality of care and quality

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5 Aged Care Sector Committee, *Aged care reform roadmap*, 2016, 2.
6 D Tune, *Legislated review of aged care 2017*, 2017, p 12.
7 D Cullen, *Review of pricing arrangements in residential aged care: historical perspectives*, 2003.
8 D Cullen, above n 7, p 2.
9 D Cullen, above n 7, pp 27–8.
10 D Cullen, above n 7, pp 39–41.

of life was also introduced. A focus on protecting and promoting the rights of elderly people who lived in nursing homes and hostels began to develop. Other elements of the current regulatory framework such as fee controls, assessment of client need and needs based planning were introduced and a range of initiatives put in place to encourage the provision of care in the home.[11]

In 1997, a package of changes was introduced to the aged care system that was based around the unification of the former hostel and nursing home sectors. The changes restructured the funding and administration of hostels and nursing homes into one system, allowing services to offer the full continuum of care. Accreditation against new care standards was linked to funding and certification arrangements were put in place to improve building quality.[12] While there have been many reforms to the aged care system since 1997, the current aged care system is underpinned by the *Aged Care Act 1997* (Cth), which came into effect on 1 October 1997, and the Aged Care Principles.

Care in the home and the community

The Australian Government first became involved in community care in 1956, providing assistance to home nursing organisations, and then providing grants to states to support alternative community care services delivered in people's homes and in the community. Financial assistance to voluntary organisations and local government bodies to provide delivered meals began in 1970. In 1985, the *Home and Community Care Act 1985* (Cth) supported grants to states for community care services for people of all ages. More substantial 'packaged' care at home was available for older people through Commonwealth legislation from 1992.[13]

As part of the National Health Reforms in 2010, and subsequently for Victoria and Western Australia, the states and territories agreed to transfer responsibility for community care services for older people delivered under the Home and Community Care Program to the Australian Government.

Community views about ageing

The ageing of Australia's population and in particular the ageing of the baby boomer generation represents a very significant demographic shift for this country. In addition to the challenges represented by the numbers and the consequent increase in demand for age related services, we can expect the boomer generation will change what it means to be older, just as they have been at the forefront of other aspects of social and economic change.[14] In particular, the boomer generation are more likely to enter their older years without a spouse or children and to live alone in a rented home than previous generations. They are more ethnically diverse than previous generations and may have different patterns of health and disability, although this is less certain.[15] All of these factors will have implications for their future care needs.

Social research in Australia has consistently confirmed a prevailing narrative that the ageing of the population is seen as a problem to be fixed and that older people are a burden facing the nation.

[11] D Cullen, above n 7, pp 63–70.
[12] D Cullen, above n 7, pp 74–5.
[13] D Cullen, above n 7, p 85.
[14] M Butler, *The politics of ageing*, 2015, p 56.
[15] G Hugo, *The demographic facts of ageing in Australia*, 2014, pp 20–2.

In June 2013, Australian Human Rights Commission research, *Fact or fiction: stereotypes of older Australians*, found:[16]

- Ageing is a term with predominantly negative connotations—particularly among younger Australians. Younger Australians and older Australians define 'old age' differently and this creates tensions between them.
- Most Australians feel that age discrimination in Australia is common, with more than a third of Australians aged 55+ years having experienced age-related discrimination. Those aged 18–34 years are the least concerned about age discrimination.
- Age discrimination and a sense of 'invisibility' result in a strong and negative emotional response amongst older people.
- Many Australians agree with a number of stereotypes about older Australians, with those aged 18–24 years the most negative about older people. Negative stereotypes about older Australians lead to negative behaviours. For example, one in ten business respondents have an age above which they will not recruit—the average age is 50 years.
- Older Australians are underrepresented and often poorly portrayed in the media which is influencing negative perceptions of older Australians. Social media portrays older people as vulnerable and as victims, and 47 percent of Australians feel that the portrayal of older people in advertising is 'unfair'.

To better understand the beliefs and behaviours that drive ageism, in 2017, the Benevolent Society commissioned a three-part research study called *The Drivers of Ageism*. Its key findings included:[17]

- The majority of people care about ageism (79%) and many have experienced it.
- The four key settings identified by survey participants as important for ageism to be addressed were: the workplace (54%); healthcare (47%); aged care (33%); and in families and local communities (31%).
- People lack awareness of the positive aspects of older people's lives and tend to overestimate the negative aspects, such as poor health, financial concerns and dependency.
- People have mixed attitudes to getting older and towards older Australians. There are concerns about the economic impact of the ageing population but also recognition of the importance of addressing discrimination and achieving positive change.
- Financial concerns as people age are just as common among younger participants as older participants.
- People don't see age as a number but more as a relative concept influenced by factors such as how old you are, the culture you belong to, your health status and how you lead your life.
- People's perceptions of, and attitudes towards their own ageing, are primarily shaped by their personal experiences (usually observing close family members or friends) and the level of contact they have with older people. Personal connection with older people—within the workplace, the community and family—was a strong indicator of more positive perceptions and attitudes.

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[16] Australian Human Rights Commission, *Fact or fiction: stereotypes of older Australians*, 2013.
[17] Benevolent Society, *The drivers of ageism*, 2017, pp 9–10.

The Councils on the Ageing's *State of the (older) nation 2018* (Older nation research) found that three in four older Australians (74%) feel that 'they have much to offer society as an older person, gained through their life experiences'. Despite this, nearly half (46%) feel less valued by society than when they were younger.[18] The Older nation research also reported that:

> One in three older Australians have experienced age discrimination of some kind and more than a fifth (22%) have experienced employment-related discrimination…Meanwhile, a quarter (24%) of older Australians feel their age is a factor in the service they receive as consumers—and for most this is in a negative way e.g. feeling ignored by sales staff.[19]

Community expectations about care and support

The third age (retirement) and older age (decline)

Positive ageing is often based on the concept of a 'third age', when older people are freed from the responsibilities of work and child rearing and have the opportunity to pursue greater self-fulfilment.[20] This phase of life can extend for a couple of decades. The Older nation research found that physical health and financial security were the key factors influencing the perceptions of quality of life for older Australians:

> When asked what they were most concerned or worried about at this point in their life, a third (32%) of older Australians mentioned health issues…with finances and the cost of living not far behind (27%). The top reason people gave for a poor (0–4 [out of 10]) quality of life rating was health problems (60% of the 7% who gave a poor rating); while 'good health' was the top reason given for a very high (9–10) quality of life rating.[21]

The third age is typically 'followed by a period of physical and cognitive decline, increasing dependence upon others and, ultimately death'—the so-called 'fourth age'—generally emerging in a person's eighties.[22] Fear about this phase is a significant issue for older people. The Drivers of Ageism research found significant concern from older people about 'losing their cognitive capacity, their identity, independence and social connections as they age', with the fear of cognitive decline greater than the fear of physical ill health.[23] Butler, as the then Minister for Mental Health and Ageing, held forums around the country with older Australians in 2011–12, and was struck by a 'deep foreboding' about the 'idea of decline and the loss of control over one's own circumstances … crystallising in the idea of life in a nursing home or a lingering death in hospital'.[24]

Most Australians who reach older age will require care and support, either from family members or from the formal care system. Around 80% will access some form of government funded aged care before their death.[25] The great majority receive home-based care and support; relatively few live in an institutional or residential setting for their care. Yet, the prevalent media and community debate is focussed on residential aged care, and indeed mainly on any quality failures that occur there.

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[18] Newgate Research on behalf of the Councils on the Ageing, *State of the (Older) Nation*, 2018, p 6.
[19] Ibid, p 9.
[20] M Butler, above n 14, p 105.
[21] Newgate Research on behalf of the Councils on the Ageing, above n 18, p 7.
[22] M Butler, above n 14, p 156.
[23] Benevolent Society, above n 17, p 22.
[24] M Butler, above n 14, p 156.
[25] Australian Institute of Health and Welfare, *Use of aged care services before death*, 2015, p 4.

Preparing for older age

When it comes to older age, there seems to be a reluctance to think ahead or plan for this phase of life. An online survey completed by National Seniors members in 2018 found evidence that many Australians over 50 years of age will be unprepared for the need to access the aged care sector, with the majority of people having very limited aged care literacy. As one surveyed member said:

> The main problem with age services, you don't know what you don't know. When a problem comes up, one is not too sure of where or how to obtain the right information.[26]

This is accompanied by a broader community reluctance to discuss or plan for death. Awareness of advance care plans including in residential aged care remains very low.[27]

Even for those motivated to understand the system, successive reviews have pointed to the complexity of the current aged care system and how difficult it is to navigate. This was comprehensively documented by the Productivity Commission in its 2011 *Caring for older Australians* inquiry.[28] In its recent position paper, *Keep fixing the aged care system*, the Council on the Ageing noted that:

> Accessing our aged care system is like navigating an obstacle course blindfolded—with no obligation for providers to publish any information about their pricing, or their performance.[29]

Older people express very strong preferences to remain in their own home as long as possible and preferably until death, and there are high levels of concern that there is not enough care available in the community to allow those preferences to be met. In the Older nation research:

> Of those aged 50+ who had tried to access home or aged care services in the past year (either for themselves or someone else such as a family member), 20% reported difficulties in doing so, mainly due to cost (24%), waiting lists (19%) and lack of suitable services (16%).[30]

Work commissioned by the then Australian Aged Care Quality Agency on the information needs of consumers found low consumer understanding of different aged care services available, the structure of aged care services or what quality in aged care even means. It also found that consumers may not want to talk about quality explicitly and are not engaged in detail about quality.[31] The Council on the Ageing also undertook a consumer led consultation process to consider systems and indicators of quality and safety in aged care for the Department of Health. It reported the consistent view of consumers that consumer experience information is the most important piece of information requested when seeking to choose aged care providers, with consumers interested in both quality of life and then quality of care measures.[32]

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[26] K Rees, J Maccora and J McCallum, *You don't know what you don't know: the current state of Australian aged care service literacy*, 2018, p 65.

[27] H Swerissen and S Duckett, *Dying well*, 2014, p 13.

[28] Productivity Commission, above n 2.

[29] COTA, *Position paper: keep fixing Australia's aged care system*, 2018, p 9.

[30] Newgate Research on behalf of the Councils on the Ageing, above n 18, p 7.

[31] Australian Aged Care Quality Agency, *New single quality standards: consumer information resources (phase 1: report)*, 2018.

[32] COTA, *Project report: measuring quality and consumer choice in aged care*, 2018, pp 7–10, 19.

What is aged care?

Current modes of care

The Productivity Commission has described aged care as covering: a range of services provided to older people who have diminished capacity to care for themselves because of physical/mental disability or frailty which can include one or more of the following:

- assistance with everyday living activities—such as cleaning, laundry, shopping, meals and social participation;
- help with personal care—such as help with dressing, eating and toileting;
- health care—such as medical, nursing, physiotherapy, dietetics and dentistry; or
- accommodation.[33]

This is consistent with international definitions for long-term care which are subdivided into long-term care (health) and long-term care (social). Long-term care (health) is medical or nursing care and personal care services which provide help with activities of daily living such as eating (support with food intake), bathing, washing, dressing, getting in and out of bed, getting to and from the toilet and managing incontinence. Long-term care (social) is services that enable a person to live independently and involve help with instrumental activities of daily living such as shopping, laundry, cooking, performing housework, managing finances and using the telephone.[34]

The intensity and type of aged care services required to meet the needs of older people increase with frailty and aged-related illnesses. A schematic summary of the structure of the system is Figure 1. The closer the service is to the top of the triangle, the greater the level of care required and the more resource intensive the service tends to be. The movement of older people through the system is subject to assessment of need.

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[33] Productivity Commission, above n 2, p xi.

[34] Organisation for Economic Co-operation and Development, Health Division, Directorate for Employment, Labour and Social Affairs, *Accounting and mapping of long-term care expenditure under SHA 2011*, 2018.

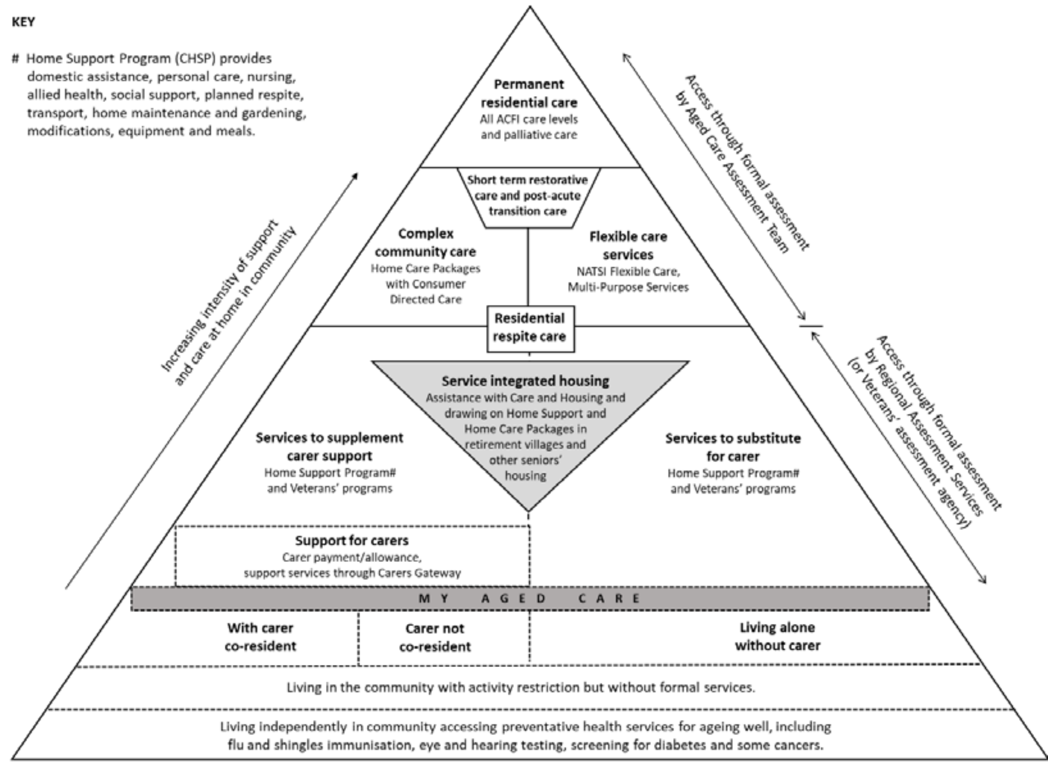

Figure 1: Intensity and type of aged care

Source: First developed by Anna Howe and published in A Howe, 'Changing the balance of care: Australia and New Zealand' in OECD, *Caring for frail elderly people: policies in evolution*, 1996. Revised in 2019 with advice from Anna Howe via personal communication.

