
2 The current aged care system

Key points

- Over one million older Australians receive some form of aged care and support each year. Services are delivered in the community and in residential facilities, and include assistance with everyday living, personal care and health care. In 2009-10:
 - over 610 000 people aged 70 years or over received Home and Community Care (HACC) services
 - around 70 000 people received more intensive packaged community care at home
 - around 215 000 people received permanent residential care, of whom 70 per cent received high level care. In recent years, around 70 per cent of residents were female and 55 per cent were aged 85 years or older.
- Australia's aged care system has evolved in an ad hoc way in response to: the increasing and changing needs and demands of older people; failures in risk management; political compromises; and concern to contain public expenditure to sustainable levels.
- The formal 'aged care system' is primarily funded and regulated by the Australian Government, with state and territory governments mainly involved in home and community care. Regulation of the sector is extensive in scope and intensive in its detail.
- Community and residential care services are provided by religious, charitable, community-based and commercial organisations, as well as state, territory and local governments.
- The aged care workforce consists of informal carers, the paid workforce and volunteers. Services are also supported by, and are dependent on, the medical workforce and allied health professionals.
- The aged care system interacts with many other social policy areas, including primary health, acute care, disability services, housing (including social housing), transport and income support. Service delivery in each of these areas affects the performance of the aged care sector and vice versa.

This chapter provides an overview of Australia’s current aged care system. It outlines the main care and support services and key characteristics of care recipients, providers and the workforce. The chapter is intended as background to the following chapters, rather than as an exhaustive description of the current system or the history of its development — this can be readily accessed elsewhere (for example, AIHW 2009a; DoHA 2010n; SCRGSP 2011).

Section 2.1 identifies the foundations of Australia’s current aged care system and sets out its legislated objectives. Section 2.2 describes the main publicly subsidised aged care programs, the numbers of older people using those programs, eligibility and assessment processes, funding arrangements, providers and the workforce. The financing of aged care is summarised in section 2.3 while the regulatory framework is profiled in section 2.4. Finally, section 2.5 briefly outlines the interfaces between the aged care system and health, disability and other services.

2.1 Foundations of Australia’s aged care system

Australian Government involvement in aged care was initially as a funder of maintenance subsidies for pensioners in Benevolent Asylums (1909 to 1963). These payments were provided as a substitute for the Age Pension and, as the costs of aged care outgrew the level of the Age Pension, the Government became involved in funding aged care.

The Australian Government’s first direct involvement in the capital funding of aged care was a housing initiative under the *Aged Persons Homes Act 1954* and, in terms of funding care, the introduction of nursing home benefits in 1963. As noted by the Department of Health and Ageing (DoHA):

The Commonwealth’s involvement in the funding of aged care arose at the intersection of pension (and more generally, income support), housing and health care policy. (sub. 482, p. 41)

There has been substantial evolution of the aged care system since those early years. (A more detailed history is provided in DoHA, sub. 482) The current system is largely reflective of various reforms undertaken in the mid 1980s, and again in 1997, in response to the increasing and changing needs and demands of older people, failures in risk management, political compromises and a concern by governments to contain the level of public expenditure.

In 1985, the Australian Government and the state and territory governments jointly funded the Home and Community Care (HACC) program, which replaced a range of disparate community care services that were being delivered to older people and

those with a disability. It aimed to provide care in the community without the need for institutionalisation and also to reduce the demand and financial pressures being placed on residential facilities.

The 1986 Nursing Home and Hostel Review (Commonwealth of Australia 1986) led to the amalgamation of the formerly separate nursing home (high care) and hostel (low care) programs and to admission into residential care being dependent on approval by a Geriatric Assessment Team.

The provision of more intensive care services for older people at home increased in 1992 through the introduction of Community Aged Care Packages (CACPs) and again in 1998 with Extended Aged Care at Home (EACH) and EACH Dementia (EACH-D) packages. Unlike HACC, these packages are funded exclusively by the Australian Government.

Further substantial reform occurred in 1997, through the introduction of the *Aged Care Act 1997* (the Act), including:

- a single Resident Classification Scale which determined the government subsidy paid for residents in high and low care. (In March 2008, the Resident Classification Scale was replaced by the Aged Care Funding Instrument (ACFI) which aimed to provide a more coherent set of subsidies based on the assessed care needs of each resident.)
- income testing of recurrent subsidies to ensure that wealthier residents made a fair and reasonable contribution to the cost of their care
- nursing home operators having the same capacity to raise market-driven entry contributions as hostel operators, subject to meeting minimum building and other standards, and with appropriate protections (overturned in November 1997, except for high care extra service places)
- accreditation procedures based on legislated standards
- improved access to anonymous complaints resolution procedures
- certification of residential services to ensure appropriate levels of safety, privacy and community access.

National regulation of aged care is effected through two principal Acts of Parliament (which also specify the Government's aged care objectives — box 2.1).

- The *Aged Care Act 1997* governs residential care, community care packages, multi-purpose services (MPS), innovative care and transition care. The main areas of regulatory control are: funding services; allocating aged care places to approved providers; assessing client eligibility; pricing; determining quality

standards (both for care and accommodation); ensuring compliance; and handling complaints.

- The *Home and Community Care Act 1985* governs the provision of basic maintenance and support services to older people who live at home (irrespective of whether that home is owned, rented or within a retirement village).

A third Act, the *Aged or Disabled Persons Act 1954* is extant and provides coverage for capital grants.

