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Aged care in Australia: Current approaches and emerging challenges

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Abstract

This chapter examines how Australia's national government engages with the market and civil society to deliver aged care services. The capabilities and capacities of charitable organisations and for-profit businesses are employed to deliver aged care services within a regulated quasi-market environment that is increasingly subject to provider competition. The government has two main roles: to provide public subsidies so that older people in need have access to essential services, and to impose regulation where it is needed to correct for market failure and to protect this vulnerable cohort of the population. Successive governments have drawn on Australia's well-established open public inquiry processes to help shape its policy settings.

Australia faces significant challenges concerning system sustainability at a time of growing demand as population ageing continues. There is evidence of poor-quality care, constrained workforce availability, a high level of non-viability among providers and significant fiscal debt. Policy options include reducing demand for subsidised aged care by investing more in primary care and wellbeing, and improving the quality and effectiveness of the services, the efficiency of service delivery, and the equity of funding between consumers and taxpayers. Policy guidance is to focus on empowering consumer

choice and control, facilitating market incentives that enhance provider responsiveness to consumer needs and preferences, and proportionately regulating to deliver improved quality and safety. In addition, there are strong arguments that support greater funding contributions from those consumers who have greater income and/or wealth.

Keywords: aged care policy and funding; publicly funded services; market-based service delivery; consumer choice.

Introduction

The policies, programs, funding and delivery of aged care services vary significantly between countries. The different approaches to caring for the elderly reflect their unique and complex amalgam of history, culture, community expectations, financial capacity and institutional capabilities across government agencies, charitable organisations and for-profit businesses.

This chapter examines how Australia's national government currently employs the capabilities and capacities of charitable organisations and for-profit businesses to deliver subsidised aged care services within a quasi-market competitive environment while gradually removing excess layers of regulation. The chapter then explores the government's unfolding responses to the challenges of managing system sustainability while ensuring consumer choice and control, enhancing provider responsiveness and delivering improved quality and safety.

A note on the impact of the COVID-19 pandemic on aged care

This chapter was written during 2020–21 at a time when the immediate impacts of the COVID-19 pandemic were being felt worldwide. Older populations, especially those in aged care homes, were suffering and dying in the greatest numbers. Vaccinations were only starting to be rolled out. Toward the end of that period the risk to older people remained and while national economies were recovering, there was a significant overhang of public and private debt. Internationally, and domestically for Australia, the social, economic and fiscal impacts of COVID-19 remained uncertain.

As an introduction to the topic of aged care, this chapter commences with an understanding of what is meant by subsidised aged care services in the context of Australia's market-based economy.

Outside of Australia's aged care system, consumers transact with producers to purchase varying types and levels of goods and services to help them with their daily needs. Consumers exercise choice and control over their purchasing decisions and providers compete for their business. Governments intervene in those markets by way of consumer law and other regulation and intermediaries participate as agents for one side or the other. The government provides income support and other assistance to those in need.

The majority of people continue to rely on the market for these services as they age, as well as for modified and additional care services as their frailty, cognitive impairment, dementia or health needs change (Woods 2020). Many increasingly rely on taxpayer-funded (government) age pensions and other concessions to purchase their goods and services, as well as on support from their family, friends and other informal carers.

What is generally referred to as 'subsidised aged care services' in Australia is a subset of these services. This subset has been created by national government policy and it exhibits government intervention primarily through the availability of taxpayer-funded subsidies and an additional layer of regulation. The same services can generally be purchased in the market directly from a range of providers, including approved providers of subsidised care.

The remaining sections of this chapter provide the following:

- an outline of the formulation of aged care policy in Australia and the roles that two major public inquiries have played in setting that policy in the decade 2011–21
- an analysis of the drivers of current demand for aged care services, demonstrating the complexity of the forces at play
- an examination of the major forms of supply of services which are subsidised and regulated by the national government and its use of the charitable and for-profit sectors for service delivery within a regulated market environment
- an appraisal of the government's various responses to the overarching challenge of developing policies that strengthen future system sustainability while proving acceptable to the various stakeholders
- a deeper dive into how the government is able to enhance consumer choice and control through the reach of market forces by uncapping the provider market for the supply of subsidised aged care homes.

Aged care policymaking in Australia and the role of policy inquiries

A significant and widely accepted rationale for government intervention in the delivery of services to older people is to enable them have equity of access to high-quality care—often through direct provision at low or no cost, or through subsidies, price control and/or income support. Equally important is personally appropriate, culturally safe and linguistically relevant to ensure that the care is within a person's local region. A second rationale is to protect this particularly vulnerable group of consumers through enhanced consumer laws. In many countries, governments also intervene to overcome a range of market failures such as information asymmetry and poorly performing principal–agent relationships.

Australian Government intervention includes formulating policy settings and operational guidelines; establishing standards for the quality, quantity and safety of care and the skills of the workforce through legislation or self-regulation; empowering, resourcing and skilling regulatory oversight agencies; and providing an appropriate level of budget funding for subsidies to aged care consumers or to the service providers. The government also intervenes with additional support for older people and providers in rural and remote areas and to providers who focus on assisting special needs groups such as First Nations people, people from culturally and linguistically diverse (CALD) backgrounds and people who are homeless.

Aged care policymaking in Australia is the primary responsibility of the minister for health and aged care in the national government. In setting policy, Australian governments have, on occasions, sought input from open, transparent and objective public inquiries to provide advice that is in the long-term interest of the community as a whole—including consumers, providers and funders (taxpayers from current and future generations). Equally, governments have been known to make decisions which strongly reflected the ideology of the political party in power at the time or which were justified through the release of high-profile consultancy reports which could be shrouded in opaque processes.

Two arms-length institutions which are empowered to undertake policy inquiries are the Australian Productivity Commission and bespoke royal commissions. Both have broad powers to hold public hearings; gather information; call witnesses to give evidence and produce documents;

undertake replicable data analyses; release draft reports for public comment; and produce final reports and recommendations to government free of ministerial or bureaucratic influence.

The Productivity Commission is an independent permanent policy agency, headed by appointed commissioners, which has been created and protected by an Act of the national parliament. It has a predisposition to making recommendations which are founded on economic principles. Royal commissions are also independent, are headed by former judicial officers and tend to make recommendations which have a stronger legislative bias.