Care for those living in the community is heavily reliant on the contribution of informal carers. The Australian Bureau of Statistics reported that in 2015, of the 1.2 million older people living in households and needing assistance with everyday activities, the informal carers most likely to provide that support were their spouse or partner (35.0%), followed by a daughter (21.0%).[35]

Who is getting care?

The aged care sector in Australia provided services to over 1.3 million Australians in 2017–18.[36] The great majority received home-based care and support. Relatively few lived in residential care (Figure 2).

[35] Australian Bureau of Statistics, *Disability, ageing and carers, Australia: summary of findings 2015* (Catalogue 4430.0), www.abs.gov.au.

[36] Australian Department of Health, *2017–18 report on the operation of the Aged Care Act 1997,* 2018, p vii.

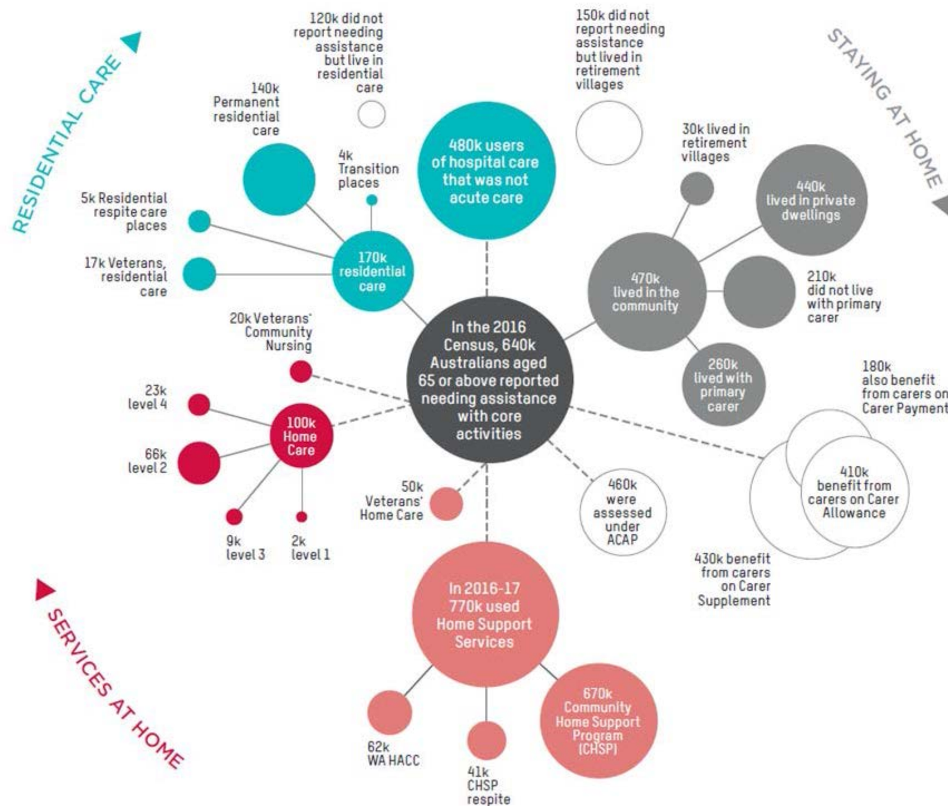

Figure 2: People receiving aged care, by type 2016

Source: ARC Centre of Excellence in Population Ageing and Research, *Aged Care Policy, Provision and Prospects*, 2019, page 2.

The average age on admission to permanent residential aged care was 82.0 years for men and 84.5 years for women. For entry to a Home Care Package, the average age was 80.3 years for men and 81.0 years for women.[37]

As people age, they are more likely to require assistance with everyday activities such as household chores and transport. The ABS reported that:

> The proportion of all older Australians who needed assistance with at least one activity decreased to 38.6% in 2015, down from 41.9% in 2012. Assistance was most commonly needed for health care tasks such as taking medications (22.9%), and property maintenance (20.2%).
>
> …
>
> Of all Australians with disability who were living in households, older people were more likely to report that their need for assistance had been met in full (67.4%) than those aged under 65 years (58.2%). Despite this, similar proportions of older people and people under the age of 65 years reported that their needs had not been met at all (around 2% for both groups). [38]

[37] Ibid, p 10.

[38] Australian Bureau of Statistics, above n 35.

The Australian Bureau of Statistics reported that in 2015 most older Australians (94.8%) were living in households, while one in twenty (5.2%) lived in 'cared accommodation' such as residential aged care.[39] Of those living in cared accommodation, 72.1% were over aged 80 years or over and 1.5% were aged between 65 to 79 years.[40]

While the proportion of people in Australia aged 65 years and over continues to increase, the prevalence of disability amongst older people has decreased. Around half (50.7%) of older people had a disability in 2015, down from 52.7% in 2012.[41]

The ageing of the population and the associated increasing number of people with dementia are the two main factors driving increased demand for aged care services. As age increases, the likelihood of needing care increases, as shown in Figure 3.

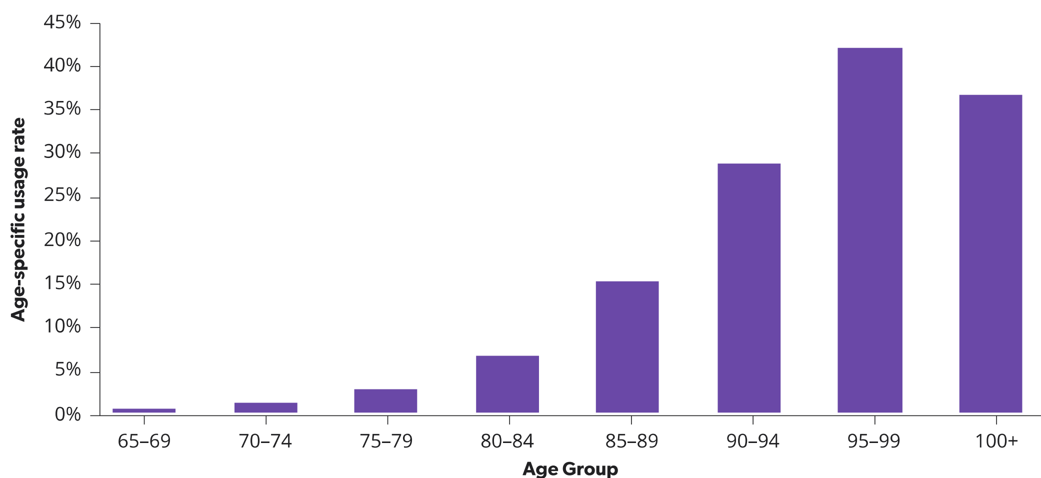

Figure 3: Use of aged care, by 5-year age group 2017–18

Source: Australian Department of Health, *2017–18 report on the operation of the Aged Care Act 1997,* 2018, p 5.

Dementia Australia reports that, in 2018, there is an estimated 436,366 Australians living with dementia. Without a medical breakthrough, the number of people with dementia is expected to increase to an estimated 589,807 by 2025 and 1,076,129 by 2058.[42]

At 30 June 2018, just over half (51.2%) of all residential aged care residents with an Aged Care Funding Instrument assessment had a diagnosis of dementia.[43]

Aged care and the economy

The aged care sector generates annual revenues totalling around $22 billion; making a significant contribution to the Australian economy.[44]

[39] Ibid.
[40] Ibid.
[41] Ibid.
[42] Dementia Australia, *Dementia prevalence estimates 2018–2058*, 2018, p 2.
[43] Australian Department of Health, above n 36, p 6.
[44] Aged Care Financing Authority, *Sixth report on the funding and financing of the aged care sector*, 2018, p 2.

The *2015 intergenerational report—Australia in 2055* notes that:

> Australian Government expenditure on aged care has nearly quadrupled since 1975. Expenditure is projected to nearly double again as a share of the economy by 2055, as a result of the increase in the number of people aged over 70 years … Expenditure is projected to increase from 0.9% of GDP in 2014–15 to 1.7% of GDP in 2054–55, and from $620 to $2000 in real, per person terms.[45]

In 2016, it was estimated that there were over 366,000 paid workers in aged care with a further 68,000 volunteers.[46] Aged care is part of the health care and social assistance sector which employed approximately 1,680,900 people in May 2018, which is around 13.4% of the total workforce.[47] The industry was the largest growing in terms of employment, over the past year—up by 57,700 or 3.6%—and has been the largest growing industry over every year (to May) since 2015.[48]

How do older people get information and access care?

Finding care and support

As older people experience a decline in their physical and cognitive health which impacts their ability to live independently, many continue to live in the community without formal care services. They rely on family and friends to assist them. When their needs reach a point where formal care is required, they have the option to pay for care privately or seek to access government subsidised care services.

Older people and their families use a variety of sources to find information on getting services including health professionals, local councils, neighbours and friends. There are also fee for service brokers and financial advisers who help some people find services and understand the financial implications. A key recommendation of the Productivity Commission in 2011 was to establish a single gateway through which older Australians would obtain information about, and access to, aged care services. It was recognised that older people and their families face a complex and confusing array of entry points and multiple sources of information about ageing and aged care.[49]

My Aged Care was established from 2013 to provide a single-entry point and gateway to access Australian Government-subsidised aged care services (Figure 4). Through a contact centre and website, it provides information on aged care, refers older people for needs-based assessments and helps them find appropriate services in their local area. In 2017–18, there were over 1.4 million calls to the My Aged Care contact centre and over 3.5 million visits to the website.[50]

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45 Australian Government, *2015 intergenerational report—Australia in 2055*, 2015, p xvii.

46 National Institute of Labour Studies, *2016 National aged care workforce census and survey—the aged care workforce*, 2017, pp 158–9.

47 Department of Jobs and Small Business, *Health care and social assistance jobs on the rise*, 10 September 2018, www.jobs.gov.au/newsroom/health-care-and-social-assistance-jobs-rise.

48 Ibid.

49 Productivity Commission, above n 2, pp lxxxv, xxiv–xxx.

50 Australian Department of Health, above n 36, p 6.

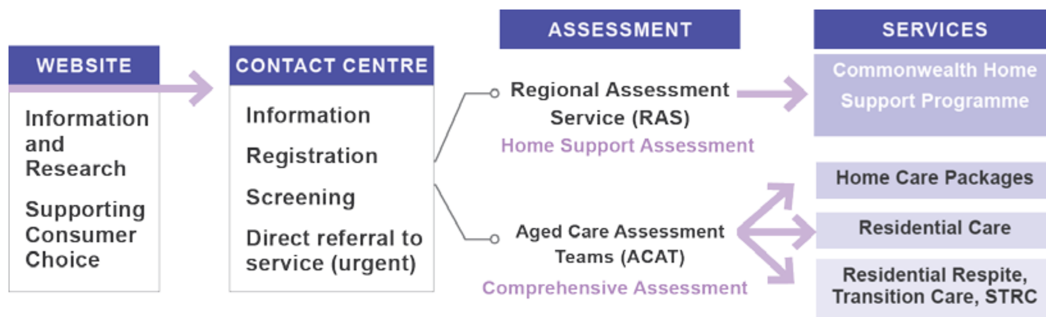

Figure 4: Accessing aged care services via the current single-entry point

Source: D Tune, *Legislated Review of Aged Care 2017*, 2017, p 124.

The recent legislated review of aged care assessed the effectiveness of arrangements for accessing aged care services and in particular the effectiveness of the relatively new My Aged Care arrangements. Tune said that the introduction of My Aged Care was a significant reform which faced 'substantial implementation challenges'.[51] While concerns continue about accessibility of the system, Tune concluded that 'My Aged Care represents an important step forward for service delivery, which is reflected in the high satisfaction levels reported in surveys of older people and carers who use the system'.[52]

However, Tune noted there were low levels of community awareness about aged care and of My Aged Care and that regular information campaigns were required to build awareness.[53] Improvements should continue to be made to the presentation of information on the website to make it easier to use.[54]

Tune also found evidence that hard to reach populations, those with complex needs and those with limited access to technology, are struggling with access and recommended the introduction of aged care system navigators and outreach services to assist those who find existing channels difficult to use.[55] In the 2018–19 Budget, the Australian Government announced additional funding to improve My Aged Care and that it would trial different options for navigation and outreach services.[56]

Assessing eligibility

To access aged care services subsidised by the Australian Government, older people must have their needs assessed. When older people contact My Aged Care looking for aged care support, they are registered and undergo a screening conversation through the contact centre where they may be referred for a face to face assessment. For home support services, they are referred to a Regional Assessment Service; for more complex care, they are referred for comprehensive assessment by an Aged Care Assessment Team. Where appropriate, they may be referred to health or other support services.[57]

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[51] D Tune, above n 6, p 10.
[52] Ibid, p 10.
[53] Ibid, p 11.
[54] Ibid, p 137.
[55] Ibid, p 134.
[56] Australian Department of Health, *Budget 2018–19 portfolio budget statements, budget related paper no. 1.9, health portfolio*, 2018, p 26.
[57] Australian Department of Health, *Streamlined consumer assessment for aged care discussion paper*, 2018, pp 4–5.

