
2 A profile of aged care

Key points

- Older Australians are an increasingly diverse group in terms of their backgrounds, care needs, preferences and incomes and wealth.
- Aged care services are provided both in the community and in residential facilities.
 - Community care is primarily provided by informal carers.
- The need for some form of assistance with personal and everyday activities increases with age. In 2003, 32 per cent of those aged 65–74 years needed some form of assistance, compared with around 86 per cent of those aged 85 or older.
- Publicly subsidised aged care services are extensively regulated and predominantly funded by the Australian Government, although all levels of government are involved to some extent. Government is involved in: allocating places to approved providers; assessing client eligibility for services; funding services; setting prices; and regulating quality.
- The regulated aged care sector has changed significantly over the past decade or so. Key trends include:
 - increasing numbers of older Australians requiring subsidised care — the number of residential and equivalent community care places increased by nearly 52 per cent between 1998 and 2007.
 - greater reliance on user contributions — their share of total residential care expenditure increased from 22 to 25 per cent between 2003-04 and 2005-06.
 - increasing emphasis on community care — its share of subsidised places under the *Aged Care Act 1997* increased from 2 to 20 per cent between 1995 and 2007.
 - greater proportion of residents in high level care — their share increased from 58 to 70 per cent between 1998 and 2007.
 - decreasing numbers of smaller residential facilities — the share of facilities with 40 or fewer beds decreased from 53 to 34 per cent between 1998 and 2007.
 - increasing investment by private for-profit providers — their share of residential care beds increased from around 29 per cent in 1998 to 32 per cent by 2007.

This chapter's overview of aged care services, clients and providers serves as a basis for the subsequent analysis of future challenges facing the aged care sector. It provides a current snapshot of the sector and highlights key changes within the sector over the past decade or so.

Detailed information about the aged care system is available from a variety of sources notably *Australia's Welfare* (AIHW 2007b), *Residential Aged Care Services in Australia* (AIHW 2008d), *Aged Care Packages in the Community* (AIHW 2008a) and *Report on the Operation of the Aged Care Act 1997* (DoHA 2007h).

The aged care sector encompasses a broad range of services reflecting differing client needs and funding arrangements. It is also characterised by extensive government regulation and high levels of public subsidy. There are two broad categories of aged care services — community (or home based) care and care provided in residential aged care facilities.

Some older people purchase aged care services that are not funded or regulated by the Australian Government. However, data on the extent of these services are not readily available. Hence, this study focuses on the regulated system of aged care service provision in Australia.

2.1 Aged care represents a 'social product system'

Aged care is essentially concerned with providing appropriate care for older Australians as the ageing process impairs their ability to care for themselves. The provision of aged care can be thought of as a complex 'social product system' (see, for example, Marceau and Basri 2001 — who examine healthcare in this context). Features that characterise the social product system for aged care services include:

- the production of 'bundles' of services tailored to the individual needs of clients, that may include personal care services, other everyday assistance, accommodation, nursing care and palliative care
- a high degree of direct contact between providers and clients rather than through arms length market transactions
- the presence of many different organisations, governance arrangements, funding instruments and incentive mechanisms
- a marked variation in the cost of service provision, with some services being particularly high cost relative to others

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- the social value nature of these services justifying a high degree of government involvement, with regulations determining how, where and to whom these services are provided and governing what prices are charged
 - high, and increasing, community expectations about the provision of these services (for example, in terms of access, flexibility and responsiveness).

In common with other complex social product systems, such as the health and education systems, there are subsystems within aged care (for example, community care, residential care and respite care) and there are important interfaces between aged care and other social policy areas, such as allied health, hospitals, disability and housing services.

Service delivery in each of these areas affects the performance of the aged care sector. For example, changes in the availability and nature of care provided by hospitals can affect the demand for community and residential care. These service interfaces are explored further in chapter 4.

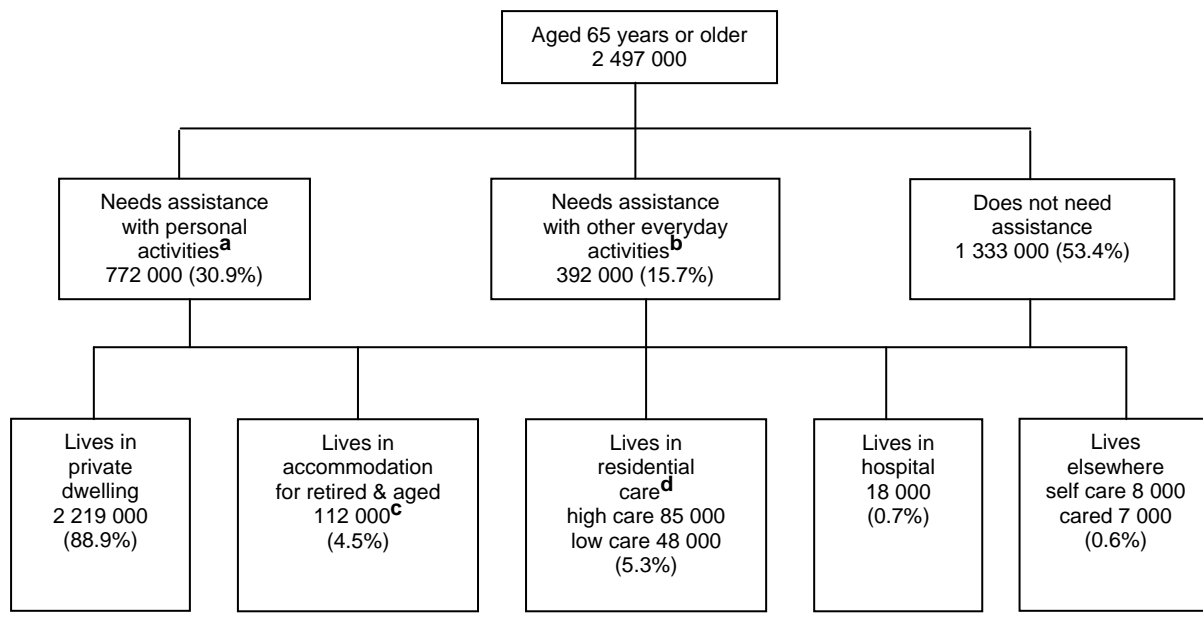
2.2 A profile of older Australians requiring care

The aged are a diverse group, having different preferences, backgrounds, functional capacities, living arrangements, income and wealth. Reflecting this diversity, older Australians enter the aged care system at different points, requiring different levels of care and combinations of services in a range of different settings. Three important points of diversity that drive much of the variation in demand for aged care services are differences in older people's need for care, their income and wealth and accommodation arrangements.

