Royal Commission into Aged Care Quality and Safety

Final Report: Care, Dignity and Respect

Volume 3B

The new system

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Introduction to Volume 3

In this volume, we set out our vision for the future of aged care in Australia. We make recommendations, the implementation of which will result in an aged care system that is capable of delivering high quality and safe aged care.

The structure of this volume

Many of the recommendations and observations that we make in this volume are joint. However, there are instances where we make differing observations and recommendations which are contained, in some cases, in separate chapters on the same topic.

This volume is divided as follows.

Chapter 1, *Foundations of the New Aged Care System:* sets out the foundations that are to underpin the aged care system that we envisage.

Chapter 2, *Governance of the New Aged Care System:* details the governance arrangements that are crucial to our proposed reform of the aged care system.

Chapter 3, *Quality and Safety:* outlines the manner in which high quality and safe care should be embedded within the new aged care system**.**

Chapter 4, *Program Design:* sets out the programs through which high quality and safe aged care are to be delivered.

Chapter 5, *Informal Carers and Volunteers:* outlines the manner in which the future aged care program should ensure that people who provide informal care and support to older people should themselves be supported.

Chapter 6, *Aged Care Accommodation:* describes what is required to ensure that people's accommodation can cater, where possible, to their changing needs, including having regard to features of accessibility and dementia-friendly design.

Chapter 7, *Aged Care for Aboriginal and Torres Strait Islander People:* sets out our blueprint for aged care for Aboriginal and Torres Strait Islander people.

Chapter 8, *Aged Care in Regional, Rural and Remote Australia:* details what is needed to ensure that people living in regional, rural and remote areas have better access to aged care.

Chapter 9, *Better Access to Health Care:* describes how health care is to be better provided to older people engaging with the new aged care system.

Chapter 10, *Aged Care for Older People with Disability:* details what is necessary to ensure that older people with disability have equivalent access to the care and support available under the National Disability Insurance Scheme as people aged 65 years or under.

Chapter 11, *Younger People in Residential Aged Care:* details the importance of ensuring that younger people in need of care have the support that they need so that they are not forced to live in residential aged care.

Chapter 12, *The Aged Care Workforce:* sets out what is needed to ensure that the aged care workforce is able to deliver safe and high quality aged care.

Chapter 13, *Provider Governance:* outlines improvements that will strengthen the integrity of the aged care system and focus approved providers on their core task of delivering safe and high quality aged care.

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Chapter 26, *Oversight, Implementation and Monitoring:* details the need for oversight and monitoring of the implementation of our recommendations.

Institutional arrangements

In Chapter 2, we each make recommendations about the governance of the new aged care system directed to the establishment of the institutions that we consider will improve the system.

We differ on the institutional form that certain aspects of these governance arrangements should take in the new system.

The model that Commissioner Pagone prefers—the Independent Commission model—involves greater independence from the Australian Government of the institutions that he proposes should govern the system. Commissioner Pagone believes the time has come for rebuilding the aged care system, rather than renovating a system that has proven not to be sufficiently effective. Commissioner Pagone believes rebuilding the aged care system is best achieved by establishing a new independent Commission—the Australian Aged Care Commission—the only objective of which is the effective governance of aged care in Australia. Commissioner Pagone proposes that this newly created body should perform the roles of System Governor, Quality Regulator and Prudential Regulator. Aged care pricing should be carried out by a new body—the Australian Aged Care Pricing Authority.

The model that Commissioner Briggs prefers—the Government Leadership model—supports greater independence in certain areas such as standard-setting, quality regulation and pricing, but maintains a strong Australian Government system leadership and stewardship role. Commissioner Briggs believes that reforming the existing institutions will deliver aged care reform quicker and more effectively, and that the Government is a necessary and important part of the transformation process. Commissioner Briggs proposes that a reformed Department of Health and Aged Care should perform the roles of System Governor and Prudential Regulator. Quality regulation should be the responsibility of a reconstituted Quality Regulator body, the Aged Care Safety and Quality Authority. Aged care pricing will be added to the responsibilities of the Independent Hospital and Pricing Authority, renamed as the Independent Hospital and Aged Care Pricing Authority.

To assist with readability, throughout the text of this volume, unless otherwise specified, we use the shorthand terms ‘System Governor’, ‘Quality Regulator’, ‘Prudential Regulator’ and ‘Pricing Authority’ which have the meanings as set out in the following table:

Term	Independent Commission model	Government Leadership model
System Governor	Australian Aged Care Commission	Australian Department of Health and Aged Care
Quality Regulator	Australian Aged Care Commission	Aged Care Safety and Quality Authority
Prudential Regulator	Australian Aged Care Commission	Australian Department of Health and Aged Care
Pricing Authority	Australian Aged Care Pricing Authority	Independent Hospital and Aged Care Pricing Authority

13. Provider Governance

13.1 Introduction

Without good governance, aged care providers are less likely to deliver high quality care. Evidence before us has shown that the level of substandard care in the aged care sector is unacceptably high.[1] If all aged care providers had good governance arrangements in place, it is highly likely that the level of substandard care would reduce significantly. The evidence emphasises the need for aged care providers to have robust governance arrangements focused on delivering safe and high quality care.

Organisational governance arrangements provide for the systems by which an organisation is controlled and operates, and the mechanisms by which the organisation, and its people, are held to account.[2] They are set by the leaders of an organisation, in particular the governing body. They are implemented by executive leaders and workers who report to those executive leaders. They involve everyone in an organisation.

The role of the governing body of an organisation is to provide leadership and set the organisation's aims, to determine its strategic objectives and direction, and to monitor management to ensure that its aims are met.[3]

Governance arrangements must reflect and promote the culture of an organisation. An aged care provider's most important objectives should be to enhance the wellbeing of older people by providing them with safe and high quality care and to put the older person's wishes and needs first. This should be the case irrespective of the size of a provider's corporate structure, of its related parties, and of the funding it receives or the nature of the services that it provides. Organisational culture and governance arrangements must be designed around this core purpose. Organisations must be structured to provide a leadership environment that fosters and reinforces that culture and purpose in everything they do, and enables employees to deliver it confidently and successfully. To this end, Commissioner Briggs makes Recommendation 89.

As the Governance Institute of Australia explains, values and behaviour determine and define organisational culture.[4] Culture is the key determinant of an organisation's performance and ability to meet its objectives.[5] Organisational culture must make the wellbeing of those receiving care paramount in aged care.

Aged care legislation requires that, for an aged care provider to be approved under aged care legislation, the provider must be incorporated unless it is a State or Territory, an authority of a State or Territory, or a local government authority.[6] An approved provider is subject to governance requirements in any legislation under which it is incorporated, as well as additional governance requirements in existing aged care legislation.

A total of 56% of all approved providers are incorporated under the *Corporations Act 2001* (Cth). The remaining approved providers include entities that are under State or Territory Associations Acts or other legislation, such as the Uniting Church or Salvation Army Property Trust Acts (28%), State and Territory and local government entities (11%) and entities incorporated under the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (Cth) (3%).[7] Not-for-profit providers registered with the Australian Charities and Not-for-profits Commission must meet the governance standards made under the *Australian Charities and Not-for-profits Commission Act 2012* (Cth).[8]

Under aged care legislation, an approved provider of residential care, home care or short-term restorative care must comply with Standard 8 on organisational governance in the Aged Care Quality Standards set out in Schedule 2 to the *Quality of Care Principles 2014* (Cth).[9] The existing governance requirements in aged care legislation have not provided, on a consistent basis, sufficiently strong governance and leadership of aged care providers. Changes are needed to improve providers' governance of care and their organisations' corporate governance, to strengthen the integrity and sustainability of the system as a whole, and to sharpen the focus on delivering high quality aged care services. We make recommendations in this chapter to achieve these changes.

Governing bodies of approved providers should be comprised of members whose integrity, skills and independence enable them to act, first and foremost, in the best interests of the people receiving care. Evidence before us has demonstrated, in particular, a lack of adequate clinical governance expertise on the boards of some providers.[10] We consider that each governing body should have a care governance committee, to ensure that quality of care is considered at the highest level of the organisation.[11] The chair of the care governance committee should be a member of the governing body and have appropriate experience in providing care. The focus on quality of care should cascade from the governing body through the executive leadership to all staff.

People receiving aged care should have a role in determining how services are delivered at an organisational level. We have been told that feedback and complaints made to aged care providers have often not been heeded or acted upon.[12] Providers must have stronger systems in place to ensure that complaints and other feedback, from people receiving care or from the providers' staff, are considered by the governing body and used to shape policies and practices.[13]

We have heard that there is a lack of transparency and accountability about what providers are doing and how well they are doing it.[14] Good quality comparative information about aged care services is not available publicly.[15] Transparency is important because it enables older people, researchers and the general public to make more informed judgements about the quality of aged care in particular services. There should be greater transparency about the operations of aged care providers. To that end, we consider that approved providers should provide to the System Governor annual reports for publication on the My Aged Care website and that the *Freedom of Information Act 1982* (Cth) should be amended.

Commissioner Briggs considers that approved providers should be required to provide information presented in a prescribed manner about finances, key personnel and other staff, service use and complaints handling in the public annual reports referred to above. Ready availability of this information will enable public scrutiny and accountability, and will encourage providers to strengthen their performance. These reports will provide a level of detail beyond the star rating system that we propose in Chapter 3, on quality and safety.

As we describe in Recommendation 88, amendments to legislation are necessary to improve provider governance. 'Key personnel' should be identified by the roles and functions those people perform and the influence they exert over the decisions and activities within an approved provider. Changes to key personnel should be notified to the Quality Regulator. The 'disqualified individual' test for key personnel should be replaced with a 'fit and proper person' test. The majority of members of governing bodies of approved providers should be independent.

In our chapter on quality and safety, we recommend that the Australian Commission on Safety and Quality in Health Care be renamed the Australian Commission on Safety and Quality in Health and Aged Care (Recommendation 18). We also recommend that the implementation of a new governance standard should be referred to the Australian Commission on Safety and Quality in Health and Aged Care for urgent review (Recommendation 19). In this chapter, we set out what we consider should be included in any governance standard for approved providers (Recommendation 90).

We conclude this chapter with a recommendation that the Australian Government establish an ongoing program to provide assistance to approved providers to improve their governance arrangements.

13.2 Improving provider governance

The governance requirements in aged care legislation do not provide a sufficiently strong basis for the governance and leadership of aged care providers. We consider that changes to legislation need to be made to improve the governance of aged care providers to give effect to the purpose of the aged care system that we propose. These changes should embed the universal right to safe and high quality aged care in legislation and in practice. As we explain in Chapter 1, on the foundations of the new aged care system, such care and support must be safe and timely and assist older people to live an active, self-determined and meaningful life in a safe and caring environment that allows for dignified living in old age.

Recommendation 88: Legislative amendments to improve provider governance

1. By 1 January 2022, the *Aged Care Act 1997* (Cth) and the *Aged Care Quality and Safety Commission Act 2018* (Cth) should be amended to require that:
    a. the governing body of an approved provider providing personal care services must have a majority of independent non-executive members (unless the provider has applied to the Aged Care Quality and Safety Commissioner for an exemption and the exemption has been granted)
    b. the constitution of an approved provider must not authorise a member of the governing body to act other than in the best interests of the provider
    c. an applicant for approval to provide aged care services must notify the Aged Care Quality and Safety Commissioner of its key personnel, and an approved provider must notify the Commissioner of any change to key personnel within 10 business days of the change
    d. a 'fit and proper person' test (as set out in the text below) apply to key personnel in place of the 'disqualified individual' test
    e. an approved provider must provide an annual report to the Secretary of the Australian Department of Health containing information (as set out in the text below) to be made publicly available through My Aged Care.
2. By 1 January 2022, the *Freedom of Information Act 1982* (Cth) should be amended to remove from Schedule 3 to that Act references to provisions in the *Aged Care Act 1997* (Cth) and the *Aged Care Quality and Safety Commission Act 2018* (Cth), thereby ensuring that the exemption in section 38 of the *Freedom of Information Act 1982* (Cth) does not apply to 'protected information' under aged care legislation merely on the grounds that it is information that relates to the affairs of:
    a. an approved provider
    b. an applicant for a grant under Chapter 5 of the *Aged Care Act 1997* (Cth)
    c. a service provider of a Australian Government-funded aged care service, or
    d. an applicant for approval under section 63B of the *Aged Care Quality and Safety Commission Act 2018* (Cth).

The new Act that is, upon implementation of our recommendations, to replace the *Aged Care Act 1997* (Cth) should contain provisions that reflect both the amendments to the Aged Care Act and the *Aged Care Quality and Safety Commission Act 2018* (Cth), as detailed in Recommendation 88(1). The system governance arrangements that are adopted as a consequence of our recommendations should also be provided for in the new Act.

In this regard, we use the terms System Governor and Quality Regulator in this chapter. Under the new Act, and in line with our recommendations in Chapter 2, the System Governor will be either the Australian Aged Care Commission under the Independent Commission model or the Australian Department of Health and Aged Care under the Government Leadership model. The Quality Regulator will be either the Australian Aged Care Commission under the Independent Commission model or the Aged Care Safety and Quality Authority under the Government Leadership model. Upon implementation of new institutional arrangements, the Quality Regulator will undertake the functions arising out of subparagraphs (a), (c) and (d) of recommendation 88(1) and the System Governor will undertake the functions in subparagraph (e).

13.2.1 Independent members on the governing body of an approved provider

Contemporary good governance practice in Australia is to have, where possible, a majority of members on an organisation's governing body who are independent of the organisation.[16] An independent member of an organisation's governing body is one who is free of any interest or relationship that might influence, or might reasonably be perceived to influence, their capacity to bring an independent judgment to bear on issues before the governing body and to act in the best interests of the organisation as a whole. An independent member of an organisation's governing body is a person whose only interest in, or relationship with, the organisation stems from the person's role as a member of that governing body. An executive employed by the organisation cannot be an independent member of its governing body. Independent members bring objectivity and independence to act in the best interests of the organisation, which in the context of the aged care system that we recommend must necessarily extend to the best interests of people receiving aged care.

This good governance practice should apply to approved providers that provide personal care services.[17] Personal care services are not limited to clinical care, and include care provided by personal care workers to assist people with activities of daily living such as washing, dressing, and going to the toilet. The dire consequences for people receiving poor personal care warrant independent input into, and scrutiny of, decisions that are likely to have a systemic effect on providing that care. Ms Anne Cross AM, Director of the Australian Institute of Company Directors, explained that:

> Given the complexity of aged care and the vulnerability of the people served…the board should have enough members who are not conflicted in ways that interfere in a material way with their capacity to bring independent judgment to bear on issues before the board and in particular, to act in the best interests of vulnerable clients and the aged care purpose of the organisation.[18]

The paramount considerations of approved providers must be to ensure the safety, health and wellbeing of people receiving aged care, and to put the best interests, preferences and needs of the people receiving care first. To ensure that governing bodies of all approved providers are best able to meet these paramount considerations, legislation should require that the majority of members of the governing body of all approved providers providing personal care services must be independent, unless the approved provider has applied for, and been granted, an exemption by the Quality Regulator.

Both the Governance Institute of Australia and the Australian Institute of Company Directors raised concerns about the proposal that legislation be amended to require that the governing body of an approved provider that provides personal care services must have a majority of independent non-executive members. While each of those bodies support the proposition that the majority of the members of the governing bodies of aged care providers should be independent, they consider that including such a requirement in legislation would result in inflexibility. They consider such a requirement would not account sufficiently for the individual circumstances of approved providers.[19]

We recognise that in some circumstances flexibility is necessary. The legislation should allow for this flexibility and permit an approved provider to apply to the Quality Regulator for an exemption from this general requirement. In our view, this approach strikes the right balance between having an enforceable general requirement and allowing exemptions in appropriate but limited circumstances. We are concerned that if these matters are merely the subject of general guidance, they may be ignored by approved providers.

The legislation should provide for the Quality Regulator to take into account a range of matters in deciding whether or not to grant an exemption, including, for example:

- the number of services operated by the approved provider
- the number of people to whom services are provided
- the location of the services
- the annual turnover of the approved provider.

Guidance in relation to the exemption for approved providers and decision-makers should be produced by the Quality Regulator.

When an approved provider applies for an exemption, it should be required to indicate why it cannot meet the requirement. It should also be required to set out the alternative arrangements that it has in place to ensure independent scrutiny of strategic decisions that affect the safety and quality of its services. In our view, these alternative arrangements should include, at a minimum, at least one independent governing body member. They might also include, for example, regular audits of decisions of the governing body by an independent third party. If an exemption is granted, it should be granted for no longer than three years. During the period of the exemption, there should be regular opportunities for the Quality Regulator and approved provider to consider whether circumstances have changed to the extent that the exemption is no longer required or justified.