In 2010 the national government requested the Productivity Commission to undertake an inquiry into the reform of aged care and that agency delivered its report *Caring for Older Australians* the following year (Productivity Commission 2011). Nearly a decade later, in 2018, the national government undertook a further review through the establishment of a Royal Commission into Aged Care Quality and Safety which submitted its *Final Report: Care, Dignity and Respect* in 2021 (Royal Commission into Aged Care Quality and Safety 2021). In both cases, recommendations were submitted via a public report to the government of the day, but it remained the responsibility of that government to respond with decisions on specific policies, programs, funding mechanisms and regulations.

Policy recognition of the roles of consumers, not-for-profit organisations and the for-profit sector within a quasi-market framework

A review of Australian social service policymaking (Woods and Gilchrist 2020) has argued that: 'policymakers are seeking to exploit the opportunity inherent in both institutional theory and neoliberal ideas, such as public choice, to influence consumer and service provider behaviour'. It was further argued that policymakers have: 'sought to establish quasi-market environments intended to empower consumers and create incentives for providers, while creating institutional structures that sought to correct for market failures' (p. 98).

Australia's reforms of publicly subsidised aged care have been constructed on three broad policy pillars:

1. the primacy of consumer choice and control, with services being aligned to individual needs and preferences

2. the delivery of services by charitable organisations and for-profit businesses within a competitive but regulated quasi-market environment
3. the intervention of government through public subsidies as well as by regulation which protects this vulnerable cohort of the community, sets quality and safety standards and corrects for market failures.

The Productivity Commission's 2011 report presented empirical evidence that: 'consumer choice improves wellbeing, including higher life satisfaction, greater life expectancy, independence and better continuity of care'. The commission advocated for the benefits of competition between providers who were operating in: 'a more dynamic system, with enhanced incentives for greater efficiency, innovation and quality'. Further, the commission was critical of the prevailing risk-averse and overly prescriptive regulatory regime, proposing instead that the government's regulatory stance should: 'revert to a more appropriate role of ensuring safety and quality, protecting the vulnerable and addressing market failures' (Productivity Commission 2011:XXIX).

The three pillars approach was affirmed in a subsequent 2015–16 review of the future directions for aged care by a government-appointed Aged Care Sector Committee. Its Aged Care Roadmap report noted that its views broadly aligned with and continued the changes that commenced with the Productivity Commission's recommendations, while identifying areas for further action to respond to future challenges (Aged Care Sector Committee 2016:2). The report summarised the committee's vision for aged care as being where: 'Greater consumer choice drives quality and innovation, responsive providers and increased competition, supported by an agile and proportionate regulatory framework' (Aged Care Sector Committee 2016:3).

The 2021 report of the royal commission adopted a variation to this approach. It proposed two paramount principles: 'to ensure the safety, health and wellbeing of people receiving aged care, and to put older people first so that their preferences and needs drive the delivery of care' (Royal Commission into Aged Care Quality and Safety 2021:Vol. 1, 80). However, the royal commission gave little attention to consumer empowerment through choice and control, or to the benefits of provider competition within a market-based economy. Instead, it placed its emphasis on a rights-based approach to consumer entitlements through the development of revised aged care legislation.

The national government's response to the royal commission's report has been to adopt some of its proposals but to also continue its ongoing program of reform to enhance consumer choice and control and to foster market competition, as discussed later in this chapter.

Demand-side drivers of the need for subsidised aged care

The scope and scale of demand for subsidised aged care services in Australia are the products of a series of interacting factors. Demography is a primary driver but can be modified by such factors as government immigration policies, the current and future health and frailty of the elderly population and the availability of, and access to, alternative forms of care and support services. A 2017 review of the government's 2012 'Living Longer, Living Better' reforms concluded that it was difficult to determine the extent of unmet demand, given the complexity of these interacting factors (Commonwealth of Australia 2017:44).

Demography — the primary driver of demand

As at 30 June 2019 a little over 4 million Australian residents, or nearly 16 per cent of the population, were aged 65 and older (Australian Bureau of Statistics 2019b). Nearly 95 per cent of this cohort were living in the community in 2015, with only 5 per cent living in residential care such as nursing homes. However, as an indicator of the potential future need for care, over one-quarter of all older people lived alone (Australian Bureau of Statistics 2016).

A closer proxy for demand for care is the 2 per cent of the population aged 85 or older (at 30 June 2019), when they are more likely to be frail, to have developed dementia or to have multiple forms of ill health (Australian Bureau of Statistics 2019b).

The health and disability of the elderly

The elderly are Australia's greatest consumers of health and age care services. Whereas Australians aged 70 and over comprised only 10 per cent of the population in 2015, they accounted for 34 per cent of the total burden of

ill health (Australian Institute of Health and Welfare 2019:11). However, the rising costs of health care in Australia are being driven mainly by forces other than the ageing of the population.

The level of disability of the elderly is also greater than that of the population on average. According to Australia's 2018 Survey of Disability, Ageing and Carers, about 12 per cent of people aged 0–64 reported having a disability, far less than the 49.6 per cent people aged 65 and over who reported a disability (Australian Bureau of Statistics 2019a).

Availability of alternative sources of care

The level of demand for publicly subsidised care is further moderated by the availability of alternative sources of care. Older people have their health needs largely met through primary health services (medical, community nursing, allied health) and public hospital acute care. Supplementary private health insurance is also available. The majority of these services are delivered separately from the aged care programs, although nursing support is a particular focus of residential aged care. Further improvement in Australia's primary health system could reduce demand for subsidised aged care. The demand for subsidised aged care services can also be influenced by their availability, quality and private costs.

Informal carers, predominantly family, but also friends and community groups, provide most of the care and support required by older people living at home who are not able to live independently or to buy care services directly from the market. Informal carers provide support for daily food and personal care, communication, mobility, household services and the coordination and facilitation of formal community care services (Productivity Commission 2011).

The expected trajectory of future demand is a primary consideration in assessing the sustainability of Australia's aged care system, as will be addressed in a later section of this chapter.