Need for care

In 2003, almost half (46.6 per cent) of all Australians aged 65 years or older reported needing assistance with personal or everyday activities such as self-care, mobility and communication (figure 2.1). As the incidence of physical and cognitive disability increases with age, so to does the need for assistance. In 2003, 32 per cent of those aged 65–74 years needed some form of assistance, compared with around 86 per cent of those aged 85 or older (figure 2.2).

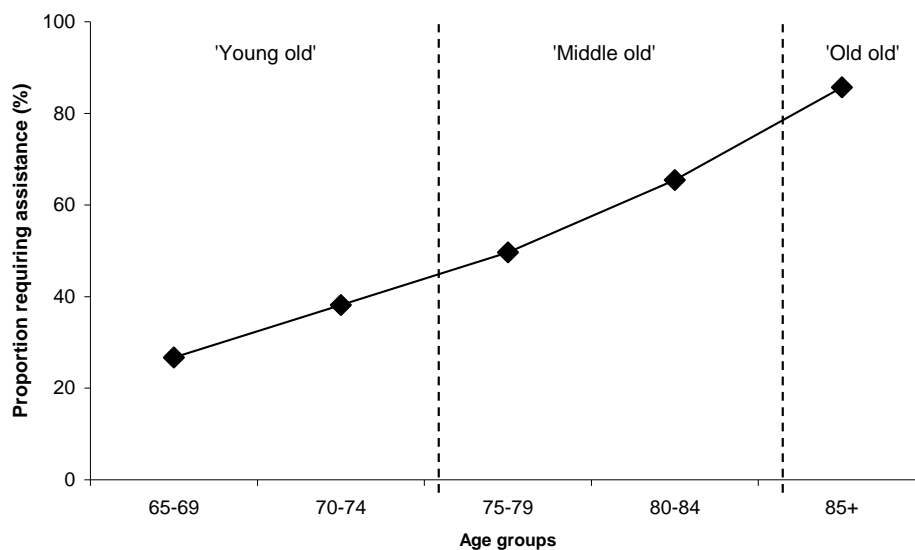
Figure 2.1 Need for assistance and living arrangements of older persons
Aged 65 years or older, 2003



^a Personal activities comprise self-care, mobility, communication, cognitive or emotional tasks and health care. ^b Other everyday activities comprise paperwork, transport, housework, meals and property maintenance. ^c Predominately retirement villages. PC estimate from ABS data allowing for difference between ABS and AIHW data regarding the number of older people in residential care. ^d AIHW (2004d).

Data source: ABS (Survey of Disability, Ageing & Carers, 2004, Basic CURF, CD-ROM).

Figure 2.2 Need for assistance by age of older persons, 2003



Data source: ABS (Survey of Disability, Ageing and Carers: Summary of Findings, Cat. no. 4430.0).

Income and wealth

The income levels of older Australians play an important part in their use of care as well as the extent of user contributions for this care. The most important source of income for a sizeable proportion of the current cohort of older Australians is the age pension. In June 2007, 66 per cent of Australians over the current qualifying age (65 years for men; 63.5 years for women) received the age pension (FaCSIA 2007). In addition, some in this cohort also received similar means tested income support from the Department of Veterans' Affairs, bringing the total Australian government age and service pension take-up for this group to 75 per cent.

Of the 1.95 million Australians who received the age pension in 2006-07, some 60 per cent received a full rate pension and 40 per cent a part rate (FaCSIA 2007).

During 2005-06, government pensions and allowances accounted for at least 90 per cent of the income for nearly half (47 per cent) of those households with at least one member aged 65 years or older (ABS 2007f). Even so, a significant proportion of households (almost 20 per cent) received less than 20 per cent of their income from the age pension in 2005-06. Further, there is great variation in wealth among older Australians whether home ownership is included or excluded (chapter 3).

Accommodation arrangements

The home is an important dimension of community care — 89 per cent of those aged 65 years or older live in a private dwelling with a further 4.5 per cent living in accommodation for the retired or aged such as retirement villages (figure 2.1). Importantly, the security of accommodation arrangements for the elderly (that is, stability of tenure) impacts on the scope to provide community care services. In 2006, 82 per cent of households with at least one member aged 65 years or older owned their own home, with or without a mortgage, and 15 per cent rented (ABS unpublished data).

2.3 Types of care

Older people's care needs can be thought of as a spectrum, depending on the degree to which the ageing process has impaired their ability to care for themselves. Older people will often experience increasing support needs either gradually or following acute care episodes. Various bundles of services are available to cater for these needs, ranging from in home support with some everyday and personal activities, through to full-time personal and nursing care provided in a residential care facility.

Community care

It is government policy and the wish of most older people to remain in the community for as long as possible. A wide range of services can assist older people to live independently: from living and personal care through to nursing, medical and palliative care. Informal carers (for example, family and friends) typically supply such services, often in conjunction with one or more formal community care providers through a range of government subsidised programs.

The Home and Community Care (HACC) program serves as the mainstay of community care by providing basic maintenance and support services to older people (and some younger people) wishing to live independently at home. HACC providers offer a wide range of services including domestic assistance, meals, nursing, transport, allied health, home maintenance, personal care, social support, aids and equipment.

Around 643 000 people aged 70 years or older received HACC services in 2006-07 (table 2.1). Most HACC clients (90 per cent) received less than two hours of service each week, although a small proportion (3 per cent) received more than 4.5 hours each week, some up to 28 hours each week.

Two programs administered by the Department of Veterans' Affairs (DVA) also assist a significant proportion of older people by offering a range of services similar to that delivered through the HACC program. The Veteran's Home Care (VHC) program provided services to around 72 100 veterans aged 70 years or older in 2006-07 while the DVA Community nursing program assisted 33 365 veterans of all ages in the same year (table 2.1).

The Australian Government also funds three programs designed for older people eligible for residential care but who have expressed a preference to remain in the community:

- Community Aged Care Packages (CACPs) provide a bundle of services averaging 7 hours a week as an alternative to low level residential care
- Extended Aged Care at Home (EACH) programs target older people eligible for high level residential care by providing an average 23 hours of packaged care a week
- EACH Dementia (EACHD) is designed to provide the highest level of community care for those with complex cognitive, emotional or behavioural needs (table 2.1).

As at 30 June 2007, there were 36 555 older people receiving packaged care through these programs, the majority receiving CACPs (32 983) with the balance (3572) receiving EACH and EACHD packages (table 2.1).