	Regional Assessment Services	Aged Care Assessment Teams
Main function	Assessment for entry-level support at home under the Home Support Program	Assessment for people requiring aged care services under the *Aged Care Act 1997* (Cth)
Contracted providers	17 Regional Assessment Services	8 State and Territory governments, operating 80 Aged Care Assessment Teams
Target clients	Frail senior Australians aged 65 years or older (or 50 years or older for Aboriginal and Torres Strait Islander people) but may include prematurely aged people 50 years or older (or 45 years or older for Aboriginal and Torres Strait Islander people) who are on a low income and who are homeless or at risk of homelessness	People with more complex needs requiring access to higher intensity care available under home care, residential care (including respite), transition care or short-term restorative care
Assessment volume (2017–18)	232,612	186,128
Assessment setting	Community setting only	Community and hospital setting
Links to *Aged Care Act 1997* (Cth)	None	Powers are delegated to specific Aged Care Assessment Team positions under the Act.
Role with access to services	Following assessment, a person may be: - referred for home support services - recommended to receive linking support or reablement services - referred for a comprehensive assessment - provided with information	Following approval, a person may be: - referred for home care, residential care (including respite), transition care or short-term restorative care - referred for home support services - referred for other aged care services - provided with information
Workforce qualifications	Assessors typically have vocational education and training qualifications in aged care and community services.	Multi-disciplinary tertiary-qualified staff from health-related disciplines such as medical practitioner, registered nursing, social work, physiotherapy, occupational therapy and psychology
Assessment Funding model	Most services are funded through unit pricing arrangements	Jurisdictions are block funded

Table 1: Aged care assessment pathways

Source: Australian Department of Health, *Streamlined consumer assessment for aged care discussion paper*, 2018, pp 4–5.

For the Multi-Purpose Services Program and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, assessment is based on clinical need and an assessment by an Aged Care Assessment Team is not required.[58]

Tune found stakeholder concern about complexity and duplication within the screening pathway and about the timeliness, quality and consistency of the assessment process under My Aged Care. He recommended a more rigorous and integrated assessment model, with the first step being combining the Regional Assessment Service and Aged Care Assessment Team workforces and, subsequently, integration with the residential care funding assessment.[59]

In the 2018–19 Budget, the Australian Government announced it will design and implement a new framework for streamlined and faster eligibility assessments for all aged care services, to be delivered by a new national assessment workforce from 2020.[60]

What care is available?

Descriptions of the Australian aged care system portray a continuum of care ranging from entry-level services at home through more structured packages of home-based support to residential care providing support and accommodation for people who have been assessed as needing higher levels of care. In addition to mainstream residential and home care, there are alternative programs such as:

- Transition Care;
- Short-Term Restorative Care;
- Multi-Purpose Services;
- Innovative Care; and
- National Aboriginal and Torres Strait Islander Flexible Aged Care Program services.[61]

Respite care is also available in a variety of settings.[62]

However, older people do not necessarily progress through the system in a linear fashion nor does program design always reflect how the system works in practice. In particular, there are people receiving care under entry level home support programs with high care needs, which may be for historical reasons as the previous Home and Community Care Program varied around the country.

While on average the government spends just $2800 per person, per year on a person receiving entry level services under the Commonwealth Home Support Program, unpublished data from the Department of Health showed 50,000 people access more than five Commonwealth Home Support Program services. A small number of people grandfathered from the former Home and Community Care Program are also receiving more

58 Australian Department of Health, *National Aboriginal and Torres Strait Islander flexible aged care program manual*, 2018; Australian Department of Health, *Multi-purpose service care recipient eligibility and fees*, https://agedcare.health.gov.au/programs/flexible-care/multi-purpose-service-care-recipient-eligibility-and-fees.

59 D Tune, above n 6, pp 140–1.

60 Australian Department of Health, above n 56, p 26.

61 Australian Department of Health, above n 36, p 3.

62 Ibid.

than $100,000 in government funding which is double the annual subsidy for a Level 4 Home Care Package.[63]

There are also inconsistent user contribution rules for different types of care in the home and this seems to be influencing choice of care type.[64] Constraints on the availability of higher-level Home Care Packages and on qualified staff may also be factors.

The Australian Institute of Health and Welfare has brought together a number of data sets and records for more than 5 million people allowing analysis of how people used aged care services between July 1997 and June 2014.[65]

This research showed that in 2013–14, 61,300 people across Australia entered permanent residential aged care for the first time. The cohort had over 1000 different pathways through the aged care system before entering permanent residential aged care using one or more of the following programs:

- Home and Community Care (now known as the Commonwealth Home Support Program);
- Home Care Packages;
- Transition Care Program; or
- Respite residential aged care. [66]

Regardless of subsequent aged care program use, 76% of this cohort had first used services from the Home and Community Care Program, and 'many of the pathways showed that people moved through aged care programs towards progressively higher levels of support'.[67] Respite was most likely to be used prior to permanent residential aged care. The last-used aged care program varied according to people's demographic characteristics and health and functional status.[68]

The Institute has also analysed cause of death patterns and any aged care services used before death for nearly 245,000 older people (Indigenous Australians aged 50 and over, and non-Indigenous Australians aged 65 and over) who died between July 2012 and June 2014.[69] Four in five (80%) of people in the study cohort had used an aged care program sometime before their death. Cause of death patterns differed somewhat between this group and people who had not used any aged care. Coronary heart disease (14%) was the leading underlying cause of death for people who had used aged care, followed by dementia (11%). For people who had not used aged care, coronary heart disease was also the leading underlying cause of death (16%), but this was followed by lung cancer (9%). Cancer-related causes were more common among those who had not used any aged care.[70]

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63 L Belardi, 'CHSP under pressure as some clients exceed intended number of services' (30 November 2017) *Community Care Review*, www.australianageingagenda.com.au/2017/11/30/chsp-pressure-clients-exceed-intended-number-services/.

64 D Tune, above n 6, p 7.

65 Australian Institute of Health and Welfare, *Pathways to permanent residential aged care in Australia: a pathways in aged care (PiAC) analysis of people's aged care program use before first entry to permanent residential aged care in 2013–14*, 2017, p 43.

66 Ibid, p 7.

67 Ibid, p vi.

68 Ibid, p vi.

69 Australian Institute of Health and Welfare, *Cause of death patterns and people's use of aged care: a pathways in aged care analysis of 2012–14 death statistics*, 2018.

70 Ibid, p 10.

Intersection with health system

Older people are also significant users of the health system, especially primary care and acute care with:

- 3 in 10 Medicare claims for un-referred general practitioner attendances for people aged 65 and over;
- 1 in 10 Medicare-subsidised services related to mental health for people aged 65 and over; and
- 1 in 5 emergency department presentations for people aged 65 and over.[71]

In 2015–16, 52.2% of palliative care-related hospitalisations were for people aged 75 and over.[72]

As noted by the Steering Committee for the Review of Government Service Provision:

> Nationally in 2016–17, the proportion of all hospital patient days used by patients waiting for residential aged care was 11.4 per 1000 patient days. Proportions were lower for Aboriginal and Torres Strait Islander people compared to other Australians, but higher for people from low socioeconomic areas compared to those from higher socioeconomic areas.[73]

Older Australians have increasingly complex care needs that frequently require multidisciplinary services drawn from across the aged care and health care systems. However, funding and jurisdictional boundaries and professional silos can impact on access to care and the care experience for the older person and increase costs for older people and governments.[74]

Care at home

Currently, there are two key mainstream programs providing care and support in home, with two programs available for veterans. The history of how the two mainstream programs have developed has a major impact on their structure today:

- The Commonwealth Home Support Program is based on the Home and Community Care Program which dates back to the mid-1980s and was managed by state and territory governments. Up until recently providers determined access to services—this is now the role of Regional Assessment Services for people newly seeking access. Providers are block funded to deliver specific support services, user contribution arrangements are principles based and some older people are charged little or no fees.
- Home Care Packages on the other hand developed in the 1990s as an alternative to residential care, and program arrangements are more closely aligned to residential care, with funding paid on occupancy and access determined through Aged Care

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71 Australian Institute of Health and Welfare, *Older Australians at a glance*, 10 September 2018, www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/health-aged-care-service-use.

72 Australian Institute of Health and Welfare, *Palliative care services in Australia*, 17 October 2018, www.aihw.gov.au/reports/palliative-care-services/palliative-care-services-in-australia/contents/admitted-patient-palliative-care.

73 Productivity Commission Steering Committee for the Review of Government Service Provision, *Report on government services 2019*, chapter 14, p 14.17.

74 Aged Care Workforce Strategy Taskforce, *A matter of care: Australia's aged care workforce strategy*, 2018, p 2.

Assessment Teams. Since July 2014 more structured means testing arrangements have been in place.[75]

In 2015, the Australian Government announced that from July 2018 the Commonwealth Home Support Program and the Home Care Packages program would be combined to create a single program offering care and support in the home.[76] While some consultation with the sector on how that might operate has occurred, implementation of the combined program has been deferred until at least 2020 and the sector awaits advice from the government on next steps. In the interim, it is clear that differences between the two programs, particularly in relation to user contributions between the programs are influencing decisions people make about their use of services.[77]

Commonwealth Home Support Program

An entry-level program, the Home Support Program is intended to provide ongoing or short-term care and support services such as help with housework, personal care, meals and food preparation, transport, shopping, allied health, social support and planned respite. Support is underpinned by a wellness approach, which is about building on each person's strengths, capacity and goals to help them remain independent and to live safely at home.[78]

The Home Support Program commenced in July 2015 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 (July 2016) and Western Australia (July 2018) joined the program later than other jurisdictions. There is a lot of variation around the country in how the program operates in practice and many people receive larger amounts of care than would be expected for an entry level program.

In 2017–18, the Home Support Program provided support to 783,043 people. In Western Australia, an additional 75,116 people received services through the jointly-funded Home and Community Care Program, of whom 64,491 were aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people), a total of 847,534 older people.[79]

Home Care Packages

Home Care Packages provide a more structured, more comprehensive package of home-based care support, over four levels of care:

- Level 1—to support people with basic care needs;
- Level 2—to support people with low level care needs;
- Level 3—to support people with intermediate care needs; and
- Level 4—to support people with high care needs.

Under a Home Care Package, a range of personal care, support services, clinical services and other services is tailored to meet the assessed needs of the person.

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[75] Catholic Health Australia, *Aged care update: what are the prospects for a single home-based care and support program for older Australians* (9 April 2018) pp 1–2.

[76] Department of Social Services, *Portfolio budget statements 2015-16*, *budget related paper no. 1.15a, social services portfolio*, p 19.

[77] D Tune, above n 6, p 7.

[78] Australian Department of Health, above n 36, p 22.

[79] Ibid, p 24.

The number of people receiving a Home Care Package at 30 June 2018 was 91,847.[80] This was an increase of 20,424 (or 28.6%) from 30 June 2017,[81] but is still well short of community expectations of the amount of care that is available for people at home.

Since February 2017, Home Care Packages have been assigned directly to the person needing care rather than allocated to providers. This allows people to direct their package to the provider of their choice as well as change providers. People assessed as requiring home care are placed on the National Prioritisation Queue based on how long they have been waiting for care and their individual needs and circumstances, regardless of where they live.

Unmet demand for home care is long standing but was not quantified or visible until the implementation of the National Prioritisation Queue.[82] Data from the Department of Health illustrates this clearly. It shows that at 30 September 2018, there were 69,086 people waiting for an approved level package who had not yet been offered a lower level Home Care Package. 91.6 % (63,280) of these people had been provided with an approval to access the Home Support Program.[83] There were 57,646 people who, while they were waiting for a package at their approved level, had been offered an interim Home Care Package at a lower level.[84]

Veterans' programs

Veterans' Home Care is a program designed to assist eligible veterans who need a small amount of practical help to continue living independently in their own home. Services include domestic assistance, personal care, respite care, and safety-related home and garden maintenance. It is not designed to meet complex or high-level care needs. Veterans' Home Care also assists carers.

The Department of Veterans' Affairs Community Nursing Program is designed to enhance the independence and health outcomes of eligible veterans by avoiding early admission to hospital and/or residential care through access to community nursing services that meet their assessed clinical and/or personal care needs.

As reported in the *Report on government services 2019*:

> In 2017–18, 47,449 older veterans were approved for [Veterans' Home Care] and 17,253 older people received community nursing services, representing 36.0 and 13.1 per cent of older eligible veterans respectively.[85]

Residential care

Residential care provides support and accommodation for people who have been assessed as needing higher levels of care than can be provided in the home. Residential care is provided on either a permanent or a temporary (respite) basis.

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80 Ibid, p 29.
81 Ibid.
82 Aged Care Financing Authority, above n 44, p 34.
83 Australian Department of Health, *Home care packages program, data report 1st quarter 2018–19*, 2019, p 11.
84 Ibid.
85 Productivity Commission Steering Committee for the Review of Government Service Provision, above n 73, p 14.5.

The services provided through residential care include:

- help with day-to-day tasks (such as cleaning, cooking, laundry);
- personal care (such as bathing, dressing, grooming, going to the toilet);
- clinical care (such as wound care and medication administration) under the supervision of a registered nurse; and
- other care services.

For people who need almost complete assistance with most activities of daily living, residential care can provide 24-hour care.

In 2017–18, 241,723 people received permanent residential aged care at some time during the year, an increase of 2344 from 2016–17.[86]

Flexible care

There are five models of flexible care which respond to the different care needs of older people, extending beyond those provided in mainstream residential and home care. These programs are:

- Transition Care;
- Short-Term Restorative Care;
- Innovative Care;
- Multi-Purpose Services; and
- National Aboriginal and Torres Strait Islander Flexible Aged Care Program services.

Transition Care Program

The Transition Care Program was established in 2005–06 and provides short-term care for older people following discharge from hospital. The program aims to help those who would otherwise be eligible for residential care to optimise their functional capacity and improve their levels of independence.

Older people may receive transition care for up to 12 weeks (with a possible extension of another six weeks) in either a community (home) or residential setting. To be assessed for transition care, older people must be in hospital at the time of the assessment. At 30 June 2018, 3,683 people were receiving transition care.[87] Over the course of 2017–18, a total of 25,113 people received transition care.[88]

State and territory governments are funded by the Australian Government, as the approved providers of transition care, to manage the program in their respective jurisdictions. Most state and territory governments then subcontract the provision of these services to state-funded health services and aged care providers.