If an approved provider does not have an exemption and fails to meet the independence requirements for membership of its governing body, it should be obliged to give the Quality Regulator an explanation about what has occurred and why, and what remedial action it has taken. The Quality Regulator could then consider further regulatory action proportionate to the breach of the requirement. We describe the regulatory powers in further detail in Chapter 14.

13.2.2 Governing body members acting in the best interests of the approved provider

Members of an organisation's governing body have a duty to act in good faith in the best interests of the organisation and for a proper purpose.[20] However, section 187 of the Corporations Act permits a director, in certain circumstances, to discharge the duty to act in the best interests of a wholly-owned subsidiary company by acting in the best interests of its holding company. In particular, the director may do so if the constitution of the subsidiary company expressly authorises the director to act in the best interests of the holding company. We do not consider that directors of a wholly-owned subsidiary that is an approved provider of aged care should be permitted by law to give priority to the interests of a holding company that does not have any responsibilities under aged care legislation.

Aged care legislation should be amended to specify that the constitution of an approved provider may not authorise a member of its governing body to act in the best interests of an entity other than that approved provider. The statutory provision should apply to all approved providers, whether or not they are wholly-owned subsidiaries. The new provision would not affect directors of any wholly-owned subsidiary that is not an approved provider under aged care legislation.

13.2.3 Notification of key personnel and of changes to key personnel

Aged care legislation should require that approved providers identify 'key personnel'. That is, every approved provider should identify those people who exercise significant influence over the activities of the approved provider. They should also ensure that those key personnel meet a 'fit and proper person' test to demonstrate that they have the necessary skill and integrity to exercise sound judgment in their practice and oversight of the operations of the organisation.

The values and behaviours of the members of an approved provider's governing body and its executive leaders play a vital role in shaping workplace culture and the quality of care that is delivered.

Identifying key personnel

The identification of the people who are an approved provider's key personnel is vital to ensure that there is no uncertainty about which people must meet regulatory standards. The provider should identify key personnel to the Quality Regulator on an ongoing basis, as a matter of course. At present, aged care legislation does not require this to occur.

Aged care legislation defines the 'key personnel' of an entity as:

- a member of the group of people responsible for the executive decisions of the entity, including directors or members of the entity's governing body
- any other person who has authority or responsibility for, or significant influence over, planning, directing or controlling the activities of the entity
- for an entity conducting an aged care service:
    - any person who is responsible for the nursing services provided by the aged care service and who holds a recognised qualification in nursing
    - any person who is responsible for the day-to-day operations of an aged care service
- for an entity proposing to conduct an aged care service:
    - any person who is likely to be responsible for the nursing services to be provided by the service and who holds a recognised qualification in nursing, and
    - any person who is likely to be responsible for the day-to-day operations of the service.[21]

We consider that there are advantages of a definition in these terms. It allows for sufficiently broad application and its underlying intent is clear. It focuses on the role and function of an individual and the influence they exert over the decisions and activities within an approved provider rather than focusing on particular job titles.

A definition of 'key personnel' with a focus on the roles and functions of an individual rather than on particular titles should be maintained. For instance, people who have 'authority or responsibility for, or significant influence over, planning, directing or controlling the activities of the organisation' may include directors of a holding company of a subsidiary approved provider.[22] Such people would also include the key personnel of a corporate entity engaged to manage the day-to-day operations of an aged care service, as well as people who are not directors of an approved provider but in accordance with whose instructions or wishes the directors are accustomed to act.[23]

Notifying changes to key personnel

Before 2016, aged care legislation expressly required that an approved provider notify the regulator of any change to the provider's key personnel. In 2016, that requirement was removed.[24]

Aged care legislation now only requires an approved provider to notify the regulator of 'a change of circumstances that materially affects the approved provider's suitability to be a provider of aged care services'.[25] The Aged Care Quality and Safety Commissioner has issued guidance to the aged care sector on the interpretation of this provision, which lists a change to key personnel as one of a number of examples of material changes that should be notified to the regulator. However, this guidance notes that these are 'examples only and approved providers should consider each situation individually'.[26]

There is also no express statutory requirement that, on applying to be approved as an approved provider, an entity must inform the regulator of the identity of its key personnel. Instead, information on key personnel is sought in the application form approved by the Aged Care Quality and Safety Commissioner.[27]

Aged care legislation should impose obligations on approved providers to notify the Quality Regulator of key personnel and any changes to key personnel within 10 business days of the change. In the absence of express obligations of this kind, the regulator is less likely to know who is controlling or directing the activities of approved providers.

If, despite the existence of obligations of this kind, the Quality Regulator becomes aware, through monitoring or regulatory action, of a person who may be one of an approved provider's key personnel but who has not been identified to the regulator as such, the regulator will be able to exercise its powers to obtain information from the provider about the role of the individual and the person's fitness and propriety to undertake that role. We describe these powers in Chapter 14, on quality regulation and advocacy.

In her report into the events at residential aged care facility Earle Haven, Ms Kate Carnell AO, recommended that the Australian Government 'revisit the requirement for approved providers to report changes in key personnel'. Ms Carnell observed that revisiting this requirement:

> should not simply see a reinstatement of the previous arrangements which clearly generated a large amount of information which could not be meaningfully used. In developing a more modern approach to key personnel changes, consideration should be given to appropriate IT [information technology] changes to simplify the reporting process for providers and to ensure information can be readily utilised by regulators.[28]

We agree. In our view, the implementation of a requirement for approved providers to notify the Quality Regulator of changes to key personnel should involve consideration of information technology changes to simplify the reporting process for approved providers and to ensure that information can be readily and meaningfully used by the regulator.

13.2.4 A 'fit and proper person' test for key personnel of an approved provider

Key personnel should be good at their jobs, competent and qualified. They should also be of good character and reputation. They must act with integrity and exercise sound judgment in their work and in the oversight of care delivery.

Leaders of an approved provider also have a significant effect on the values and culture of the organisation. When asked how it is the case that some organisations do such a good job in aged care whereas others provide substandard care, Ms Sandra Hills OAM, Chief Executive Officer of Anglican Aged Care Services (Benetas), told us that 'it all starts from the culture of the organisation right from the very top, the board of directors, right through to the executive'.[29]

Key personnel hold critical roles within approved providers to ensure the delivery of safe and high quality aged care. Aged care legislation does not currently promote or achieve this end. Replacing the negative 'disqualified individual' test with a positive 'fit and proper person' test would improve the regulation of key personnel. A fit and proper person test should be applied to key personnel, along with the criminal history checks that apply to all other staff members employed by aged care providers.

Under existing aged care legislation, regulatory standards applicable to key personnel are limited. The aged care regulator must not approve an entity as a provider of aged care if the entity's key personnel includes a 'disqualified individual'.[30] Having become an approved provider, the provider commits an offence if the provider recklessly permits a disqualified individual to be one of its key personnel.[31] The disqualified individual also commits an offence if they are reckless about the fact of being a disqualified individual.[32]

The term 'disqualified individual' is defined in aged care legislation in a narrow and exhaustive way. A disqualified individual is a person who:

- has been convicted of an indictable offence
- is an insolvent under administration, or
- has been certified by a registered medical practitioner as unable to perform their duties because of mental incapacity.[33]

No discretion attends the determination of a person's status as a disqualified individual. Beyond any impact on the person concerned, the narrow terms of the current definition may produce anomalies. We are concerned that some people may be able to remain involved in the provision of aged care services when they ought not to be. Others may be prevented from being involved when they have a valuable contribution to make.

A wider, less rigid approach to assessing the suitability of key personnel is needed. An approved provider's key personnel should be fit and proper to ensure that the provider discharges its responsibilities.[34] The expression 'fit and proper person' is commonly used in legislation that deals with eligibility to engage in a profession or to hold a position of responsibility. The High Court has observed that these 'traditional words' refer to a person's honesty, knowledge and ability, and that the purpose of the words 'is to give the widest scope for judgment and indeed for rejection'.[35]

Statutory 'fit and proper person' tests usually set out a range of matters relevant to the suitability of a person to hold a particular position or undertake a particular role. In this regard, there are similarities in the services provided in the aged care and disability care sectors, and some providers operate across both sectors.

We propose that a fit and proper person test for key personnel of approved providers should require consideration of matters similar to those relevant to the suitability of key personnel of registered National Disability Insurance Scheme providers.[36] For key personnel of approved providers, those 'suitability matters' should be specified in aged care legislation and should include matters relating to:

- previous involvement in delivering aged care
- criminal offending
- insolvency and other financial mismanagement
- adverse findings and decisions by courts, tribunals and government regulators.

It should not fall to the Quality Regulator to consider these suitability matters for each member of key personnel of every approved provider. Nor should the regulator have a positive obligation to determine whether each member of every approved provider's key personnel is a fit and proper person. That would impose an onerous and unnecessary burden on the regulator's resources.[37] Rather, it should be the responsibility of an approved provider to undertake due diligence when engaging a person as one of its key personnel.[38]

The Quality Regulator should need only to focus on the application of the fit and proper person test in those cases that warrant its attention and potential intervention. Accordingly, aged care legislation should require every provider to satisfy itself of, and to report to the Quality Regulator on, the existence, or otherwise, of matters relevant to the suitability of key personnel. This should not impose an unreasonable burden on approved providers.[39]

Aged care legislation should require an approved provider to exercise due diligence in gathering information about the existence or otherwise of suitability matters for each of its key personnel, and subordinate legislation should set out the steps to be taken in that process. Those steps could include conducting various specified searches or inquiries.

Aged care legislation should also require that, for each member of an approved provider's key personnel, the provider must disclose to the Quality Regulator the existence of any matter relevant to the person's suitability to be a member of the key personnel. The approved provider must attest—that is, state in writing—to the regulator that:

- it has exercised due diligence in gathering information about the matters relevant to the suitability of that person, and
- either:
    - if the due diligence process does not reveal the existence of any matter relating to suitability, the approved provider has no reason to believe that the person is not fit and proper to be one of its key personnel, or
    - if that process reveals the existence of one or more matters relating to suitability, the approved provider nevertheless considers that the person is fit and proper to be one of its key personnel.

An approved provider should have an opportunity to inform the Quality Regulator about any reasons why, in spite of the existence of one or more matters relevant to suitability, the provider considers that the person is nonetheless fit and proper to be one of its key personnel. Natural justice would require the regulator to take that information into account.

The existence of one or more of the matters relating to suitability would not necessarily establish that a person is not fit and proper. For example, the fact and circumstances of a person being an insolvent under administration might have little bearing on their fitness to undertake a particular role as one of an approved provider's key personnel. Similarly, an old conviction that is not a 'spent' conviction might not affect a person's fitness and propriety, given the age and other circumstances of the person at the time of offending, the time that has elapsed since the conviction, and evidence of the person's subsequent rehabilitation and good standing.[40]

Aged care legislation should provide that if the Quality Regulator determines that a member of an approved provider's key personnel is not a fit and proper person, the Quality Regulator can exercise a range of regulatory powers in respect of the approved provider and the member of key personnel. Merits review before the Administrative Appeals Tribunal would be available in respect of decisions involving the exercise of those regulatory powers. We describe those powers in Chapter 14, on quality regulation and advocacy. The Quality Regulator should be able to apply to the Federal Court for a remedial order if it considers an 'unacceptable key personnel situation' exists because a member of an approved provider's key personnel is not a fit and proper person.[41]

A process of due diligence, disclosure and attestation should apply for the key personnel of an entity applying for approval as a provider. The applicant would have to exercise due diligence in gathering information about the existence or otherwise of suitability matters for each of its key personnel, disclose to the Quality Regulator the existence of any suitability matters for the person, and make an attestation about their fitness and propriety. Aged care legislation should require that the regulator must not grant approval to an approved provider if the Quality Regulator is satisfied that one or more of the provider's key

personnel is not a fit and proper person. Merits review before the Administrative Appeals Tribunal would be available in respect of such a decision.

In a joint submission to us, Leading Age Services Australia (known as LASA) and law firms Hall & Wilcox and HWL Ebsworth supported the inclusion of a 'clearly defined and reasonable' fit and proper person test. However, they described as 'excessively onerous' Counsel Assisting's proposal that disclosure be made within 10 business days of any change in circumstances that give rise to the existence of one or more suitability matters for key personnel.[42]

The burden of disclosure and attestation on an approved provider must be weighed against the risk of harm to those receiving aged care in circumstances where there has been a change that raises a question about the suitability of key personnel. As we said at the outset of this section, key personnel hold critical roles within approved providers to ensure the delivery of safe and high quality aged care. Having weighed the burden of disclosure and attestation against the risk of harm to people receiving aged care, we do not consider Counsel Assisting's proposal to be 'excessively onerous' or even onerous.

We consider that the due diligence, disclosure and attestation process should be undertaken on a regular and ongoing basis.[43] In summary, aged care legislation should require that it occur:

- at the time of applying for approval as a provider of aged care
- at the time of notifying the Quality Regulator of a change in key personnel
- within 10 business days of becoming aware of any change of circumstances giving rise to the existence of one or more suitability matters for key personnel
- for the preceding year, in any annual report to the Australian Government.

The annual reporting to the Australian Government that we refer to above is distinct from the public annual reporting which we describe in the paragraphs below. Although annual reporting on the suitability of key personnel could occur at the same time as other annual reporting, we do not consider that information on the suitability of key personnel should be made available to the public on the My Aged Care website.

13.2.5 Public annual reporting to the System Governor by every approved provider

Accountability and transparency are critical features of good governance. They are particularly important in the case of approved providers of aged care which receive most of their funding from taxpayers and provide care to vulnerable people. Approved providers should be required to provide ready access to information about their operations to enable proper scrutiny. To that end, aged care legislation should require that every approved provider must give to the System Governor an annual report for publication on the My Aged Care website.

The annual report should include at least the following information:

- the names and positions of all key personnel
- any attestation by the governing body of the kind we describe below
- information on staffing levels, qualifications, hours worked, employment status, and staff turnover.[44]

The System Governor should review the requirements, from time to time, for the content of annual reports to ensure that they remain relevant and useful to members of the public.

Mr John Simpson, an experienced company director and member of the Council of Monash University, submitted that:

> Aged care facilities across Australia demonstrably require greater scrutiny, accountability and transparency. ...We need to feel reassured that government subsidies are being used to improve the quality of life of residents, not the pockets of providers. We need to ensure that those entrusted to provide care for the elderly are trained, qualified and professional in doing so. We need to ensure that those occupying senior governance roles…(Board members and Chairs) are appropriately equipped and qualified to appreciate the sensitive and unique aspects of the sector. We need to maintain high levels of transparency in this sector—ensuring that failures, breaches, inappropriate behaviours are brought to the attention of the community.[45]

Commissioner Briggs considers that people receiving aged care services or contemplating entry to aged care, and their families and advocates, should have access to clear, timely and meaningful information about the quality of services and the performance of providers. In her view, providing transparency enables accountability by shining a light on what is happening and exposing service failings.

Commissioner Briggs considers that approved providers should report openly to the Australian public on their operations and performance. Her view is that the annual report should include:

- financial reports, including profit and loss and balance sheet information
- details of the provider's related party transactions such as, for example, transactions between an approved provider and a member of its key personnel or the provider and another entity which is part of the same corporate group
- the names and positions of key personnel
- any attestation by the governing body of the kind described below
- information on staffing levels, qualifications, hours worked, employment status, and turnover
- information on service provision and use, which could include, for example:
    - in the case of approved providers of residential aged care, the number of residents who entered and left the service, the reason for leaving and the average number of residents

    - in the case of an approved provider of home care services, the number of people who started with and left the provider, the reason for leaving and the total number of hours of different kinds of services delivered
- information on the number, type, and outcome of complaints.

Some information that approved providers should be required to include in their annual report, such as financial reports and names of members of an approved provider's governing body, is already available to the public for some providers, but the totality of this information is not readily and publicly available, in one place and at no cost, about all providers.[46] Commissioner Briggs believes that it should be.

The Australian Charities and Not-for-profits Commission Act provides for the Australian Charities and Not-for-profits Register, which contains information about current and former registered entities.[47] The Commissioner of the Australian Charities and Not-for-profits Commission is required to maintain the register, which must be available for public inspection on the internet.[48] The legislation specifies a variety of information that must be made available on the register. This includes the entity's name, contact details and governing rules, the name and position of each director or trustee, and financial reports and any audit or review reports given by the entity to the Commissioner.[49]

Under the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth), the Australian Prudential Regulation Authority is required to publish an annual report on the operations of each private health insurer, including profit and loss and balance sheet information.[50] Commissioner Briggs considers that similar transparency measures should be adopted in the aged care sector.

Approved providers may, depending on how they are structured, be required to provide the same or similar information about their affairs to a number of regulators. We both consider that those regulators should aim to harmonise reporting obligations as far as possible. This would not only reduce the regulatory burden on providers but also increase efficiency.