Table 2.1 Profile of main community care programs
People aged 65 years or older, unless otherwise indicated^a

<i>Program</i>	<i>Recipients</i>	<i>Service usage^b</i>	<i>Usage of main service types (% of clients)</i>
Home and Community Care ^c	• 642 650 in 2006-07	<ul style="list-style-type: none"> • 90% use < 2 hours a week; • 97% use < 4.5 hours a week 	<ul style="list-style-type: none"> • Domestic 30% • Meals 22% • Nursing 21%
Veterans' Home Care	• 72 100 in 2006-07 ^d	<ul style="list-style-type: none"> • 79% received 1 service • 98% received up to 2 services 	<ul style="list-style-type: none"> • Domestic 89% • Home & garden 19% • In-home respite 16%
DVA Community Nursing	• 33 365 in 2006-07 ^e		<ul style="list-style-type: none"> • Bathing 54% • Dressing 45%
Community Aged Care Packages	• 32 983 as at June 2007	<ul style="list-style-type: none"> • average 7 hours a week • 50% use 4.5–9.5 hours a week 	<ul style="list-style-type: none"> • May include bathing, toileting, dressing, meal preparation, laundry, home help, gardening and mobility.
Extended Aged Care at Home (including EACH Dementia)	• 3572 as at June 2007	<ul style="list-style-type: none"> • average 23 hours a week • 50% use 17–29 hours a week 	<ul style="list-style-type: none"> • As for CACPs, but may also include nursing, allied health, oxygen and enteral feeding.
National Respite for Carers Program	• 42 884 in 2004-05 ^f		<ul style="list-style-type: none"> • In-home 46% • Commonwealth residential 21%

^a Due to data availability, numbers refer to different time periods. Some recipients receive services from more than one program. ^b Hours standardised to 'personal care equivalent hours' (DoHA 2007g). ^c Aged 70 years or older. Usage rates are for 2004-05. ^d Estimated number of veterans provided with services who were aged 70 years or older. 96.7 per cent of veterans who were assessed for services were aged 70 years or older. Veterans approved for VHC services including domestic assistance, home and garden maintenance, personal care and respite. The actual number of recipients will be lower than those approved. ^e Clients of all ages. ^f Covers carers looking after people of all ages who received direct respite care services through Commonwealth Carer Respite Centres.

Sources: AIHW (2007b, 2008b); DoHA (2007g); DVA (2007, 2008); SCRGSP (2008); PC estimates.

A number of government initiatives provide support to informal carers. The role of an informal carer is often demanding — financially, physically, socially and emotionally. As such, caring diminishes opportunities to engage in full-time employment and limits the scope to have a break from this role.

In recognition of these demands, governments provide assistance to carers through respite services for the person they are assisting (such as through the National Respite for Carers Program), as well as through carer specific payments and allowances (table 2.1). Such assistance also influences the ongoing feasibility of providing informal care and thereby affects the demand for formal modes of care, including residential aged care services.

Residential care

Aged people with physical, medical, psychological or social care needs that cannot be practically met in the community are eligible for residential aged care. There are two main classes of residential care — low level care and high level care. Low level care covers the provision of suitable accommodation and related living services (such as cleaning, laundry and meals), as well as personal care services (such as help with dressing, eating and toileting). High level care covers accommodation and related living services, personal care, nursing care and palliative care within a full-time supervised framework.

At 30 June 2007, there were around 145 000 permanent residential aged care recipients in Australia aged 65 years or older, with around 70 per cent receiving high level care (table 2.2). Over 50 per cent of recipients were aged 85 years or older and by far the greatest number were women.

Table 2.2 **Characteristics of permanent residential care clients**
30 June 2007

		<i>High care^a</i>	<i>Low care^b</i>	<i>Total</i>
Age				
64 years & under	%	4.6	3.3	4.2
65–74 years	%	8.8	7.9	8.5
75–84 years	%	33.4	32.6	33.2
85 years & over	%	53.2	56.2	54.1
Permanent clients aged 65+^c				
Female	'000	73.4	31.8	105.2
Male	'000	27.9	11.9	39.8
<i>All</i>	'000	101.3	43.7	145.0
Average length of stay^d				
Less than 1 year	%	35.7	44.5	36.9
1–3 years	%	27.8	30.7	28.1
More than 3 years	%	36.5	24.8	35.0

^a Residential Classification Scale 1–4. ^b Residential Classification Scale 5–8. ^c Data from 0.8 per cent of residents whose dependency levels were not reported have been allocated proportionally. ^d Level of care for permanent residents at time of separation during 2006–07.

Sources: AIHW (2008d); PC estimates.

2.4 Profile of aged care providers

Community aged care providers

Community aged care providers can be characterised as either informal or formal. Family and friends are the main providers of informal care. Of those older Australians receiving assistance in community settings in 2003, 83 per cent received assistance from informal carers and 64 per cent from formal care providers (table 2.3). Most informal assistance is for communication, paperwork, mobility, cognitive or emotional tasks, and transport. Only in the area of health care do formal carers provide a larger proportion of support than informal carers. Many older people who are dependent on informal carers rely increasingly on formal sources of care as they age (figure 2.3). This arises because of changes in their assistance needs and because access to informal carers who can continue to provide assistance diminishes over time. Counter to this pattern is assistance with cognition or emotion. Here older people generally become more reliant on informal carers and less reliant on formal carers over time for assistance with decision making, maintaining relationships and coping with feelings or emotions (figure 2.3).

Table 2.3 **Likelihood of receiving assistance by provider type**

For those aged 65 years or older in 2003 (per cent)