Box 2.1 **Objectives of Australia's aged care system**

Objectives set out in the *Aged Care Act 1997* and *Aged Care Principles*:

- promote a high quality of care and accommodation for the recipients of aged care services that meets the needs of individuals
- protect the health and wellbeing of the recipients of aged care services
- ensure that aged care services are targeted towards the people with the greatest needs for those services
- facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstances or geographic location
- provide respite for families, and others, who care for older people
- encourage services that are diverse, flexible and responsive to individual needs
- help those recipients to enjoy the same rights as all other people in Australia
- plan effectively for the delivery of aged care services
- promote ageing in place through the linking of care and support services to the places where older people prefer to live.

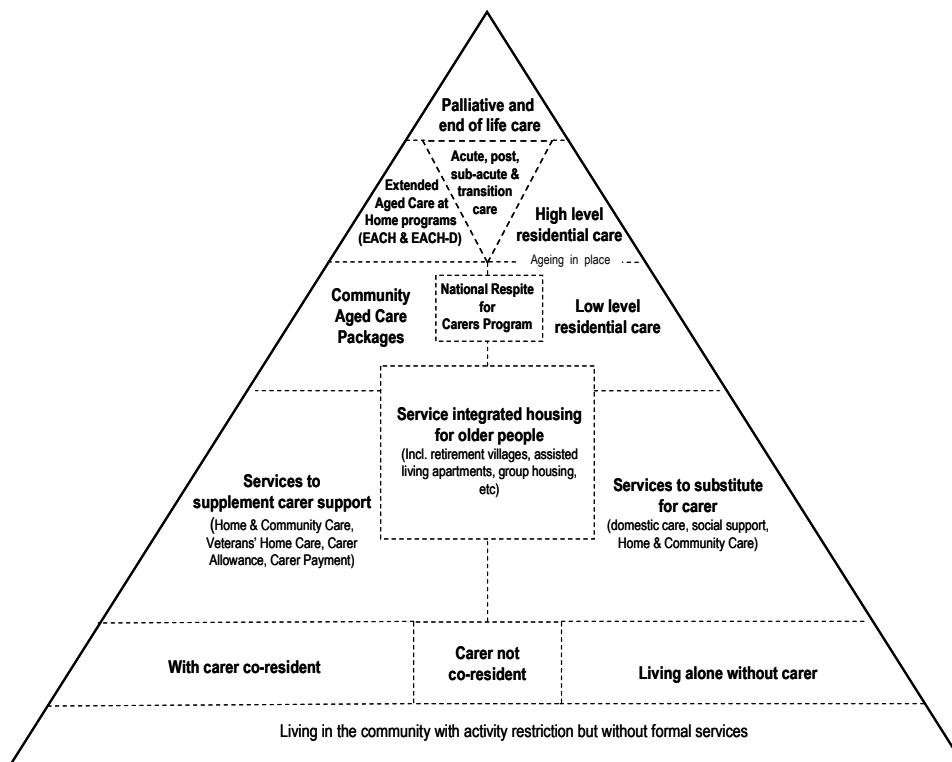
Objectives of the *Home and Community Care Act 1985*:

- ensure access to HACC among all groups within the target population
- ensure that, within available resources, priority is directed to persons within the target population most in need of HACC
- provide services which are equitably between regions and responsive to regional differences
- ensure delivery of services in a cost effective manner
- promote an integrated and coordinated approach between the delivery of HACC and related health and welfare programs (including residential care).

2.2 Care and support services

Older people receive care and support from informal carers, from publicly subsidised formal community and residential care services and directly from market suppliers of services ranging from home maintenance to private nursing (figure 2.1). The most resource intensive services are located in the upper half of the pyramid.

Figure 2.1 **Current modes of care in the aged care system**



Data source: Howe (1996), revised with advice from Howe, A., pers. comm., 18 May 2010.

Most older Australians, including those who receive formal aged care services, live at home. As the Australian Institute of Health and Welfare (AIHW) states:

Despite a common myth that most older people live in some type of cared accommodation, the majority of older Australians (in 2006 92%) lived in private dwellings as members of family, group or lone-person households. Only 8% were usual residents in non-private dwellings, which include hotels, motels, guest houses, and cared accommodation such as hospitals, aged care homes and supported accommodation offered by some retirement villages. Although the proportion of older people living in non-private dwellings increased with age, most people in each age group — 65–74 years, 75–84 years and 85 years and over — lived in private dwellings. (2009a, p. 88)

The care needs of older people can vary markedly and they may need intensive periods of restorative care or rehabilitation to assist them to regain their independence. Overall, however, their needs tend to rise over time and the availability of able informal carers tends to decline. As a result, those aged 85 years or above have a higher level of reliance on formal care services.

Informal carers

Informal carers, predominantly family, but also friends, neighbours and community groups, provide most of the care and mainly provided support required by older people (chapter 13). Informal assistance is in the form of communication, paperwork, mobility, cognitive tasks, emotional support and transport (ABS 2003). Informal carers also play a fundamental role in the coordination and facilitation of formal community care services. According to the Australian Bureau of Statistics' (ABS) 2009 *Survey of Disability Ageing and Carers*, there were 352 000 primary carers of people aged 65 years and over (ABS 2010b; appendix H).

Access Economics (2010b) 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 \$40 billion per annum in 2010.