Supply-side funding and delivery of subsidised aged care within a competitive quasi-market environment

Australia's current suite of aged care services displays many legacy design features that are no longer relevant to current consumer needs or to the government's fiscal circumstances, as set out below. Nonetheless, reform can be strongly opposed by some providers who have vested interests in protecting their past investments and in retaining their ongoing stream of publicly funded 'rents'. Reform can also be opposed by consumers who are resistant to any increase in their financial contribution for their care services, even when they have the capacity to pay.

The following summary explanation of Australia's three major subsidised aged care programs in 2021 provides insights into issues of consumer choice and control, the competition between not-for-profit and for-profit providers and the national government's roles as funder and regulator.

Detailed descriptions of the programs are available on the national government's MyAgedCare website (www.myagedcare.gov.au). Key data for each program were drawn from the Aged Care Financing Authority (2020), with further information available at: www.health.gov.au/committees-and-groups/aged-care-financing-authority-acfa. Subsequent to the authority being wound up on 30 June 2020, the Department of Health and Aged Care undertook to publish similar data for 2020–21 onwards. That year's data was not released until November 2022 (www.health.gov.au/health-topics/aged-care/aged-care-research-and-reporting#financial-performance-of-the-australian-aged-care-sector).

Entry-level support at home

The Commonwealth Home Support Programme (CHSP) provides a basic range of subsidised services to help people live independently in their own homes. Supply of services is capped by an annual level of national government funding allocated to regionally based approved providers. It has the broadest reach of all programs, providing services to 840,984 older Australians nationally in 2018–19. There is no transparency on the level of unmet demand.

Services include meals, transport, home cleaning and maintenance, social outings, personal care, and some nursing and allied health. Providers are block funded by the national government and they ration their services to meet the higher priority needs of eligible older people in their region. Around half of CHSP consumers receive only one type of service and less than 10 per cent receive five or more types of service. The average cost of services provided to a consumer is around AUD3,000 per annum.

In 2018–19, the national government contributed AUD2.5 billion to service delivery in the CHSP and consumers contributed only AUD252 million (10 per cent of total CHSP funding).

There were 1,458 funded providers, most of whom (69 per cent) were not-for-profit organisations. Government agencies (often local councils) made up a further 24 per cent. This profile reflects the legacy involvement of charitable community groups and local governments in supporting their local communities. More than half of all providers (801) are small scale, receiving annual grants of less than AUD0.5 million.

Complex care at home

For older people requiring more complex care while still living in their home, the Home Care Packages program (HCP) provides four levels of subsidised care, with the level of support determined by an assessment of need. Home care services were provided to 133,439 consumers in 2018–19 and the number of funded home care packages is growing steadily. There is a single National Priority System that had a further 99,000 people on the waiting list who had been assessed as eligible for subsidised care (as at September 2020). People on the waiting list are offered interim CHSP or lower-level HCP program care in the interim.

Public funding is made available to consumers who can then choose from a list of approved providers. Consumers and their providers jointly develop a care plan that supports them to remain living at home and can be delivered within their level of approved funding.

The four funding levels range from approximately AUD9,000 per year for Level 1 basic care to AUD52,000 for Level 4 complex high care (2020). Consumers may be asked to pay a basic fee based on 17.5 per cent of the single age pension (about AUD11 per day). They are required to pay an income-tested fee of up to about AUD31 per day. That fee has both annual and lifetime limits on the total contribution by each consumer.

In 2018–19, the national government expenditure on HCP packages was AUD2.5 billion while consumer contributions totalled only around AUD107 million (4 per cent of the total). Many providers forego the basic daily fee as part of their marketing strategy as they compete with other providers to attract consumers.

There were 928 home care providers at 30 June 2019. A majority of the sector is not-for-profit, accounting for 52 per cent of providers and a higher 72 per cent of total consumers. For-profit businesses accounted for 36 per cent of providers and only 12 per cent were government agencies. A net profit/surplus was recorded by 72 per cent of home care package providers in 2019–20.

From 2017 the national government removed the supply-side caps on the number of approved providers, other than requiring compliance with quality, safety, management and prudential standards. Limits remain on consumer eligibility and on the overall supply of funded packages.

Aged care homes

The national government provides a range of means-tested financial assistance for those older people who can no longer manage with living at home and need to move into a residential aged care home (nursing home). At 30 June 2019 there were 213,397 operational places and during 2018–19 residential care was provided to 242,612 older Australians.

Aged care homes provide three broad types of service: health and personal care; daily living support; and accommodation.

Health care is delivered by nursing and allied health workers, with residents also having access to primary medical care and acute hospital care on the same basis as the rest of the community. Personal care in aged care homes is mainly delivered by lesser-trained workers. Care funding is determined through an aged care funding assessment. The national government provides the majority of care funding and the means-tested resident contributions account for only 5 per cent of care costs and have annual and lifetime limits.

Daily living support includes food, cleaning, utility services and transport. All residents pay a basic daily fee (set at 85 per cent of the single age pension), which is not publicly subsidised (while recognising that the majority of residents pay the fee from their taxpayer-funded aged pension).

Accommodation costs are paid for by many residents by either a refundable accommodation deposit (repayable lump-sum) or daily accommodation payment (rent) or a combination of the two. A means test is applied, and the national government provides either a full or partial accommodation subsidy for low-means residents.

Aged care home subsidies account for the majority of public aged care expenditure by the national government in 2018–19. Public funding of AUD13 billion makes up 67 per cent of total revenue received by aged care home providers. Residents contributed 26.7 per cent (AUD5.2 billion), primarily through the basic daily fee and as accommodation rent. Separately, a significant minority of residents paid refundable lump sums which represent temporary loans to providers.

At 30 June 2019 there were 873 providers of aged care homes, continuing the gradual consolidation of providers in recent years. Not-for-profit organisations accounted for 56 per cent of providers and 55 per cent of places, while nearly all of the remainder were for-profit homes (government-run homes were only 4 per cent of the total). Residential care providers have been experiencing declining financial performance over the medium term as expenses grew faster than subsidies. In 2019–20, only 46 per cent of providers reported a net profit/surplus.

The national government has a supply-side cap on the number of operational places, which are allocated to approved providers on a regional basis through regular rounds of requests for proposals.

The overarching challenge facing the aged care system — sustainability

The sustainability of Australia's aged care system is the most significant aged care challenge facing not only the national government, but also providers (not-for-profit organisations, for-profit businesses, government agencies), the workforce, investors and, more fundamentally, aged care consumers.