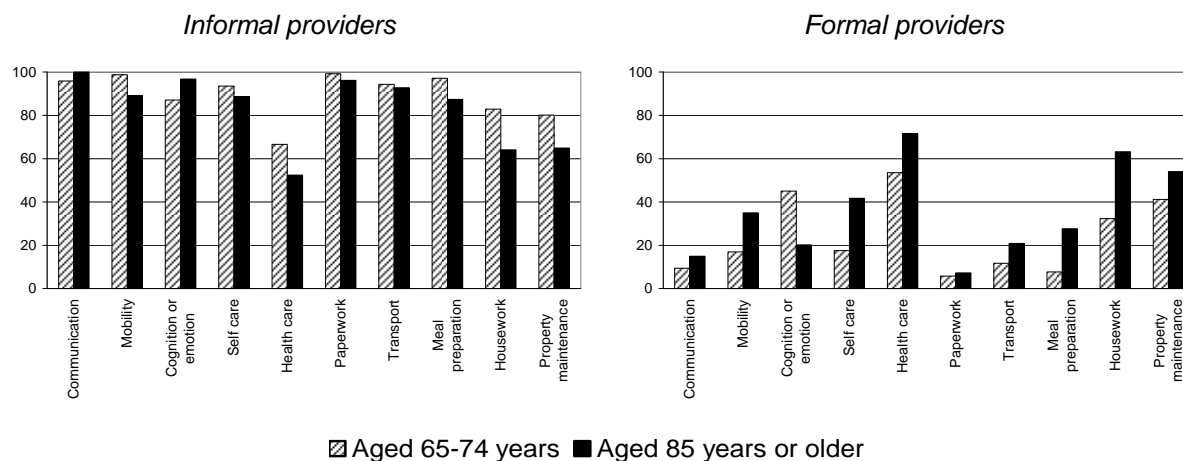
	<i>Informal providers^a</i>		<i>Formal providers</i>			<i>Both informal & formal providers</i>	
	<i>All informal</i>	<i>Partners only</i>	<i>All formal</i>	<i>Govern-ment</i>	<i>Private non-profit</i>		<i>Private commercial</i>
Personal activities							
Communication	98.4	42.5	7.8	4.4	1.9	1.5	6.2
Mobility	93.8	38.1	26.6	16.6	7.1	4.3	20.3
Cognition or emotion	93.6	39.3	29.2	12.0	1.7	19.5	22.7
Self care	89.1	53.6	28.8	18.5	6.6	4.8	17.9
Health care	54.2	30.5	65.9	26.3	6.4	37.9	20.1
Other activities							
Paperwork	97.5	34.8	6.1	2.2	1.0	2.9	3.6
Transport	93.4	29.8	16.0	8.4	3.6	4.8	9.4
Meal preparation	86.7	41.3	24.3	14.6	5.3	4.4	11.1
Housework	70.6	34.8	51.0	29.8	6.8	15.3	21.5
Property maintenance	71.6	26.5	49.7	9.3	6.4	36.4	21.3
All assistance^b	83.0	36.7	63.7	31.1	10.5	42.0	46.7

^a Informal providers include partners, children, other relatives, friends and neighbours. ^b Persons may receive assistance from more than one provider.

Source: ABS (*Survey of Disability, Ageing and Carers: Summary of Findings*, 2004, Basic CURF, CD-ROM).

Figure 2.3 Assistance with personal and other activities by provider type and client age^a

Likelihood of receiving assistance in 2003 (%)



^a Persons may receive assistance from more than one provider.

Data sources: ABS, (Survey of Disability, Ageing & Carers, 2004, Basic CURF, CD-ROM); PC estimates.

Residential aged care providers

There were around 2900 residential aged care facilities operated by accredited providers in 2007 (table 2.4). Private organisations owned 88.3 per cent of these facilities with most being not-for-profit organisations such as religious, community-based and charitable organisations.

Table 2.4 Ownership of residential aged care facilities

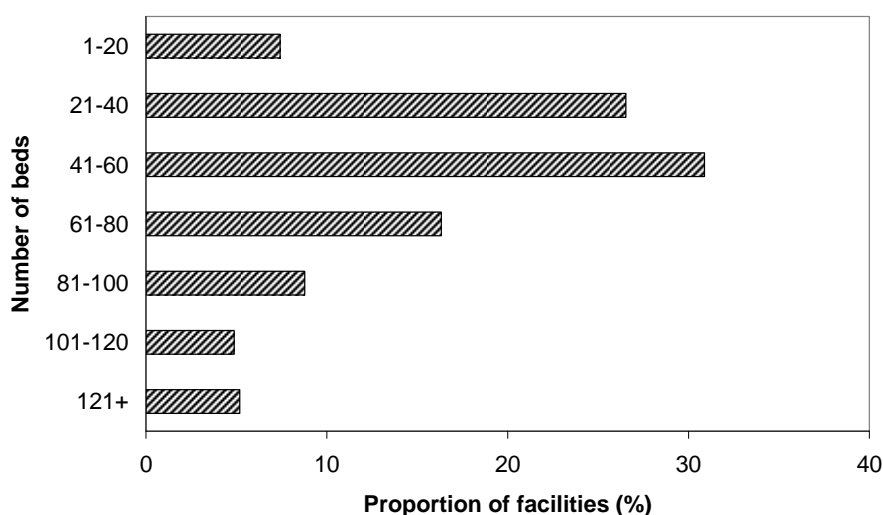
As at 30 June 2007

	Number of facilities	Per cent
Private not-for-profit	1762	61.4
Religious	827	28.8
Community-based	504	17.5
Charitable	431	15.0
Private for-profit	773	26.9
Government	337	11.7
State/ Territory	262	9.1
Local	75	2.6
Total	2872	100.0

Source: AIHW (2008d).

Around 65 per cent of all residential facilities offer less than 60 places while around 10 per cent offer over 100 places (figure 2.4).

Figure 2.4 Size of residential aged care facilities
As at 30 June 2007



Data source: AIHW (2008d).

2.5 The role of government in aged care

Australia's aged care sector is subject to extensive regulation and high levels of public subsidy. A summary of the current policy and legislative framework and the main areas of regulatory control follows.

Current policy and legislative framework

National Strategy for an Ageing Australia

The *National Strategy for an Ageing Australia* (Andrews 2002a) was introduced to provide a strategic framework for a coordinated national response to the challenges associated with population ageing. The strategy is structured around four key elements: independence and self provision; attitude, lifestyle and community support; healthy ageing; and world class care.

In relation to providing ‘world class care’, the national strategy specifies four goals:

- A care system that has an appropriate focus on the health and care needs of older Australians and adequate infrastructure to meet these needs
- A care system that provides services to older people that are affordable, accessible, appropriate and of high quality
- A care system that provides integrated and coordinated access, assistance and information for older Australians with multiple, significant and diverse care needs
- A sustainable care system that has a balance between public and private funding and provides choice of care for older people (Andrews 2002a).

Aged Care Act 1997

The *Aged Care Act 1997* is the principal regulatory instrument of the Australian Government relating to aged care. Section 2-1 of the Act nominates the Government’s objectives in this area, including:

- to provide funding that takes account of the quality, type and level of care
- to promote a high quality of care and accommodation and protect the health and wellbeing of residents
- to ensure that care is accessible and affordable for all residents
- to plan effectively for the delivery of aged care services and ensure that aged care services and funding are targeted towards people and areas with the greatest needs
- to provide respite for families and others who care for older people
- to encourage services that are diverse, flexible and responsive to individual needs
- to help residents enjoy the same rights as all other people in Australia
- to promote ‘ageing in place’ through the linking of care and support services to the places where older people prefer to live.

These objectives are elaborated in the *Aged Care Principles* that accompany the Act.

The Act also recognises the need to efficiently integrate aged care planning and service delivery across the related areas of health and community services.

The Act specifies that in interpreting its objectives, due regard must be given to: the limited resources available to support services and programs under the Act; and the need to consider equity and merit in assessing those resources (s. 2-1(2)).