In recognition of the demands placed on informal carers, governments provide support through 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). In 2009-10, almost 60 000 people received short term respite care in residential care facilities, equivalent to around 1.34 million respite days. The National Respite for Carers Program, which complements residential respite care, provided 5.1 million hours of respite in 2009-10 (DoHA 2010n).

Formal aged care services

The Australian Government and state and territory governments provide a number of subsidised formal aged care programs (table 2.1). These include the block funded HACC program, community care packages, and residential aged care.

Table 2.1 Total number of clients serviced by program, 2009-10^a

<i>Program</i>	<i>Clients</i>
Residential care ^b	214 418
Community care packages	
CACP	57 742
EACH	7 995
EACH-D	3 847
Transition Care	14 976
Residential Respite	44 160
Home and Community Care ^c	616 000
Veterans' Home Care ^d	73 100
Department of Veterans' Affairs (DVA)	
Community Nursing ^d	33 100

^a Some clients receive services from more than one program in any one year. As some people do not spend the entire year in residential care or on a community care package, multiple people can use the same residential place or package at different points of time through the year. As such, the number of people who receive care throughout the year exceeds the number of care places available. ^b 70 per cent of all permanent residents were classified as high care at 30 June 2010. ^c For those aged 70 years or over. ^d The 2009-10 numbers reflect the services provided as notified to the Department by the extraction date. Once all provider notifications have been received, the final number of clients is likely to be higher.

Sources: DoHA (2010n); DVA's DMIS Service Item Cube (extracted 17 June 2011).

Home and community care and related programs for veterans

HACC is by far the largest and most extensive program of support for older people. It plays a valuable role in assisting older people to continue to live independently in their own accommodation and remain part of their local community.

In 2009-10, around 616 000 people aged 70 years or older received HACC services — representing around 70 per cent of the people receiving care under the program. (HACC is also widely used by younger people with disabilities.) HACC primarily provides low intensity levels of support. It includes meal preparation and delivery, community transport, domestic assistance such as house cleaning and home maintenance, home modification, personal care and allied health care (table 2.2).

Providers of HACC range from large organisations which deliver multiple services over a wide area to local community groups that might supply only one service. There were over 3300 HACC agencies providing services at 30 June 2009 (DoHA 2009c). They employ a significant proportion of the community care workforce and draw on a large contingent of volunteers (box 2.2).

Table 2.2 Community care programs: services provided to clients aged 65 years or over, 2007-08

Per cent of clients in program

Service Type	HACC	Veterans' Home Care	DVA Community Nursing	CACP	EACH	EACH-D
	2007-08	2007-08 ^a	2007-08	Dec 2008	Dec 2008	Dec 2008
Non-specialist care services						
Domestic assistance	32.6	93.1	x	81.5	68.3	61.6
Meals at home or a centre	19.5	x	x	13.7	7.4	8.1
Other food services	0.6	x	x	21.4	35.3	34.6
Transport services	17.0	x	x	20.8	9.9	14.2
Home or garden maintenance	17.8	18.7	x	11.6	11.4	11.2
Activity programs	10.9	x	x	3.1	9.8	9.8
Social support	12.0	x	✓	36.4	26.4	34.4
Personal care	10.0	4.3	31.2	39.3	83.3	74.2
Counselling (care recipient)	6.8	x	✓	✓	11.7	18.0
Counselling (carer)	1.3	x	x	x	x	x
Goods and equip.	3.1	x	x	✓	✓	✓
Home modifications	4.3	x	x	✓	✓	✓
Respite care	2.2	8.3 ^b	x	4.4	32.2	44.0
Linen services	0.3	x	x	0.7	2.0	2.6
Accommodation and related services	x	x	x	x	x	x
Specialist services						
Nursing (home and centre)	21.1	x	78.7	x	21.9	16.9
Allied health/therapy (home and centre)	19.5	x	x	x	7.1	6.4
Total clients (number)	638 218	77 284	32 625	33 411	3 354	1 314

✓ Service type provided but data unavailable. x Service type not provided. ^a Clients who received VHC services may have received DVA Community Nursing at the same time. Data on simultaneous use is not provided. ^b Figure related to provision of in-home respite care and emergency respite care only, and excludes DVA clients who used residential respite.

Source: AIHW (2009a).

Box 2.2 **Community care workforce**

Researchers at the National Institute of Labour Studies found that around 87 500 people were employed in the provision of community care services to older Australians in 2007. The authors consider this figure is an underestimate.

About 85 per cent of the community care workforce is involved in direct care activities. By occupation, the direct care workforce is a mix of registered nurses (10.2 per cent), enrolled nurses (2.4 per cent), community care workers (82.6 per cent) and allied health workers (4.8 per cent).

Data limitations mean it is not possible to split community care workers by program type — that is, between HACC, CACP, EACH and EACH-D.

A large number of volunteers also provide support services to older Australians living in the community and are integral to the delivery of community programs such as meals-on-wheels.

Source: Martin and King (2008).

HACC providers undertake a needs assessment for older people who may require services, and support is prioritised to those with the greatest need, within the budget funding available to the provider. The majority of HACC clients (90 per cent) receive less than two hours of support each week.

HACC is jointly funded by the Australian, state and territory governments under the *Home and Community Care Act 1985*. In line with the changes to roles and responsibilities under the National Health and Hospitals Network Agreement, aged care funding (but not the component relating to disability) under the National Partnership on Home and Community Care will transfer to the Commonwealth from 2011-12 (at the time of writing, the Victorian and Western Australian Governments are not parties to these reforms).