13.2.6 Increased access to documents about affairs of approved providers

Secrecy provisions in aged care legislation restrict disclosure of 'protected information'.[51] In broad terms, protected information is information acquired under, or for the purposes of, the relevant aged care legislation, and is either personal information (as defined in the *Privacy Act 1988* (Cth)) or relates to the affairs of an approved provider or an applicant for approval as an aged care provider.[52]

These provisions do not prevent disclosure of protected information if that disclosure is authorised under another Act, such as the Freedom of Information Act.

The Freedom of Information Act provides for a general right of access to documents, other than 'exempt documents' or 'conditionally exempt documents', held by Australian Government agencies.[53] If access to an exempt document is requested, there is no obligation to grant that request.[54] If access to a conditionally exempt document is requested, access must be granted unless it would, on balance, be contrary to the public interest.[55]

Various kinds of documents relating to approved providers could fall within one or more classes of exempt or conditionally exempt documents under the Freedom of Information Act. For example:

- under section 47, a document is an exempt document if its disclosure would disclose: trade secrets; or any other information having a commercial value that would be, or could reasonably be expected to be, destroyed or diminished if the information were disclosed, and
- under section 47G, a document is conditionally exempt if its disclosure would disclose information concerning the business, commercial or financial affairs of an entity and that disclosure could reasonably be expected to:
    - unreasonably affect that entity in respect of its lawful business, commercial or financial affairs, or
    - prejudice the future supply of information to the Australian Government.

When a request is made for access to any document containing information about the business, commercial or financial affairs of an entity, no decision to give access to the document can be made until the entity has had an opportunity to make submissions in support of a contention that the document is exempt under section 47 or conditionally exempt under section 47G and access to the document would, on balance, be contrary to the public interest.[56]

In addition to the classes of exempt documents in sections 47 and 47G, section 38 of the Freedom of Information Act provides that a document is an exempt document if disclosure of the document, or information in it, is prohibited under a provision of another Act and the provision is listed in Schedule 3 to the Freedom of Information Act. At present, the secrecy provisions in aged care legislation are listed in Schedule 3 to the Freedom of Information Act. Insofar as documents containing 'protected information' are prohibited from disclosure under those secrecy provisions, they are exempt documents for the purposes of the Freedom of Information Act.

Evidence before us has demonstrated the effect of the section 38 exemption on the public availability of information about approved providers and on the culture of the aged care system more broadly.[57] For instance, when a complaint is made to the Aged Care Quality and Safety Commission about an approved provider, the complaint is given to the provider but the provider's response is not given to the complainant. At the Brisbane Hearing, the Executive Director, Performance, Education and Policy within the Aged Care Complaints Resolution Group at the Aged Care Quality and Safety Commission explained that this is because the response may contain 'protected information' about the affairs of the provider, and that obtaining the approved provider's consent to provide the response is necessary.[58]

In its response to Counsel Assisting's final submissions, the Australian Government submitted that we should consider targeted amendments to the definition of 'protected information' in aged care legislation as an alternative to amending Schedule 3 to the Freedom of Information Act.[59]

In our view, the existing provisions of aged care legislation which deal with the definition, use and disclosure of protected information serve to deter irregular and unauthorised disclosures of information and ought to be maintained. We also consider that the combined effect of sections 27, 47 and 47G of the Freedom of Information Act strikes the right balance between approved providers' interests in non-disclosure of commercially sensitive information and the public interest in disclosure of information about the affairs of providers which receive significant funding from the Australian Government. We are satisfied that other exemptions in the Freedom of Information Act are capable of protecting other essential interests, such as the privacy of older people who receive aged care services.[60] This information will remain protected. We consider that the additional exemption under section 38 tips the balance too far in favour of unjustifiable non-disclosure.

For these reasons, Schedule 3 to the Freedom of Information Act should be amended to remove the references to aged care legislation.

13.3 Leadership and culture

Over the course of our inquiry, we have heard about the importance of leadership and management culture in ensuring high quality care.

We visited many aged care services during our inquiry. On those visits, Commissioner Briggs found that where services' directors and managers showed a clear commitment to the wellbeing of people receiving care, that attitude was generally reflected in the approach of staff members who provided care. Their staff took the time to engage with people, and there were smiles and laughter all round. However, where directors and managers saw their business as simply doing the basic job of providing care, staff members tended to provide care in an unfeeling, mechanistic way, which does not provide good outcomes for older people.

Good leadership is vital to develop a proactive and caring workplace culture that is necessary for the delivery of safe and high quality care. Dr Duncan McKellar, Head of Unit, Older Persons' Mental Health Service in the Northern Adelaide Local Health Network, identified workplace 'cultural failing' to be 'at the core of what went wrong' at the Oakden Older Persons Mental Health Service.[61] Dr McKellar said that organisational commitment to providing quality care is required 'from the CEO level right through to the…grass roots delivery of care'.[62]

The Bupa South Hobart Case Study provided an example of the effect that governance, leadership and culture can have upon the quality and safety of aged care. Bupa Aged Care Australia accepted that there were deficiencies in its governance, leadership and culture during the period examined by the case study. It also accepted that these deficiencies impacted upon the quality and safety of care at its South Hobart aged care facility. Effective leadership, the right culture and strong organisational governance are key factors contributing to the ability to provide high quality and safe care. Bupa Aged Care Australia acknowledged that its leadership, culture and governance at the South Hobart aged care facility were deficient. Bupa Aged Care Australia agreed that the failure to foster an organisational culture that encourages feedback is a systemic failure that may cause substandard care.[63]

We came across examples of leadership that supported a strong 'older people first' culture in their organisations. Mr Bryan Lipmann AM, the Chief Executive Officer of Wintringham, a provider that specialises in providing housing and care to older people who are experiencing homelessness or are at risk of homelessness, said that:

> Staff at Wintringham are regularly reminded that they are special people doing special work, which is valued and appreciated by the clients, their management and the organisation's executive. This helps to instil a culture that after nearly 30 years is as strong as it was when the company was formed.[64]

Mr Chris Mamarelis, Chief Executive Officer of Whiddon, described how he sets the tone and culture of that organisation, which provides aged care services in regional, rural and remote New South Wales and Queensland. He said that the 'Whiddon Way' was:

> to really support our staff and our team members to understand what was expected culturally from the organisation as well—so a lot of restructuring from the organisation and reinforcing these directions from the top down, from the board level down, through the organisation, in order to meet these objectives.[65]

Mr Mamarelis explained that a central element of the Whiddon Way has been a move away from a clinical task-focused approach to care to a relationship-based approach involving reablement and social connection.[66]

Those who hold managerial and leadership positions in providers of aged care are in a position to exert a profound influence over the culture of the care environment and the people who operate within it. Good leaders represent the organisational values, model these to others through their behaviours, and help team members understand sound caring practice which puts older people's needs first. According to Dr Veronique Boscart of Schlegel Villages in Canada:

> if you invest in a team, which is a costly investment from an organisational perspective, this leads to better care, therefore it does lead to better care outcomes…But if you don't have a staff team that is going to exemplify that practice, you will not get to better care outcomes because change in care is not going to happen by one specific group. It needs to be a team approach.[67]

Some providers offer a range of training, education and career development opportunities to their staff, seeing this as an investment in their ability to attract and retain the workforce.[68] Other providers highlighted that a strong culture lays the foundation for staff commitment. Mr Lipmann observed that a by-product of positive culture is staff loyalty.[69]

We are encouraged that some providers understand that investments in workforce development will be rewarded with higher staff performance, commitment and retention. More should share this understanding.

Our recommendations in this report are wide-ranging and will lead to reform of the sector. This will result in major changes in policies and practices for providers and those who work in aged care. Many will find this challenging.

To support and drive the reforms that we recommend, consistent and confident leadership at all levels of aged care organisations is essential, together with renewed emphasis on leadership development, staff training, professional development and continuing learning, and staff engagement and communications. This should ensure that leaders have the professional experience and qualifications in management roles from both a theoretical perspective and a practical background to enable them to manage complex aged care businesses well and to deliver the reform directions we propose.

While this should be reinforced through strategies, policies, practices and behaviours, it begins with a genuine commitment by boards, executives and staff to the core values and philosophies on which high quality and safe care are built.

We understand the importance of leadership and culture to the delivery of high quality and safe aged care. Commissioner Pagone encourages providers to have regard to the matters set out above as a matter of internal pride, governance and visibility. In his view, the values, attitudes and standards that leaders need to instil as the culture of an organisation are matters for encouragement rather than imposition by obligation.

Commissioner Briggs agrees that all good providers will show such leadership. However, the experience of our inquiry is that many do not take leadership, effective staff management and culture seriously. She considers that the transformational nature of the changes envisaged in our recommendations will require a significant step-up in leadership quality and expectations. Accordingly, she recommends that the Australian Government should act to require that all aged care providers implement arrangements to support staff in adopting a new caring culture and managing the necessary workforce changes as the aged care system is transformed.

Recommendation 89: Leadership responsibilities and accountabilities

Commissioner Briggs

By 1 July 2021, the Aged Care Quality and Safety Commission (and any successor body) should, as part of its approval of aged care providers and accreditation of aged care services, require governing bodies to:

a. ensure that their leaders and managers have professional qualifications or high-level experience in management roles

b. ensure that employment arrangements for the executive and other senior managers include performance appraisal against the demonstration of leadership, team development and support for organisational culture and practice consistent with the new Act, and

c. adopt and implement a plan to manage and support staff training, professional development and continuous learning, staff feedback and engagement, and team building.

13.4 A new governance standard

As we have stated elsewhere in this report, the Australian Commission on Safety and Quality in Health and Aged Care should assume responsibility for setting and reviewing quality and safety standards in the new aged care system. One of the matters that we have recommended that the responsible Minister should refer to the Commission for urgent review is a new governance standard.[70]

Whether the Australian Commission on Safety and Quality in Health and Aged Care conducts such a review and how it might do so are ultimately matters for that independent authority to determine. However, we consider that any governance standard directed to providers of aged care should encompass the matters that we recommend below.

The Australian Commission on Safety and Quality in Health and Aged Care should consider how to ensure that sufficient flexibility is retained to allow approved providers to operate with a governing body that fits their needs and the nature of their services. We accept the submission of the Australian Government that the focus should remain 'on positive outcomes for care recipients, rather than compliance with standards in a "tick box" approach'.[71]

Recommendation 90: New governance standard

Any governance standard for aged care providers developed by the Australian Commission on Safety and Quality in Health and Aged Care should require every approved provider to:

a. have members of the governing body who possess between them the mix of skills, experience and knowledge of governance responsibilities, including care governance, required to provide governance over the structures, systems and processes for ensuring the safety and high quality of the care delivered by the provider

b. have a care governance committee, chaired by a non-executive member with appropriate experience in care provision, to monitor and ensure accountability for the quality of care provided, including clinical care, personal care and services, and supports for daily living

c. allocate resources and implement mechanisms to support regular feedback from, and engagement with, people receiving aged care, their representatives, and staff to obtain their views on the quality and safety of the services that are delivered and the way in which they are delivered or could be improved

d. have a system for receiving and dealing with complaints, including regular reports to the governing body about complaints, and containing, among other things, an analysis of the patterns of, and underlying reasons for, complaints

e. have effective risk management practices covering care risks as well as financial and other enterprise risks, and give particular consideration to ensuring continuity of care in the event of default by contractors or subcontractors

f. have a nominated member of the governing body:

    i. attest annually on behalf of the members of the governing body that they have satisfied themselves that the provider has in place the structures, systems and processes to deliver safe and high quality care, and

    ii. if such an attestation cannot be given, explain the inability to do so and how it will be remedied.

13.4.1 Skills mix of members of an approved provider's governing body

The business of an approved provider is to provide care to older people who are often vulnerable and can have complex health care needs. A provider's governing body should include people with experience and expertise in providing such care.[72] In the case of an approved provider which provides clinical care, this means people with clinical experience and qualifications. Without relevant experience and expertise, governing bodies are less able to interpret reports about delivery of care or see signs of potential problems with that care delivery.[73]

Aged care regulatory standards do not require that the governing body of an approved provider must include members with a range of specific skills relevant to the provision of high quality and safe aged care.[74] This contrasts with the arrangements that apply to some local hospital networks, which require the selection of board members with specific expertise and knowledge.[75]

Any new governance standard should require that every approved provider must have members of their governing body who between them possess a mix of skills, experience and knowledge of governance responsibilities—including care governance—required to provide governance of structures, systems and processes necessary for ensuring the provider's delivery of safe and high quality care.

Any approved provider without such members on its governing body should explain to the Quality Regulator how, and by when, it intends to remedy this gap. We accept that certain providers, such as small providers and those in regional and remote areas, may face challenges in recruiting members with the necessary skills and experience.[76] We anticipate that providers in that position would work closely with the Quality Regulator to ensure an appropriate mix of skills and expertise on their governing bodies. Such arrangements may include, for example, certain members of the governing body participating in some meetings remotely.

Approved providers will need to implement processes to ensure that they can meet the requirement for the make-up of governing bodies. The governing body of an approved provider should review the skills of its members annually. As part of this annual review, the governing body should identify any skills gaps and develop a plan and a timeframe for filling identified gaps by recruiting new members, if necessary, and developing the skills of existing members. Each member of the governing body should contribute to the annual skills review by identifying gaps in their own knowledge and skills relevant to the discharge of their governance responsibilities.

In their submission to us, the Australian Medical Association suggested that governance bodies should include people with clinical care experience, including doctors and nurses. The Royal Australian College of General Practitioners submitted that all bodies which provide advice on, or oversee, clinical governance should include a general practitioner.[77] We consider that our recommendation strikes the appropriate balance between requiring a certain make-up of approved providers' governing bodies and providing approved

providers with flexibility to ensure that their governing bodies reflect the nature of their organisation and the types of services that they provide. We are concerned that prescribing certain professions or qualifications for members of governing bodies of all approved providers would be unworkable.

13.4.2 Care governance committee

Governing bodies of approved providers do not always pay sufficient attention to the quality of care being delivered to older people. We therefore consider that every governing body of an approved provider should have a care governance committee to monitor and ensure accountability for the quality of care delivered by the provider. The care governance committee should be chaired by a non-executive member with appropriate experience in providing care.

A requirement for a care governance committee is consistent with a recommendation already made by the Australian Government's Aged Care Workforce Strategy Taskforce's 2018 report, which states that every approved provider should establish an integrated care and clinical governance committee concerned with the provider's delivery of care.[78]

For such a requirement to be effective, the role of an approved provider's care governance committee must be understood, not just by committee members but across the organisation.[79] Care governance committee members must be well organised, knowledgeable and engaged if such a committee is to be effective and fulfil its purpose.

The care governance committee should have responsibility for ensuring that processes are established and maintained to record, monitor and report relevant information to the governing body in a systematic way. The committee should also ensure that effective mechanisms are in place so that the governing body can take action, whether remedial or proactive or both, when issues are identified.

There should be scope for an approved provider to determine the structure of its care governance committee. For example, in the case of an approved provider with a very small board, the care governance committee may need to be comprised of the entire membership of the board. The Quality Regulator could approve such an arrangement as complying with the requirement to establish a care governance committee.

13.4.3 Engagement, feedback and complaints

Feedback mechanisms are an important means by which aged care providers can learn about day-to-day practices in their services. They can highlight for a provider what is important to those using their services, and what improvements are needed. Feedback from those who work in the service is equally valuable in alerting providers to substandard care and allowing them to address those problems.

People receiving aged care, and their family members and advocates, have described the powerlessness, despair, anger and frustration that they have felt when confronted with providers' resistance to feedback and complaints. We have received evidence that people—both those receiving aged care and those who provide care—are sometimes fearful about making complaints or speaking up. Ms Gwenda Darling said:

> After my first experience of having my service cut off by the provider after complaining, I have been a bit fearful that I could lose my package if I complain. The providers have a lot of power. I had to fight really hard to get my package reinstated. I felt hopeless and disempowered after that experience. It felt like there was no point raising issues and complaining.[80]

People receiving aged care and their representatives, as well as the staff providing care, must have opportunities to express their views on the quality and safety of the services that are delivered, and to affect the way in which services are delivered. They must also receive timely and satisfactory responses to their feedback. An approved provider should have processes to ensure systemic problems are identified and addressed.

Any new governance standard should require each approved provider to:

- allocate resources and implement mechanisms to support regular feedback from, and engagement with, people receiving aged care, their families, their advocates, and staff to obtain their views on the quality and safety of the services and ways of improving the delivery of those services
- have a system for receiving and dealing with complaints, including regular reports to the governing body about complaints—and containing, among other things, an analysis of the patterns of, and underlying reasons for, complaints.[81]

Engagement with people receiving care, their families and their advocates, and with the staff providing care, can take many forms. In addition to seeking people's views about services they receive directly, engagement with people receiving aged care and their representatives should include activities that enable them to influence and determine how services are provided at an organisational level. For example, an approved provider might involve people receiving care or their representatives in the design and planning of services or the development of policies and procedures. That could occur through representation on committees, or other means suited to the people receiving aged care and the services that are provided.