Short-Term Restorative Care Program

This program began in February 2017 and provides early intervention care that aims to optimise the functioning and independence of older people and to reverse and/or slow

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86 Australian Department of Health, above n 36, p 43.
87 Ibid, p 54.
88 Ibid, p 54.

functional decline. The program improves wellbeing through the delivery of a time-limited, goal-oriented, multidisciplinary and coordinated range of services.

It is delivered in the form of a tailored package of services and supports such as physiotherapy, social work, nursing support, personal care and the provision of assistive technologies, to enable older people to regain independence and autonomy rather than entering long term care prematurely. Restorative care services may be delivered in a home care setting, a residential care setting, or a combination of both. During 2017–18, a total of 1638 people received short term restorative care, with 296 people receiving care at 30 June 2018.[89]

Innovative care services

Innovative care was originally established in 2001–02 to pilot new approaches to providing aged care to support people with aged care needs who lived in state or territory-funded supported accommodation facilities, who were at risk of entering residential aged care at the time the pilots started.

At 30 June 2018, there were nine projects, delivered through four services in New South Wales, two in South Australia, and one each in Tasmania, Victoria and Western Australia. No new entrants are being accepted into the program, so the number of care recipients decreases as people leave. At 30 June 2018, there were 54 operational innovative care places, compared to 62 at 30 June 2017.[90]

Multi-Purpose Services Program

This program is a jointly-funded Australian Government and state and territory government initiative which operates in all states and the Northern Territory. Through flexible and integrated service delivery, the program provides access to a mix of aged care, health and community services tailored to meet local community needs.

The program enables older people living in regional, rural and remote areas to receive the aged care services they need in their own community. The majority of services are co-located with a hospital or health service. There was a total of 3624 operational residential care and home care places at 30 June 2018.[91]

National Aboriginal and Torres Strait Islander Flexible Aged Care

This is also a type of flexible aged care. Services are administered outside the Aged Care Act and provide culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to home and community. Such services are located mainly in remote areas. In 2017–18, funding of $36.5 million was provided to 35 services under the program, with 860 operational places.[92]

89 Ibid, p 55.
90 Ibid, p 57.
91 Ibid, p 56.
92 Ibid, p 58.

Respite care

Respite care provides a short-term support and care service for older people and their carers and is available in a number of settings.

The Commonwealth Home Support Program provides flexible planned respite services, including flexible respite, cottage respite, and centre-based respite. In 2017–18, 46,098 people received respite services under the Home Support Program.[93]

Residential respite provides short-term care in Australian Government subsidised aged care homes, with the primary purpose of giving a carer or the person being cared for a break from their usual care arrangements. Residential respite may be used on a planned or emergency basis. To access residential respite a person must be assessed as eligible by an Aged Care Assessment Team. Throughout 2017–18, a total of 61,993 people received residential respite care.[94] On 30 June 2018, there were 5674 people receiving residential respite care.[95]

The Aged Care Financing Authority, a statutory committee established to provide advice to government on funding and financing issues, has identified a noticeable uptake in the use of residential respite care in recent years, reflecting in part a demand for the use of respite as a 'try before you buy' model before a person enters permanent residential care.[96] The Tune review made similar observations. With more people with higher care needs being cared for at home, Tune expected further increases would be needed. He recommended a review of existing respite arrangements, noting the need to ensure there are adequate and appropriate respite services available to support informal carers in their role.[97]

Care for people with special needs

One of the objectives of the Aged Care Act is to facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location. The Act designates certain people as 'people with special needs'.

The special needs groups under the Act are:

- people from Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse (CALD) backgrounds;
- veterans;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- people who are homeless or at risk of becoming homeless;
- people who are care-leavers;
- parents separated from their children by forced adoption or removal; and
- lesbian, gay, bisexual, transgender and intersex (LGBTI) people.[98]

These groups are also recognised in aged care programs outside of the Act.[99]

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[93] Ibid, p 37.
[94] Ibid, p 37.
[95] Ibid, p 37.
[96] Aged Care Financing Authority, *Report on respite for aged care recipients*, 2018, p 3.
[97] D Tune, above n 6, pp 62–4.
[98] Australian Department of Health, above n 36, p 62.
[99] Ibid, p 67.

The aged care chapter in the *Report on government services 2019* measures the proportion of service clients who are from a special needs group, compared with the proportion of the aged care target population who are from that special needs group. Data is available for Aboriginal and Torres Strait Islanders, those from culturally and linguistically diverse backgrounds and from rural and remote areas. Measures are under development for veterans and those from financially and socially disadvantaged backgrounds but are not available for the remaining special needs groups.[100] In 2018, it was found that nationally:

- Aboriginal and Torres Strait Islander Australians are overrepresented for low level Home Care Packages (levels 1−2), similarly represented amongst those accessing the Home Support Program, but are underrepresented in all other service types;
- people from culturally and linguistically diverse backgrounds are overrepresented amongst those accessing both low and high level Home Care Packages, but underrepresented in all other service types; and
- people receiving aged care services in rural and remote areas are overrepresented amongst those accessing the Home Support Program, but underrepresented in all other service types.[101]

The Aged Care Diversity Framework seeks to embed diversity in the design and delivery of aged care and support action to address perceived or actual barriers to people accessing safe, equitable and quality aged care. The Dementia and Aged Care Services fund seeks to strengthen the capacity of the aged care sector to better respond to existing and emerging challenges through new and innovative, generally time-limited projects. This includes support for existing and emerging priorities in dementia care. It also funds other measures to support Aboriginal and Torres Strait Islander people and people from diverse backgrounds to receive the same quality of aged care as other older Australians.[102]

There are specific supplements in place for some groups:

- A viability supplement for aged care services in rural and remote areas recognises the additional costs providers face in service provision. As part of the viability supplement, support is available for eligible residential services specialising in care for people at risk of homelessness, low-care in rural and remote areas, and care for Aboriginal and Torres Strait Islander Australians.
- A Homeless Supplement supports aged care homes that specialise in caring for people with a history of, or who are at risk of homelessness.
- A Hardship Supplement is paid on behalf of care recipients in financial hardship who are unable to pay their aged care costs.
- An Accommodation Supplement is payable for people who are unable to pay all or part of their accommodation costs.
- A Veterans' Supplement in residential care facilitates access to residential care for veterans with a mental health condition accepted by the Department of Veterans' Affairs as related to their service.[103]

Other programs and initiatives support providers to deliver aged care appropriate to the needs of particular groups.

[100] Productivity Commission Steering Committee for the Review of Government Service Provision, above n 73, p 14.13.
[101] Ibid, p 14.14.
[102] Australian Department of Health, above n 36, p 71.
[103] Ibid, p 45.

Dementia support

The Australian Government funds various programs and services to improve understanding and awareness of dementia, and increase the skills and confidence of those living with dementia, as well as their carers, family members, health professionals, volunteers and community contacts. Programs include:

- The National Dementia Support Program;
- Dementia Education and Training for Carers; and
- Dementia Training Program.[104]

A particular area of attention has been how best to support providers to care for people with behavioural and psychological symptoms of dementia. As part of the Living Longer Living Better reforms, the Dementia and Severe Behaviour Supplement was put in place to support an estimated 2000 people who experience severe and extreme behaviours and psychological symptoms associated with dementia. However, more than 25,000 people were receiving the supplement within its first year with expenditure increasing from an initial estimate of $11.7 million to $110 million.[105] The supplement was ceased in July 2014 while consultation occurred on alternative approaches.

A tiered approach to providing support is being put in place. The first tier of support is Dementia Behaviour Management Advisory Services which provide support and advice to service providers and individuals caring for people with dementia where behavioural and psychological symptoms of dementia are affecting a person's care. The second tier is Severe Behaviour Response Teams which are a mobile workforce of clinical experts who provide timely and expert advice to residential aged care providers who request assistance in caring for people with more severe behavioural and psychological symptoms of dementia. $54.5 million over four years is being provided from 2015–16 to 2018–19 for this service.[106]

The third tier will be the Specialist Dementia Care Program which will provide a 'person-centred, multidisciplinary approach to care for people exhibiting very severe behavioural and psychological symptoms of dementia who are unable to be appropriately cared for by mainstream aged care services'.[107] According to the Department of Health, the program will offer 'specialised, transitional residential support, focussing on reducing or stabilising symptoms over time, with the aim of enabling people to move to less intensive care setting'.[108] The Department of Health estimates that up to 1% of all people living with dementia would be in the target group. It will commence with a prototype service from mid-2019 and it is expected that there will be at least one specialist dementia care unit (within a broader residential aged care service) operating in each of the 31 Primary Health Networks by full rollout in 2022–23.[109]

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[104] Australian Department of Health, *Australian Government programs to support people living with dementia and their support networks*, 2018, www.health.gov.au.
[105] J McNamee et al, *Alternative aged care assessment, classification system and funding models final report*, 2017, Vol 2, p 7.
[106] Australian Department of Health, above n 36, p 72.
[107] Australian Department of Health, *Specialist dementia care program*, 2019, www.health.gov.au.
[108] Ibid.
[109] Ibid.

Younger people in aged care

As of 30 June 2018, there were 6045 people aged under 65 years living in residential aged care,[110] in addition to there being young people in receipt of Home Care Packages. This included people with intellectual and learning disability, physical disability such as acquired brain injury, stroke or other neurological conditions, psychosocial disability, sensory disability, younger onset dementia or premature ageing associated with life experiences.

It is a matter of long-standing public policy interest and community concern that the disability service system is not providing appropriate supports and services for these young people and they are inappropriately being admitted to aged care.

Young people accessing aged care services may now be eligible for supports through the National Disability Insurance Scheme as it rolls out across Australia through to 2020. As of 30 June 2018, there were 3112 people in aged care who were active participants of the Scheme.[111]

Who provides care?

Informal carers

Informal carers, mainly family, but also friends, neighbours and community groups, provide most of the care and support required by older people. Informal assistance has primarily been recorded for tasks such as reading or writing, communication and mobility.[112] Informal carers also play a major role in managing formal community care services. The Survey of Disability, Ageing and Carers found there were 306,500 households where primary carers lived with someone aged 65 years and over.[113]

Deloitte Access Economics estimated that if the informal care provided by unpaid family carers to all people in need, including the frail aged, were replaced by formal paid care, the cost would be in excess of $60.3 billion per annum in 2015. In the next ten years, the demand for informal care is set to significantly outstrip its supply.[114]

In recognition of the demands placed on informal carers, the Australian Government provides support through planned and emergency respite services (both in home, at day centres and in residential care), as well as income support (such as the Carer Allowance and Carer Payment). A Carers Gateway has been set up to provide information about services and support available for people who care for someone with disability, chronic illness, dementia, mental illness or who are frail aged. It includes a website, phone service and service finder to assist carers to locate their nearest support services.

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[110] Productivity Commission, *Report on government services 2019: services for people with disability*, table 15A.52.
[111] Ibid.
[112] Australian Bureau of Statistics, above n 35.
[113] Ibid.
[114] Deloitte Access Economics, *The economic value of informal care in Australia in 2015: Carers Australia*, 2015, p iii.

Aged care providers

Aged care providers range from small businesses to large national enterprises. Table 2 below shows that the majority of aged care services are provided by not-for-profit service providers across all three types of care, with the market share of these providers ranging from 56% in residential care to 69% in the Home Support Program.

However, much of the growth in aged care supply in recent years reflects growth of for-profit providers.[115] This is especially true for residential care where, while the number of for-profit providers has remained stable, the number of places supplied by each for-profit provider has increased.[116]

At 30 June 2018, there were a total of 1550 approved providers of aged care services under the Aged Care Act. In 2017–18, over 1450 organisations were funded to deliver services under the Home Support Program.[117]

The majority of providers operate only one type of aged care service. In 2016-17, across the main aged care programs (Home Support Program, home care and residential aged care):

- 7% of providers provided services across three programs;
- 17% of providers provided services across two programs; and
- 76% provided services in one program.[118]

	Residential care	Home care	Commonwealth Home Support*	Flexible Care
Number of providers	886	873	1456	100
For profit	33%	35%	7%	7%
Not for profit	56%	53%	69%	58%
Government**	11%	12%	24%	35%

* In addition, there were 91 providers under the WA HACC Program
** Some state and territory and local governments are aged care providers

Table 2: Number and type of aged care providers, 2017–18

Source: data provided by the Department of Health, November 2018

[115] Aged Care Financing Authority, above n 44, p 67.
[116] Deloitte Access Economics, *Australia's aged care sector: economic contribution and future directions: the Aged Care Guild*, 2016, 3.
[117] Australian Department of Health, above n 36, p 79.
[118] Aged Care Financing Authority, above n 44, p 13.

Aged care workforce

Workforce Data

A National Aged Care Workforce Census and Survey was conducted by the National Institute of Labour Studies on behalf of the Australian Department of Health in 2003, 2007, 2012 and 2016.