Thus, although the Act does not explicitly identify sustainability as an objective, it does recognise that resources are limited. The Act was clearly framed in the context of meeting the challenges associated with Australia's ageing population. On the introduction of the legislation to the House of Representatives, the then Minister for Family Services, the Hon. Judi Moylan, stated:

It is essential we undertake reform now, to meet the challenges of our ageing population. In little over 30 years, Australia's population of over 65s will increase by more than 50 per cent to 5 million people. This bill provides the path forward. (Commonwealth of Australia 1997, p. 3192)

The Home and Community Care Act 1985

The *Home and Community Care Act 1985* provides for the HACC program to be jointly administered and financed by the Australian, State and Territory Governments. The HACC program has a number of principles and goals including several that encompass notions of equity and efficiency:

- to ensure access to HACC among all groups within the target population, including migrants, Indigenous Australians, persons suffering from brain failure and financially disadvantaged persons
- to ensure that, within available resources, priority is directed to persons within the target population most in need of HACC
- to ensure that, within available resources, HACC services are provided equitably between regions and are responsive to regional differences
- to ensure that HACC services are delivered in a manner that is cost effective, achieves integration, promotes independence and avoids duplication
- to promote an integrated and coordinated approach between the delivery of HACC and related health and welfare programs, including programs providing residential or institutional care (*Home and Community Care Act 1985*, s. 5(1)).

Charter of Budget Honesty and Intergenerational Reports

Aged care policy, like other areas of government policy, is framed in the broader context of the *Charter of Budget Honesty Act 1998* and the *Intergenerational Reports*.

The *Charter of Budget Honesty Act 1998* sets out the principles of sound fiscal management and commits the Government to preparing an intergenerational report at least every five years. These reports assess the long-term fiscal sustainability of current government policies (such as aged care) over the next 40 years, including by taking account of the financial implications of demographic change.

The first intergenerational report identified seven priorities for ensuring fiscal sustainability. One of these was to develop an affordable and effective residential care system that can accommodate the expected high growth in the number of very old people (people aged 85 years or older) (Treasury 2002).

The second intergenerational report noted that, looking out over the next 40 years, aged care continues to be one of the main pressures on government expenditure (Treasury 2007).

State, Territory and Local government regulation

State, Territory and Local government regulation also impacts on the provision of aged care through regulations covering building planning and design, occupation health and safety, fire, food and drug preparation/storage and consumer protection (Hogan Review 2004).

Beyond these measures, Australian, State and Territory governments do not actively regulate the operation of their aged care sectors, except for the Northern Territory. The Northern Territory Government still licenses aged care facilities that receive Australian Government subsidies and controls their conduct through annual inspections and powers over licence renewals (Hanks and De Ferrari 2003). The Territory Government has designed its inspection and licensing processes to complement those of the Australian Government (Aagaard 2002).

The main areas of regulatory control

In order to meet the objectives outlined above, governments control key aspects of aged care by: allocating aged care places to approved providers, assessing client eligibility, funding services, setting prices and controlling quality.

Some guidance on the nature of involvement in each area is presented below.

Allocating aged care places to approved providers

The Australian Government funds and allocates new aged care places each year to broadly match growth in the target population — those aged 70 years or older plus Indigenous people aged 50–69 years. It signals its long-run intentions through a target provision ratio which provides some guidance to investment by the private sector.

The Government is currently aiming to achieve a ratio of 113 places per 1000 of the target population by 2011. It comprises 88 residential places (44 high care and 44 low care) and 25 community care packages (21 CACPs and 4 EACH).

The Government also balances the provision of services between metropolitan, regional, rural and remote areas, as well as between people needing differing levels of care. The Secretary of the Department of Health and Ageing, acting on the advice of the Aged Care Planning Advisory Committees, allocates places to each Aged Care Planning Region within each state and territory.

Following the allocation of new places to regions within each state and territory, the Government conducts an open tender to allocate these places to approved providers. Because of the time required for building approval and construction, providers have two years to make residential places operational. CACP packages and EACH places tend to become operational sooner after allocation (DoHA 2007h).

The Government also expects service providers to meet regional targets for places for concessional residents. These targets range from 16 to 40 per cent of places and aim to ensure residents who cannot afford to pay an accommodation bond (low care) or accommodation charge (high care) have equal access to care.

Assessing client eligibility

The Australian Government provides grants to State and Territory Governments to operate Aged Care Assessment Teams (ACATs), or Aged Care Assessment Services in Victoria, under the Aged Care Assessment Program. ACATs may include doctors, nurses, social workers and other health professionals.

Their role is to assess the care needs of frail older people and help them receive the most appropriate care and support in accordance with the aged care legislation and *Aged Care Assessment Program: Operational Guidelines* (DoHA 2002a). This may involve simply referring clients to community care providers such as those available under the HACC program. Alternatively, they may approve their eligibility for residential or community care services (DoHA 2007h).

Funding services

Aged care in Australia is largely publicly funded. The Australian Government provides most of the recurrent funding for residential aged care services, an estimated \$5.4 billion to people aged 65 years or older in 2006-07 (table 2.5). State and Territory Governments also provide some funding for these services.

Table 2.5 Recurrent government expenditure on aged care programs in Australia, 2006-07

Estimated share for clients aged 65 years or older

<i>Mode of care</i>	<i>Government expenditure^a</i>	<i>Care mode expenditure to total expenditure</i>
	\$m	%
Aged care assessments	58	0.7
Residential aged care^b	5398	62.8
Community care	2117	24.6
HACC ^c	1151	13.4
CACP	381	4.4
VHC	93	1.1
Flexible care ^d	248	2.9
Respite care ^e	191	2.2
Information, support & other community care ^f	53	0.6
Financial support for carers^g	1018	11.9
<i>Total</i>	8591	100.0

^a Expenditure estimates are based on the proportions of clients aged 65 years or older. Where applicable, estimates are for total Australian, State and Territory government expenditure. Components may not add due to rounding. ^b Includes expenditure on residential aged care by the Department of Veterans' Affairs and State and Territory government funding. ^c Estimated aged care share of total government HACC expenditure. Includes some respite services. ^d Includes EACH and EACHD, TCP, MPS and flexible care pilot projects. ^e National Respite for Carers Program and Australian Government funded Day Therapy Centres. Residential respite expenditure estimated as a share of total residential expenditure on basis of days occupied. ^f Includes Commonwealth Carelink Centres, information and assistance with continence, dementia, housing, Indigenous specific issues and other care needs. ^g Estimated share of total government expenditure on carers payments and allowances received by those caring for people aged 65 years or older.