The sustainability of Australia's aged care system has four significant dimensions.

- Fiscal sustainability—taxpayer affordability of publicly funded services: now and over the longer term

- Financial sustainability—provider operational viability and confidence to invest (at sector level and in thin markets)
- Workforce sustainability—ongoing availability of sufficient labour force with the right knowledge, skills and professional attributes
- Societal sustainability—community confidence in the quality and safety of care for those in need, and in the equity and fairness of the distribution of costs and benefits across consumers, providers and taxpayers.

There are many consequences from the aged care system becoming unsustainable. They include reduced service availability; reduced numbers of providers, which can lead to less competition and consumer choice; reduced provider investment in quality and safety; less equity of access across the elderly population; higher financial demands on consumers and on future generations of taxpayers; and a shrinking and poorly-trained workforce that is under pressure to maintain high-quality consumer-centred care.

Australia's national governments across the political divide have long recognised the significant impact that its ageing population would inevitably have on the fiscal position of the budget and on the performance of the economy overall. In 1998 the parliament passed the *Charter of Budget Honesty Act 1998* (Cth), with one of the requirements being the periodic publication of a set of long-term economic and budgetary projections:

> An intergenerational report is to assess the long-term sustainability of current Government policies over the 40 years following the release of the report, including by taking account of the financial implications of demographic change. (*Charter of Budget Honesty Act 1998*: Part 6, Section 21)

The first Intergenerational Report (IGR) was published in 2002 and set an expectation for forward-looking policies that would address emerging, but already knowable, challenges.

> Although the ageing of the Australian population is not expected to have a major impact on the Commonwealth's budget for at least another 15 years, forward planning for these developments is important, to ensure that governments will be well placed to meet emerging policy challenges in a timely and effective manner. (Commonwealth of Australia 2002:1)

That first report identified a number of macro-level policy priorities that would contribute to sustainability: government debt needs to be low over the economic cycle so that the pressures of an ageing population can be

accommodated; the health system needs to be efficient and effective; residential aged care (and, increasingly, home-based aged care) needs to be affordable and effective; working-age people need to be encouraged to be employed, including in their later years; and the retirement incomes policy needs to encourage private saving for old age (Commonwealth of Australia 2002).

Since 2002 there have been four further IGRs. While the central themes have remained relatively constant, each has in some way reflected the policy agendas of the government in power at that time. A particular example of differentiation was the overtly political 2016 IGR produced by a conservative government.

The effectiveness of IGRs can be judged against several parameters, one of the simpler being the accuracy of their projections. The most recent 2021 IGR has included several analyses which track the changing projections for some key economic indicators against actual outcomes. Unsurprisingly, the projections have had material margins of error, but their rationales at the time were seen to be reasonably sound.

An alternative criterion could be whether the IGRs have made a relevant contribution to public policy in Australia. At a high level, and by examining the 2002 IGR policy prescriptions some two decades later, there is ample evidence that large parts of the health system are still neither efficient nor effective. Residential aged care is affordable for most residents but decreasingly so for taxpayers, and it is not effective nor is it viable for most providers. Retirement incomes policy still has shortcomings, such as the significant tax advantages it offers for high income earners who have large balances in their superannuation accounts.

There is little research on whether the IGRs have promoted greater community understanding of the medium- and longer-term challenges facing Australia, although an analysis by the Australian Parliamentary Library cites examples of where governments have drawn on specific parts of IGR reports to add to their public justification for policy initiatives (Swoboda 2022).

A 2021 Intergenerational Report Policy Roundtable of invited experts, conducted by the Academy of the Social Sciences in Australia, debated the role and merits of the report and will publish roundtable papers in a forthcoming publication.

The consequences of greater longevity

Australia's high life expectancy and low fertility rates will continue to have significant social, economic and fiscal impacts into the future. Australia had the sixth highest life expectancy for persons at birth in 2018. In the last decade alone, in Australia, life expectancy for males increased by 1.6 years and females by 1.1 years (United Nations, reported in Australian Bureau of Statistics 2021a).

Population projections for the Australian population in 2066, relative to the base year of 2017, show ongoing growth in the proportion of older people over the next few decades (Australian Bureau of Statistics 2021b). People aged 85 years and over are projected to increase from 2 per cent of the population in 2017 to between 3.6 per cent and 4.4 per cent, but the proportion of people of working age (15–64 years) is projected to decrease from 66 per cent in 2017 to between 61 per cent and 62 per cent in 2066, thereby worsening Australia's dependency ratio, workforce availability and capacity to raise public revenue from income tax.

This evidence, however, is not a sufficient basis for concluding that, as life expectancies increase, the demand for publicly funded age care services necessarily increases proportionately for those additional lived years. There is an ongoing debate in the health literature between the theory of the expansion of morbidity, which draws on evidence that modern medicine and health care are able to maintain people's lives for longer while still having significant illness and ongoing care, and an opposing theory that there is a compression of morbidity, where the increase in life expectancy is accompanied by more years of greater health (Australian Institute of Health and Welfare 2020). The latter theory, and its supporting evidence (Swartz 2008), has become widely recognised as the dominant paradigm for healthy ageing.

A third theory (dynamic equilibrium) proposes that the proportion of a person's lifetime spent in ill health remains relatively constant, even as life expectancy increases. A study of adult life expectancy and disability in New Zealand (Graham et al. 2004) found support for this theory. A study in Australia using data up to 2015 concluded that 'At a national level, what is evident from these analyses is that, for people aged 65, with continuing increases in life expectancy, the proportion of their lifetime spent in ill health has remained constant' (Australian Institute of Health and Welfare 2020:259).

At a more disaggregated level of analysis, however, the Australian study found that for people living in the lowest socio-economic areas within cities and in regional areas, the increase in longevity was accompanied by an expansion of morbidity as a greater proportion of later life was spent in ill health. Similarly, there is strong evidence that Australia's First Nations people, people living in rural and remote areas, and people with a disability or poor mental health are all more likely to have lower health outcomes and higher healthcare needs (Australian Institute of Health and Welfare 2020). These findings point to a greater future demand for aged care subsidies amongst certain cohorts of the population.