The 2016 Census and Survey reported that:

- there were estimated to be 366,027 workers in aged care with 240,317 in direct care roles;[119]
- 70% of direct residential workers were personal care attendants, 15% were registered nurses and 10% were enrolled nurses;[120]
- community care workers were the largest home care and home support direct care occupational group (84%) followed by registered nurses (8%) and allied health professionals (6%);[121]
- the aged care workforce remains predominantly female, older, and in good health. The direct care residential workforce is getting younger, while the home care and home support workforce is getting older;[122] and
- negative perceptions of aged care work as an occupation of low pay and status remain.[123]

Trends over time

The residential aged care workforce is estimated to have grown by 17% between 2012 and 2016 and by about 50% since 2003. However, the estimated proportion of the residential aged care workforce working in direct care roles is falling significantly. In 2016, 65% of residential aged care employees worked in direct care roles, compared with 73% in 2012, 76% in 2007 and 74% in 2003.[124]

In that same time period, there have been changes in the occupational mix. Residential facilities continue to rely increasingly on personal care attendants to provide direct care to residents, with registered nurses reducing from 21% to 14.6%, enrolled nurses reducing from 13.1% to 10.2% and personal care attendants increasing from 58.5% to 70.3% of the workforce.[125]

In home care and home support the total workforce decreased by 13% between 2012 and 2016. During the same time period the overall direct care workforce fell by 7% and the full-time equivalent workforce by 19%. This reduction followed an earlier rise between 2007 and 2012. The National Institute of Labour Studies attributes this to the home care sector undergoing considerable structural change in the way labour is used and in the differential use of direct and non-direct care employees. The occupational distribution has been relatively stable as 'home care and home support outlets continue to rely on [community care

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[119] National Institute of Labour Studies, above n 46, p 158.
[120] Ibid, p 10.
[121] Ibid, p 67.
[122] Ibid, p xviii.
[123] Ibid, p xviii.
[124] Ibid, p 12.
[125] Ibid, p 13.

workers] to provide direct care without much change in the occupational distribution for direct care workers'.[126]

Since 2012 there has been a significant move away from casual or contract employment arrangements, most notably within the home care and home support sector.[127]

Workforce programs

Since 2002, successive governments have funded different types of workforce programs.[128]

The Aged Care Workforce Fund was introduced in 2011 with the aim of improving quality of aged care by providing a flexible pool of funds for initiatives that improve the skills of the aged care workforce. The fund provided access to education, training and other form of supports (for example, nursing scholarships and financial support for aged care providers to provide training places), and targeted training and development for priority groups, including for Aboriginal and Torres Strait Islander peoples.[129]

Following a stocktake of Australian Government funded aged care workforce activities in 2015, the Government announced that the Aged Care Workforce Fund would be combined with health workforce funding a single Health Workforce Program.[130]

In the 2017–18 Budget, the Government announced funding of $1.9 million over two years to support the Aged Care Workforce Taskforce to develop an Aged Care Workforce Strategy.[131] $33 million over three years was allocated for the Boosting the Local Care Workforce Program.[132] The new program aims to develop the capacity of disability and aged care service providers to operate effectively and expand their business offerings and workforces.[133]

Workforce challenges

Successive reviews of the aged care system have framed the workforce challenges facing the aged care sector. There have been longstanding concerns around workforce numbers and skills mix, attraction, retention and career paths, remuneration and the levels of skills and qualifications. It is also recognised that the aged care workforce will need to expand considerably as the population ages and adopt new models of care and scopes of practice to meet changing expectations. The Productivity Commission estimated that by 2050 the aged care workforce will need to have grown to around 980,000 workers.[134]

In 2011, the Commission proposed that scheduled care prices take into account the need to pay fair and competitive wages to nursing and other care staff. It also supported the development of more attractive career paths, opportunities for professional development,

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[126] Ibid, p 69.
[127] Ibid, p xviii.
[128] D Tune, above n 6, p 176.
[129] Australian Department of Health, *Portfolio budget statements 2012-13, budget related paper no. 1.10, health and ageing portfolio,* 2012, p 173.
[130] D Tune, above n 6, p 178.
[131] Australian Department of Health, *Budget 2018–19 fact sheet: strengthening aged care—developing an aged care workforce strategy*, 2017; Australian Department of Health, *Aged care workforce strategy taskforce*, www.agedcare.health.gov.au/reform/aged-care-workforce-strategy-taskforce.
[132] Hon Christian Porter MP, Hon Ken Wyatt AM, MP, Hon Jane Prentice MP, *Joint media release—Boosting the local care workforce program to support local job creation in the National Disability Insurance Scheme*, 15 December 2017.
[133] Ibid.
[134] Productivity Commission, *Caring for older Australians*, Report No 53, 2011, Vol 2, p 354.

improved managerial expertise and a review of registered training organisations to ensure the quality of delivery of accredited courses.[135]

In response, the Living Longer Living Better package allocated $1.2 billion over four years for a Workforce Supplement, with funding directed to providers on condition that it contributed to wage increases negotiated with their employees. There were also other requirements that related to education and training and career development. The Supplement was available from 1 July 2013.[136]

Following the change in government in September 2013, the Supplement ceased and the remaining funding was redirected into the sector more generally rather than being tied specifically to wages. There was a 2.4% increase in basic subsidy for residential, home care and flexible care providers, an equivalent increase for grant funded programs such as the Home and Community Care Program, and a 20% increase in the Viability Supplement to assist rural and remote providers. The Government also committed to undertake a stocktake of workforce initiatives to inform future education and training priorities.[137]

Tune notes that since the Supplement was ceased the Government has not directly engaged on pay and conditions in the sector, although pay and conditions remains a key issue for the workforce.[138] Tune concluded that since the Supplement's redirection, the wage gap between workers in the aged care sector and the acute care sector remains and has not narrowed. Competition with other parts of the social services sector such as disability is also relevant.[139] Pay levels are the area of their work with which workers in all parts of the aged care sector are least satisfied.[140]

In September 2018, the Australian Government released a *Matter of care: Australia's aged care workforce strategy*. The strategy, which was developed by an independent taskforce chaired by Professor John Pollaers, is industry focused and identifies 14 strategic actions to help the aged care industry to address the current and future workforce challenges:

1. Creation of a social change campaign to reframe caring and promote the workforce
2. Voluntary industry code of practice
3. Reframing the qualification and skills framework—addressing current and future competencies and skills requirements
4. Defining new career pathways including accreditation
5. Developing cultures of feedback and continuous improvement
6. Establishing a new standard approach to workforce planning and skills mix modelling
7. Implementing new attraction and retention strategies for the workforce
8. Developing a revised workforce relations framework to better reflect the changing nature of work
9. Strengthening the interface between aged care and primary/acute care
10. Improved training and recruitment practices for the Australian Government aged care workforce
11. Establishing a remote accord
12. Establishing an Aged Care Centre for Growth and Translational Research

[135] Ibid, pp 347–57.
[136] D Tune, above n 6, p 177.
[137] Ibid.
[138] Ibid, p 178.
[139] Ibid, p 181.
[140] National Institute of Labour Studies, above n 46, p 11.

13. Current and future funding considerations, including staff remuneration
14. Transitioning the existing workforce to new standards.

The taskforce took a broad view of the workforce to ensure it included all of the 'touchpoints' for people in their ageing journey—from 65 years of age until end of life (from 50 years of age for Aboriginal and Torres Strait Islander people, and for the homeless and other prematurely ageing populations).[141]

The ageing continuum and the consumer journey
Multiple entry points and place-based consumer experiences

Consumer
People aged 65+ | Aboriginal and Torres Strait Islander people aged 50+ | Groups ageing earlier due to disadvantage
Individuals accessing services | Their families | Carers | Trusted entities or people designated to act on behalf of consumers | Local community

Industry and consumer participation across the consumer journey—formal and informal workforces

Planning	Primary health	Carers	In-home care	Functional health	Specialist care	Residential care	Acute and subacute care
• Financial planning • Retirement planning • Decision-making	• GPs • Pharmacy • Preventative health • Chronic disease management • Reablement • Wellness	• Interactions with formal workforces • Partners in care • Source of information on care needs • Respite	• Paid workforce • Volunteers • Flexible aged care services • Respite care • Specialist services • Veterans • People with a disability	• Preventative • Therapy • Dental care • Reablement • Wellness	• Chronic conditions • Specialist nurses (e.g. Parkinson's) • Palliative care • Mental health • Dementia	• Paid workforce • Volunteers • Flexible aged care services • Respite care • Palliative care • Specialist services • Veterans • People with a disability	• Emergency departments • In hospital wards • Outpatients • Transition back to home or residential care • Multi-purpose services • Cognitive and physical rehabilitation

System facilitators and navigators
Assessment teams and services—government | My Aged Care contact centre—government | System navigators—government and private | Advocates | Aged care—financial planners | Primary Health Networks Local Health Networks—governments

Governance and expectations
Regulation, compliance and healthy ageing—within and across all levels of government | Governance and management—across industry, within organisations and cross-sector collaboration | Consumer and community shared value

Figure 5: Integrating care across the ageing continuum, widely defined industry and workforces

Source: Aged Care Workforce Strategy Taskforce, *A matter of care: Australia's aged care workforce strategy*, 2018, p 3.

Three key industry peak bodies are setting up a leadership group to oversee implementation of the Aged Care Workforce Strategy.

Continuing attention and scrutiny are needed to address some of the complex and long-standing workforce challenges in the aged care sector and to assess what further action is required to meet future aged care needs. This will necessarily include consideration of the respective roles of government and the sector.

Who pays and for what?

Overview

The Government pays for the bulk of aged care in Australia, but older people may be asked to contribute towards the cost of their care and/or accommodation if they can afford to do so.

[141] Aged Care Workforce Strategy Taskforce, above n 74, p 1.

Currently the Australian Government provides about three-quarters of all aged care funding, with older people meeting less than a quarter of the cost.[142]

Australian Government funding

Australian Government expenditure on aged care was $18.1 billion in 2017–18[143] and is expected to increase to $22.2 billion by 2021–22.[144] Spending on aged care is expected to be the fastest grown budget item after the National Disability Insurance Scheme. The aged care sector is one of the fastest growing industries in Australia.[145]

In addition, other relevant Australian Government funding is the estimated $4 billion on carer payments for 2017–18.[146]

Where funding is directed

Of the $18.1 billion in the system in 2017–18, nearly 70% went to residential aged care (Figure 6); while only 21% of people in aged care were in residential care (with 67% of people receiving basic support at home).[147]

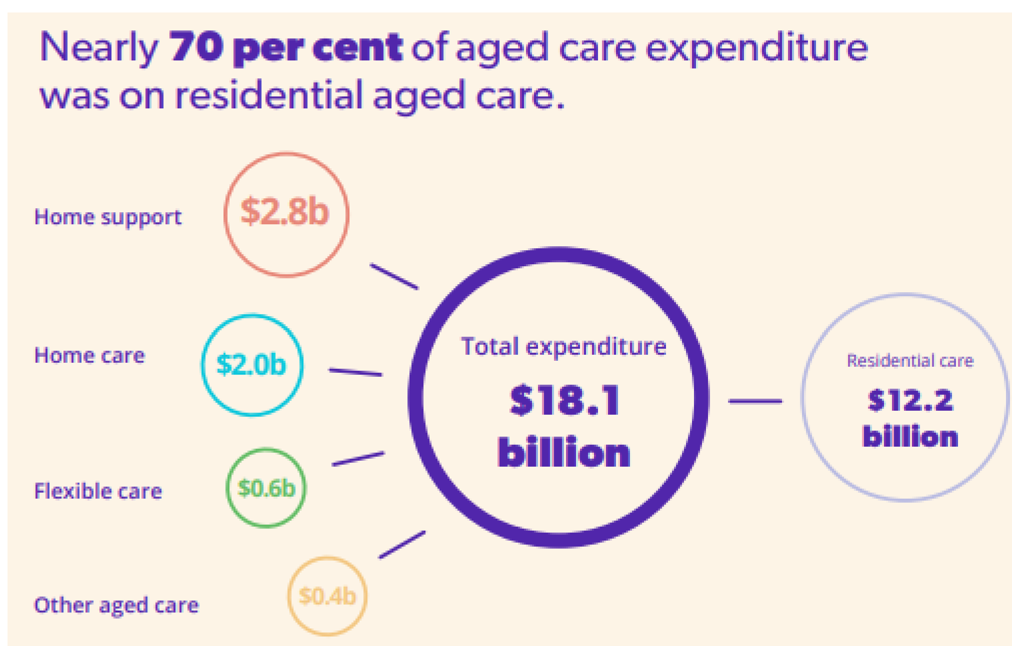

Figure 6: Australian Government aged care expenditure by type of care, 2017–18

Source: Australian Institute of Health and Welfare, *ROACA key facts*, 2019, referring to Australian Department of Health, *2017–18 report on the operation of the Aged Care Act 1997*, 2018.

[142] D Tune, above n 6, p 8.
[143] Australian Department of Health, above n 36, p 8.
[144] Australian Department of Health, above n 56, p 133.
[145] Aged Care Financing Authority, above n 44, p iii.
[146] ARC Centre of Excellence in Population Ageing and Research, *Aged Care Policy, Provision and Prospects*, 2019, p 2.
[147] Australian Department of Health, above n 36, p 10.

Residential aged care funding

Funding for residential aged care is made up of:

- operational funding, which supports day-to-day services such as nursing and personal care, living expenses and accommodation expenses; and
- capital financing, which supports the construction of new residential aged care facilities and the refurbishment of existing facilities.[148]

A combination of Australian Government and resident contributions provides the operational funding for residential aged care as described below.

Figure 7: Types of operational funding for Residential Aged Care

Source: Aged Care Financing Authority, *Annual report on funding and financing of the aged care sector*, 2018, p 89.

As illustrated in Figure 7, the Australian Government determines its contributions to operational funding by setting:

- a basic care subsidy for personal and nursing care;
- the rates of supplements paid to support aspects of residential care that incur higher costs to deliver; and
- the maximum rate of accommodation supplement for those residents who cannot afford to pay their accommodation costs. [149]

Care subsidies and supplements

The majority of residential care funding is made up of the basic care subsidy. For permanent residential care, this is determined by providers appraising the care needs of their residents by applying the Aged Care Funding Instrument.

[148] Aged Care Financing Authority, above n 44, p 88.
[149] Ibid, p 89.

The Aged Care Funding Instrument is a funding allocation tool. It assesses the care needs of permanent residents by allocating funding around the three main areas that differentiate relative care needs among residents—rating from nil, low, medium or high in each of:

- activities of daily living;
- behaviour; and
- complex health care.[150]

As at 20 September 2018, subsidies provided under the Funding Instrument range from:

- $0 per day for those with the lowest care needs (nil in all three domains); to
- $216.59 per day for those with the highest care needs (high in all three domains).[151]

In 2015–16, a third of Funding Instrument claims were high in all three domains. In major cities, there were more cases of Funding Instrument claims that are high in all three domains than other areas. Where pain and behaviour were well managed, there were less of these types of claims.[152]

The average Funding Instrument subsidy for the period 1 July 2017 to 30 June 2018 was $172.23 per day.[153]

To assess whether residents' care needs are being correctly funded, and to protect public expenditure, the Department of Health conducted 6636 reviews of Funding Instrument claims in 2017–18. Of these reviews 2290 (34.5%) resulted in reductions in funding and only 44 (0.7%) resulted in increased funding.[154]

Additional supplements are provided for needs such as enteral feeding, oxygen, and for the care of special needs groups (eg veterans, people who have been homeless, people in remote areas). Aged care facilities can receive one or more supplements in addition to subsidies and fees.