The Department of Veterans' Affairs (DVA) also assists a large number of older people through its Veterans' Home Care (VHC) and Community Nursing programs (see table 2.2 for a list of services). These programs offer a range of services similar to those available through HACC. In 2009-10, 69 700 veterans aged 70 years or over received VHC and 32 000 received Community Nursing.¹

¹ From DVA's DMIS Service Item Cube, extracted 17 June 2011. The 2009-10 numbers reflect the services provided as notified to the DVA by the extraction date. Once all provider notifications have been received, the final number of clients is likely to be higher.

Community care packages

The three community care packages — CACPs, EACH and EACH-D — are designed for older people who are eligible for residential care but who prefer to remain in the community and are safely capable of doing so (normally with the support of family or other informal carers).

In 2008, CACPs provided 5.4 hours of direct assistance per week on average, primarily for home help (including meals and laundry) and personal care (including showering and dressing) (DoHA 2010e).

EACH and EACH-D packages are individually planned and coordinated for people with complex needs who require higher levels of care, including nursing and allied health. EACH-D packages are designed specifically for people who experience behaviours of concern and psychological symptoms associated with dementia. In 2008, the average weekly hours of direct assistance provided was 14.1 hours under EACH packages and 15.2 hours under EACH-D packages (DoHA 2010e).

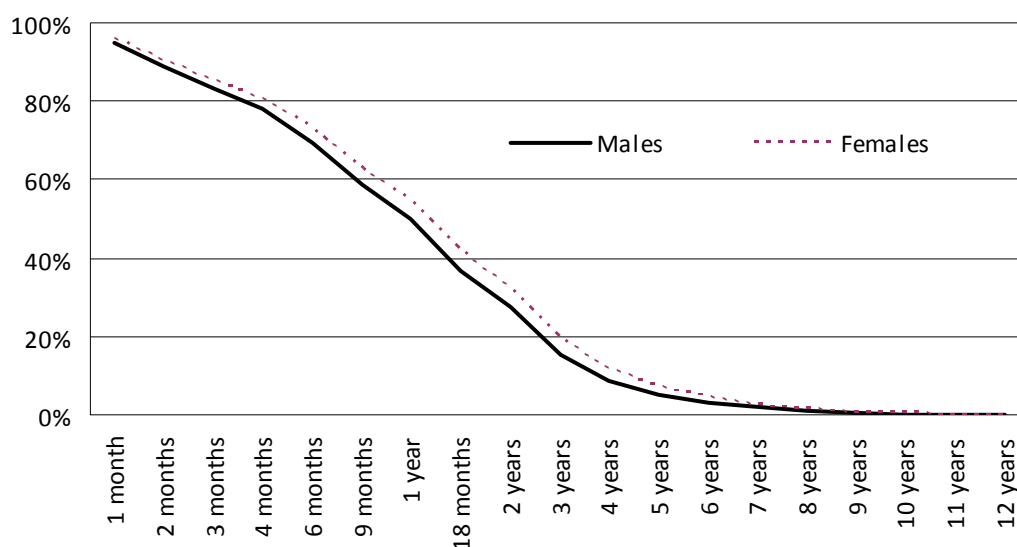
At June 2010, there were around 47 700 community care package recipients — including 40 100 CACPs, 5200 EACH packages and 2300 EACH-D packages — with over 69 000 people using those packages during 2009-10. (See table 2.2 for care package services provided to clients at December 2008.)

Most people do not receive community care services for an extended period of time. The median length of stay on a community care package for people receiving community care between July 1997 and December 2009 was just under 12 months for males and 14 months for females. However, there is considerable variation in the length of time people spend receiving services from packages (figure 2.2).

Around 84 per cent of community care packages are delivered by charitable and other not-for-profit (NFP) community-based providers. The remaining 16 per cent of packages are provided by commercial organisations, state and territory and local governments (DoHA 2010n).

Figure 2.2 Probability of remaining on a community care package after a length of time

Per cent of all people who were enrolled on a CACP, EACH or EACH-D package for at least some of the period July 1997 to December 2009



Data source: DoHA Aged Care Data Warehouse (supplied on 29 October 2010).

The assessment of an older person’s eligibility for a package (and for subsidised residential care — see below) is undertaken by Aged Care Assessment Teams (ACATs) (known as Aged Care Assessment Services in Victoria). ACATs generally comprise, or have access to, a range of health professionals, including geriatricians, physicians, registered nurses, social workers, physiotherapists, occupational therapists and psychologists. Having assessed the care needs of an older person, the ACAT team works closely with the client, their carer and family to identify the most suitable aged care services available to them. The Australian Government will take over full responsibility for the Aged Care Assessment Program from 2012-13, although it will still be provided by state and territory governments under contract.

The Australian Government subsidises the cost of community care packages. Its fiscal exposure is limited by the number of older people approved as eligible for a subsidised service and by the restricted allocation of formal care places through a needs based planning framework (box 2.3). The framework seeks to align places with the growth in the aged population through a target provision ratio. The current ratio is scheduled to reach 113 operational places per 1000 people aged 70 years or over by June 2011 — 25 of the places are for community care and 88 for residential care (table 2.3).

Box 2.3 Needs-based planning arrangements

The Australian Government makes available new residential care licences and community care packages for allocation in Aged Care Planning Regions in each state and territory. From 1985 the planning arrangements provided 100 aged care places for every 1000 people aged 70 years or over. This is scheduled to reach 113 aged care places for every 1000 people aged 70 years or over by June 2011. Planning also takes account of the Indigenous population aged 50–69 years.