Fiscal outlook

In Australia, two decades on from its initial IGR, the 2021 Report (Commonwealth of Australia 2021c) projected that health spending by the national government is to increase from 4.6 per cent of GDP in 2021–22 to 6.2 per cent in 2060–61. There are two points worthy of note.

The first is that a figure of 4.2 per cent of GDP for expenditure on health looks low (and is) because public expenditure on health care in Australia is a shared responsibility between the national government (predominantly in funding primary care, subsidies for pharmaceuticals, rebates for private health insurance and a contribution to public hospitals) and the states and territories (for public hospitals and community health). Overall expenditure on health care represents around 10 per cent of GDP, with funding sourced from the national government (42 per cent), states and territories (27 per cent) and private contributions (32 per cent, including for out-of-pocket fees and private insurance) (Commonwealth of Australia 2021c).

The second point is that the rising costs of health care are not primarily driven by demographic ageing but by rising incomes, changes in consumer preferences and the costs of using new health technology.

In contrast, the increased public expenditure on aged care is predominantly driven by demography, at least for the next decade or more, as the number of baby-boomers (reaching age 85 and older) increases substantially. Additional non-demographic drivers include the costs of improving quality and safety standards, competition for skilled staff, the need to respond to the changing incidence of frailty and disease among the elderly and recognition of changing consumer preferences. Aged care subsidies are almost entirely the responsibility of the national government and the 2021 IGR projects

that the budgetary cost of the subsidies will almost double as a percentage of GDP over the next 40 years, from 1.2 per cent of GDP in 2021–22 to 2.1 per cent in 2060–61.

There are also other factors that constrain the ability of the national government to increase its funding of aged care subsidies in future years. The 2021 IGR identifies the significant fiscal impact of Australia's increasing public expenditure on caring for those with disabilities, with a commensurate increase in the caring workforce. National, state and territory governments' interest payments are also projected to increase as a proportion of total spending over time, in large part as a result of the debt incurred in responding to the COVID-19 pandemic.

Workforce and financial viability outlooks

As noted earlier, the increasing proportion of the Australian population aged 85 years and older and the declining proportion of people of working age 15–64 years will negatively impact Australia's dependency ratio, add pressure to workforce availability and reduce the capacity to raise public revenue from income tax (Australian Bureau of Statistics 2021b).

In relation to workforce availability the royal commission, among other reports, recognised that aged care staff were poorly paid and worked in difficult conditions, including coping with the pressure of minimum staff numbers on rosters. This applied especially to the lowest paid personal care workers but also extended to the professional levels of nursing and managerial staff. The aged care sector was also in direct competition with providers of health services, disability care and childcare to attract and retain staff. The closed international borders resulting from the COVID-19 pandemic has recently further exacerbated Australia's economy-wide labour shortage.

The financial viability of aged care providers is also a fundamental requirement for sector sustainability. Without viable providers, aged care consumers will not have access to services. The 2020 September quarter results from an aged care financial performance survey highlighted that the underlying financial performance of the residential aged care sector continued to deteriorate in all regions across the nation. Over half (52 per cent) of aged care homes recorded an operating loss for that quarter and average occupancy levels decreased to 91.5 per cent. The survey authors concluded that: 'unless additional specific targeted funding and structural

reform is implemented it may lead to closure of residential aged care homes and will risk further necessary investment into the sector' (StewartBrown 2021:10).

For residential aged care, workforce costs account for around 70 per cent of providers' expenses. In recent years the continued growth in these costs has been putting pressure on the financial performance of providers and adding to the government's fiscal burden through the rising cost of subsidies (Catholic Health Australia 2019). However, to compete in the market for staff, aged care providers will need to significantly improve wages and conditions. Further, given the already high rates of operational losses being experienced, there is little scope to absorb these costs and the level of government subsidies and consumer contributions will need to increase further.

In addition to these system-wide pressures, the Aged Care Financing Authority found that there are specific additional circumstances facing organisations which provide services in rural and remote areas and to other special needs groups. Most of these providers lack economies of scale, incur high operating costs and are constrained by the limited availability and higher costs of a skilled workforce. On the other hand, they also often lack competition and have reduced incentives to be innovative. Consumers in these areas and special needs groups are fewer in number, may have less purchasing power, have a limited choice of provider and incur high costs and extended times in travelling to service centres (Aged Care Financing Authority 2016). The national government has adopted several strategies to address these issues, including additional viability payments and workforce initiatives.

The extent of the future availability of informal carers is also uncertain. Any reduction in the provision of informal care from family and friends can increase the demand for paid care and require further government expenditure on public subsidies. A range of factors is at play. Australia's declining family size has reduced the pool of non-partner relatives potentially able to provide informal care. In addition, female labour force participation is increasing, as is mature age participation more generally. Somewhat counterintuitively, the increase in publicly funded home-based formal care has also increased the reliance on informal carers to coordinate and manage the delivery of care into older persons' homes (Deloitte Access Economics 2020).

The royal commission's *Final Report* proposed a great many initiatives and explained:

> we have not attempted a comprehensive costing of the full suite of recommendations. However, the extent of the reforms and size of their financial impact is so significant that they will stand beside Medicare and the National Disability Insurance Scheme as landmark Australian social policy reforms. (Royal Commission into Aged Care Quality and Safety 2021:Vol. 1, p. 57)

The only significant source of revenue for subsidised aged care, apart from taxes, is from the consumers of those services and their families. Despite the need to increase the quality and safety of care, and for the sector to compete for its workforce by offering higher wages and conditions, the royal commission recommended the abolition of consumer contributions toward the cost of their care. In contrast, the aforementioned Legislated Review of Aged Care recommended that, in home care for example, providers should be required to charge the basic care fee as well as the income-tested care fee (Commonwealth of Australia 2017:78, Recommendation 12).

The issue of consumer contributions is explored next.

Increasing the level of consumer contributions

An analysis of aged care revenue received by service providers in 2017–18 found that the national government paid AUD16.6 billion, or 77 per cent of the total cost of AUD21.4 billion. In contrast, aged care consumers paid less than 10 per cent of the cost of home support and home care. They paid a similarly low proportion of the cost of the health and personal care they received in residential aged care homes but are required to pay a basic daily fee (for food, cleaning, electricity and similar costs of daily living) and many residents who had higher means also paid part or all of their accommodation (Woods 2020).