A number of transitional supplements are also payable for residents who were impacted by previous changes to aged care financing arrangements as part of grandfathering provisions.

Accommodation supplement

Accommodation supplements are paid by the Australian Government to assist with the accommodation costs of permanent residents who do not have the means to meet all of that cost themselves (supported residents). These supplements include both the current accommodation supplement and grand-parented supplements under previous policies. The government determines the amount of accommodation supplement payable. It sets the maximum rate of accommodation supplement and calculates the share to be paid by residents based on a means test.[155]

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[150] Australian Department of Health, *Aged care funding instrument (ACFI) reports*, www.agedcare.health.gov.au/tools-and-resources/aged-care-funding-instrument-acfi-reports.

[151] Australian Department of Health, *Aged care subsidies and supplements—new rates of payment from 20 September 2018*, 2018, www.health.gov.au.

[152] Department of Health, *AHSRI transcript 19 November 2018—presenting on the Resource Utilisation and Classification Study and the Australian National Aged Care Classification at the Department of Health's stakeholder forum*, 2018, www.agedcare.health.gov.au/reform/resource-utilisation-and-classification-study.

[153] Australian Department of Health, *ACFI monitoring report—June 2018*, 2018, www.agedcare.health.gov.au/tools-and-resources/aged-care-funding-instrument-acfi-reports, p 2.

[154] Australian Department of Health, above n 36, p 81.

[155] Aged Care Financing Authority, above n 44, p 92.

Funding assessment challenges

Care related funding from the Australian Government under the Aged Care Funding Instrument is the primary revenue source for residential aged care providers, accounting for 60.5% of revenue in 2016–17 with the next main source the basic daily fee paid by residents for living expenses (18 %) followed by the Australian Government accommodation supplement for supported residents (5%) and daily accommodation payments from residents (4%).[156]

The StewartBrown June 2018 *Aged Care Financial Performance Survey* incorporates detailed financial and supporting data from over 974 residential care facilities and over 24,952 Home Care Packages (455 home care programs) across Australia. The 2017–18 financial results for the residential care sector showed a significant deterioration from the previous year.[157] In particular, the financial viability of outer regional, rural and remote aged care providers was of concern, with 'over 63% of residential facilities in these geographic locations … operating at a loss, [and] more than 37% now operating at a cash deficiency'.[158]

The deterioration in financial performance followed government measures to pause Aged Care Funding Instrument indexation and make adjustments to the tool. There were similar measures taken in 2012–13 and on both occasions were a response by the government to 'growth in care funding it considered could not be justified by growth in resident frailty alone, but rather involved some level of over claiming by providers'.[159]

Providers and the government have differing views about the legitimacy of the increases in claims. Providers have argued that the growth in care payments per resident per day above indexation has reflected a continuing increase in the acuity/frailty of residents. The government has maintained that 'the rate of growth of care claims cannot be explained by pure growth in frailty, which would be expected to increase gradually over time'.[160]

A Resource Utilisation and Classification Study is underway to help inform consideration of funding reform options. The Aged Care Financing Authority has argued that a key element of any reform package should be a tool that accurately and objectively assesses the funding needs of residents.[161]

Home care funding

Government assistance for home care is paid at the rates set out below, with the amount increasing as the level of package rises:

- Level 1—basic care—$22.66 per day ($8,270.90 annually);
- Level 2—low level care—$41.22 per day ($15,045.30 annually);
- Level 3—intermediate care—$90.62 per day ($33,076.30 annually); or
- Level 4—high level care—$137.77 per day ($50,286.05 annually).[162]

Supplements are also paid for eligible care recipients.

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[156] Ibid, p 129.
[157] StewartBrown, *Aged care financial performance survey June 2018*, 2018, p 4.
[158] Ibid, p 6.
[159] Aged Care Financing Authority, above n 44, p 130.
[160] Ibid, p 132.
[161] Ibid, p 132.
[162] Australian Department of Health, above n 151.

The Tune Review received lots of input that people with significant care needs were not able to be effectively cared for at home for long periods, even when receiving a level 4 package. Tune recommended the introduction of a fifth level of Home Care Package with the level of assistance being no higher than the average costs of care in residential care (at that time around $63,000).[163]

Following the introduction of consumer directed care in 2015, and the allocation of Home Care Packages to the person receiving care rather than to the provider in February 2017, home care providers charged significant fees for management and administration costs in 2015–16 and 2016–17, with a consequent decrease in charges to the package for care and service delivered. Together these costs amounted to 31.8 % in 2016–17 with only 61.5% charged to care.[164] This high cost of administration led to a number of measures to improve transparency and require home care providers to publish their pricing schedules.

StewartBrown found that the financial performance of home care providers declined in 2017–18 with 'revenues reducing by an average of 6.1% underpinning an overall reduction in profitability of 29.8%'.[165]

Other programs

Funding for residential respite care is provided as a supplement. Flexible care is paid as a flexible care subsidy or a funding agreement depending on the program.

The Commonwealth Home Support Program is a grant-funded program.

What do people receiving aged care pay?

Residential care

A person accessing residential aged care has their means (both income and assets) tested to determine the fees they can be asked to pay.

Older people who have entered residential care on or after 1 July 2014 can be asked to pay:

- a basic daily fee to cover day-to-day living costs;
- a means-tested care fee if income and assets are over a certain amount;
- accommodation costs—their income and asset levels determine whether they receive any support from the Government;
- fees for extra and additional services—people may have to pay extra if they choose a higher standard of accommodation or additional services.

The government sets the maximum means-tested care fee (as of 20 September 2018 this was $249.93 per day or $27,232.33 per annum) and the basic daily fee, which equates to 85% of the single rate of the basic age pension or $50.66 a day.[166]

Annual ($27,232.33) and lifetime ($65,357.65) caps on the means-tested care fees payable by residents apply to the post-1 July 2014 fee arrangements to limit the amount a person can

[163] D Tune, above n 6, p 62.
[164] Aged Care Financing Authority, above n 44, p 71.
[165] StewartBrown, above n 157, p 6.
[166] Australian Department of Health, *Schedule of fees and charges for residential and home care: from 1 January 2019*, 2018, www.health.gov.au.

be asked to pay.[167] Safeguards are also available through the financial hardship provisions administered by the Department of Human Services.

Both income and assets are now included in the means test to determine the resident's contribution towards their accommodation and care costs. A resident's home is included in the asset test up to a value of $166,707.20, unless occupied by a protected person such as a spouse or other dependent.[168] People with assets above this level must pay the full cost of their accommodation. A person whose only asset is their house and whose income is below the income free threshold (aligned with eligibility for the age pension) will pay the full cost of their accommodation but no means-tested care fee. This would include a full pensioner whose only asset is their former home without a protected person in it. Any other assets and any income above the income free threshold will be counted towards the means-tested care fee.[169]

Residents who need to pay in full or in part for their accommodation pay a cost based on market prices, which is negotiated directly with the provider. They can choose to pay for their accommodation as:

- a lump-sum refundable deposit; or
- a daily payment; or
- a combination of both.

Providers must publish the maximum accommodation price that they propose to charge for each room on My Aged Care and their own website. The average accommodation bond in 2013–14 was $296,000 for new entrants, but prices have gradually increased and were reported as being $391,000 in February 2017. Prices above a threshold of $550,000 must be approved by the Aged Care Pricing Commissioner.[170]

Accommodation payments, especially in the form of a lump sum, play a central role in funding capital investment in residential aged care. In 2016–17, the total value of accommodation deposits held by providers was $24.78 billion.[171]

The Aged Care Financing Authority reports that, in 2016–17, for the first time since 1 July 2014, daily payments were slightly more popular than the refundable or lump sum deposit (see Figure 8 below).

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[167] Ibid.
[168] Ibid.
[169] D Tune, above n 6, p 79.
[170] Ibid, p 95.
[171] Aged Care Financing Authority, above n 44, p 27.

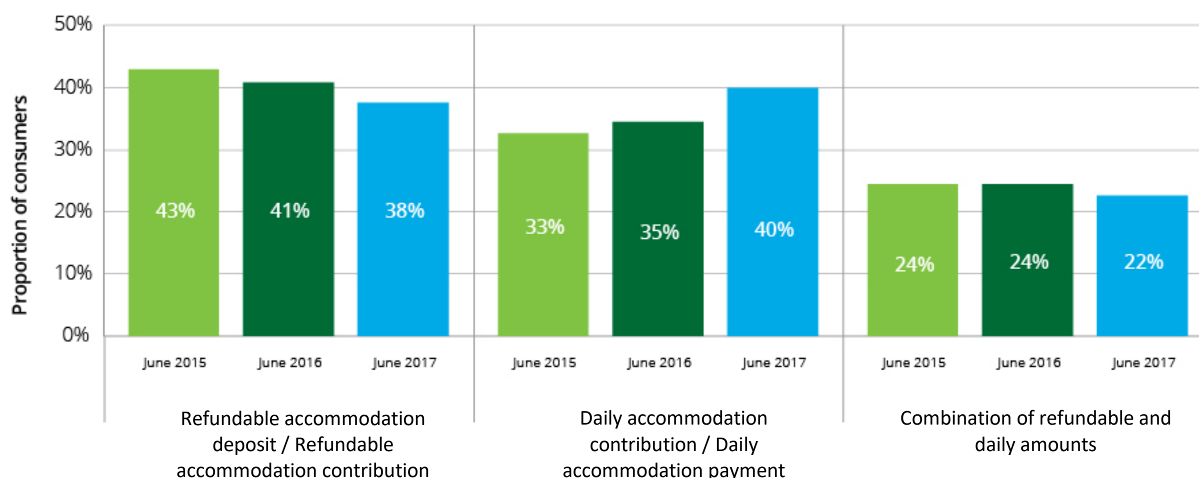

Figure 8: Resident method of accommodation payment, June 2015 to June 2017

Source: Aged Care Financing Authority, *Sixth report on the funding and financing of the aged care sector*, 2018, p 28.

The Aged Care Financing Authority reports that in 2016–17, people in residential care contributed $3.1 billion towards their living expenses, $753 million towards accommodation costs (excluding lump sum deposits) and $547 million towards care costs.[172]

People contribute a higher proportion of all costs for their residential care, but the amount remains constrained due to fee caps.[173] As noted by Tune, capping the value of an older person's former home included in the assets test for both care and accommodation has effectively preserved the pre-2014 concept that a person's home only counts towards accommodation costs (and not their care costs).[174]

Home care and home support

Older people who have taken up a Home Care Package on or after 1 July 2014 can be asked to pay:

- a basic daily fee—the maximum basic daily fee is 17.5% of the single rate of the basic age pension;
- an income-tested care fee—if they are assessed as having sufficient income to contribute to the cost of their care.

There are annual and lifetime limits to how much a person has to pay in income-tested care fees. As at 1 January 2019, the maximum annual amount of income-tested care fees a person can be asked to pay is:

- $14.96 per day or $5446.43 per year for people with income below $52,036.40 (single person income rate);
- $29.92 per day or $10,892.89 per year for people with income above $52,036.40 (single person income rate).[175]

The lifetime cap of $65,357.65 also covers income tested care fees payable by people in home care. Once these limits have been reached, the Australian Government will pay the person's share of income-tested care fees to the provider. Safeguards are also available

[172] Ibid, p 13.
[173] D Tune, above n 6, p 9.
[174] Ibid, p 79.
[175] Australian Department of Health, above n 166.

through the financial hardship provisions administered by the Department of Human Services.

As noted by Tune:

> Well over 80 per cent of consumers of home care are pensioners, and contribute only a very small proportion of the costs of care. Most providers are not charging consumers the full basic daily care fee, despite it being a modest amount, while consumers are contributing less than 3 per cent of the income-tested component of care costs.[176]

In 2016–17, people receiving a Home Care Package contributed around $150 million to their care costs in 2016–17.[177]

There is no formal means testing in the Commonwealth Home Support Program. Instead, a Client Contribution Framework outlines a number of principles that providers should adopt in setting and implementing their own client contribution policy. The principles seek to introduce fairness and consistency, with a view to ensuring that those who can afford to contribute do so, while protecting the most vulnerable. In 2016–17, people receiving home support services contributed $204 million.[178]

Tune concludes that:

> The current arrangements for consumer contributions and fees in home support and home care packages are creating several problems. The flat rate of basic daily care fee being charged across all home care package levels means that low-level packages may be perceived as poorer value for money. This is affecting the uptake of packages and, in turn the extent to which assessed needs are being met. Meanwhile, the low level of fees and inconsistent charging practices in home support is encouraging people to enter and stay in home support services, even though home support does not always offer the most appropriate level of service to meet their needs.[179]

Other programs

The Australian Government sets the maximum level of the basic daily fee that providers may ask residential respite care recipients to pay (standard resident contribution), which equates to 85% of the single rate of the basic age pension. However, it is at the provider's discretion whether they charge the residential respite care recipient the maximum level of the basic daily fee.

In short term restorative care, providers are able to charge recipients a daily care fee. The maximum basic daily rate is an amount equivalent to:

- 85% of the age pension for care delivered in a residential setting; and
- 17.5% of the age pension for care delivered in a home or community setting.

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[176] D Tune, above n 6, p 8.
[177] Aged Care Financing Authority, above n 44, p 13.
[178] Ibid, p 13.
[179] D Tune, above n 6, pp 8–9.

How is aged care regulated?

Overview

The Aged Care Act and delegated legislation provide the framework for aged care providers and provide protection for people receiving aged care.

The legislative framework sets out the requirements to be an approved provider, for the allocation of aged care places and for the approval and classification of care recipients. It also provides for government subsidies and sets out the responsibilities of approved providers, including in relation to aged care quality and compliance.[180]

This detailed and complex regulatory framework governs the government subsidies and supplements that are payable, the fees that can be charged to people and the conditions that must be met for funding to be provided. It has developed to protect people receiving care and ensure fiscal sustainability but has also been criticised for constraining choice and innovation and imposing regulatory burdens.[181] The system is one where its size and shape is constrained by government through controls on the supply of aged care places rather than driven by demand.[182] This manages the government's budget risks but also means that people may not get the services they need.