There has been a small, but growing emphasis on community care and a re-balancing from low level residential care to high level residential care. The intention is for 25 out of every 113 places to be for community care places (which includes CACPs, EACH packages and other flexible care places), 44 places for residential low care and 44 for residential high care.

Operational aged care provision differs from these planning ratios. ‘Ageing in place’ allows a resident who enters a low care place to remain in that place if and when he/she comes to need high care; that is, effectively high care is provided under a low care licence. In addition, providers may decide to not take up new licences and they may fail to operationalise their licences or hand them back.

New places are allocated, after an open tender, to approved providers that demonstrate they can best meet the aged care needs within a particular planning region. Providers have two years to make residential places operational. Community care packages tend to become operational relatively soon after allocation.

Providers are expected to meet regional targets for supported (formerly concessional and assisted) residents to ensure that those who cannot afford to pay for accommodation have equal access to care. The targets are based on socio-economic indicators and range from 16 to 40 per cent of residents.

Some residential aged care facilities may be approved to offer ‘extra service’ to residents, up to a limit of 15 per cent of places in each state or territory, and with regional limits as well. Approval of extra service status is not granted if it would result in an unreasonable reduction of access for supported, concessional or assisted care recipients in any particular region. Many extra service facilities are exempt from providing a minimum number of supported resident places.

Source: SCRGSP (2010b).

Over the last 20 years, there has been an increasing emphasis on community care (though it still represents only one quarter of all places) and a re-balancing from low level residential care to high level residential care.

Table 2.3 Target provision ratios announced between 1985 and 2007

Aged care places/packages per 1000 people aged 70 years or older, including Indigenous people aged 50–69 years

<i>Year</i>	<i>Residential high care places</i>	<i>Residential low care places</i>	<i>Total residential places</i>	<i>CACP packages</i>	<i>EACH & EACHD packages</i>	<i>Total community packages</i>	<i>Total aged care places & packages</i>
1985	40	60	100		100
1992	40	55	95	5	..	5	100
1993	40	52.5	92.5	7.5	..	7.5	100
1995	40	50	90	10	..	10	100
2004	40	48	88	20	..	20	108
2007	44	44	88	21	4	25	113

Sources: AIHW (1995, 2001); Cullen (2003); Hogan (2004b); PC (2008); Pyne (2007); Santoro (2007); SCRGSP (2006).

Residential care

Residential care is provided to older people when their care needs (physical, medical, psychological and/or social) exceed the scope of community care. These needs can be triggered by a range of factors, including an acute health episode, inappropriate living arrangements or a lack of support from an informal carer. Some facilities specialise in providing care and support for homeless and drug and alcohol affected older people.

Low level residential care provides accommodation and related everyday living support (meals, laundry, cleaning), as well as some personal care services. ‘Personal care services’ can include assistance with bathing, toileting, eating, dressing, mobility, managing incontinence, community rehabilitation support, assistance in obtaining health and therapy services and support for people with cognitive impairments

High level care covers additional services such as nursing care, palliative care, other complex care, equipment to assist with mobility, medical management and therapy services. With ‘ageing in place’, many people who entered a facility as a low care resident are now receiving high care in that facility.

Extra service places in high care facilities provide a higher standard of accommodation, food and other hotel-type services for a higher charge.

At June 2010, permanent residential aged care was provided to around 163 000 people (with a greater number of people receiving residential care during the year). Of these, 70 per cent received high level care (DoHA 2010n). In recent years,

around 70 per cent of residential care residents were female and 55 per cent of all residents were aged 85 years or older.

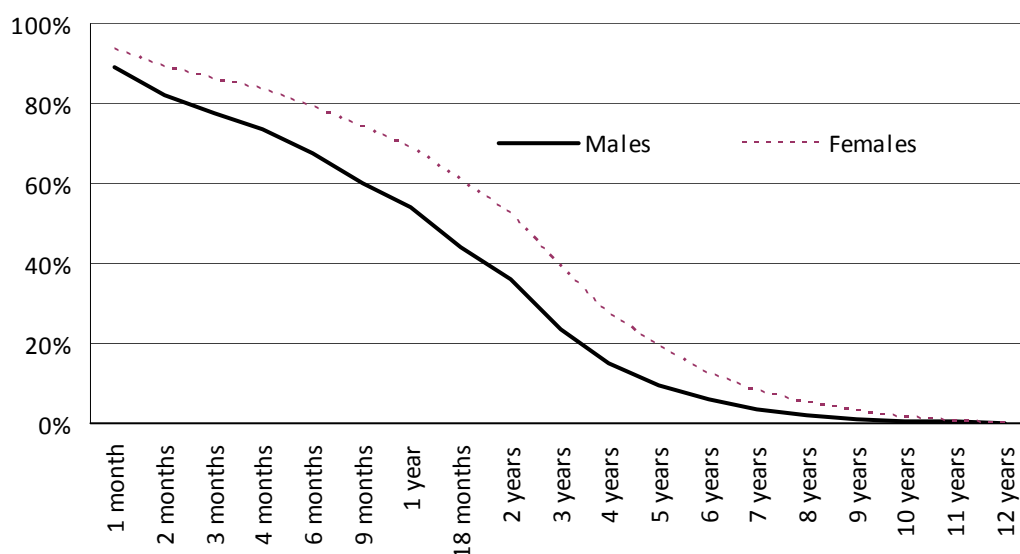
There has been a steady increase in the proportion of residents being classified as needing high level care. That is, an increasingly dependent and frail group of older people are entering residential aged care. Between 1998 and 2008, the proportion of high care entrants rose from 58 to 70 per cent of total residential aged care entrants (AIHW 2008b).