These low levels of consumer contributions contrast with the large store of wealth that many older people have—predominantly in the value of their home but also in their superannuation capital balances. A review into Australia's retirement income system has revealed that many retirees saw their 'retirement income' as being the investment returns from their

superannuation balances but not the stream of funding that could be attained from also drawing down the capital value of those balances to help fund their living standards in older age (Commonwealth of Australia 2020).

Similarly, there is a strong reluctance by many older people to draw on the wealth of their home to improve their quality of life in their retirement years and to increase their contributions for aged care services. The retirement income review concluded that 'most retirees leave the bulk of the wealth they had at retirement as a bequest (Commonwealth of Australia 2020:18).

A major expressed concern by older people (and often their children) is having to sell their home during their lifetime to contribute to the cost of their aged care. On this issue, the Productivity Commission recommended the establishment of a government-backed home credit (reverse mortgage) scheme to assist older Australians contribute to the costs of their aged care and support (Productivity Commission 2011:Vol. 2, p. 5).

Although the national government did not accept that recommendation, it has subsequently expanded the scope of its Pension Loans Scheme. That scheme was described in the retirement income review as being an effective option for accessing equity in the home for both age pensioners and self-funded retirees (Commonwealth of Australia 2020:19).

Many consumer advocacy groups and other civil society bodies have recognised that consumers of publicly funded aged care services should contribute to the services they use according to their capacity to pay. In a submission to the royal commission, the Council on the Ageing acknowledged that current levels of taxpayer support are likely to be unsustainable into the future and that: 'an equitable assessment of capacity to pay should have regard to total wealth regardless of the form in which it is held (real property, cash, equities, superannuation, etc)' (Council on the Ageing, Australia 2020:30).

Catholic Health Australia, in a pre-budget submission in 2019 to the treasurer of the national government, similarly identified the financial pressures facing residential aged care services in an environment of declining revenues, increasing costs and rising community expectations as being a significant issue. Being mindful of the government's overall budgetary pressures, Catholic Health Australia advised that it would publicly support improving the fairness of consumer contributions based on capacity to pay: 'including the full value of the consumer's former home in the means test for residential care when there is no protected person in that home' (Catholic Health Australia 2019:3).

These views are opposed by some older people and organisations such as the Combined Pensioners and Superannuants Association 2019: 'CPSA opposed the Productivity Commission's proposal on the grounds that it would reduce the housing security of older Australians' (Combined Pensioners and Superannuants Association 2019).

The national government's response to the royal commission's proposal to abolish aged care consumer contributions was to note that: 'This recommendation is subject to further consideration' (Commonwealth of Australia 2021a:82). In parallel, however, the government proceeded with reforms to its funding of aged care by strengthening the incentives for providers to collect the full value of consumer contributions (Commonwealth of Australia 2022).

In addition to the need to improve the fiscal sustainability of aged care, there are other benefits from requiring higher wealth consumers to pay contributions. The Aged Care Sector Committee 2016 Report noted, for instance, that there is a link between the higher payment of private contributions and the related benefit of greater consumer choice and control.

> A fiscally sustainable aged care system that requires consumers to contribute to their care costs where they can afford to do so means that there will be increased consumer expectations for greater choice and control. The ability for consumers to choose who provides care and support will create a more competitive and innovative market. (Aged Care Sector Committee 2016:2)

Through the direct self-interest arising from contributing to the funding task, consumers can demand, and help drive, providers to deliver services that better reflect their needs and preferences.

Enhancing consumer choice and control through the reach of market forces — uncapping the supply of residential aged care

As described in the Productivity Commission's 2011 report, Australia's aged care arrangements at that time were characterised by high levels of government regulation which encompassed all facets of the system: the quantity, scope, location, quality, safety and funding of subsidised places; the selection and monitoring of the providers; and the standards of the workforce.

The regulation went beyond that required to protect vulnerable consumers and ensure quality and safety. The capping of supply through the licensing of individual providers aimed to protect the national government's budgetary exposure, but the contemporaneous regulation of consumer eligibility served a similar purpose. Licence allocations also aimed to achieve greater regional distribution of care services but failed to address the fundamental issues facing service delivery in rural and remote areas. One of the downside consequences was that the selected providers had a privileged position within the system and were sheltered from competition from other providers.

Despite some deregulation following the introduction of reforms by national governments in the years from 2012, the 2017 Legislated Review noted:

> Several important recommendations from the [Productivity] Commission were not implemented but remain at the centre of aged care policy discussion, particularly the issue of 'uncapping supply': the removal of regulatory restrictions on the number of aged care places and packages made available to the community. (Commonwealth of Australia 2017:6)

In line with the recommendations of the Productivity Commission in 2011, the national government's subsequent 2017 reform of the home care program changed the assignment of care package funding from providers to eligible consumers when they reached the top of a new national priority list. However, the government retained fiscal control by capping the number and value of available packages rather than making care available to all who met the eligibility criteria. Consumers who had been allocated a package of care were able to approach any approved provider to contract for the supply of services on a consumer-directed care basis (Commonwealth of Australia 2021b). The Legislated Review noted that these reforms, which transferred funding from providers to consumers, had led to an increase in consumer control.

Providers reacted in different ways to the opening of the market to new providers. Some existing providers argued that their business model and workloads were under challenge from the greater competition. Most, however, responded positively to the opportunities provided by the reforms: 59 per cent were considering offering packages in new locations and 81 per cent anticipated increasing their customer market share (Healthdirect Australia 2018).

Although these reforms took place in 2017 for home care packages, the allocation of new approved places for residential care have continued to be both capped and allocated to providers (at no cost) in specified areas across the nation through government-run competitive Aged Care Allocations Rounds (ACAR). The 2017 Legislated Review recommended that the government discontinue ACAR, instead assigning places directly to the consumers within the residential care cap (Commonwealth of Australia 2017:13). A study into the impact of such a proposal was subsequently commissioned by the national government.

The Impact Study developed a set of principles against which to evaluate several reform options: 'These principles are consistent with the foundations of aged care reform already in place, which are that aged care services should be consumer driven, market based, equitably and sustainably subsidised and proportionately regulated' (Woods and Corderoy 2020:xi).