Beverley Johnson

Ms Beverley Johnson gave evidence at the Brisbane Hearing. At the time, Ms Johnson was 83 years old and had lived in a residential aged care facility in Victoria for the previous 10 years.[82]

Ms Johnson was initially encouraged by a senior staff member at the aged care facility to join the Continuous Improvement Committee as a resident representative.[83] She was appointed to that role following a vote by the residents.[84]

Ms Johnson said that being 'on this Committee was important to me'.[85] She said that:

> When the Committee discussed issues, they respected my perspective as a resident about how things could be improved. I could also point out any faults with their suggestions from a resident's perspective.[86]

Ms Johnson served on the Continuous Improvement Committee for about two years before the Care Manager removed her.[87] Ms Johnson said she was told by the Care Manager that 'two years was long enough'.[88] Ms Johnson said that she was not replaced on the committee by another resident. Ms Johnson was 'very disappointed that there would be no resident having a say about how the place was run'.[89]

Of the monthly forums held at the facility for residents, Ms Johnson said 'not much is done as a result of these meetings'.[90] She said:

> There is very little resident involvement in these meetings, the residents being little more than a submissive audience. These meetings have been very repetitive. For example, we have been told each month for a period of two years that we are getting new curtains in the dining room.[91]

In her witness statement, Ms Johnson made several suggestions for improvements to residential aged care. She told us that 'there should be some way for residents to be able to put their views forward'.[92] Ms Johnson explained that:

> There needs to be more than simply monthly meetings with residents, which do not allow an in-depth or meaningful way of getting residents' opinions about whether they are really happy.
>
> …
>
> The residents are the people who benefit or suffer from decisions made so there should be ways of allowing us to make contributions and have our voices heard.[93]

To be meaningful, engagement must be supported by a clearly articulated strategy and plan that is appropriately resourced. While the existing standards impose obligations on approved providers to engage with people receiving aged care and others about the quality and safety of services, they do not go far enough.[94] They do not require a properly-resourced and fully-implemented feedback system. They do not include any express requirement for approved providers to engage with staff.[95]

Much evidence has been given about the value of complaints in improving the quality of service delivery in aged care.[96] Complaints have been described as 'the canaries in the coal mine'.[97] Other evidence has referred to complaints as 'a wonderful thing in terms of quality improvement'.[98]

The current legislative framework requires that approved providers have mechanisms in place for receiving and dealing with complaints.[99] However, evidence and information before us suggests that providers often do not manage complaints well, and sometimes discourage complaints.[100] There is no express regulatory obligation on an approved provider's governing body to receive reports on complaints.

Complaints will sometimes have details and information which are sensitive and which ought not to be disclosed to others or disseminated without care, caution and confidentiality. It may, therefore, not be appropriate for the members of a governing body to be told the details of a complaint or the responses that may be received to a complaint. But a governing body does need to ensure that it has in place systems to understand the substance of complaints, and that the organisation has a process to deal properly with complaints.

Every provider should implement arrangements to ensure its governing body has appropriate mechanisms and systems to monitor how complaints are dealt with, including an analysis of the patterns of, and underlying reasons for, complaints. Arrangements of this kind would reflect the clinical governance standard in the National Safety and Quality Health Service Standards developed by the Australian Commission on Safety and Quality in Health Care.[101]

An arrangement for regular reporting to the governing body about complaints may form part of an approved provider's risk management practices, which we describe in further detail below. Elsewhere in this report, we make recommendations concerning access to advocacy services to support people receiving care to engage with providers.

13.4.4 Risk management

Any new governance standard should require approved providers to have in place effective risk management systems and practices. The events of 2020, including bushfires and the COVID-19 pandemic, have brought the need for risk management systems and practices into sharp focus.[102]

Every approved provider should have effective risk management systems and practices covering care risks as well as financial and other enterprise risks. Approved providers should give particular consideration to ensuring continuity of care in the event of default by contractors or subcontractors or other external events, such as bushfires or natural disasters.

The Aged Care Quality Standards go some way towards that end—but not far enough.[103] Although it requires that every approved provider should have in place effective risk management systems and practices, it is silent about the way in which effective risk management is to be achieved and demonstrated. Guidance materials prepared by the Aged Care Quality and Safety Commission provide only limited guidance on the practical content of this risk management requirement.[104]

Risk management systems and practices should encompass the full range of risks involved in operating a business that provides care to vulnerable people. They should also include measures to identify emerging problems with organisational culture.

Commissioner Briggs considers that risk management systems and practices should be updated to address explicitly the balance between the wishes of people receiving care and the risks they may face in pursuing those wishes. She considers that the inability to

maintain a sufficient, adequately skilled and engaged workforce should be a key indicator of risk to the quality and safety of services. Providers should be prepared and capable of continuing to provide care in the case of extraordinary events like COVID-19, bushfires or natural disasters. Risk management should also address the risk-taking that may be necessary for innovation and improvements in aged care services to occur, and to identify emerging problems with organisational culture. Regulators should hold providers to a high standard in demonstrating that their risk management practices are effective.

Regulatory guidance, which we refer to below, could indicate how approved providers might adopt contemporary risk management systems and practices.

13.4.5 Annual attestation to safe and high quality care

The governance standard should include a requirement that a nominated member of the governing body of the approved provider must attest annually, on behalf of the members of the governing body, that they have satisfied themselves that the approved provider has in place the structures, systems and processes to deliver safe and high quality care. If the approved provider cannot give such an attestation, they must explain their inability to do so and how they will remedy this.[105]

While the attestation would be made by a nominated member of the governing body, the attestation would represent a collective view of the board. We agree with the Australian Institute of Company Directors that it would be inappropriate for the attesting member to face greater exposure to repercussions than other members as a result of having made the attestation.[106]

Governing bodies of approved providers are too often unaware of, or unresponsive to, emerging and significant risks to the safety and wellbeing of older people receiving care from the provider.[107] Governing bodies should direct at least equal attention to their role and responsibility for ensuring the delivery of good care to older people as to other responsibilities, such as the financial performance of the provider.

For that reason, the governance standard should require that governing bodies take steps to satisfy themselves, and attest, that the approved provider has in place the structures, systems and processes to deliver safe and high quality care.[108]

Such a requirement would mirror the requirement already introduced in standards developed by the Australian Commission on Safety and Quality in Health Care for health service organisations.[109] On the requirement to give that attestation, Professor Debora Picone AO, Chief Executive Officer of the Australian Commission on Safety and Quality in Health Care, gave evidence that:

> This is mandated. It is compulsory. It has been one of our observations, that often in—when there have been failures, the boards will tell you they had no idea these problems were going on, which quite frankly I don't accept on any of the times I've been told that. So we wanted to make safety and quality as important as finance and as general performance. So we now require each member of the governing body to sign an attestation statement to say that they're satisfied that a whole range of issues are in place for safety and quality.[110]

The fact of attestation should be made public and should also be taken into account by the Quality Regulator as part of the body of materials considered when undertaking a regulatory assessment of the approved provider. Ensuring that the attestation is available to the general public and to the Quality Regulator will help ensure that the attestation process does not become an administrative or tokenistic exercise.[111]

13.4.6 The role of regulatory guidance

While the regulatory standards specify what an approved provider must achieve, regulatory guidance specifies how these outcomes may be achieved.[112] The Aged Care Quality and Safety Commission has published a document entitled *Guidance and Resources for Providers to support the Aged Care Quality Standards*. This document describes:

> the intent of the Standards and expectations of performance, along with supporting information, and examples of evidence of compliance…[and] provides an indication of the matters that Aged Care Quality Assessors (quality assessors) consider in assessing compliance.[113]

These guidelines should exemplify good governance practices for the benefit of approved providers, service users and the wider public. They should demonstrate how compliance with the regulatory standards, including any new governance standard, may be achieved in accordance with contemporary best practice.

To that end, it is important that the guidelines are reviewed regularly, and updated whenever necessary. The guidelines could form the basis of a Code of Practice prepared by the Quality Regulator in the future.

13.5 Assistance to improve governance arrangements

The governing bodies of approved providers vary significantly in their size, expertise and resources. Providers of all sizes and kinds and in all locations can struggle to implement good governance arrangements. As we observed earlier in this chapter, providers in regional and remote areas may face challenges in recruiting members for their governing bodies with the right skills and experience to deliver effective governance.

Australian Government funding is available for approved providers to improve their operations, including their governance arrangements. Among the formal programs available to approved providers to help improve governance arrangements are the Remote and Aboriginal and Torres Strait Islander Aged Care Service Development Assistance Panel Program, the Business Advisory Service and the Business Improvement Fund.[114] The Australian Government acknowledged that supports provided by such organisations 'could be expanded or enhanced to assist regional, rural and remote service providers to build their capacity and sustainability'.[115]

The Australian Government should establish a single ongoing program to provide practical assistance to approved providers to improve any aspect of their governance arrangements, including care governance arrangements. The program should also continue to provide any successful elements of assistance given under existing programs. By establishing a single program, we do not wish to take away assistance that is available under existing, successful programs.

In response to Counsel Assisting's final submissions, the Australian Government indicated its support for the establishment of an ongoing program to provide assistance to approved providers to improve their governance arrangements, in particular for 'stand-alone, not for profit service providers in regional or remote areas'. The Government considered that it 'may be prudent for any such program to also focus on financial sustainability'.[116]

While the assistance should be made available to approved providers of all service types, we expect that the body administering the program would prioritise assistance to smaller providers with limited resources. In our view, financially-viable providers with the capacity to obtain similar support through other channels should not, in normal circumstances, receive assistance under this program. The program should also make special provision to assist approved providers that deliver aged care services to Aboriginal and Torres Strait Islander people, an area for which the Aboriginal and Torres Strait Islander Commissioner we recommend will have responsibility.[117]

We also expect that the body administering the program would take into account the approved provider's record, capability and capacity to provide high quality care when determining applications for assistance under this program. It will be important to ensure that the program does not facilitate undue recourse to, and reliance on intervention by, the Australian Government.[118] It may therefore be appropriate for the body administering the program to adopt a general rule that approved providers can only receive assistance under the program twice unless exceptional circumstances exist.

The body administering this program will need to implement processes to ensure that there is accountability for the funding under this program. We anticipate that approved providers that receive funding under the program would be subject to ongoing monitoring to reduce the risk of problems re-emerging and to hold the approved provider accountable for the proper expenditure of funds. Funding should be tied to specific outcomes which are agreed between the approved provider and the administering body, and then measured through regular reporting.

The form of assistance offered to approved providers would be tailored according to the particular needs of each successful applicant. Such assistance should include, where appropriate, access to care governance advice, in addition to advice on corporate governance arrangements. For example, funding could be provided to an approved provider to engage a person with equivalent skills to an eligible adviser appointed under the Aged Care Quality and Safety Commission Act. That person would attend the service in person and offer practical guidance on a provider's governance processes. The evidence we have heard suggests there will be significant benefits from a program that enables access to such an adviser before problems within an approved provider reach a crisis point.[119]

Recommendation 91: Program of assistance to improve governance arrangements

The Australian Government should establish an ongoing program, commencing in the 2021–22 financial year, to provide assistance to approved providers to improve their governance arrangements, including their care governance arrangements.

13.6 Conclusion

We consider that our recommendations in this chapter, if implemented, will lead to improvements in the governance of care and in corporate governance. This will strengthen the integrity of the aged care system and focus approved providers on their core task of delivering safe and high quality aged care.

In particular, approved providers would be required to ensure that their governing bodies are comprised of people with appropriate experience, expertise and independence.

Further, governing bodies of approved providers would have a care governance committee to ensure that issues about the quality of care are considered, and resolved, at the highest level of the organisation. The focus on high quality care would cascade from the governing body through executive leadership to all staff, including nurses, personal care workers, caterers, and cleaners.

Approved providers would also have strong systems in place to ensure that complaints and feedback from those people receiving care and their families and advocates, as well as staff members, are considered by the governing body and used to shape policies and practices. People receiving care would have a genuine influence over the way services are delivered and an ability to effect changes in care arrangements. Insights from staff members about how to improve the care that is being provided would be valued and acted upon.

Approved providers would also have effective risk management practices to address the full range of risks involved in providing care to older people.

Finally, Commissioner Briggs considers there would be a higher level of transparency about the operations of aged care providers if all approved providers of aged care were required to provide an annual report about their operations to the System Governor for publication on the internet.

Endnotes

1 In relation to the nature, extent and systematic causes of substandard care, see Volume 2, Chapter 3.
2 Governance Institute of Australia, *Adding value to governance in aged care: A practical guide for any potential or current member of a board of an aged care provider*, 2019, p 1 (Exhibit 13-1, Hobart Hearing, general tender bundle, tab 1, RCD.9999.0260.0001).
3 Governance Institute of Australia, *Adding value to governance in aged care: A practical guide for any potential or current member of a board of an aged care provider*, 2019, p 2 (Exhibit 13-1, Hobart Hearing, general tender bundle, tab 1, RCD.9999.0260.0001).
4 Governance Institute of Australia, *Adding Value to Governance in Aged Care: A practical guide for any potential or current member of a board of an aged care provider*, 2020, p 48.
5 Governance Institute of Australia, *Adding Value to Governance in Aged Care: A practical guide for any potential or current member of a board of an aged care provider*, 2020, p 48; C Etherton-Beer et al., 'Organisational Culture in Residential Aged Care Facilities: A Cross-Sectional Observational Study', *PLoS One*, 2013, Vol 8, 3, p 6; A Nightingale, 'Developing the organisational culture in a healthcare setting', *Nursing Standard*, 2018, Vol 32, 21, pp 53–63; D Simpson et al., 'Measuring and Assessing Healthcare Organisational Culture in the England's National Service: A Snapshot of Current Tools and Tool Use', *Healthcare*, 2019, Vol 7, 4, pp 1–4.
6 *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 63D, 63F.
7 Data derived from information provided by the Australian Department of Health under NTG-0729 (CTH.0001.1001.7831 – list of aged care providers) for 2019 service delivery, as at 30 June 2019.
8 *Australian Charities and Not-for-profits Commission Regulation 2013* (Cth) made under the *Australian Charities and Not-for-profits Commission Act 2012* (Cth).
9 *Aged Care Act 1997* (Cth), ss 54-1, 54-2; *Quality of Care Principles 2014* (Cth), ss 17, 18. In addition, an approved provider of residential care that holds Refundable Accommodation Deposits, accommodation bonds or entry contributions must comply with the Governance Standard set out in Division 4 of Part 5 of the *Fees and Payments Principles 2014 (No. 2)* (Cth).
10 Transcript, Cairns Hearing, Petronella Neeleman, 15 July 2019 at T3584.1–20; Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, WIT.0258.0001.0001 at 0038 [208]–0044 [209]; Exhibit 13-5, Hobart Hearing, Statement of Jo-Anne Hardy, WIT.0496.0001.0001 at 0009 [36]–0010 [41]; Transcript, Darwin Hearing, Paul Cohen, 10 July 2019 at T3161.43–3162.6; T3168.32–3169.43; Transcript, Darwin Hearing, Donato Smarrelli, 10 July 2019 at T3179.21–3180.9; Transcript, Cairns Hearing, Petronella Neeleman, 15 July 2019 at T3581.42–3582.22; T3584.1–20; T3592.6–44.
11 See, for example, Transcript, Hobart Hearing, Penny Webster, 15 November 2019 at T7116.25–31; Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 2, pp 201, 206, 207; Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 163, BPA.060.002.5503.
12 Exhibit 1-3, Adelaide Hearing 1, Statement of Ian Yates, WIT.0006.0001.0001 at 0008 [31]; Exhibit 1-11, Adelaide Hearing 1, Statement of Susan Elderton, WIT.0003.0001.0001 at 0007–0008 [10]; Transcript, Adelaide Hearing 1, Matthew Richter, 20 February 2019 at T526.10–23; Exhibit 8-36, Brisbane Hearing, Statement of Beverley Johnson, WIT.0332.0001.0001 at 0009 [51]–[52].
13 Transcript, Hobart Hearing, Bethia Wilson and Janet Webster, 15 November 2020 at T7105.1–7106.2; T7111.21-46.
14 See, for example, John Simpson, Public Submission, AWF.001.02459 at 0002; Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4602.38–44; Exhibit 1-60, Adelaide Hearing 1, Statement of Gerard Hayes, WIT.0019.0001.0001 at 0013 [69g].
15 Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Professor Ron Paterson ONZM, RCD.9999.0143.0001 at 0003 [28].
16 See, for example, Transcript, Hobart Hearing, Catherine Maxwell, 15 November 2019 at T7164.28–7165.29; Exhibit 21-28, Sydney Hearing 5, Provider Governance tender bundle, tab 2, RCD.9999.0478.0001 at 0002–0003 [10]; Australian Institute of Company Directors, *Role of non-executive directors – Board composition*, 2016, p 1; ASX Corporate Governance Council, *Corporate Governance Principles and Recommendations*, 2019, p 15; Submission of the Governance Institute of Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0012.0112 at 0113.
17 Exhibit 21-28, Sydney Hearing 5, Provider Governance tender bundle, tab 2, RCD.9999.0478.0001 at 0002–0003 [10]; Exhibit 21-28, Sydney Hearing 5, Provider Governance tender bundle, tab 4, RCD.9999.0512.0009 at 0010 [9].
18 Exhibit 21-28, Sydney Hearing 5, Provider Governance tender bundle, tab 2, RCD.9999.0478.0001 at 0003 [10].
19 Submissions of the Governance Institute of Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0012.0112 at 0113; Submissions of the Australian Institute of Company Directors, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0014.0369 at 0371.
20 For those approved providers which are incorporated under the *Corporations Act 2001* (Cth), this duty is set out in ss 181–184.
21 *Aged Care Quality and Safety Commission Act 2018* (Cth), s 8B.
22 *Australian Securities and Investments Commission v King* (2020) 376 ALR 1 [52]–[59].
23 See, for example, *Corporations Act 2001* (Cth), s 9, definitions of 'director' (para (b)(ii)) and 'officer' (para (b)(iii)).
24 *Aged Care Act 1997* (Cth), s 9-1(1)(b) repealed by the *Budget Savings (Omnibus) Act 2016* (Cth).
25 *Aged Care Act 1997* (Cth), s 9-1(1).
26 Aged Care Quality and Safety Commission, *Notifying material changes for approved providers*, 2018, https://www.agedcarequality.gov.au/providers/notifying-material-changes-approved-providers, viewed 4 December 2020.
27 *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63B(2); Aged Care Quality and Safety Commission, *Application for approval to provide aged care – New applicant*, https://www.agedcarequality.gov.au/media/87218, viewed 4 December 2020.