On average, older people spend more time in permanent residential care than on community care packages. The Commission estimates that the median length of time in permanent residential care for anyone who received residential care between July 1997 and December 2009 was 1.2 years for males and 2.2 years for females. However, as with community care packages, there is considerable variation in the length of time individuals spent in residential care (figure 2.3).

There were 2773 aged care facilities in Australia delivering formal residential care in June 2010. Around 59 per cent of the beds were operated by NFPs; 35 per cent by commercial organisations; and 6 per cent by some state and local governments (DoHA 2010n). The average size of residential facilities increased from 46 to 61 places between 1998 and 2008, although there remains a wide range of facility sizes (AIHW 2009c).

Figure 2.3 Probability of remaining in residential care after a length of time

Per cent of all people who were in residential care for at least some of the period July 1997 to December 2009



Data source: DoHA Aged Care Data Warehouse (supplied on 24 September 2010).

Assessments of older people for entry into residential care are undertaken by ACATs. An ACFI is used by providers to assess the level of government funding according to a resident's assessed level of personal and health care needs (box 2.4).

Box 2.4 The Aged Care Funding Instrument

Aged care residents are classified into one of 65 Aged Care Funding Instrument (ACFI) classifications based on the level of approval for care granted to the resident by an ACAT and on the approved residential care provider's appraisal of the care needs of the resident against the ACFI. A provider's appraisals of the care needs of a resident are subject to validation by the DoHA on a risk assessed basis.

The ACFI was introduced on 20 March 2008 to replace the Resident Classification Scale, which had been in place since 1997. The ACFI was intended to more closely match funding to the care needs of residents; reduce documentation; and reduce the level of disagreement between providers' appraisals of the care needs of their residents and the findings of DoHA's validators.

In terms of overall design and structure, the ACFI consists of 12 care need questions that align with three major care domains, namely, activities of daily living, behaviour and complex health care.

In the course of completing the ACFI, diagnostic data about mental and behavioural disorders and other medical conditions are collected and used to categorise residents as having nil, low, medium or high needs in each of the three care domains. No funding is provided for a domain if the resident has no or minimal assessed care needs in that domain.

A care subsidy is paid for each level of the three care domains, except the nil level. The total care subsidy paid for each resident is generally the sum of the rates for all three domains.

Source: DoHA (2009g).

In 2007, around 175 000 people were employed in residential care and, of those, around 133 000 were direct care employees (Martin and King 2008) comprising:

- registered nurses (16.8 per cent of the workforce)
- enrolled nurses (12.2 per cent)
- personal carers, including assistants in nursing (63.6 per cent)
- allied health workers (7.4 per cent).

The non-direct care staff of the residential care workforce included cooks, cleaners and administrators.

In addition, over 50 000 volunteers provided companionship and support services to older Australians in residential facilities in 2008-09 (ABS 2010a).

Flexible care, care in rural and remote areas and care for people with special needs

Flexible care is aimed at addressing the needs of care recipients in ways other than through mainstream community and residential care. It includes transition care places, MPS and innovative pool care and was an important part of the growth in community care places over the past decade.

Transition care places provide time-limited, goal-oriented and therapy-focused care for older people after a hospital stay. This form of care can be provided for up to 12 weeks in either a residential setting or in the community. Transition care is a jointly funded initiative of the Australian, state and territory governments.

MPS integrates health and aged care services and are individually tailored for rural and remote communities depending on their geography, population and care needs. Each MPS is financed from a flexible funding pool, with contributions from the Australian and relevant state or territory governments.

Innovative pool care supports the development and testing of flexible models of service delivery. The program provides opportunities to use flexible care places to test new approaches to providing care for specific target groups.

Flexible models of care are also provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. The services aim to provide culturally appropriate aged care close to the communities of older Indigenous people, principally in rural and remote areas.

Additional funding and assistance (including through the provision of zero nominal interest loans) is provided to aged care services in rural and remote areas to assist with the extra cost of delivering services. In 2008-09, a further 1488 community aged care places and 1418 residential places were allocated to regional, rural and remote areas (DoHA 2009e).

Places are allocated to providers of care for special needs groups, involving a further 1425 community care places and 851 residential aged care places (DoHA 2009e). These places are provided for:

- people from Indigenous communities
- people from non-English speaking (culturally and linguistically diverse) backgrounds

-
- people who are financially or socially disadvantaged
 - veterans.

Retirement villages

Retirement villages (inclusive of independent and assisted living units) are playing an increasingly important role in accommodating older Australians. The Retirement Village Association (RVA) estimates that there are currently around 160 000 residents living in 1870 retirement villages in Australia. Over the period 1999–2010, the market penetration in the retirement living sector has more than doubled from 2.3 to 5.3 per cent of people aged 65 years or over (RVA 2010). For those aged 75 or over, the current market penetration rate is around 10 per cent (RVA, sub. 424). The RVA also estimates that the national penetration rate could increase to 7.5–8 per cent by 2025 as a result of population ageing and stronger preferences for this form of accommodation.