The five principles they adopted were:

1. provide greater consumer choice and control in a competitive residential aged care market
2. drive outcomes for quality and safety in residential aged care that meet or exceed approved standards
3. facilitate timely and equitable access to residential aged care and respite services for those in need
4. facilitate a residential aged care sector that has continued growth and financial investment which responds to increasing consumer demand and changing preferences
5. have transparent and accountable processes.

The study found there were several adverse consequences arising from the existing program design, including that it was not providing a consumer-driven market which could offer real choice for consumers. The supply-side capping of places and their allocation to specific providers resulted in less-preferred homes enjoying higher occupancy than they would in a more open market. Providers had 'little incentive to compete, to excel in the quality of their care, or to innovate in their services and accommodation'. Providers also had 'little ability to respond to consumer demand and changing preferences … [and had] limited flexibility to increase the scale, location and diversity of their market offerings' (Woods and Corderoy 2020:xii). New entrants gained proportionately fewer places under the government allocation rounds.

The study recommended assigning residential care funding directly to consumers, while opening up the provider market to new entrants who were able to meet the required standards. It also recommended abolishing any remaining supply-side caps, relying instead on improved assessment processes using clearer eligibility criteria (Woods and Corderoy 2020).

The study noted that the circumstances facing both consumers and providers in rural and remote areas, and some special needs groups, did not lend themselves to the development of competitive market environments. It further noted that almost all providers in these areas were not-for-profit or government (including in joint health and aged care multipurpose services) and that there was a lack of sustainable return, despite some additional national government support. The presence of the providers in these areas reflected either their mission-based approach to service delivery (not-for-profit organisations) or their requirement to be provider of last resort (generally government agencies).

The study concluded, however, that the current program design did not provide a solution

> While locational targeting may lead to a greater allocation of places in targeted areas, it does not guarantee that provision will eventuate. The ACAR's capacity to achieve this goal is limited by its reliance on providers being willing to follow through with investing in those locations and being confident of remaining viable over the longer term (including at times through internal organisational subsidisation). (Woods and Corderoy 2020:80)

Instead, the study considered that removal of the allocation and locational constraints on providers would increase operational flexibility for those organisations committed to delivering to these rural and remote areas and to special needs groups. The overriding concerns of the providers were the availability of adequate funding and skilled workforces.

Critics of the proposed reforms to abolish ACAR argued that there would be disruption in the delivery of care, investment uncertainty and reduced occupancy of aged care homes. The Royal Commission on Aged Care Quality and Safety did not make any recommendations on the proposals put forward in the Impact Study. Overall, the royal commission gave little recognition of the role that markets can play in incentivising competition between providers to the benefit of informed consumers exercising both choice and control.

The national government, in its response to the royal commission's *Final Report*, supported the proposals of the Impact Study by announcing that the elderly would be given more control and flexibility when selecting a residential aged care provider of their choice. ACAR would be discontinued, and packages would be allocated directly to consumers from July 2024 (Commonwealth of Australia 2021a). As such, providers would be required to compete for residents, just as they have been doing for consumers with home care packages since 2017.

The challenges facing the ongoing reform of aged care policy

The challenges involved in managing and overcoming the future risks to sustainability of subsidised aged care services are profound. The policy prescriptions are not easy for governments to adopt, and the aged care sector is showing reform fatigue. This has been compounded by the additional layers of expense and government direction being driven by the COVID-19 pandemic.

The range of potential policies which could improve aged care sustainability include: reducing demand by strengthening the primary healthcare sector and improving the wellbeing of the elderly; assessing the effectiveness of the current range of publicly funded services to ensure that they are providing both private and public benefits; reviewing the criteria by which older people become eligible for the public subsidies; and strengthening the eligibility assessment processes to improve their equity, accuracy and consistency.

The strengthening of competitive market conditions for the supply of services in major urban areas would create strong incentives for increased provider efficiency, innovation and responsiveness to consumer demand. In turn, the increase in service efficiency would reduce costs and improve resource allocation, as would a more flexible labour market. However, the workforce would need to be paid a competitive wage, be well trained, have supportive career pathways and work in consultative and collaborative workplaces.

On the funding side of the sustainability equation, consumers who have greater income and/or wealth would need to make a greater financial contribution that recognises the considerable private benefit of the services, while preserving community-wide equity by providing targeted safety nets to those in financial need.

References

Aged Care Financing Authority (Australia) (2016). *Financial issues affecting rural and remote aged care providers*, Aged Care Financing Authority, Canberra. Accessed 14 November 2022. Available at: www.dss.gov.au/sites/default/files/documents/02_2016/11415_acfa_financial_report.pdf.

Aged Care Financing Authority (Australia) (2020). *Eighth report on the funding and financing of the aged care industry,* Aged Care Financing Authority, Canberra. Accessed 8 January 2021. Available at: www.health.gov.au/committees-and-groups/aged-care-financing-authority-acfa.

Aged Care Sector Committee (Australia) (2016). *Aged care roadmap,* Department of Health, Canberra. Accessed 1 February 2021. Available at: www.health.gov.au/sites/default/files/aged-care-roadmap_0.pdf.

Australian Bureau of Statistics (2016). 'Older people: 4430.0—Disability, ageing and carers, Australia: Summary of findings, 2015'. Accessed 8 February 2012. Available at: www.abs.gov.au/ausstats/abs@.nsf/Lookup/4430.0main+features302015.

Australian Bureau of Statistics (2019a). 'Disability, ageing and carers, Australia: Summary of findings' (reference period: 2018). Accessed 8 January 2021. Available at: www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release.

Australian Bureau of Statistics (2019b). '3101.0—Australian demographic statistics, Jun 2019'. Accessed 8 January 2021. Available at: www.abs.gov.au/ausstats/abs@.nsf/lookup/3101.0Media%20Release1Jun%202019%23:~:text=Australia's%20population%20grew%20by%201.5%20per%20cent%20during%20the%20year,annual%20increase%20of%20381%2C600%20people.%22.

Australian Bureau of Statistics (2021a). 'Life tables' (reference period: 2017–2019). Accessed 5 January 2021. Available at: www.abs.gov.au/statistics/people/population/life-tables/2017-2019#international-comparison.