Regulation and funding are intertwined. For example, in order to receive Australian Government subsidised care, four key conditions must be met:

- the recipient must be assessed as eligible;
- the care must be provided by a government approved provider;
- care must be provided through a government allocated place; and
- care must be of a specified quality.[183]

Assessing eligibility

Before subsidies can be paid in respect of a person for residential care, residential respite care, home care, transition or short-term restorative care under the Aged Care Act, the person must have been approved as eligible based on an assessment of their physical, medical, social or psychological needs. This assessment is undertaken by Aged Care Assessment Teams as delegates of the Secretary of the Department of Health. The Approval of Care Recipients Principles provide more detailed guidance. Importantly for a person who is not an aged person, approval depends on there being no other care facilities or care services more appropriate to meet the person's needs.

A person is eligible to receive residential care only if they are assessed as having a condition of frailty or disability requiring continuing personal care and being incapable of living in the community without support.

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[180] Australian Department of Health, above n 36, p 7.
[181] Productivity Commission, above n 2, p xlvi; Productivity Commission, above n 134, pp 387–447.
[182] D Tune, above n 6, p 34.
[183] Productivity Commission, *Issues paper: caring for older Australians*, 2010, p 21.

Approval of providers

Providers of residential aged care services, Home Care Packages or flexible care must first be approved by the Australian Government, in accordance with the Aged Care Act, before providing care delivery. This process requires an organisation to be incorporated, to be suitable to provide aged care and to not have any disqualified individuals as key personnel. Suitability to provide care is assessed on experience in providing aged care or other relevant care; on understanding of their responsibilities as a provider; governance systems; and financial management.

The Department of Health has the power to revoke approved provider status if the suitability criteria are no longer met.

Planning and allocation

The Australian Government regulates the supply of residential aged care places and Home Care Packages by specifying national and regional targets for the provision of subsidised aged care places. These targets—termed the 'aged care target provision ratios'—are currently based on the number of people aged 70 years and over for every 1000 people in the Australian population.

An overall aged care target provision ratio was first set in 1985 at 100 operational places per 1000 people aged 70 and over. Governments have increased the ratio several times and changed the target service between home care and residential care. The current ratio is set at 125 aged care places per 1000 people aged 70 years and over.[184]

Over the period 2012 to 2022, the target for Home Care Packages was to increase from 27 to 45, while the residential care target was to reduce from 86 to 78, with the remaining two places for the Short-Term Restorative Care Program.[185] However, in the 2018–19 Budget, the Australian Government decided to combine the previously separate budget items for home care and residential care.[186] This allows much more flexibility for available places to be allocated to home care or residential care in response to the preferences of people needing care. The Government has also in successive budget updates released additional Home Care Packages, especially at higher levels in response to demand. On top of the already budgeted increase in Home Care Packages, it is likely that the supply of Home Care Packages will exceed the target provision ratio of 45 places by 2021–22.[187]

The change in the allocation process for Home Care Packages so that they are assigned to eligible people rather than providers has operated since February 2017 and does not change the overall restriction on the supply of packages through the target provision ratios.[188]

Quality and safeguards

The origins of the current quality framework for residential aged care date back to reforms in the mid-1980s and late 1990s which are seen as having led to substantial improvements in

[184] D Tune, above n 6, p 7.
[185] Ibid, p 7, 51.
[186] Australian Department of Health, above n 56, p 135.
[187] Catholic Health Australia, *Aged care update: A closer look at the 2018–19 aged care budget*, 14 May 2018, p 2.
[188] Aged Care Financing Authority, above n 44, p 14.

the quality of care and the quality and safety of buildings.[189] However, quality of care has remained an area of significant public concern, through to the current day. Quality arrangements for care delivered in the home are much less well developed and have varied significantly both within and across programs.[190]

The responsibilities of approved providers in relation to quality are set out in Chapter 4 of the Aged Care Act and the associated Quality of Care Principles, User Rights Principles, and Accountability Principles.

The responsibilities of aged care providers relate to:

- the quality of care they provide;
- user rights for the people to whom the care is provided; and
- accountability for the care that is provided, and the basic suitability of their key personnel.

In relation to residential care those responsibilities include maintaining an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met. In recent community debate on the quality of care, there has been significant focus on the adequacy of this requirement. It is consistently expressed that there is a close connection between quality and staffing levels and mix, but there are different views on how concerns should be addressed.[191] Many stakeholders argue for ratios of staff to residents and minimum levels of qualified nursing staff. Others do not consider that mandated staffing ratios are the answer.

There are a number of mechanisms in place to regulate for quality including:

- quality of care standards and other rules which govern the general care and services that must be provided;
- accreditation and processes for monitoring the care provided by approved providers;
- processes for managing non-compliance;
- complaints mechanisms; and
- mechanisms to empower care recipients such as charters of rights and the provision of advocacy services.

Up until recently this framework has been administered by three responsible agencies:

- The Department of Health—which is responsible for aged care policy and programs and which also performs a number of regulatory functions such as approving providers and enforcing compliance with the Aged Care Act.
- The Australian Aged Care Quality Agency—which accredited residential aged care facilities against quality standards, and monitored compliance against those standards through audits and site visits. It also played a similar role in relation to quality in home care, home support and some other programs.

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[189] L Gray, D Cullen and H Lomas, 'Regulating long-term care quality in Australia' in V Mor et al (eds), *Regulating long-term care quality: an international comparison*, 2014, p 158.

[190] Ibid, 163.

[191] D Tune, above n 6, p 186.

- The Aged Care Complaints Commissioner—which dealt with complaints from individuals about the quality of care, which it could resolve with the provider or investigate.[192]

Following the 2017 publication of a review of the Oakden Older Persons Mental Health Facility conducted by the Chief Psychiatrist of South Australia, the Australian Government commissioned a review of national aged care quality processes to look at why regulatory processes had failed to detect longstanding failures in care at the Oakden Older Persons Mental Health Facility and what improvements to the regulatory system were required.[193] The review found the current regulatory system was fragmented, lacked reliable, comparable information about care quality for older people, did not sufficiently support older people and representatives to exercise their rights, needed more effective accreditation and compliance monitoring and enhanced complaints handing.[194] The review recommended a number of changes to the regulatory system including establishment of an independent Aged Care Quality and Safety Commission.

In response, the government announced broad support for the direction of the report.[195] As of 1 January 2019, the Aged Care Quality and Safety Commission has taken on the roles previously performed by the Australian Aged Care Quality Agency and the Aged Care Complaints Commissioner.[196] From 1 January 2020, subject to the passage of legislation, the Aged Care Quality and Safety Commission will also take on the provider approval and compliance functions of the Department of Health.

Work is also underway to develop:

- enhanced risk profiling of aged care providers, to inform the frequency and rigour of visits and to ensure failures are quickly identified and rectified by providers;
- options, in consultation with the sector, for a Serious Incident Response Scheme to ensure the right systems are in place to identify an incident and prevent it from occurring again;
- a performance rating against the new quality standards; and
- a user-friendly provider comparison tool on the My Aged Care website.[197]

Development of a single aged care quality framework is underway. This includes:

- implementation of a single set of quality standards for all aged care services from 1 July 2019;
- improved quality assessment arrangements for assessing provider performance against quality standards;
- development of single charter of rights for all aged care recipients; and
- publication of improved information about quality to help older people choose aged care and services.

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[192] K Carnell and R Paterson, *Review of national aged care quality regulatory processes*, 2017, pp 7–8.
[193] Ibid, p 2.
[194] Ibid, pp vii–ix.
[195] Hon Ken Wyatt AM, MP, *Media release—powerful new reforms to ensure safe, quality aged care*, 18 April 2018.
[196] Hon Ken Wyatt AM, MP, *Media release—new Commission, new era for aged care quality and safety*, 2 January 2019.
[197] Australian Department of Health, *Review of national aged care quality regulatory processes*, 2019, www.health.gov.au; Hon Ken Wyatt AM MP, above n 195.

Quality of Care

The Quality of Care Principles include the residential accreditation standards and the home care standards which providers must meet and a schedule which specifies the care and services that must be provided.

Accreditation Standards

The current Accreditation Standards have been in place for around two decades. They apply to residential care and short-term restorative care provided in a residential setting. The four standards relate to:

- the facility's management systems, staffing and organisational development;
- the health and personal care the facility provides to its resident;
- the lifestyle residents can lead; and
- the physical environment, including the safety of that environment.

Within those four standards there are 44 outcomes to meet which are not prescriptive but guide the delivery of care. These establish minimum standards rather than providing incentives to achieve higher quality.[198]

In 2007, an evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes was undertaken.[199] The evaluation noted significant criticism about the accreditation standards lacking specificity and being too open to interpretation. It found that 'accreditation has had a positive impact on resident quality of care and quality of life'. Improvement was most notable in relation to the quality of clinical care or quality of care, and there were calls for further improvements in relation to resident quality of life or lifestyle.[200]

The review also concluded that there is a need for ongoing review of the standards to ensure that best practice can be integrated into the accreditation framework and recommended establishment of 'system-wide measurements to identify the extent of quality improvement measures over time, such as quality indicators and surveys'.[201]

A decade later, in 2017, Carnell and Paterson received contrasting feedback on the current accreditation standards. Many argued that the standards needed to be more specific, especially in relation to clinical care. Others argued against prescriptive standards for quality and safety. Despite high levels of compliance with standards for health and personal care, many of the complaints about residential care relate to aspects of clinical care, and particularly the intersection of aged care and health services.[202] Carnell and Paterson stressed the importance of regular review of the standards and supporting guidance material, as recommended in 2007 by Campbell Research and Consulting.[203] They called for more clearly defined outcome measures in standards guidance material linked to best practice resources for clinical care. Greater emphasis should be given to measures of quality of life

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[198] L Gray, D Cullen and H Lomas, above n 189, p 154–5.

[199] Commonwealth of Australia, *Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised aged care homes*, 2007.

[200] Ibid, p xii.

[201] Ibid, p x.

[202] K Carnell and R Paterson, above n 192, p 140.

[203] Ibid, p 144, referring to Campbell Research and Consulting, *Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes*, 2007.

such as time and relationships with staff and importance of a home like environment and assessment must be 'consistent, objective and reflective of current expectations of care'.[204]

Home Care Standards

The Home Care Standards apply to care provided in a person's own home or the community, including short-term restorative care delivered in a home setting. The Home Care Standards are detailed in the Quality of Care Principles 2014. There are three standards and 18 expected outcomes. These standards are:

- Standard one: Effective management;
- Standard two: Appropriate access and service delivery; and
- Standard three: Service user rights and responsibilities.

Aged Care Quality Standards

From 1 July 2019, a new single set of standards, called the Aged Care Quality Standards, will replace the Accreditation Standards, Home Care Standards and the standards that apply in the National Aboriginal and Torres Strait Islander Flexible Aged Care Program and Transition Care. The Standards have been structured so that aged care providers will only have to meet those Standards that are relevant to the type of care and services they provide and the environment in which services are delivered. Providers will continue to be assessed against the current standards until 30 June 2019, with assessment and monitoring against the new Aged Care Quality Standards starting from 1 July 2019.[205]

The Aged Care Quality Standards consist of eight standards which include a greater focus on outcomes for consumers instead of provider processes. The Aged Care Quality and Safety Commission says that the standards 'reflect the level of care and services the community can expect from organisations that provide Commonwealth subsidised aged care services'.[206]

Each of the eight Standards includes:

- a statement of outcome for the consumer;
- a statement of expectation for the organisation; and
- organisational requirements to demonstrate that the standard has been met.

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[204] Ibid, pp 142–7.
[205] Aged Care Quality and Safety Commission, *Guidance and resources for providers to support the aged care quality standards*, 2019, www.agedcarequality.gov.au/providers/standards.
[206] Ibid.

Figure 9: Aged Care Quality Standards

Source: Australian Aged Care Quality and Safety Commission, *Guidance and resources for providers to support the aged care quality standards*, 2019.

Accreditation and Quality Monitoring

Residential aged care

The Aged Care Quality and Safety Commission assesses the performance of residential care providers against the Accreditation Standards.

A residential care service must be accredited to receive funding from the Australian Government. For a commencing service this occurs via desk audit and the service is initially accredited for a 12-month period. For most services, accreditation is for a three-year period unless the Aged Care Quality and Safety Commission considers the service poses a higher risk of non-compliance.

The standards are assessed on a met or not basis rather than a sliding scale.[207] As at 30 June 2018, 96.9 % of the 2669 re-accredited residential aged care services had been given three-year accreditation.[208] The most frequent areas of non-compliance of residential aged care services across all types of regulatory activity over a three-year period ending 30 June 2018 were: human resource management, clinical care, information systems, medication management and behavioural management.[209]

The Aged Care Quality and Safety Commission uses three types of visits to monitor residential care services—site audits as part of the reaccreditation process, assessment contacts and review audits. Since 1 July 2018, unannounced re-accreditation audits apply to

[207] K Carnell and R Paterson, above n 192, p 11.
[208] Productivity Commission Steering Committee for the Review of Government Service Provision, above n 73, p 14.19.
[209] Australian Aged Care Quality Agency, *Annual report 2017–18*, 2018, p 26.

all residential aged care services that apply for re-accreditation. Assessment contacts can be done at any time and can be announced or unannounced. It is government policy that each residential facility receives at least one unannounced assessment contact every year. Review audits are undertaken in cases of suspected non-compliance and include an assessment against all 44 outcomes of the accreditation standards.

Feedback from residents and their experience of the quality of care and services they receive is an integral part of site and review audits. As part of a site audit at least 10% of residents and their representatives must be interviewed.

If the provider does not meet one or more of the 44 outcomes of the Accreditation Standards, the Aged Care Quality and Safety Commission sets a timetable for improvement which is then monitored. If the provider fails to rectify the issues of concern, the Aged Care Quality and Safety Commission may undertake a review audit and may vary or revoke the facility's accreditation. If the unmet outcomes represent a 'serious risk' to the health, safety and well-being of care recipients, the Aged Care Quality and Safety Commission contacts the provider and requests a response within a very short timeframe. The Aged Care Quality and Safety Commission must also advise the Department of Health which can consider appropriate compliance action.