The quality of the accommodation in retirement villages (and choice of in-house services) can range from basic to luxury resort-style living. Following the successful piloting of CACPs and EACH packages in retirement villages in 2003-04, retirement village operators have greater scope for competing in aged care approval rounds for new community care places.

2.3 The financing of aged care

Formal aged care services in Australia are predominantly financed by taxpayers with some user co-contributions (including contributions from government-funded income support pensions, principally the Age Pension).

In 2009-10, total direct government expenditure on aged care services was around \$11 billion (SCRGSP 2011). Around two-thirds of that expenditure was directed at residential care, with the balance for community care, assessment and information services and services provided in mixed delivery settings (table 2.4). The Australian Government funds community care packages (CACPs, EACH and EACH-D) and residential care and currently shares funding responsibility for HACC with the states and territories.

Table 2.4 Government expenditure on aged care services, 2009-10

<i>Expenditure component</i>	<i>\$ million</i>
Assessment and information services ^a	97
Residential care services ^b	7 290
Community care services ^c	3 169
Services provided in mixed delivery settings ^d	458
Total	11 014

^a Assessment and information services include only Australian Government expenditure. ^b Residential care services include DoHA and DVA (including payroll tax supplement) and state and territory governments' expenditure. ^c Community care services include HACC, CACP, EACH and EACH-D, National Respite for Carers Program, community care grants, VHC, DVA Community Nursing, Assistance with Care and Housing for the Aged. ^d Services include the Transition Care Program, MPS and residential ATSI flexible services, Day Therapy Centres, Continence Aids Assistance Scheme, National Continence Management Strategy, Innovative Care Pool and Dementia Education and Support, Long Stay Older Patient Initiative, Community Visitors Scheme and Culturally and Linguistically Diverse expenditure.

Source: SCRGSP (2011).

The HACC program receives the bulk of public subsidies that are directed to the provision of community care — around \$1.9 billion in 2009-10. Currently, the Australian Government provides 60 per cent of funding and the states and territories 40 per cent (DoHA 2010n). While there are national guidelines for HACC service standards, there is significant variation in the operation and charging regimes for services across the jurisdictions. User contributions for HACC services are estimated to average around 5 per cent of the cost of the services (DoHA 2008b).

In 2009-10, Australian Government spending on CACPs was \$510 million, and \$306 million on EACH and EACH-D packages combined (DoHA 2010n). On average, user contributions account for around 16 per cent of the costs of CACPs and about 5 per cent of the cost of EACH packages (DoHA 2008b).

Australian Government funding for residential care, paid to aged care providers, was \$7.1 billion in 2009-10. Around 70 per cent of the cost of residential care is provided by the government subsidy, with the annual subsidy per residential place averaging \$43 050 in 2009-10 — \$51 550 for high care residents and \$20 150 for low care residents (DoHA 2010n).

Aged care residents who can afford to, contribute to the cost of their care and accommodation. Residents contribute via basic daily fees, income tested fees, total asset tested accommodation payments, extra service fees and additional services fees (box 2.5). Total direct private expenditure on aged care services cannot be reliably calculated as data on private expenditure for some services are not collected.

Box 2.5 Residential aged care co-contributions

Basic daily fee — all residents in aged care facilities, including respite residents, can be asked to pay a basic daily fee as a contribution towards accommodation costs and living expenses like meals, cleaning, laundry, heating and cooling. The maximum basic daily fee for permanent residents entering an aged care home on or after 20 September 2009 is 84 per cent of the annual single basic Age Pension.

Income tested fee — residents in permanent aged care with total assessable income above the maximum income of the full rate of the Age Pension are asked to pay an income tested fee (in addition to the basic daily fee) as a contribution to the costs of care. The amount they pay depends on their income and the level of care they require.

Accommodation charge — as at 21 March 2011, residents with total assets, including the former principal residence (unless it is exempt because of the presence of a protected person), in excess of \$39 000 who enter high care may be asked to pay an accommodation charge. The charge increases to a maximum of \$30.55 per day for residents with assets of just over \$102 500.

Accommodation bonds — as at 21 March 2011, residents with sufficient assets who enter low level or who enter an extra service high care place may be asked to pay a bond. The bond amount and payment arrangements are negotiated between providers and residents. However, residents cannot be charged a bond which would leave them with less than \$39 000 in assets. The aged care provider can deduct monthly retentions from the bond for up to five years and derive income from the investment of the bond. The Australian Government sets the maximum retention amount, currently \$307.50 a month (fixed at the date of entry). The balance of the bond is refunded to the resident or their estate on leaving the facility.

Lump sum accommodation bonds paid by residents in aged care homes are exempt from the Age Pension assets test. A resident's former principal residence is exempted from the Age Pension assets test for two years for people entering residential care (and longer if the person's partner is living there). If a resident's former principal residence is rented out to pay some or all of a periodic payment for an agreed accommodation bond, the former residence and the rental income are exempt from the Age Pension assets and income tests for as long as the former residence is rented out and the periodic payment continues to be made.

Extra service charges — for the provision of a higher standard of accommodation services and food (where extra service applies to residents occupying extra service places).

Additional service fee — where the resident requests or agrees to additional services (such as newspapers and hairdressing).

Sources: DoHA (2010o, 2011h).