28 A similar consideration was addressed in the Earle Haven Inquiry in support of Recommendation 16 of that report, which recommended that the Australian Government revisit the requirement for approved providers to report changes in key personnel: K Carnell AO, *Inquiry into Events at Earle Haven*, 2019, p 64 (Exhibit 13-1, Hobart Hearing, general tender bundle, tab 4, RCD.9999.0266.0003).
29 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6166.17–18.
30 *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63D(2)(c).
31 *Aged Care Act 1997* (Cth), s 10A-2(1).
32 *Aged Care Act 1997* (Cth), s 10A-2(3).
33 *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 7, 8A; *Aged Care Act 1997* (Cth), sch 1.
34 Exhibit 21-28, Sydney Hearing 5, Provider Governance tender bundle, tab 2, RCD.9999.0478.0001 at 0006–0007 [15]; Exhibit 21-28, Sydney Hearing 5, Provider Governance tender bundle, tab 4, RCD.9999.0512.0009 at 0013 [14]–[15]; Exhibit 21-28, Sydney Hearing 5, Provider Governance tender bundle, tab 1, RCD.9999.0470.0001 at 0006–0007 [7].
35 *Hughes and Vale Pty Ltd v New South Wales* (1955) 93 CLR 127 [156]–[157].
36 *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth), s 10.
37 Exhibit 21-28, Sydney Hearing 5, Provider Governance tender bundle, tab 5, WIT.0780.0001.0001 at 0006–0007 [29].
38 Exhibit 21-28, Sydney Hearing 5, Provider Governance tender bundle, tab 4, RCD.9999.0512.0009 at 0013 [15].
39 Exhibit 21-28, Sydney Hearing 5, Provider Governance tender bundle, tab 2, RCD.9999.0478.0001 at 0006 [14].
40 Statutory spent convictions schemes are set out in Part VIIC of the *Crimes Act 1914* (Cth); *Criminal Records Act 1991* (NSW); *Spent Convictions Act 1988* (WA); *Criminal Law (Rehabilitation of Offenders) Act 1986* (Qld); *Spent Convictions Act 2009* (SA); *Annulled Convictions Act 2003* (Tas); *Criminal Records (Spent Convictions) Act 1992* (NT); and *Spent Convictions Act 2000* (ACT).
41 See *Aged Care Act 1997* (Cth), s 10A-3.
42 Submission of Leading Age Services Australia, Hall & Wilcox and HWL Ebsworth, Response to Counsel Assisting's final submissions, RCD.0013.0014.0255 at 0259; Counsel Assisting's final submissions, RCD.9999.0541.0001 at 0245 [811].
43 Exhibit 21-28, Sydney Hearing 5, Provider Governance tender bundle, tab 1, RCD.99999.0470.0001 at 0007.
44 Exhibit 1-60, Adelaide Hearing 1, Statement of Gerard Hayes, WIT.0019.0001.0001 at 0013 [69g]; Exhibit 1-45, Adelaide Hearing 1, Statement of Patricia Sparrow, WIT.0014.0001.0001 at 0013 [83]; Transcript, Adelaide Hearing 1, Patricia Sparrow, 19 February 2019 at T431.44–46. Other publicly available information will include star ratings for approved providers and their services.
45 John Simpson, Public Submission, AWF.001.02459 at 0002.
46 In relation to financial reports, see *Accountability Principles 2014* (Cth), pt 4 div 2; *Fees and Payments Principles (No. 2) 2014* (Cth), pt 5 div 5.
47 *Australian Charities and Not-for-profits Commission Act 2012* (Cth), pt 2-2 div 40.
48 *Australian Charities and Not-for-profits Commission Act 2012* (Cth), ss 40-5(1), (4).
49 *Australian Charities and Not-for-profits Commission Act 2012* (Cth), s 40-5(1).
50 *Private Health Insurance (Prudential Supervision) Act 2015* (Cth), s 167.
51 *Aged Care Act 1997* (Cth), pt 6.2 div 86; *Aged Care Quality and Safety Commission Act 2018* (Cth), pt 7 div 4.
52 *Aged Care Act 1997* (Cth), s 86-1; *Aged Care Quality and Safety Commission Act 2018* (Cth), s 60(2).
53 *Freedom of Information Act 1982* (Cth), ss 3, 3A, 11, 11A.
54 *Freedom of Information Act 1982* (Cth), s 11A(4).
55 *Freedom of Information Act 1982* (Cth), s 11A(5).
56 *Freedom of Information Act 1982* (Cth), s 27. The requirement to consult applies only where it appears to the decision-maker that the entity might reasonably wish to make a contention that an exemption under section 47 or 47G applies: *Freedom of Information Act 1982* (Cth), s 27(1)(b).
57 Transcript, Adelaide Hearing 1, Ian Yates, 11 February 2019 at T56.1–18; Exhibit 21-28, Sydney Hearing 5, Provider Governance tender bundle, tab 3, RCD.9999.0512.0001 at 0007 [41]–[43].
58 Transcript, Brisbane Hearing, Shona Reid, 9 August 2019 at T4763.9–4764.18; T4765.23–43.
59 Submissions of the Commonwealth of Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0014.0037 at row 379.
60 *Freedom of Information Act 1982* (Cth), ss 27A, 47F.
61 Transcript, Melbourne Hearing 2, Duncan McKellar, 8 October 2019 at T5466.39–5467.4.
62 Transcript, Melbourne Hearing 2, Duncan McKellar, 8 October 2019 at T5480.35–38.
63 Submissions of Bupa Aged Care Australia Pty Ltd, Hobart Hearing, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0002 [5b]–0003 [5d]; 0020 [49]–0021 [50]; 0018 [47]; Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0033–0034 [130]. See also Volume 4B, Chapter 13, of this report.
64 Exhibit 5-19, Perth Hearing, Statement of Bryan Lipmann, WIT.1135.0001.0001 at 0007 [53].
65 Transcript, Perth Hearing, Chris Mamarelis, 25 June 2019 at T2429.38–42.
66 Transcript, Perth Hearing, Chris Mamarelis, 25 June 2019 at T2430.1–11.
67 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8023.15–22.
68 Opal Aged Care, Public submission, AWF.650.00039.0002 at 0003, 0011–0012.
69 Transcript, Perth Hearing, Bryan Lipmann, 25 June 2019 at T2465.44–2466.10.
70 See Chapter 3: Quality and Safety.
71 Submissions of the Commonwealth of Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0014.0037 at row 386.

72 See, for example, Transcript, Hobart Hearing, Carolyn Cooper, 15 November 2019 at T7129.24–33; Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6864.14–28; Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6864.32–43; Kay Horgan, Public submission, AWF.001.04058 at 0002.
73 See, for example, Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6864.32–43; T6867.9–13; Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6864.22–28; Transcript, Darwin Hearing, Donato Smarrelli, 10 July 2019 at T3179.27–3180.9.
74 See *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63D(3), (4).
75 See, for example, *Health Services Act 1997* (NSW), s 26(3)(a)–(e); *Health Services Act 2016* (WA), s 70(5)(a)–(h); *Hospital and Health Boards Act 2011* (Qld), s 23(2).
76 See, for example, Submission of Aged and Community Services Australia, Response to Counsel Assisting's final submissions, 11 November 2020, RCD.0013.0013.0102 at row 387; Submission of the Governance Institute of Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0012.0112 at 0115.
77 Submission of the Royal Australian College of General Practitioners, Response to Counsel Assisting's final submissions, 11 November 2020, RCD.0013.0008.0115 at row 386; Submission of the Australian Medical Association, Response to Counsel Assisting's final submissions, 11 November 2020, RCD.0013.0014.0086 at rows 374, 387.
78 Aged Care Workforce Strategy Taskforce, *A Matter of Care: Australia's Aged Care Workforce Strategy*, 2018, p 53 (Exhibit 1-4, Adelaide Hearing, WIT.004.001.001, UVH.0001.0007.0001)
79 See A Groves et al., *The Oakden Report: The report of the Oakden Review*, 2017, pp 74–75.
80 Exhibit 8-24, Brisbane Hearing, Statement of Gwenda Darling, WIT.0329.0001.0001 at 0007 [44].
81 Exhibit 1-3, Adelaide Hearing 1, Statement of Ian Yates, WIT.0006.0001.0001 at 0008 [31]; Exhibit 1-11, Adelaide Hearing 1, Statement of Susan Elderton, WIT.0003.0001.0001 at 0008–0009 [10]; Transcript, Adelaide Hearing 1, Matthew Richter, 20 February 2019 at T526.10–23.
82 Transcript, Brisbane Hearing, Beverley Johnson, 8 August 2019 at T4682.32–39.
83 Exhibit 8-36, Brisbane Hearing, Statement of Beverley Johnson, WIT.0332.0001.0001 at 0008 [47].
84 Exhibit 8-36, Brisbane Hearing, Statement of Beverley Johnson, WIT.0332.0001.0001 at 0008 [47].
85 Exhibit 8-36, Brisbane Hearing, Statement of Beverley Johnson, WIT.0332.0001.0001 at 0008 [48].
86 Exhibit 8-36, Brisbane Hearing, Statement of Beverley Johnson, WIT.0332.0001.0001 at 0008 [48].
87 Exhibit 8-36, Brisbane Hearing, Statement of Beverley Johnson, WIT.0332.0001.0001 at 0009 [49].
88 Exhibit 8-36, Brisbane Hearing, Statement of Beverley Johnson, WIT.0332.0001.0001 at 0009 [49].
89 Exhibit 8-36, Brisbane Hearing, Statement of Beverley Johnson, WIT.0332.0001.0001 at 0009 [50].
90 Exhibit 8-36, Brisbane Hearing, Statement of Beverley Johnson, WIT.0332.0001.0001 at 0009 [52].
91 Exhibit 8-36, Brisbane Hearing, Statement of Beverley Johnson, WIT.0332.0001.0001 at 0009 [52].
92 Exhibit 8-36, Brisbane Hearing, Statement of Beverley Johnson, WIT.0332.0001.0001 at 0011 [60].
93 Exhibit 8-36, Brisbane Hearing, Statement of Beverley Johnson, WIT.0332.0001.0001 at 0011 [60], [62].
94 *Quality of Care Principles 2014* (Cth), sch 2 stds 1(2)(a), 6, 8(3)(a); Aged Care Quality and Safety Commission, *'Care that is right for me': A resource for working with aged care consumers*, 2020, p 14.
95 See *Quality of Care Principles 2014* (Cth), sch 2 std 8(3)(b).
96 See, for example, Transcript, Brisbane Hearing, Graeme Head, 8 August 2019 at T4677.4–9.
97 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4589.44–46.
98 Transcript, Hobart Hearing, Bethia Wilson, 15 November 2019 at T7105.5–8.
99 *Aged Care Act 1997* (Cth), s 56-4; *Quality of Care Principles 2014* (Cth), sch 2 stds 6, 8; *User Rights Principles 2014* (Cth), sch 1 item 2(12). See also Aged Care Quality and Safety Commission, *Better Practice Guide to Complaint Handling in Aged Care Services*, 2019, pp 10, 12.
100 See, for example, Exhibit 1-1, Adelaide Hearing 1, Statement of Barbara Spriggs, WIT.0025.0001.0001 at 0002 [12]; Exhibit 5-9, Perth Hearing, Statement of Noleen Hausler, WIT.1124.0001.0001 at 0009 [77]; Exhibit 13-22, Hobart Hearing, Statement of Elizabeth Monks, WIT.0558.0001.0001 at 0011 [4eii].
101 See Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2nd edn), 2017, pp 7–8; Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards Second Edition User Guide for Governing Bodies*, 2019, pp 2, 7, 23–24. See also R Hislop, *Board governance in the aged care sector*, *Director Tools: Organisation*, 2019, p 7.
102 See, for example, RSL LifeCare, Public submission, AWF.600.02120.0007.
103 *Quality of Care Principles 2014* (Cth), sch 2 std 8(3)(d).
104 Aged Care Quality and Safety Commission, *Guidance and Resources for Providers to support the Aged Care Quality Standards*, 2019, pp 182,184.
105 Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6876.21–22; T6876.43; Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6877.13–16; Transcript, Hobart Hearing, Cynthia Payne, 14 November 2019 at T7074.37–44.
106 Submission of the Australian Institute of Company Directors, Response to Counsel Assisting's final submissions, 11 November 2020, RCD.0013.0014.0378 at row 392.
107 See, for example, Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 2, pp 314, 331.
108 Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0029 [144]; Transcript, Brisbane Hearing, Debora Picone, 9 August 2019 at T4778.6–12. See also Australian Commission on Safety and Quality in Health Care, *Fact Sheet 7: Governing body attestation statement*, 2020, p 1.
109 Australian Commission on Safety and Quality in Health Care, *Fact Sheet 7: Governing body attestation statement*, 2020, p 1. See also Australian Commission on Safety and Quality in Health Care, *Governing body attestation statement template*, 2020.
110 Transcript, Brisbane Hearing, Debora Picone, 9 August 2019 at T4778.6–12.

111 See, for example, a submission from the Australian Institute of Company Directors in which this concern was raised: Submission of the Australian Institute of Company Directors, Response to Counsel Assisting's final submissions, 11 November 2020, RCD.0013.0014.0378 at row 392.

112 See, for example, *Work Health and Safety Act 2011* (Cth), s 275.

113 Aged Care Quality and Safety Commission, *Guidance and Resources for Providers to support the Aged Care Quality Standards*, 2019, p 3.

114 In relation to the Remote and Aboriginal and Torres Strait Islander Aged Care Service Development Assistance Panel Program, see Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0037 [144]–[146]. In relation to the Business Advisory Service, see Submissions of the Commonwealth of Australia, Mudgee Hearing, Pioneer House Case Study, 4 December 2019, RCD.0012.0044.0002 at 0004 [3.5]–0005 [3.11]; PricewaterhouseCoopers, *Business advisory services for aged care providers*, undated, https://www.pwc.com.au/health/aged-care-advisory.html, viewed 4 December 2020. In relation to the Business Improvement Fund, see Australian Department of Health, *Business Improvement Fund for residential care*, 2020, https://www.health.gov.au/initiatives-and-programs/business-improvement-fund-for-residential-care, viewed 4 December 2020. In addition to these formal programs, providers may access relevant information and resources at no cost through a range of sources, including, for example, from the Australian Care Quality and Safety Commission. See, for example, Aged Care Quality and Safety Commission, *Resource Library*, undated, https://www.agedcarequality.gov.au/resource-library, viewed 4 December 2020.

115 Submissions of the Commonwealth of Australia, Mudgee Hearing, Pioneer House Case Study, 4 December 2019, RCD.0012.0044.0002 at 0004 [3.4].

116 Submissions of the Commonwealth of Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0014.0037 at row 394.

117 See Chapter 7, on aged care for Aboriginal and Torres Strait Islander people.

118 Transcript, Mudgee Hearing, David Hallinan, 6 November 2019 at T6566.1–14; Submissions of the Commonwealth of Australia, Mudgee Hearing, Pioneer House Case Study, 4 December 2019, RCD.0012.0044.0002 at 0007 [3.18].