Home care

Home care providers undergo a quality review every three years, which involves reviewing the quality of services delivered against the Home Care Standards. For home care services, the most frequent areas of non-compliance with standards at 30 June 2018 were: regulatory compliance, service user reassessment, care plan development and delivery, risk management, and information management systems.[210]

The process includes a notification of a quality review, a site visit, an interim quality review report and then a final quality review report. If non-compliance with the standards is found, the Aged Care Quality and Safety Commission can place the service on a timetable for improvement. The Aged Care Quality and Safety Commission can also determine the non-compliance poses a serious risk to care recipients and notify the Department of Health.

Compliance action

The focus of the Aged Care Quality and Safety Commission is on compliance with the standards within individual aged care services. The Department of Health's role is focused on compliance by the approved provider including against a broader set of responsibilities. In managing non-compliance, the Department's focus is on returning the provider to compliance as soon as possible.[211]

Under the Aged Care Act, the Department has several options available to address the non-compliance from education and support through to sanctions. Where non-compliance is more serious, or where the provider fails to address concerns appropriately, the Department may enforce compliance through its legislative powers. The Act provides a number of steps the Department must go through, with the provider at each step being given an opportunity to demonstrate they are addressing the issues of concern.

If the Department considers that the non-compliance constitutes an 'immediate and severe risk' to care recipients, the Department may impose sanctions immediately. The most common way to identify such a risk is through a 'serious risk' report from the Aged Care

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[210] Ibid.

[211] K Carnell and R Paterson, above n 192, p 19.

Quality and Safety Commission. The most common sanctions imposed are to restrict subsidies for new care recipients and revoke approved provider approval unless the provider brings in an administrator or adviser or implements specific training.[212]

Imposition of the sanction is notified to care recipients and their representatives and is published on the My Aged Care website.

In 2017–18, the Department of Health issued:

- 26 notices of decision to impose sanctions to 21 providers; and
- 166 notices of non-compliance against aged care providers with 153 of those for failure to meet quality standards. The main areas of non-compliance related to providers not meeting Standard 2 of the Accreditation Standards: health and personal care.[213]

Protecting residents' safety

Reportable assaults

Other than in very specific circumstances, approved providers of residential aged care services must report suspicions or allegations of assaults to local police and the Department of Health within 24 hours of becoming aware or suspecting a reportable assault. This requirement is intended to ensure that those affected receive timely help and support. The police are responsible for substantiating the allegation. Providers are responsible for ensuring they have systems in place to help maintain a safe and secure environment for care recipients.

A reportable assault is an allegation, a witnessed incident, or suspicion of:

- unreasonable use of force on a resident, ranging from deliberate and violent physical attacks on residents to the use of unwarranted physical force; or
- unlawful sexual contact, meaning any sexual contact with residents where there has been no consent.

In 2017–18, the Department of Health received 4013 notifications in relation to assaults. Of these 3773 were required to be reported under the Aged Care Act. Of the 3773, 3226 were recorded as alleged or suspected unreasonable use of force, 513 as alleged or suspected unlawful sexual contact, and 34 as both. With 241,723 people receiving permanent residential care in 2017–18, the incidence of reports of suspected or alleged assaults was 1.6%.[214]

Missing residents

A resident is considered missing when they are absent, and the service is unaware of any reason for the absence. The Department of Health must be informed within 24 hours by providers about missing residents in circumstances where:

- a resident is absent from a residential aged care service;
- the absence is unexplained; and

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[212] Ibid, pp 20–1.
[213] Australian Department of Health, above n 36, p 78.
[214] Ibid.

- the absence has been reported to police.[215]

In 2017–18, there were 1450 notifications of unexplained absences of residents.[216]

User rights

Under aged care legislation, there are currently four Charters of Rights and Responsibilities depending on the setting in which care is delivered. Commonwealth-subsidised aged care providers delivering care and services across aged care must comply with all relevant Charters. It is evident that there are several problems with four Charters, including:

- it may be difficult for people to understand which program they are receiving care under, and therefore which Charter relates to their rights;
- there is considerable duplication between all Charters; and
- there are also differences between the Charters that raise the question as to why some aged care recipients are not afforded the same rights as others.[217]

The Charters specifically list the right of care recipients to complain and take action to resolve disputes and to have access to advocates. Quality standards also require that care recipients have access to internal and external complaints mechanisms. Where people are unable to resolve complaints directly with the provider, the Aged Care Quality and Safety Commission is the main external mechanism for resolution of concerns.

The Department of Health is working on a single Charter across aged care which will make rights clearer, regardless of subsidised care type, and in turn reduce regulatory compliance for providers delivering multiple types of care.[218]

Advocacy services

The National Aged Care Advocacy Program is funded by the Australian Government under the Aged Care Act. The Advocacy Program provides free, independent and confidential advocacy support and information to older people (and their representatives) receiving, or seeking to receive, Australian Government funded aged care services.

From 1 July 2017, the Older Persons Advocacy Network has been engaged to deliver the Advocacy Program as a single national provider. The Network delivers the Advocacy Program through its nine service delivery organisations across Australia. Each provides a nationally consistent model of independent advocacy, information and education focused on the rights of older Australians in need of care.[219]

Community Visitors Scheme

The Community Visitors Scheme uses volunteers to make regular visits to people who are socially isolated or are at risk of social isolation or loneliness. The Scheme provides friendship and companionship by matching aged care recipients with volunteer visitors. Visits can be one-on-one as well as group visits in aged care homes and one-on-one visits to Home Care Package recipients. The Scheme commenced in 1992 and is available to

[215] Ibid.
[216] Ibid.
[217] Australian Department of Health, *Draft charter of aged care rights consultation paper*, 2018, pp 3–4.
[218] Ibid.
[219] Australian Department of Health, *National aged care advocacy program*, 2019, www.health.gov.au.

recipients of Australian Government subsidised residential aged care services or Home Care Packages.

Complaints

Anyone, not only care recipients or their family, can make a complaint to the Aged Care Quality and Safety Commission about the quality of care being delivered to people receiving aged care subsidies from the Government.

The complaints process seeks to resolve the concerns of the individual whose care is the subject of the complaint, but the process can also give an early warning of deficiencies in care and identify potential systemic failure.

If providers do not engage cooperatively with the complaints process, the Aged Care Quality and Safety Commission can direct the provider to demonstrate it is meeting its responsibilities under the Aged Care Act.

If the provider fails to take action in response to a direction, the Aged Care Quality and Safety Commission can refer the provider to the Department of Health for potential compliance action. The Aged Care Quality and Safety Commission can make referrals to other relevant regulatory bodies.

In 2017–18, the Aged Care Complaints Commissioner received 5779 formal complaints, an increase of 23% from 2016–17. There were 4315 complaints about residential care, which accounted for 75% of all complaints.[220] In residential aged care, the issues most commonly subject to complaint were medication administration and management (706), personal and oral hygiene (473) and personnel numbers/ratio (452).[221] In home care, the issues most commonly subject to complaint were fees and charges (336), lack of consultation and communication (167) and communication about fees and charges (144).[222]

National Aged Care Quality Indicator Program

The implementation of quality indicators in aged care was recommended in 2007 by Campbell Research and Consulting and then in 2011 by the Productivity Commission. Since 1 January 2016, a voluntary program has been in place in which residential care providers can compare their performance on a number of quality indicators against national data. The three indicators are: pressure injuries, use of physical restraint and unplanned weight loss.[223]

At 30 June 2018, only 8% (223) of residential aged care services were participants in the voluntary National Quality Indicators Program.[224] It is intended that the data will be published on My Aged Care when it is reliable. Work is underway on people focussed quality of life indicators and to expand the program to home care.

Information on care quality

The Aged Care Quality and Safety Commission publishes a range of information including performance information on the services it accredits and monitors, consumer experience reports for aged care homes and guides on consumer rights and how to make a complaint. My Aged Care also publishes a range of relevant information. This includes information

[220] Aged Care Complaints Commissioner, *Annual report 2017–18*, 2018, p 20.
[221] Ibid.
[222] Ibid, p 21.
[223] Australian Department of Health, above n 36, p 77.
[224] Ibid.

about compliance action taken against residential services and Home Care Package providers and information about how to find quality services and what questions to ask.

However, Carnell and Paterson considered that:

> the absence of reliable, comparable information about care quality in residential aged care is a striking feature of the current system.[225]

They recommended the publication of 'clear, readily intelligible information that includes some form of star rating against core standards'.[226] Carnell and Paterson also recommended that the current voluntary National Quality Indicators Program be made mandatory.[227]

Prudential regulation

Refundable Accommodation Deposits in residential aged care (which include accommodation bonds and/or entry contributions) must comply with the prudential requirements in the Aged Care Act and Fees and Payments Principles. The prudential requirements aim to protect refundable accommodation deposits paid to providers by recipients of aged care services.

The four Prudential Standards (liquidity, records, disclosure, and governance) seek to reduce the risk of providers defaulting on their refundable accommodation deposit balance refund obligations to care recipients. Providers who have charged refundable accommodation deposits are required to complete and submit an Annual Prudential Compliance Statement within four months of the end of their financial year, disclosing refundable accommodation deposit holdings and compliance with charging, managing and refunding refundable accommodation deposits against the prudential requirements.

Accommodation Payment Guarantee Scheme

The Accommodation Payment Guarantee Scheme (Guarantee Scheme) was established under the *Aged Care* (*Accommodation Payment Security) Act 2006* (Cth). If a provider becomes insolvent and defaults on its obligation to refund a refundable accommodation deposit, the Guarantee Scheme enables the government to pay care recipients an amount equal to each refundable accommodation deposit balance.

On receipt of their payment, the rights of each resident to recover the amount from their provider are transferred to the Australian Government so it can pursue recovery of the funds.

Quality in other programs

For programs beyond residential aged care and Home Care Packages, there are less well-developed quality arrangements.

The Commonwealth Home Support Program is a grants program administered under the *Public Governance, Performance and Accountability Act 2013* (Cth). Its operation is guided by a program manual, grants guidelines and a standard suite of Commonwealth contractual arrangements. Currently, the Home Care Common Standards apply to the Home Support Program. Separate quality standards apply to care delivered under the National Aboriginal

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[225] K Carnell and R Paterson, above n 192, p vii.
[226] Ibid, p viii.
[227] Ibid pp 93–101.

and Torres Strait Islander Flexible Aged Care Program services and to Transition Care. From 1 July 2019, the new Aged Care Quality Standards will apply.

Complaints can be made to the Aged Care Quality and Safety Commission about flexible care where a person is receiving 'residential care' or 'home care', which includes services provided through transition care, innovative care or multi-purpose services. Complaints can also be made about the Commonwealth Home Support Program and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

Effectiveness of quality arrangements

In 2017 Carnell and Paterson concluded that 'considered in an international context, the regulatory system governing aged care in Australia performs relatively well', although they considered that further reform was necessary.[228] The review considered that the accreditation of residential care providers in Australia has generally had a positive impact on the quality of care, including by removing non-performing homes, raising the standard of quality of care across the sector and setting a minimum standard for quality although it may not be adequate in delivering quality of care outcomes.[229]

The Tune review did not examine quality and safety in depth but commented on the interaction between workforce and quality of care. Tune said that there was 'no evidence to suggest that there had been a decline in quality of care since the Living Longer Living Better reforms'.[230]

Regularly over the last couple of decades, and intensely since 2017, there has been media scrutiny and community debate about quality and safety in aged care, especially in residential aged care. Specific failures of care and the regulatory framework under which aged care operates have been the subject of media scrutiny, community debate and numerous reviews. These reviews tend to position the failures of care, even when particularly egregious, as unusual in a system generally providing good quality care. However, failures of care have not always been picked up by regulatory processes and Carnell and Paterson suggested that the reported level of compliance with the accreditation standards cannot necessarily be viewed as a robust indicator of quality.[231]

Reviews of aged care quality and media outlets have received thousands of contacts raising concerns about the use of restraints, both physical and chemical, alleged abuse and neglect, food and nutrition and many other areas of clinical care, including infection control, wound management, medication management and end of life care. Inadequate staffing levels and skills leading to poor quality care and loss of dignity and respect are also commonly raised.

The Australian Law Reform Commission in its report on Elder Abuse in 2017 considered the potential for older people in both home and residential aged care to experience abuse or neglect whether from paid staff, other residents, family members or friends. The Commission recommended reform to enhance safeguards including:

- establishing a serious incident response scheme in aged care legislation;
- reforms relating to the suitability of people working in aged care—enhanced employment screening processes, and ensuring that unregistered staff are subject to the proposed National Code of Conduct for Health Care Workers;

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[228] Ibid, p v.
[229] Ibid, p 62.
[230] D Tune, above n 6, p 187.
[231] K Carnell and R Paterson, above n 192, p 40.

- regulating the use of restrictive practices in aged care; and
- national guidelines for the community visitors' scheme regarding abuse and neglect of care recipients.[232]

The regulatory framework for quality in aged care is in a state of flux, with the establishment of the Aged Care Quality and Safety Commission, the pending introduction of the new aged care quality standards, and the planned development and implementation of a number of other measures in response to the Carnell-Paterson review.

In instigating the Carnell-Paterson review, the Government outlined:

> The community expects the Commonwealth's regulation of aged care to be able to assure it that people in residential aged care are safe, well cared for and have a good quality of life.[233]

The Royal Commission into Aged Care Quality and Safety has an important role in assessing the extent of substandard care across the aged care sector and whether the measures already implemented, and those underway, meet those community expectations or whether further changes are required.

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[232] Australian Law Reform Commission, *Elder abuse—a national legal response*, 2017, recommendations 4-1, 4-8, 4-9, 4-10 and 4-14.

[233] The Hon Ken Wyatt AM, MP, *Media release—Federal Aged Care Minister to commission review of aged care quality regulatory processes*, 1 May 2017.