Australian Bureau of Statistics (2021b). 'Population projections, Australia' (reference period: 2017 (base)–2066), Accessed 6 January 2021. Available at: www.abs.gov.au/statistics/people/population/population-projections-australia/2017-base-2066.

Australian Institute of Health and Welfare (2019). *Australian Burden of Disease study: Impact and causes of illness and death in Australia 2015*, Australian Burden of Disease series no. 19. Cat. no. BOD 22, Australian Institute of Health and Welfare, Canberra.

Australian Institute of Health and Welfare (2020). *Australia's health 2020 data insights*, Australia's health series no. 17. Cat. no. AUS 231, Australian Institute of Health and Welfare, Canberra.

Catholic Health Australia (2019). 'Pre-budget submission—2020–21', submitted to the Treasurer of the Australian Government, 18 December 2019. Accessed 8 February 2021. Available at: treasury.gov.au/sites/default/files/2020-09/115786_CATHOLIC_HEALTH_AUSTRALIA_-_SUBMISSION_1.pdf.

Combined Pensioners and Superannuants Association (Australia) (2019). 'Submission to the Royal Commission into Aged Care Quality and Safety: The family home and aged care funding', 10 September 2019. Accessed 8 February 2021. Available at: cpsa.org.au/publication/submission-to-the-royal-commission-into-aged-care-quality-and-safety-the-family-home-and-aged-care-funding/.

Commonwealth of Australia (2002). *Intergenerational report 2002–03*, 2002–03 Budget Paper No. 5, Commonwealth of Australia, Canberra.

Commonwealth of Australia (2017). *Legislated review of aged care 2017,* Commonwealth of Australia, Canberra. Accessed 13 January 2021. Available at: www.health.gov.au/sites/default/files/legislated-review-of-aged-care-2017-report.pdf.

Commonwealth of Australia (2020). *Retirement income review final report*, Commonwealth of Australia, Canberra. Accessed 8 January 2021. Available at: treasury.gov.au/sites/default/files/2020-11/p2020-100554-complete-report.pdf.

Commonwealth of Australia (2021a). 'Australian Government response to the *Final report of the Royal Commission into Aged Care Quality and Safety*', Australian Department of Health and Aged Care. Accessed 14 November 2022. Available at: www.health.gov.au/sites/default/files/documents/2021/05/australian-government-response-to-the-final-report-of-the-royal-commission-into-aged-care-quality-and-safety.pdf.

Commonwealth of Australia (2021b). MyAgedCare website. Accessed 8 January 2021. Available at: www.myagedcare.gov.au/.

Commonwealth of Australia (2021c). *2021 intergenerational report: Australia over the next 40 years*, Australian Treasury website. Accessed 14 November 2022. Available at: treasury.gov.au/sites/default/files/2021-06/p2021_182464.pdf.

Commonwealth of Australia (2022). 'Improved payment arrangements for home care', Australian Department of Health and Aged Care website. Accessed 14 November 2022. Available at: www.health.gov.au/health-topics/aged-care/aged-care-reforms-and-reviews/improved-payment-arrangements-for-home-care.

Council on the Ageing, Australia (2020). 'Submission to the Royal Commission into Quality and Safety in Aged Care', Council on the Ageing, Canberra. Accessed 8 February 2021. Available at: www.cota.org.au/wp-content/uploads/2020/08/COTA-Australia-ACRC-General-SubmissionAttachments.pdf.

Deloitte Access Economics (2020). *The value of informal care in 2020,* Report for Carers Australia. Accessed 8 February 2021. Available at: www.carersaustralia.com.au/wp-content/uploads/2020/07/FINAL-Value-of-Informal-Care-22-May-2020_No-CIC.pdf.

Graham, Patrick, Tony Blakely, Peter Davis, Andrew Sporle and Neil Pearce (2004). 'Compression, expansion, or dynamic equilibrium? The evolution of health expectancy in New Zealand', *Journal of Epidemiology & Community Health* 58:659–66. doi.org/10.1136/jech.2003.014910.

Healthdirect Australia (2018). *Home Care Package research.* Accessed 4 February 2021. Available at: www.health.gov.au/sites/default/files/home-care-packages-program-research-report_0.pdf.

Productivity Commission (Australia) (2011). *Caring for older Australians*, Report No. 53, Final Inquiry Report, Productivity Commission, Canberra. Accessed 8 January 2021. Available at: www.pc.gov.au/inquiries/completed/aged-care/report.

Royal Commission into Aged Care Quality and Safety (2021). *Final report*. Commonwealth of Australia, Canberra. Accessed 15 November 2022. Available at: agedcare.royalcommission.gov.au/publications/final-report.

StewartBrown (2021). *Aged Care financial performance survey sector report (Q1 September 2020)*. StewartBrown, Sydney. Accessed 10 February 2021. Available at: www.stewartbrown.com.au/images/documents/StewartBrown_-_ACFPS_Sector_Financial_Performance_Report_September_2020.pdf.

Swartz, Aimee (2008). 'James Fries: Healthy aging pioneer', *American Journal of Public Health* 98(7):1163–66. doi.org/10.2105/AJPH.2008.135731.

Swoboda, Kai (2022). *Intergenerational reports—key influences on policy?* Australian Parliamentary Library, Canberra. Accessed 31 May 2022. Available at: www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BriefingBook44p/IntergenerationalReport.

Woods, Michael (2020). 'Home-owning older Australians should pay more for residential aged care', *The Conversation*, 18 February 2020. Accessed 2 February 2021. Available at: theconversation.com/home-owning-older-australians-should-pay-more-for-residential-aged-care-131565.

Woods, Michael and Grant Corderoy (2020). *Impact analysis: Alternative models for allocating residential aged care places, Final report*. Accessed 31 January 2021. Available at: www.health.gov.au/resources/publications/final-report-impact-analysis-alternative-models-for-allocating-residential-aged-care-places.

Woods, Michael and David Gilchrist (2020). 'Practical action, theoretical impacts: Aged care and disability services reform in Australia', in Andrew Podger, Tsai-tsu Su, John Wanna, Hon S. Chan and Meili Niu (eds), *Designing governance structures for performance and accountability developments in Australia and Greater China,* ANU Press, Canberra. doi.org/10.22459/DGSPA.2020.05.

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