Entrants to high care are required to pay an accommodation charge, while those entering low level care or those receiving extra services in high level facilities can be asked to pay an accommodation bond, effectively an interest free loan to the facility. Providers can deduct monthly retention amounts from the bond for up to five years and derive income from the investment of the bond, or offset other interest bearing debt. The income from accommodation bonds and retention amounts is intended to be used to meet capital costs, retire debt related to residential care, or to improve the quality and range of aged care services. In 2009-10:

- the average accommodation charge for new residents was \$22.51 per day
- the average bond agreed with a new resident was \$232 276 (DoHA 2010n).

The average new resident's bond is now more than three and a half times than it was in 1998 (when the average new bond value was around \$60 000). Between 1998 and 2008, the average value of each new accommodation bond increased by 13 per cent per year (ANAO 2009). The balance between public and private contributions to aged care has changed over the past decade, with a rise in user contributions and private funding for services.

2.4 Regulation of aged care

Australian Government

Australian Government regulation of residential care facilities and community care packages is both extensive in scope and intensive in its level of detailed prescription. It limits the number of available residential care bed licences and community care packages, and sets the level of payments to providers and co-contributions from care recipients. Australian Government regulation also includes quality assurance and consumer protection measures, such as:

- accreditation of residential care facilities by the Aged Care Standards and Accreditation Agency (ACSAA)
- prudential regulation in relation to accommodation bonds
- building certification requirements (in addition to those included in the Building Code of Australia)
- a Complaints Investigation Scheme (CIS)
- an Aged Care Commissioner.

The Office of Aged Care Quality and Compliance (OACQC) (a division of DoHA) is responsible for aged care regulation policy and its enforcement. It has overarching responsibility (and is accountable) for accreditation and compliance (through ACSAA) as well as complaints handling (through the CIS).

Accreditation of quality

ACSAA, an independent company limited by guarantee and under the *Commonwealth Authorities and Companies Act 1997*, is appointed by DoHA as the accreditation body for residential aged care. Its legislative functions are set down in the *Aged Care Act 1997*, the *Accountability Principles 1998*, and the *Accreditation Grant Principles 2011*, and include:

- management of the accreditation process for residential care using the Accreditation Standards
- promotion of high quality care and assistance to industry to improve service quality by identifying best practice and providing information, education and training
- assessment and strategic management of services working towards accreditation
- liaison with DoHA about services that do not comply with the relevant Accreditation Standards.

Community-based providers (that is, those funded by the Australian Government's packaged community care programs and the HACC Program) must also be approved under the *Aged Care Act 1997*, but are subject to a number of different quality standards and reporting arrangements. The Council of Australian Governments (COAG) has recently agreed on Community Care Common Standards (DoHA 2010d).

Complaint handling

The CIS is managed by the OACQC within DoHA although, in practice, the reporting arrangements are complex and spread across all state and territory offices of DoHA (Walton Review 2009). It is available to anyone who wishes to provide information or raise a complaint or concern about an Australian Government-subsidised aged care service, including:

- people living in residential care facilities
- people receiving packaged community aged care or flexible care
- relatives, guardians or legal representatives of those receiving care.

The CIS is also able to receive complaints in relation to care funded under the *Home and Community Care Act 1985*.

The Office of the Aged Care Commissioner (OACC) has been established independently of DoHA. The Aged Care Commissioner (the AAC) is appointed by the Minister for Mental Health and Ageing and is able to review decisions and examine complaints about CIS processes and examine the conduct of AOCQC audits and assessors. The AAC may only make recommendations (generally to the Secretary of DoHA) when examining complaints. While the AAC is a statutory appointment, the AAC's officers are DoHA employees.

The Administrative Appeals Tribunal (AAT) is the main avenue for appeals to administrative decisions.

A more detailed description of regulation of aged care is provided in appendix F. Issues relating to aged care regulation are examined in chapter 15.

State, territory and local government regulation

State, territory and local government involvement in aged care regulation covers building, planning and design, occupational health and safety, fire, food and drug preparation and storage and consumer protection (Hogan 2004b; PC 2008, 2009a). Nurses, allied health professionals and personal carers are regulated under different state and territory acts, while further layers of regulation deal with financial assistance programs, complaints handling and the operation of retirement villages, social housing and caravan parks.

2.5 Aged care and other social policy areas

The aged care system sits within a much broader framework of services and policies that assist older Australians. Service delivery in many of these other areas affects the performance of the aged care sector and vice-versa. For example, the National Health and Hospitals Reform Commission (NHHRC) considered that improved interactions of services would be beneficial in reducing unnecessary hospitalisations:

Greater choice in aged care services, better primary health and palliative care support and improved communication, advice and outreach to residential care facilities should reduce avoidable hospitalisations and enable more effective discharge to the best care environment for patients. (2009, p. 75)

Indeed, there are fundamental interactions between aged care and health care including, particularly, acute care in hospitals and primary care provided by general practitioners (GPs), clinical nurse specialists and allied health professionals. A more detailed discussion is contained in chapters 9 and 10.

Other services that a number of older people access regularly, and which may be necessary to ensure their continued wellbeing, include disability services, housing (including social housing) and transport. There are also fundamental and complex interactions between the aged care and income support systems, with the design features of the latter giving rise to various distortions in the aged care system. These interactions are discussed in several chapters of this report.

For each of the interacting systems there are key interfaces, or points of entry and exit, that older people frequently deal with. A common complaint of many older people is that they ‘fall between the gaps’. This report explores ways to achieve a more seamless delivery of aged care services and to help ensure that the system will meet the needs of future older Australians requiring care and support.