Sources: AIHW (2007b); FaHCSIA (2008 unpublished data); SCRGSP (2008); PC estimates.

Residents' fees and charges provide most of the remaining service revenue, around \$2.1 billion in 2005-06 (AIHW 2007b). Since most user contributions are financed indirectly from aged pension payments — around 88 per cent of permanent residents receive Centrelink or DVA pensions (AIHW 2008d) — the bulk of the cost of residential care is effectively sourced from general revenue.

Residents' assessed care needs largely determine government funding of residential aged care. Until recently, the instrument used to classify residents and determine care subsidies was the eight-level Resident Classification Scale (RCS).

On 20 March 2008, the Aged Care Funding Instrument (ACFI) replaced the RCS with a three-year phase-in period. The Australian Government developed the ACFI in consultation with industry following two reviews (DoHA 2003a; Hogan Review 2004).

The ACFI calculates basic care subsidies according to each client's level of need (none, low, medium or high) in three care domains:

- activities of daily living (such as nutrition, mobility, personal hygiene, toileting and continence)
- behaviour supplement (cognitive skills, wandering, verbal behaviour, physical behaviour and depression)
- complex health care supplement (DoHA 2007c).

For example, a resident with high care needs in all three care domains would attract a basic care subsidy of around \$138 a day under the new ACFI (DoHA 2008d). However, the basic subsidy payable to some residents is reduced by an income test reflecting their income and the cost of care. Providers can recover this amount directly from clients through an income tested fee. Additionally, the Government pays a variety of other subsidies including an oxygen supplement, enteral feeding supplement, conditional adjustment payment and a viability supplement that is paid to rural and remote providers.

The HACC program receives the bulk of community care subsidies — around \$1.15 billion in 2006-07 for people aged 65 years or older (table 2.5). The Australian, State and Territory Governments fund the bulk of HACC services; the shares being approximately 60 and 40 per cent respectively. In general, the States and Territories allocate HACC funds to meet regional priorities. Within individual programs and projects, service providers seek to allocate funds to provide the most benefit to the greatest number of people.

The Australian Government also contributed around \$774 million towards other community care programs including CACP, EACH, MPS and VHC in 2006-07. Funding for packages allocated under these programs provide recipients with a constant level and quality of care. As at 1 July 2008, the basic subsidies for community care were: CACP (\$34.75 a day), EACH (\$116.16 a day) and EACH Dementia (\$128.11 a day) (DoHA 2008d). Additional supplements are also available for oxygen, enteral feeding and remoteness. Many recipients of community care contribute towards the cost of these services.

Older people and their carers largely fund the provision of their informal care, although the Australian Government funds a range of carer support programs. Total funding for the National Respite for Carers Program, Australian government funded day therapy centres, carer payments and carer allowances was around \$1.2 billion in 2006-07 (table 2.5).

Setting prices

The Australian Government regulates the amount that aged care clients pay for subsidised care. For most standard service offerings, charges are means tested and capped, with concessional rates applying to pensioners. Additional charges may apply to remote residents.

As of 1 July 2008, the three main daily user fees and charges for *new* non-pensioner residents receiving standard care in residential facilities that are 2008 compliant are the:

- basic daily care fee, up to \$32.05 a day
- asset tested accommodation charge, for high care residents with assets worth more than \$34 500, the rate increasing from zero to \$26.88 a day when assets exceed \$90 410.40
- income tested fee, with residents being charged up to \$56.57 a day or the cost of their care, whichever is the lesser (DoHA 2008e).

An accommodation bond may be required of people entering low care or extra service residential facilities. The regulations do not cap bond amounts. However, providers cannot levy a bond that leaves a resident with assets worth less than a threshold amount — \$34 500 as at 1 July 2008 (DoHA 2008e). Providers are able to deduct a retention amount over five years and charge interest on bonds paid periodically, the rate being 11.75 per cent as at 1 July 2008 (DoHA 2008e). The balance of the bond is refundable on departure. Accommodation charges are levied on residents in high care, providing their assets exceed a certain amount. The ACFI classifies a resident as ‘high care’ if they are in any one of the following categories:

- medium or high care needs in activities of daily living
- high behaviour needs
- medium or high complex health care needs (DoHA 2008b).

The value of a resident’s home is counted as an asset for aged care accommodation payment purposes unless their:

- partner or dependent child/student lives in it
- carer who is eligible to receive an Australian income support payment has been living in it for the past two years
- close relative who is eligible to receive an Australian income support payment has been living in it for the past five years (Centrelink 2008).

Further, if a resident is renting out their former home and paying either an accommodation charge or bond by periodic payments at the same time:

- the rental income from the former home is exempt in full for both the pension income test and aged care fees
- the value of the home is exempt from the pension asset test (Centrelink 2008).

The fees for community care services vary with the type of service and the client's capacity to pay. State and Territory Governments develop their own HACC service fee policies and scales, guided by the principles outlined in the *Draft HACC Fees Policy* (Commonwealth of Australia 2007). For those care recipients whose income exceeds the basic rate of pension, the maximum fee for CACP, EACH or EACH Dementia packages is 17.5 per cent of the person's income to the level of the basic pension, plus up to 50 per cent of their income (minus tax and the Medicare levy) above the basic pension (DoHA 2008a). However, people assessed for community care services cannot be refused service on the basis of their inability to pay (DoHA 2006b).

Regulating quality

Both community and residential aged care services are subject to quality regulation. This is justified on the basis that 'providers and aged care recipients have unequal access to relevant information and the frailty of residents can make them vulnerable to exploitation' (Hogan Review 2004, p. 273).

Australian government funded residential facilities are subject to a quality assurance system based on:

- legislated responsibilities, which are specified in the *Aged Care Act 1997* and in the Aged Care Principles
- an accreditation based quality assurance regime, encompassing four accreditation standards: management systems, staffing and organisational development; health and personal care; resident lifestyle; and physical environment and safety systems
- a certification process to encourage improvement, particularly of the physical standard of residential aged care buildings.

The *Quality of Care Principles 1997* outline standards that cover the quality of care and quality of life dimensions of both residential and community aged care (table 5.1).

The Aged Care Standards and Accreditation Agency assesses compliance with the quality standards and the Department of Health and Ageing monitors compliance

with other legislated obligations. Services found to be noncompliant face sanctions, including suspension of funding and, in the case of the most serious breaches, revocation of approval.

Since the 2004-05 Budget, Australian Governments have also allocated funding to the development of a quality assurance and monitoring system across a number of community care programs (CACP, EACH and NRCP). This system involves a three step process: self-reporting against uniform quality standards; departmental monitoring through desk audits; and validation visits.

The 2007-08 Budget included additional funding to enhance the community care quality assurance system and provide for the development of best practice models and benchmarking in key areas of community care.