119 See, for example, Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6356.10–6357.25.

14. Quality Regulation and Advocacy

14.1 Introduction

Effective regulation is an essential part of ensuring that aged care services are safe and high quality. Regulation should seek to prevent harm to people receiving aged care services, and ensure that instances of substandard care are detected and addressed. Where people have been harmed as a result of substandard care, the regulator should ensure that measures are put in place to prevent future harm, and that those responsible are held to account. While we recognise that regulation cannot fix everything, it should complement other measures to incentivise good care.

In Chapter 1 of Volume 2, we detail the aged care system as it existed during our inquiry. In Chapter 4 of Volume 2, we noted that ineffective regulation has been one of the causes of the high levels of substandard care that exist in the system. Here, we focus on the role that a more effective approach to regulation should play in the new system.

Aged care quality and safety regulation has been marked by frequent reviews and piecemeal reform and change for at least a decade. In 2011, the Productivity Commission recommended a significant restructuring of aged care quality and safety regulatory functions.[1] In 2017, following significant failures in the quality of care provided at Oakden Older Persons Mental Health Service in South Australia, Ms Kate Carnell AO and Professor Ron Paterson ONZM examined aged care regulation in detail (the Carnell-Paterson review).[2]

Significant changes have been made to the way the aged care system is regulated since the Carnell-Paterson review. These changes include the creation in 2019 of the Aged Care Quality and Safety Commission and the staged integration of regulatory functions previously performed by the Australian Department of Health into that agency, a process that was completed on 1 January 2020.[3] A Charter of Aged Care Rights and new Quality Standards have been implemented. The Australian Government has committed to further reforms, including a new Serious Incident Response Scheme. These changes have included many positive developments. However, we consider that there remains considerable scope for improvement of the regulation of aged care. We make recommendations directed at approval and accreditation, monitoring, complaint handling, serious incident reporting, enforcement and regulatory capability generally.

We want people who receive aged care, and their families and advocates, to be at the heart of aged care regulation. We endorse the observations of Professor Paterson that:

> the regulation of aged care in Australia has paid lip-service to the welfare of care recipients. The system fails to ensure the provision of safe, high quality care and pays insufficient attention to the quality of life of aged care users.[4]

While improvements are needed in the regulation of residential care, the regulation of home care is particularly lacking. This was the case when we commenced our inquiry.[5] Eighteen months later, it remained the case.[6] This is particularly concerning, and in view of the significant expansion of the home care sector that we recommend, it needs urgent attention. Measures that apply to residential aged care, including accreditation, mandatory quality indicators, consumer experience reports and the compulsory reporting scheme, do not apply to home care. Yet we know that there are substantial risks associated with the provision of care to older people in their own homes.

We make a number of recommendations to improve the regulation and oversight of aged care provided in the home.

Commissioner Pagone considers that there is a lack of clarity in the definition of a 'home care service' which impacts on the regulation of home care.[7] For example, it is unclear whether a quality review of a home care service is required to be carried out at a provider level or at an outlet level.[8] We understand that the Australian Department of Health and the Aged Care Quality and Safety Commission are developing a consistent definition of a home care service, including for the purposes of developing a risk profiling model.[9] This definition will impact upon our recommendations for a star rating system, graded assessments and home care accreditation, among others. The definition will need to be sufficiently targeted to ensure these mechanisms allow the regulator, and the broader public, to compare the quality and safety of home care services in different areas. One option is to regulate home care services at the State or Territory level.

The aged care regulator must adopt a proactive and flexible approach to its functions. It needs to be more curious about what is happening in the system based on a wider range of information about the quality and safety of services, and the circumstances of a service provider's track-record and current operations. It should be prepared to follow through on events that may point to risks to the wellbeing of older people. It needs to be less trusting of what providers tell it. The regulator must be equipped with appropriate powers and be adequately resourced so that it can identify deficiencies in the quality and safety of care, and respond appropriately. The prospect of genuine accountability for those responsible for poor care is vital.[10]

In Chapter 3, on quality and safety, we recommend that a general duty to provide high quality and safe care be imposed on providers. This duty should, over time, provide a focus for the work of the regulator.

The aged care regulator should be governed by an independent board. It should be subject to a capability review, as a matter of priority, to ensure that it has the resources, personnel and structures to carry out its vital role. In Chapter 2, we also recommend establishing an Inspector-General of Aged Care to review systemic issues in the aged care sector, including where relevant, the operations of the aged care regulator. We consider that these arrangements will help to ensure that the culture, capabilities and approach of the regulator are such that it can fulfil its important mandate of protecting and enhancing the safety, health, wellbeing and quality of life of people receiving aged care.

We use the term 'the Quality Regulator' to describe the statutory body responsible for quality and safety regulation of the aged care system. At present, that is the Aged Care Quality and Safety Commission.[11] As a result of legislative changes described in Chapter 1 of Volume 2 of our report, that Commission performs all of the quality regulatory tasks—including the approval of aged care providers and the accreditation of services.

Under the new Act, in line with our recommendations in Chapter 2, the Quality Regulator will be either the Australian Aged Care Commission or the Aged Care Safety and Quality Authority.

14.2 Approval and accreditation

A rigorous assessment of those wanting to provide Australian Government-funded aged care services is the first and best opportunity to ensure that they are able to provide high quality and safe care to older people on a sustainable basis. If that assessment excludes organisations that are unlikely to be able to meet those high standards, there will be a reduced need to take corrective regulatory action in the future. The point was well made by UnitingCare Australia, in response to Counsel Assisting's final submissions:

> As system design progresses it will be important to consider the full suite of measures designed to ensure safe and high quality care. UnitingCare Australia considers accreditation to be the critical step in the process of regulating services. Effective approval systems should mitigate the need to use punitive regulatory schemes and enable risk based monitoring of performance. Commission resources should be deployed relative to the preventive value of rigorous approval processes.[12]

In Chapter 4, we recommend reforms to the aged care program. These include the integration of the Commonwealth Home Support Programme and the Home Care Packages Program. This will require major changes to the current approval processes. Unlike providers of Home Care Package services, organisations providing aged care services under the Commonwealth Home Support Programme are not currently approved. They are engaged by the Australian Department of Health through grant agreements without any scrutiny, at that time, by the Aged Care Quality and Safety Commission.

When the new aged care program commences, new arrangements for approvals will be needed. Design of the new approval process should happen at the same time as design of the new aged care program. Under these new arrangements, all providers of subsidised aged care services should be required to be approved by the Quality Regulator. There is a clear benefit, from the outset, in giving the Quality Regulator oversight of all organisations applying to provide aged care services subsidised by the Australian Government. This will enable the Quality Regulator to integrate information obtained through the approvals process into its ongoing risk profiling, and adjust its level of oversight accordingly.

In 2018–19, around 905 organisations provided services only under the Commonwealth Home Support Programme and were therefore not approved providers.[13] A careful and flexible approach will need to be taken to the transition of these organisations to the new approval process. Meals on Wheels submitted that small, single-service providers within

the social support category, such as a rural Meals on Wheels service, would require resources and support to transition to an approval or accreditation process.[14] We accept this and address the need for the approval process to be proportionate in the following section.

The approval and accreditation processes should also be strengthened for residential aged care. Currently, when it allocates new places, the Australian Department of Health considers the performance of a provider, including its compliance record and sanction history. The future approval and accreditation processes must be sufficiently rigorous to mitigate the impact of the removal of this secondary vetting of providers.[15] We agree with the observations of the NSW Ageing and Disability Commission that:

> there are risks associated with an overly rapid open market approach to the provision of human services, including aged care. Any market is likely to attract the competent, the incompetent, and the exploitative. Regulators and system owners must be attentive to ensure systems for vetting, accrediting, oversighting and responding are designed with such anticipatory knowledge. The expansion of the vocational training market, the early childhood development / childcare market, and the new NDIS [National Disability Insurance Scheme] disability services market all provide informative examples.[16]

Reforming the approval process provides an opportunity to ensure that it is effective and efficient both for the regulator and existing and new providers.

14.2.1 Assessment of suitability

The current approval process requires the Aged Care Quality and Safety Commissioner to assess the suitability of an organisation that wants to provide aged care services.[17] The Commissioner may also consider the suitability of the 'key personnel' of the organisation.[18] In addition, the Aged Care Quality and Safety Commissioner must revoke a provider's approval if satisfied that the provider has ceased to be suitable to provide aged care.[19] In assessing suitability of an organisation and its key personnel, the Commissioner must consider a range of matters. These include experience providing care, demonstrated understanding of provider responsibilities, systems in place and record of financial management.[20] When considering suitability, the Commissioner is not limited to considering the matters set out in the *Aged Care Quality and Safety Commission Act 2018* (Cth).[21]

In future, the Quality Regulator must take a more proactive approach to assessing suitability, both initial and ongoing. It must consider a broader range of matters when doing so. In addition to the matters already listed in the Aged Care Quality and Safety Commission Act, the Quality Regulator should be required to consider the fitness and propriety of the provider and its key personnel, the provider's capacity to deliver high quality and safe aged care services within its scope of approval, and, where relevant, the provider's prior performance in delivering high quality and safe aged care services.

The need for this was illustrated by the Earle Haven Case Study, at the Brisbane Hearing.

Earle Haven Case Study—assessing suitability

The Earle Haven Case Study examined the circumstances leading to the closure of two residential aged care facilities, Orchid House and Hibiscus House, at the Earle Haven Retirement Village located on Queensland's Gold Coast.[22] This resulted in the evacuation of 68 aged care residents by emergency services on 11 and12 July 2019.

People Care was the approved provider of these facilities. The Australian Department of Health revoked its approval with effect from 23 October 2019, for both its residential and home care services.[23] Commissioner Briggs found that this case study exposed four circumstances that should have caused the Australian Department of Health to reconsider People Care's suitability before 11 July 2019. These are: People Care's history of non-compliance, People Care's conduct in respect of its Home Care Packages service in 2017, the attitude and responsibilities of People Care's key personnel, and People Care's relationship with its adviser appointed pursuant to sanctions in 2016.

There is no evidence that the Department ever reconsidered People Care's suitability to remain an approved provider before 11 July 2019. The Australian Government agreed that the conduct of People Care in 2016 should have invited further consideration of its suitability to provide aged care services.[24]

There are dangers in relying on paper-based approval processes that may not involve personal contact with the applicant. In future, when determining the suitability of applicants, the Quality Regulator should be required to consider whether it should conduct interviews with all or some key personnel. The Quality Regulator should have clear powers that enable it to do this, and to take information obtained into consideration as part of the assessment process.

When approvals were handled by the Australian Department of Health, there was evidence that it received a lot of similar or near-identical applications.[25] A 2020 report commissioned by the Department stated 'there is an increasing trend in the industry to utilise third party consultants to draft applications due to the perceived complexity of the application process'.[26]

The option to conduct interviews should enable the Quality Regulator to apply more proportionate scrutiny to certain applications.[27] The prospect of an interview may also deter applicants 'with little starting capability and minimal interest in investing to meet the required standards of care and services'.[28] A similar recommendation was made by the Aged Care Quality and Safety Advisory Council in a 2019 options paper. It noted that interviews would only need to be deployed 'on a risk basis to a sample of providers who are proceeding to a later stage of processing their application'.[29]

Recommendation 92: Approval of providers

1. The new Act should provide for the commencement by 1 July 2024 of new approval requirements for all aged care providers to ensure their suitability, viability and capability to deliver the kinds of services for which they receive subsidies.
2. Applicants for approval as a provider or existing approved providers may seek approval from the Quality Regulator to provide particular kinds of aged care services, or general approval to provide all kinds of aged care services attracting Australian Government funding.
3. An existing approved provider should be taken to be approved to provide the kinds of services it has been regularly providing in the 12 months prior to the commencement of the new Act (or since their approval, whichever is more recent), and there should be an administrative process to record each such approved provider's scope of approval.
4. When assessing the suitability of new or existing providers, the Quality Regulator should consider (in addition to the matters referred to in sections 63D and 63J of the *Aged Care Quality and Safety Commission Act 2018* (Cth)), the fitness and propriety of the provider and its key personnel, the provider's capacity to deliver high quality and safe services within its scope of approval, and, where relevant, the provider's performance in delivering high quality and safe services of the kinds for which they are approved.

14.2.2 Accreditation of high-level home care services

To receive funding from the Australian Government, a residential aged care service must be accredited by the Aged Care Quality and Safety Commissioner.[30] This is in addition to the provider of that service being approved. However, there is no equivalent to accreditation for home care services. Once approved, a provider may begin to provide Home Care Package services. 'Home services', including home care services, are subject to a quality review at least once every three years.[31] However, there is some uncertainty as to whether such a quality review is conducted at the provider or service level.[32]

There is a concerning lack of oversight of new home care providers. Ms Janet Anderson PSM, the Aged Care Quality and Safety Commissioner, told us that a number of providers of home care services may take some time to establish their business and take on clients after being approved. Mr Mark Rummans, Director, Home Care Compliance and Investigations at the Aged Care Quality and Safety Commission, added that the Commission is not currently automatically notified when a new home care provider begins to take on clients.[33]

As at 30 June 2019, 159 out of the 928 approved providers had never had a quality review conducted on any of their active home care services.[34] A 2020 report commissioned by the Australian Department of Health noted that 'a large proportion of approved providers are pre-operational at approval and may not be audited for up to 12 months after approval'.[35]

The introduction of accreditation for services that provide personal or clinical care in the home is necessary to address this lack of oversight. Service-level accreditation will provide an additional level of quality assurance for higher risk services on an ongoing basis.[36] This will become more essential as an increasing number of older people remain at home for longer and there is a resultant increase in the frailty of people receiving more complex care at home. The risk profile of home care services will increase due to the greater provision of acute clinical care.

Currently, the Aged Care Quality and Safety Commissioner may accredit a new residential aged care service for one year.[37] If the Commissioner decides to re-accredit an existing residential aged care service, they must decide how long the further accreditation period should be. In making this decision, the Commissioner must consider various matters, including the site audit report conducted under section 36 of the *Aged Care Quality and Safety Commission Rules 2018* (Cth) and any relevant information given by a person receiving care (or a nominated representative).[38]

A similar approach should be adopted for accreditation of home care services. In addition to an audit report and information given by people receiving care, other matters that should be considered include the nature of the service(s) being delivered, the provider's record of compliance, and information obtained through other sources such as complaints, quality indicators, serious incident reports and prudential regulation functions. Adjusting accreditation periods on the basis of a risk analysis will reduce the regulatory burden for higher-performing providers, and provide an incentive for all providers to provide high quality care. It will also allow the Quality Regulator to monitor higher-risk services more closely, and use its resources more efficiently.

14.2.3 Proportionate approval and accreditation assessments for home care providers

Aged care services provided in the home range from services that pose a low risk to an older person, such as gardening, to services that require greater regulatory oversight, such as clinical services. Providers of home-based aged care services are similarly diverse. They range from very small community organisations to very large corporate entities.[39] Given this diversity, a robust but flexible approval system is required.

Currently, organisations seeking to provide residential aged care services or Home Care Packages become 'approved providers' after progressing through a single assessment process conducted by the Aged Care Quality and Safety Commissioner. Applicants for approval to provide Home Care Packages must be able to demonstrate capability across all four Home Care Package levels 'to maintain continuity of care for the consumer'.[40] This is the case even if they are only intending to provide entry-level services such as delivering meals or gardening.

This applies a 'one size fits all' approach to the approval of providers of home care services. Ms Anderson said that in her view this design feature of the current approval model 'does not assist in the regulation of the sector' and that she was 'not sure it's in the consumer's best interests either'.[41] An employee of the Australian Department of Health who was formerly responsible for assessing applications, gave evidence that:

> providing complex care to somebody on [a] level 4 package is different to providing entry-level services such as meals on wheels or social support. That is what takes up so much time assessing the applications. Many applicants just want to deliver [a] level 1-2 package. But you need to be able to do all levels as an approved provider of Home Care Packages, so we apply level 4 package standards to them.[42]

We agree with the Advisory Council to the Aged Care Quality and Safety Commissioner that there should be 'risk-based requirements for provider approval and market entry that can better differentiate the regulatory oversight to fit the type of service and level of risk to consumers'.[43]

Home care providers should be able to seek approval for only a limited scope of services, and the regulator should be able to adjust the rigour of the approval process accordingly. While all applicants should be subject to a basic suitability assessment, the scope of an assessment of a provider's capability should be more confined for those seeking only to provide relatively low risk services, such as basic domestic assistance. Where an approved provider wants to expand the scope of the services it is approved to provide, it will need to demonstrate its capability to provide the additional services safely and to a high standard. This process should be streamlined and efficient.[44] This will reduce the impact of the home care approval process on the regulator and providers alike, with no reduction in safety standards.