2.6 Recent trends in aged care

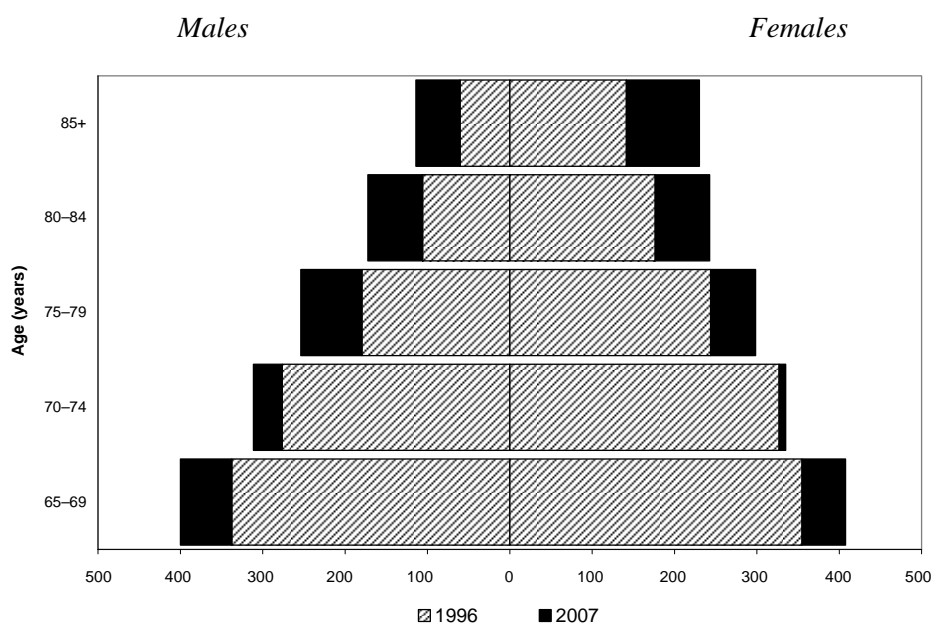
The aged care sector has changed considerably over the past decade or so, driven by a combination of demographics, changing care needs, increased funding for community care and restructuring by service providers. The most important trends have been:

- increasing numbers of older Australians requiring care
- greater reliance on user contributions
- increasing emphasis on community care
- greater proportion of residents in high level care
- decreasing numbers of small residential facilities
- increasing investment by private for-profit providers.

Increasing numbers of older Australians requiring care

The number of older Australians requiring assistance with day to day activities has increased over the past decade. As disability rates for those aged over 65 years have been roughly stable (ABS 1998, 2004b; AIHW 2006a), the main growth driver has been the increase in the numbers of older Australians. In 1996, there were around 2.2 million people aged 65 or older. By 2007, this had grown to almost 2.8 million (ABS 1997, 2007a). Importantly, most of this growth has occurred in the older age groups (figure 2.5) — the groups that are more likely to require assistance. Indeed, while the total number of people aged 65 years or older increased by 25.5 per cent between 1996 and 2007, the number of people aged 85 or older grew by almost 70 per cent.

Figure 2.5 Numbers of older Australians, 1996-2007
Thousands



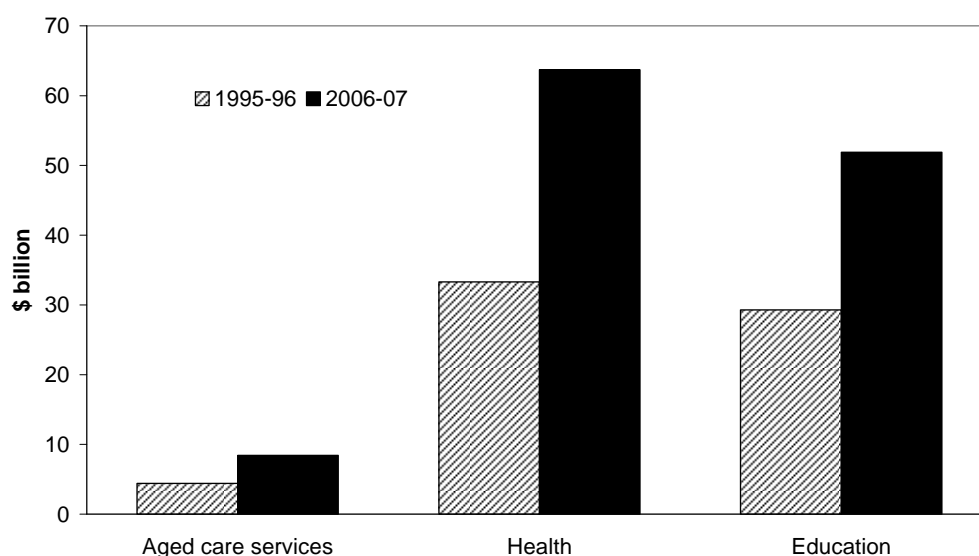
Data sources: ABS (*Australian Demographic Statistics*, Cat. no. 3101.0); ABS (*Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0).

The growth in older Australians requiring assistance has driven a large increase in the number of subsidised care places. In 1996, there were around 141 282 operational residential and equivalent community care places in Australia. By 2007, the number of these places had grown to 214 250, an average annual growth rate of 3.9 per cent (AIHW 2008d).

The growth in the aged care sector over the past decade has, not surprisingly, been associated with a large increase in funding for the sector, from both private and public sources.

Aged care funding by Australian, State and Territory Governments increased from \$4.4 billion in 1995-96 (2006-07 dollars) to \$8.6 billion in 2006-07 — an average annual real increase of 6.1 per cent in real terms (figure 2.6). This compares with an average annual increase of 6.1 per cent for health and 5.3 per cent for education.

Figure 2.6 Government real expenditure on selected social services
2006-07 dollars



Data sources: ABS (*Government Finance Statistics, Australia 1997-98*, Cat. no. 5512.0); ABS (*Government Finance Statistics, Education, Australia, 2006-07*, Cat. no. 5518.0.55.001); AIHW (2007d); SCRCSSP (1998); SCRGSP (2008).

Greater reliance on user contributions

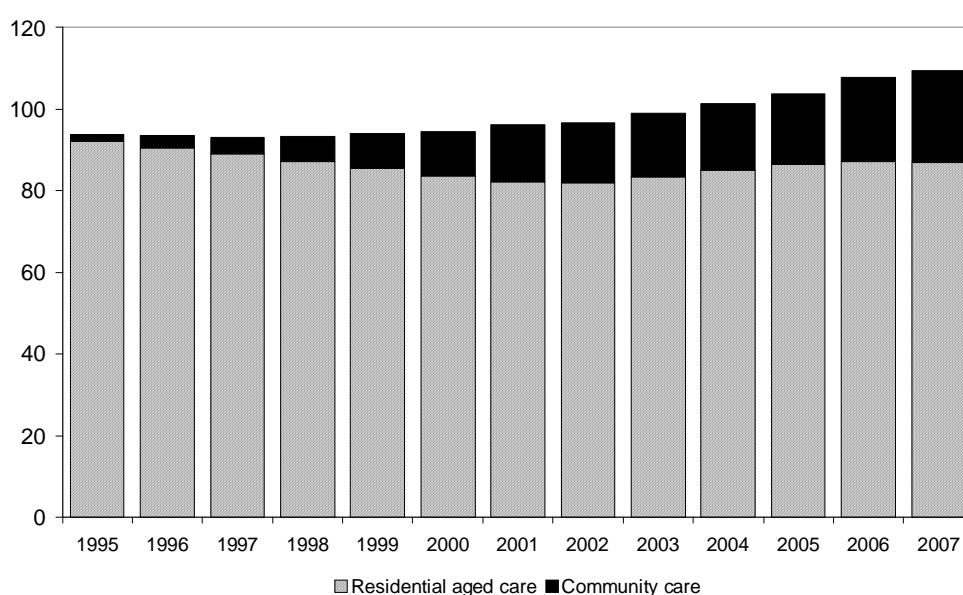
The past decade has seen a shift towards greater private funding of aged care services. As part of the structural reform of the residential aged care sector in 1997, accommodation payments and income testing of daily care fees, which previously only applied to low level care, were introduced for all residential care. The daily care fees paid by residents, plus income tested fees, as a proportion of the total expenditure on care in residential aged care facilities increased from 22 per cent in 2003-04 to 25 per cent in 2005-06 (AIHW 2007b).

Additionally, residential care providers have been able to request an accommodation bond from clients entering low care or making use of extra service high care facilities since 1997. Providers are able to retain the interest and deduct a retention amount over five years. Between October 1997 and June 1999, accommodation bonds were held by 63 per cent of aged care facilities, with the average bond being \$58 400. By 2006-07, 78 per cent of facilities held bonds with an average value of \$167 450 (DHAC 1999; DoHA 2007h).

Increasing emphasis on community care

Government policy, and the choice of most aged people, is to receive assistance in their own residence when possible. As a result, there has been a trend away from residential care towards community care in recent years (figure 2.7). Indeed, between 1995 and 2007, 54 per cent of the growth in funded places under the *Aged Care Act 1997* has been in community care (AIHW 2008d).

Figure 2.7 Aged care places and packages
Places and packages per 1000 people aged 70 year or older^a



^a Community care includes CACP, EACH and EACH Dementia packages and TCP places.

Data source: AIHW (2008d).

In 1995, there were around 2500 subsidised community care places on offer across Australia, representing less than 2 per cent of total subsidised care places. By 2007, community care places had grown to around 44 000, representing around 20 per cent of total places (AIHW 2008d). An important part of this growth has been the expansion of funding to support flexible care places (EACH, EACH Dementia and Transition Care Program). The first of these programs started in 2002-03, and by June 2007 there were almost 6200 such places (AIHW 2008d). The growth of these places reflects the broadening range of community care services that are provided to older people. In the past, many of the services that are now provided in community settings through CACP, EACH and EACH Dementia would only have been accessed in a residential care setting.

Increasing support for carers

With greater reliance on community care, there has also been an increase in funding for carers and for respite services. For example, the combined payments and allowances for carers (caring for people of all ages) increased from around \$450 million in 1995-96 to almost \$2.8 billion in 2006-07, representing an average annual increase of 15 per cent in real (constant dollar) terms. Similarly, funding for the National Respite for Carers Program has increased in real terms by an average of 19 per cent annually since it commenced in 1996-97, to around \$170 million in 2006-07 (SCARC 2005; SCRGSP 2008). In addition, the number of occupied place days for respite care within residential care facilities increased by 7.1 per cent between 1998-99 and 2006-07 (AIHW 1999, 2008d).

Greater proportion of residents in high level care

Older people are more likely to use residential aged care facilities for high level care than in the past. Between 1998 and 2007, the proportion of all permanent residents receiving high care increased from 58 to 70 per cent, an increase of around 32 000 (AIHW 1999, 2008d). High care residents aged 85 years or older accounted for most of this growth, increasing by around 31 127 to 56 446 (AIHW 1999, 2008d). This trend has resulted from ageing in place initiatives and accompanying changes to the target provision ratio.

Australian Governments have rebalanced the mix of aged care services on a number of occasions since 1985 by adjusting the target provision ratio (table A.2). This has had two effects. First, the proportion of community care places has increased relative to residential places over the past 20 years — largely by substitution for low level care residential places. Second, the proportion of high level care residential places has increased relative to those available for low level care.

Decreasing number of small facilities

Although the number of residential care places has increased in recent years, the number of aged care facilities has declined by 4.7 per cent, from 3015 in 1998 to 2872 in 2007 (table 2.6). The increased average size of residential aged care facilities reflects this consolidation. For example, around 47 per cent of facilities offered more than 40 beds in 1998. By 2007, this proportion had increased to around 66 per cent. In particular, the number of facilities with more than 100 beds increased by 121 per cent over this period.

Table 2.6 Number and size of residential aged care facilities, 1998 and 2007

As at 30 June

	1998		2007		Percentage change
	Facilities	Per cent	Facilities	Per cent	
Size of facilities (Number of places)					
1–20	396	13.1	213	7.4	-46.2
21–40	1194	39.6	762	26.5	-36.2
41–60	831	27.6	887	30.9	6.7
61–80	322	10.7	469	16.3	45.7
81–100	141	4.7	252	8.8	78.7
101–120	64	2.1	140	4.9	118.8
121+	67	2.2	149	5.2	122.4
Total	3015	100.0	2872	100.0	-4.7

Sources: AIHW (2000b, 2008d).

Increasing investment by private for-profit providers

Private not-for-profit operators own and operate the bulk of residential aged care homes and beds (table 2.4). Even so, a number of private for-profit operators have emerged as important players in the market, such as the Moran Health Care Group, TriCare and Macquarie Capital Alliance Group/Retirement Care Australia.

Reflecting this, the share of residential care beds provided by private for-profit operators has increased, from around 29.5 per cent in 1998 to 32.5 per cent in 2007 (SCRCSSP 1999; SCRGSP 2008). These for-profit facilities also tend to be larger, offering an average of 70 places in 2007, compared with 57 for not-for-profit facilities and 37 for government facilities (AIHW 2008d; SCRGSP 2008).