14.2.4 Oversight of the scope of services

The Quality Regulator should have oversight of any substantial expansion or contraction of the aged care services offered by an approved provider. A significant change in the number of people receiving aged care services from a particular provider, or the locations in which a provider operates, are matters that should be identified as part of ongoing risk profiling.[45] To enable planning for future aged care needs, such information should be shared within the System Governor.

An approved provider should be required to notify the regulator of any plans to operate a new aged care service or significantly expand an existing aged care service.[46] Other changes that should be subject to mandatory reporting include significant changes in the geographical area or the location at which services are provided, and a significant increase or decrease in the number of people receiving aged care services or in the number of workers providing such services.[47] Such changes will be likely to change the risk profile of the provider and should prompt at least an inquiry by the regulator.

The Quality Regulator should have the power to impose restrictions on the permissible scope of aged care services through the approval process, accreditation process and through the sanctions process in response to evidence of non-compliance. In circumstances where the regulator considers that a provider may only be able to provide high quality care to a limited number of older people, it may be prudent for the regulator to impose a cap on the number of older people who can receive services from that provider. In other circumstances, it may be necessary to restrict the growth of a non-compliant provider until it has proven to the regulator's satisfaction that it can provide high quality and safe care to all the older people it cares for.

Recommendation 93: Accreditation of high-level home care services

1. **By 1 July 2024, the new Act should require a home care service that provides care management, personal care, clinical care, enabling and therapeutic care, or palliative and end-of-life care to be accredited in order to receive Australian Government subsidies.**
2. **Accreditation periods should vary based on an analysis of performance and risk. Initial accreditation for a new home care service should be for no more than one year, and subsequent accreditation should be for no more than three years.**
3. **The Quality Regulator should have the power to limit the range of aged care services that a provider may deliver through the approval, accreditation and sanctions processes.**

14.3 Monitoring quality and safety

The primary function of the Aged Care Quality and Safety Commission is to protect and enhance the safety, health, wellbeing and quality of life of people receiving aged care.[48] It must therefore be able to identify risks and areas where care could be improved in a timely and effective way, drawing on all relevant sources of information. This might include information obtained through inspections, through the approvals and accreditation processes and through the complaints and serious incident reporting schemes. Professor Paterson referred to the importance of an integrated regulator that can 'bring the intelligence together'.[49]

The Carnell-Paterson review made a number of recommendations to improve compliance monitoring in relation to residential aged care. Some of these have been, or are in the process of being, implemented. For example, from 1 July 2018, the Aged Care Quality and Safety Commission began unannounced re-accreditation audits.[50] Legislative changes were introduced to empower the Commission to conduct unannounced visits to home care providers from January 2019.[51] Work has also commenced on enhancing risk

profiling of residential and home care services.[52] These are important developments. Other recommendations have not been advanced. Overall, progress in implementing the Carnell-Paterson recommendations has been slow, and should be progressed.

In this section, we make further recommendations to improve the monitoring of the quality of care. We also recommend in Chapter 3, on quality and safety, that a general duty to provide high quality and safe care be imposed on providers. We consider that this duty should, over time, provide a focus for the monitoring and enforcement work of the Quality Regulator. A similar effect has been seen in the areas of occupational health and safety. The introduction of a general duty on employers has shifted the approach of regulators away from enforcing prescriptive standards to targeting compliance with the general duty.[53] Mr Robert Fitzgerald AM, the NSW Ageing and Disability Commissioner, observed:

> If you look back on our workplace health and safety legislation and regimes, Australia was a nation that actually accepted that people would become ill at work, would die at work, or suffer injury. We no longer think in that way and the workplace health and safety regime changed the way in which we saw workplaces. We now think, act, and hopefully abide by the regulations to create a safe workplace.[54]

This effect was recently recognised by a comprehensive review of Victoria's environmental laws and has led, for the first time, to the inclusion of a general duty in those laws.[55]

14.3.1 Hearing from the people at the heart of the system

The most valuable feedback on the quality and safety of care will come from older people receiving aged care, and their families and advocates. They must be encouraged and supported to provide feedback at any time, and particularly during site inspections and accreditation processes.

Dr Lisa Trigg, Assistant Director of Research, Data & Intelligence at Social Care Wales in the United Kingdom, who has conducted research comparing the approach to improving the quality of residential aged care in England and Australia, observed:

> inspection reports in England set out to tell the story of what it is like to live in the home, with both good and bad aspects. The inspection process in England prioritises the views and experiences of residents and their families as part of the policy of putting the person at the heart of regulation. Inspections in England place a large emphasis on talking to residents and their relatives, and lay assessors called 'Experts by Experience' are employed to assist in this process. Experts by experience are people who use services and their family carers, regarded as best placed to assess the quality of services.[56]

Dr Trigg said that historically the emphasis of reviews in Australia has been on checking care plans and other documentation. She said that 'several participants [in her research] in Australia commented that it is possible to pass accreditation with little consideration of the quality of life of the older person'.[57]

Consumer experience interviews of aged care residents have been conducted in Australia since May 2017 but were only introduced for home and community care from 1 July 2019.[58] As the Aged Care Quality and Safety Commission has noted, these interviews:

> contribute intelligence that assists in assessing the prevailing level of risk in a service and inform performance assessment of a home service against the Quality Standards. They provide evidence of performance by an approved provider, as well as indicators of possible areas of risks or concern at a service that may require further enquiry by the ACQSC [Aged Care Quality and Safety Commission].[59]

Aggregated results of these interviews should be publicly available to inform those choosing an aged care provider or service, and as an incentive for providers to improve the quality of care.[60] The results of these interviews were published in the form of a 'Consumer Experience Report' for residential aged care services. However, since 9 December 2019, these reports have no longer been published. This is disappointing. The Aged Care Quality and Safety Commission explained that this change is because the questions asked during consumer experience interviews 'are now selected on a purposeful basis by quality assessors based on the Evidence Domain they are assessing and are not in a standardised format or sampling methodology that can be published'.[61] The Aged Care Quality and Safety Commission has advised that it is working on developing 'appropriate sampling methodology' to enable it to publish Consumer Experience Reports for residential and home care services. It anticipates that publication will occur from 2021.[62]

Assessors from the Aged Care Quality and Safety Commission are required to meet at least 10% of residents, or the nominated representatives of residents, during a site audit to discuss the care and services that they are receiving.[63] When preparing a performance report after a site audit or quality review, the Commissioner must consider any relevant information from a person receiving aged care, or their nominated representative.[64] There is no set proportion of people receiving home and community aged care who need to be interviewed.[65]

The Carnell-Paterson review recommended that the regulator should seek the views of 20% of older people and their representatives when conducting assessments.[66] This recommendation was not implemented. In evidence, Professor Paterson said that 'all sorts of reasons' could be proffered to reject the increase to 20%, but that such reasons contributed to 'diminishing the voices of the people who we need to hear from'.[67] We agree.

We consider that any report on the experience of people receiving aged care should be informed by interviews by assessors with at least 20% of people receiving care or their nominated representative and should reflect a representative sample of views and experiences.[68] The Quality Regulator must have effective mechanisms for engaging with people with dementia or cognitive impairment.[69] Relationships Australia said, in response to Counsel Assisting's final submissions, that it:

> does not consider a 20% threshold will, in itself, provide a sufficiently nuanced picture that reflects the significance that user experience should have in this context. While the proportion is a major improvement on the current state, we would urge Government to consider requiring that, in determining the users who make up that proportion, the views of a representative sample be sought.[70]

The Australian Government advised that it did not support Counsel Assisting's recommendation 'on the basis that although 20% is appropriate for most services, setting a fixed minimum proportion of 20% would create logistical difficulties in some situations, for example a home care provider with a large geographical area'.[71] We do not consider that this is a sufficient reason to refrain from imposing a general requirement on the Quality Regulator. Commissioner Pagone considers that, if necessary, the minimum number of interviews that need to be conducted could be capped for large home care providers.[72] The legislation could set out a narrowly defined exception to the requirement to meet people receiving home care services. Where necessary, interviews could occur over the telephone or by use of other communication tools, such as video conferencing services.

Reports capturing the experience of people receiving aged care from a particular service provide an invaluable insight into the quality and safety of care at that service. For this reason, they should be available through the star ratings system that we have recommended in Chapter 3 be established.

Engagement with people receiving aged care services, and their families and friends, should not be limited to periodic interviews but should occur on an ongoing basis.[73] The Aged Care Quality and Safety Commission has advised that it is:

> currently considering options to introduce an online survey, which will allow consumers and their representatives in residential aged care facilities to provide their opinion on the services being received at that facility through an online portal.[74]

This is encouraging but consideration needs to become action, and the initiative should be extended to home and community care services.

Recommendation 94: Greater weight to be attached to the experience of people receiving aged care

From 1 July 2021 onwards, the Aged Care Quality and Safety Commissioner (and from the commencement of a successor body, that body) should:

a. **periodically publish a report on the experience of people receiving care from an aged care service**

b. **ensure that these reports are informed by interviews with at least 20% of people receiving aged care through the service (or their nominated representative)**

c. **take into account information from people receiving aged care services and their representatives in accreditation assessments and other compliance monitoring processes**

d. **establish channels (including an online mechanism) to allow people receiving aged care services and their families to report their experiences of aged care and the performance of aged care providers, year round.**

14.3.2 Assessing provider performance

The need for better, comparable, publicly available information about the quality of care has been recognised in previous reviews of aged care in Australia.[75] The Aged Care Quality and Safety Commission currently assesses providers against the Quality Standards on a binary 'met' or 'not met' basis. Assessments of this kind do not permit a meaningful comparison of the performance of different services. This is particularly the case in circumstances where a high percentage of providers has historically been assessed as meeting all minimum standards and outcomes. Under the previous accreditation standards, during 2016–17, about 98% of providers received assessments that they had 'met' all minimum standards and outcomes. In 2017–18, the equivalent figure was 95% of providers and in 2018–19 it was 93%.[76]

Professor Paterson explained that an accreditation regime which simply provides for a binary 'met' or 'not met' outcome does not meet the 'minimum standards' of information.[77] Dr Anna Howe, a researcher, submitted that 'we do not know very much about variations in quality of care across the residential aged care system', and noted that the imposition of sanctions happens only rarely.[78]

A pass or fail assessment does not recognise or assess the extent to which care that has passed exceeds the minimum standards. A pass or fail can depend on where the pass mark is set. If the pass mark is 50%, a pass can mean anything between 51% and 100%. Similarly, a 'fail' can mean 49% or 1%. Without knowing where the pass mark has been set, or how providers have been graded against this mark, it is difficult to assess the significance of a simple pass or fail.

The current assessments do not provide meaningful information for older people and their families, or offer incentives for providers to strive for excellence or to do more than deliver adequate care.[79] Mr David Panter, Chief Executive of a large not-for-profit aged care provider, said that in his view incentives indicate what is seen as being significant or not. He gave evidence that it usually takes about 18 months for an organisation to get 'Rainbow Tick' accreditation for being inclusive of people in the LGBTI communities. He continued:

> all too often issues around diversity in the [aged care] accreditation process are not taken seriously, don't warrant high-enough an issue to give you a 'not met'. They're almost like… it's nice, if you've got them; you don't have to have them.[80]

Evidence in the MiCare Case Study, at the Brisbane Hearing, raised other issues with the approach to assessment by the Aged Care Quality and Safety Commission and its predecessors.

MiCare Case Study[81]

Avondrust Lodge is a residential aged care facility in suburban Melbourne operated by MiCare Ltd. In April 2018, following a re-accreditation audit, the then Australian Aged Care Quality Agency found that Avondrust Lodge had met all 44 of the 44 expected outcomes across the then four Accreditation Standards.[82] It was re-accredited for the maximum period of three years.[83]

In August 2018, Ms Johanna Aalberts-Henderson lodged a complaint with the then Aged Care Complaints Commissioner about the treatment of her mother at Avondrust.[84] The Commissioner referred information in this complaint to the Australian Aged Care Quality Agency, and it resulted in a review audit of Avondrust.[85] Two different Agency assessors found that the service at Avondrust did not meet 13 of the 44 expected outcomes.[86] Sanctions were imposed on MiCare in respect of Avondrust, and the accreditation period was varied. In September 2018, the Agency found that MiCare had placed the safety, health or wellbeing of 14 residents at Avondrust at serious risk.[87]

In December 2018, three assessors found that Avondrust now met the 13 previously 'not met' expected outcomes, and in January 2019, three assessors found that Avondrust met 44 out of 44 expected outcomes. The sanctions were lifted in January 2019, and in February 2019 Avondrust was accredited for one year.

On February 2019, the nurse adviser and administrator appointed by Avondrust pursuant to the sanctions provided a draft report to MiCare. That report set out concerns about the sustainability of the changes which Micare had made, and provided a range of observations about shortcomings in culture and leadership, staffing structure, and provision for the lifestyle and clinical needs of residents.[88] The assessors who inspected Avondrust in December 2018 and January 2019 did not speak with this nurse adviser and administrator during their assessments.[89]

In July and August 2019, the Complaints Resolution Group of the Aged Care Quality and Safety Commission (which had been established on 1 January 2019) made four referrals to the Commission's Assessment Group relating to complaints about, among other things, organisational governance at Avondrust, staffing levels, and the personal and clinical care of residents, including allegations of poor wound management.[90]

Commissioner Briggs found that the review audit conducted in August 2018 was more rigorous in its assessment of compliance than the April 2018 re-accreditation audit had been. She also found that in preparing re-accreditation audit assessment documentation in April 2018 and January 2019, assessors made extensive use of computer-generated template reasons, which were substantially the same. In addition, over half of the findings that Avondrust had 'met' expected outcomes in the January 2019 re-accreditation audit rested on reasoning that 'The team was not presented with any evidence indicating that the expected outcome is not met.'[91]

There needs to be a more sophisticated approach to assessment against the Quality Standards. Rather than a pass or fail approach, there should be a range of outcomes. These outcomes could, for example, range from 'very poor performance that fails to meet the standard' to 'excellent performance that exceeds the standard' in all respects. This should promote a greater degree of rigour in the conduct of assessments. AgeWorks Australia, an aged care consulting company, responded to Counsel Assisting's final submissions that it strongly supports this recommendation, explaining that there is an opportunity for services to get more useful feedback on where they can improve.[92]

In March 2020, we asked the Aged Care Quality and Safety Commission to explain whether there are any plans to move to accreditation and audit reports with graduated scores against outcomes. The Commission responded that it has 'considered the merits of introducing graduated ratings for each assessed requirement and has considered stakeholder comments through the consultation process'. It also noted that after implementing the service compliance ratings in July 2020, it 'will consider enhancements over time that can be reliably…made'.[93] In response to Counsel Assisting's final submissions, the Australian Government noted that it supports this recommendation in principle, but that the proposed timetable of implementation by 1 July 2021 is 'not feasible'.[94]

In Chapter 3, we recommend that a star ratings system be introduced for aged care services by 1 July 2022. Graded assessments against the standards should be a central part of this new scheme, and for this reason should be in place by no later than 1 July 2022.

Recommendation 95: Graded assessments and performance ratings

From 1 July 2022, the Quality Regulator should adopt a graded assessment of service performance against the Aged Care Quality Standards.

14.3.3 Coronial reports

Certain deaths are required to be reported to the Coroner in each State and Territory, some of which are investigated.[95] It is common for coroners to investigate deaths that have occurred in residential aged care facilities. The broad purpose of coronial investigations is to contribute to a reduction of the number of preventable deaths through the findings of an investigation and the making of recommendations.[96]

Reports by State and Territory coroners can be a source of significant information concerning systemic issues in aged care. A number of coronial reports which have highlighted systemic issues in aged care have been the subject of evidence before us.[97]

Inquest into the death of John Frederick Reimers

In 2019, the Victorian State Coroner conducted an inquest into the death of a man in a residential aged care facility in Victoria. Coroner Audrey Jamieson found that Mr John Reimers died after he fell from his wheelchair and his head became trapped in the bottom drawer of his bedside drawers. He was unable to remove himself from the drawer and remained entrapped in that position until paramedics from Ambulance Victoria arrived at the facility and discovered him to be pulseless and not breathing. On the night of Mr Reimers' death, there were only two staff members, an enrolled nurse and a personal care worker, on duty to care for 34 residents.

Coroner Jamieson found that Mr Reimers's death was preventable. She concluded that the circumstances of this death 'have highlighted a concerning norm in aged care: staffing to patient ratios administered at minimalistic levels which places the delivery of appropriate care at risk', and that 'regulation has not followed minimum standards of training and…measurement of competency levels lack benchmarks and are at the behest of facility owners'.[98]

A study into deaths of nursing home residents resulting from external causes between 1 July 2000 and 31 December 2013 found that 21,738 deaths were reported to a Coroner, and that in 53 cases the Coroner made one or more recommendations.[99] Professor Joseph Ibrahim, Head of the Health Law and Ageing Research Unit at Monash University, who has studied coronial findings in relation to aged care, gave evidence that 'studies have concluded that coroners' recommendations have the potential to reduce the incidence of fatal injury'.[100]

Yet despite their potential significance, there is no system for the implementation of recommendations and findings of coronial determinations relevant to the quality and safety of aged care.[101] The significance of this was revealed during our COVID-19 hearing, where we learned that a 2012 coronial report had recommended that all aged care facilities should be required to have a designated Infection Control Manager.[102] This had not been implemented and we replicated the recommendation in our report into the impact of COVID-19 on the aged care sector.[103] An officer of the Australian Department of Health gave evidence in August 2019 that 'a formalised protocol to consider and review Coroner reports is currently being developed by the Department'.[104]

Professor Ibrahim told us that in his view:

> A centralised system that is available to RACS [residential aged care service] providers, that provides the recommendations, along with the responses to what changes have or have not been made along with a one to five year follow-up about whether the recommendation had the intended impact would be invaluable.[105]

Some jurisdictions, such as Victoria, require public bodies to respond to coronial recommendations directed to them in writing by specifying a 'statement of action (if any) that has or will be taken in relation to the recommendations'.[106]

We consider that a similar requirement should be imposed upon the System Governor with respect to reports or recommendations about the death of a person in connection with the receipt of aged care services. We expect that in fulfilling this function, the System Governor would require advice from the Quality Regulator on any regulatory issues that may arise. This should not be limited to deaths in residential aged care facilities. The tragic death of Anne-Marie Smith, a National Disability Insurance Scheme participant who received care in her home where she lived alone, reveals the risks associated with care of vulnerable people in their own homes.[107]

In its response to Counsel Assisting's final submissions, the Australian Government supported this recommendation in principle, subject to conventional safeguards. For example, publication in some instances may need be delayed until it can be done without compromising other investigations or proceedings. The Australian Government also raised a concern that the 'proposed three month period to respond to reports, may not be practicable if a meaningful response is to be achieved in all cases'.[108]

We consider that three months is sufficient time to formulate a plan for responding to a report or recommendation, and in some cases to implement that plan. It is consistent with the timeframes imposed in Victoria.[109] However, we acknowledge that in some cases, it may take longer to respond meaningfully to a coronial report. For this reason, we recommend that the System Governor should report annually to the Inspector-General of Aged Care on action taken in response to coronial reports and an assessment of the impact of that action. This will allow the Inspector-General to oversee reforms that may need to be implemented over a longer period of time. It should also inform the Inspector-General's systemic review function.

Recommendation 96: Responding to Coroner's reports

The new Act should provide that the System Governor is required to:

a. **maintain a publicly available register of reports sent to the relevant body by a State or Territory Coroner that concern the death of a person in connection with the receipt of aged care services**

b. **where a Coroner has made a recommendation to the relevant body in the report, within three months of receiving the report, publish a response to the recommendation stating what action it has taken, or intends to take, in relation to the recommendation**

c. **in any other case, publish a response to the report on the register within three months of its receipt**

d. **provide annual reports to the Inspector-General of Aged Care detailing any action taken in response to Coroner's reports, and an assessment of the impact of such action.**

14.3.4 Conducting inquiries

As we noted above, the aged care regulator must be informed about instances of substandard care. To ensure this, the Quality Regulator should be empowered to commence an inquiry of its own initiative about a serious issue affecting the safety, health and wellbeing of people receiving aged care and it should be encouraged to exercise that power as required. This should include serious incidents and potential non-compliance by providers.

At the time of Sydney Hearing 2 in August 2020, which examined the response to COVID-19 in aged care, the Aged Care Quality and Safety Commission had not undertaken any investigation into the circumstances of outbreaks of COVID-19 at Dorothy Henderson Lodge or Newmarch House, residential aged care facilities in New South Wales where a total of 23 residents had died of COVID-19. Nor had it signalled an intention to do so. The Quality Regulator should be empowered and encouraged to investigate matters such as this. Incident investigations are an important function for regulators to ensure they are equipped with the requisite knowledge of the sector to identify and respond to problem areas.

Guidance about the appropriate powers of investigation can be drawn from the powers of inquiry given to the National Disability Insurance Scheme Quality and Safeguards Commissioner. That Commissioner is specifically empowered to authorise an inquiry:

- about an issue connected with a complaint, or a series of complaints, relating to the provision of support or services by a National Disability Insurance Scheme provider
- in relation to a reportable incident, or series of reportable incidents, in connection with the provision of supports or services by a National Disability Insurance Scheme provider.[110]

Such inquiries can be carried out whether or not a complaint or notification of a reportable incident has been made to the Commissioner. The Commissioner may prepare and publish a report setting out its findings in relation to the inquiry.[111] We would expect that the Quality Regulator would publish most reports and would report at least annually on the inquiries it has undertaken and their outcomes.

14.3.5 Greater powers to enter and search premises, and obtain documents and evidence

The powers of the regulator to enter the premises of an approved provider and obtain information, documents and evidence for the purposes of its functions should be strengthened. The powers of the Aged Care Quality and Safety Commission are limited in several ways, which may affect its ability to uncover and thoroughly investigate quality and safety issues in aged care. In summary, those limitations are as follows:

- Authorised officers of the Commission can only enter a premises and exercise monitoring powers relevant to a provider's responsibilities if the occupier of the premises has consented to the entry, or the entry is made under a monitoring warrant.[112]

- In relation to an application for approval as a provider of aged care, complaints, accreditation and quality reviews, authorised officers can only enter a provider's premises with the consent of the provider. Consent can be refused or withdrawn without the need to give reasons.[113]
- Where an authorised officer of the Aged Care Quality and Safety Commission enters premises under a monitoring warrant, they have a power to compel a person on the premises to answer questions or produce documents. A failure to comply is an offence.[114] However, where an authorised officer enters a premises with consent, a person is not required to comply with such a request.[115] A person asked a question may refuse to answer it and they are not required to have a reason for doing so. Similarly, a person asked to produce a document or record may refuse to do so and does not require a reason.[116]

Unannounced visits are an essential tool in assessing the 'real picture of care'.[117] While the Aged Care Quality and Safety Commission has the ability to conduct unannounced visits, it does not have the power to enter premises for this purpose without the consent of an approved provider.[118]

Approved providers have a general responsibility to cooperate with any person who is performing functions or exercising monitoring, entry and search powers relating to provider approval applications, complaints, or other specified regulatory purposes.[119] A failure to comply with this responsibility could result in the imposition of a sanction.[120] However, in a submission from the Commonwealth Public Sector Union, the members of which include staff employed by the Aged Care Quality and Safety Commission, the Union suggested this requirement is insufficient:

> ACQSC [Aged Care Quality and Safety Commission] staff are frustrated that their agency does not use all the powers it has. For example, what information and how information is gathered as part of the regulatory process. Assessors tell us they are consistently restricted in the use of taking photographic imagery as part of the gathering information role. That ACQSC still relies on 'note taking' when compiling information from sources such as care plans, progress notes and reports. Approved providers are still able to restrict or monitor access of assessors to documentation. Assessors should be able to access all information/documentation relevant to their regulatory function where legitimate and there should be serious consequences to approved providers who impede this process.[121]

The approach to entry and search powers under the Aged Care Quality and Safety Commission Act is broadly consistent with the *Regulatory Powers (Standard Provisions) Act 2014* (Cth). However, it may be contrasted with that of workplace inspectors under the *Work Health and Safety Act 2011* (Cth). Under that Act, a workplace safety inspector may 'at any time enter a place that is, or that the inspector reasonably suspects is, a workplace'. The consent of the person in management or control of the place is unnecessary.[122] Similarly, a person authorised by the Commissioner of Taxation may at all reasonable times enter and remain on any land, premises or place without the consent of the occupier.[123] However, the person is not entitled to enter or remain on any land, premises or place if, after having been requested by the occupier to produce proof of their authority, the individual does not produce a relevant authority signed by the Commissioner.[124]

We consider that the aged care Quality Regulator should have entry and search powers that go beyond the Regulatory Powers (Standard Provisions) Act. Many, if not most, approved providers care for people who are very vulnerable, including due to frailty, dementia and cognitive impairment. The providers receive significant funding from the Australian Government to do so. We consider that regulatory officials should, when performing a function under the Act, have the power to enter and remain on any premises of an approved provider at all reasonable times without a warrant or consent, provided they hold and produce a written authority from the Quality Regulator. Regulatory officers should have the power to enter premises at other times if the Quality Regulator reasonably believes that there is an immediate and severe risk to the safety, health and wellbeing of people receiving aged care. We do not intend that these powers would extend to a right of entry to a private residence in which home care services are provided.

When on the premises of an approved provider, authorised officers should have full and free access to documents, goods or other property of an approved provider, and powers to inspect, examine, make copies of or take extracts from any documents. A failure to provide all reasonable facilities and assistance for the Quality Regulator to exercise its powers under the Act should be an offence provided the officer concerned is authorised in writing.[125]

Ms Anderson, the Aged Care Quality and Safety Commissioner, gave evidence that enhanced information gathering powers would, if used judiciously, 'serve a useful purpose'.[126] We note that these are strong powers that require appropriate oversight.[127] They should be reviewable by the Federal Court. Use and disclosure of documents obtained should also be subject to the usual safeguards, including legal professional privilege. These powers should only need to be used where a provider refuses to adopt a cooperative approach.

Recommendation 97: Strengthened monitoring powers for the Quality Regulator

From 31 December 2021, the *Aged Care Quality and Safety Commission Act 2018* (Cth) should be amended to confer on the Aged Care Quality and Safety Commissioner (and from the commencement of a successor body, that body) the following additional statutory functions and powers, to be exercised in connection with, or for the purposes of, its functions conferred by that Act:

a. **the function of conducting inquiries into issues connected with the quality and safety of aged care, including matters raised in complaints or reported serious incidents**

b. **a power to authorise in writing an officer to enter and remain on any premises of an approved provider at all reasonable times without warrant or consent, and a power to enter premises at other times if the regulator reasonably believes that there is an immediate and severe risk to the safety, health and wellbeing of people receiving aged care**

c. full and free access to documents, goods or other property of an approved provider, and powers to inspect, examine, make copies of or take extracts from any documents.

14.4 Complaints handling

The importance of a transparent and effective complaint handling process cannot be overstated. A complaint can be a window into the quality and safety of care. A complaint provides an opportunity to improve the care of an individual, address systemic issues with the provision of care, and remedy the consequences of poor care. The complaints system should be capable of providing answers and redress when there have been failures in the quality and safety of care provided.

Evidence before us indicates that there is considerable scope to improve the response to aged care complaints. Witnesses who had complained about poor care also complained about a lack of transparency around the complaints process.[128] For example, Ms Debra Barnes, who advocated for her mother, who was in residential aged care, said that she felt like the Aged Care Quality and Safety Commission 'had simply been through the steps of a process, rather than critically assessing the outcome to see if it was reasonable and fair'.[129] Ms Gwenda Darling, who receives home care services, said this about her experience with the former Aged Care Complaints Commissioner:

> I didn't feel like there was any compassion for me and my experience. It felt like the woman I spoke to had a script to read and there was no personalisation…I felt like it was useless to keep trying to complain so didn't pursue it…I feel like no one cares.[130]

Many people spoke at community forums of being given the run around when they tried to get a satisfactory response to their concerns.

We know that many older people are very reluctant to complain about the people who provide their care and the system under which they receive care.[131] Research commissioned by us from the National Ageing Research Institute, based on a survey of 391 aged care residents or their representatives, suggests that overall awareness of the complaints process is low: less than 40% of concerns are raised as formal or official complaints to approved providers. Complaints to the regulator are even rarer.[132] The rarity of complaints to the regulator cannot be taken as a good sign: the research also indicated that about two-thirds of 'official' complaints to providers were not resolved to the satisfaction of the complainant.[133]

A complaints scheme that is ineffective or that does not engender trust will diminish the supply of information about the quality and safety of care. It is a lost opportunity to improve the system by addressing issues at their inception, before they have become major problems. In Chapter 13 of this volume, on provider governance, we recommend that approved providers have systems in place to receive and deal with complaints. However, we know that there will be times when complaints are not adequately addressed by an approved provider, or where an older person and their family will not feel comfortable raising a complaint with an approved provider.

In those circumstances, a robust external complaints handling process is important. We make recommendations about external complaints handling that are directed to ensuring complaints are dealt with in a timely and effective way in the new aged care system and given the priority they deserve.

14.4.1 Commissioner responsible for complaints

Effective complaints management requires a dedicated focus on resolving and investigating complaints. A degree of separation and independence from other functions that regulate the quality and safety of services is desirable.[134] Compliance monitoring is ultimately focused on whether approved providers are meeting the Aged Care Quality Standards and other provider responsibilities. Complaint handling should have a different focus—that of the person receiving aged care and any person making a complaint on their behalf. Professor Paterson said:

> Consumers and their families must be confident that there is a strong, independent complaints handling function...The Complaints Commissioner must be highly visible in the aged care sector and more broadly in the community; it must be, and be seen to be, rigorously independent from regulatory functions; its complaint handling must be skilled, timely and effective; and the lessons and trends from complaints must be well publicised (promptly and in user friendly formats) for consumers, providers and the community.[135]

We agree with Professor Paterson's observations. We consider that the role of Complaints Commissioner should be re-established within the Quality Regulator. This should be a statutory appointment. As set out in the following section, we recommend an increase in the scope of complaints that can be dealt with beyond complaints about providers to include complaints about assessors, care finders and inspectors.

Given the need to preserve the independence of the complaints function, the Complaints Commissioner should not be responsible for other regulatory functions that may undermine an objective and impartial assessment of complaints.

At the same time, regulatory intelligence obtained through the complaints process must feed into broader compliance and monitoring work in a timely and effective manner. As the Earle Haven Case Study illustrated, complaints are a most valuable source of information about poor care.[136] Information from complaints needs to be shared in a timely fashion with compliance staff, and should inform assessments about risks to older people and performance of providers. However, the handling of complaints should remain operationally separate from other functions of the Quality Regulator.

Earle Haven Case Study—the importance of integrating complaints information

The Earle Haven Case Study illustrated the dangers of a disconnect between complaint handling and other regulatory functions.

On 4 April 2019, a complaints officer from the Aged Care Quality and Safety Commission visited Earle Haven to investigate complaints about services. He was advised that People Care was the approved provider, that HelpStreet managed the facilities, and that HelpStreet would not be continuing contracts for domestic services with People Care.[137] On 5 April 2019, a further complaint was made about HelpStreet management and an alleged assault by a staff member. This was handled by the same complaints officer.[138] On 24 April 2019, the complaints officer advised the complainant that HelpStreet's business relationship with People Care was not a matter he was able to take into account.[139]

On 30 May 2019, the complaints officer attended Earle Haven to provide an education session on complaints resolution. During this visit, the complaints officer was informed that HelpStreet was not passing on complaints to People Care, and that the executive director at Earle Haven, who was employed by HelpStreet, did not have direct contact with the director of People Care.[140]

There is no evidence that this important information raised a red flag or was acted upon, and it appears that the information was not provided by the complaints area of the Aged Care Quality and Safety Commission to its quality and monitoring area.[141]

The relationship between the two companies broke down irretrievably on around 11 July 2019, with serious and in some cases tragic consequences for the residents.[142]

Recommendation 98 is similar to one made by the Carnell-Paterson review in 2017 that an Aged Care Complaints Commissioner become a statutory role within the proposed Aged Care Commission.[143] This recommendation was not implemented. Instead, the Aged Care Quality and Safety Commissioner has responsibility for complaints, along with other regulatory functions.[144] At the Brisbane Hearing, Professor Paterson elaborated on the rationale behind this recommendation. He said of dealing with complaints:

> We needed to know that the commissioner is free to get on and do that independently and not constrained by…other organisational objectives.[145]

The Complaints Commissioner should have processes and arrangements in place to ensure that they can make timely and appropriate referrals within the Quality Regulator, and to other government agencies.

Where a complaint has been referred to another complaint handling or disciplinary body, there should be mechanisms in place to ensure the Complaints Commissioner is informed of the outcome of that referral. New Zealand's *Health and Disability Commissioner Act 1994* is a useful model. It provides that where the Commissioner refers a complaint to another agency or person, that agency or person must promptly acknowledge the complaint, and advise the Commissioner of any significant step taken in considering the complaint and of the outcome of that consideration.[146] Such a mechanism would enable the Complaints Commissioner to ascertain any deficiencies with referral pathways, and it may also reveal other information relevant to the Quality Regulator's monitoring functions.

The Complaints Commissioner should also have the function of promoting 'open disclosure' and better complaint handling practices by providers. 'Open disclosure' requires discussion by an aged care provider with a person receiving aged care and other people involved in their care when something goes wrong. It involves telling an older person, or their representative, what has happened, listening to their experience, apologising where appropriate, and explaining the steps the provider has taken to prevent the problem happening again.[147] The Aged Care Quality Standards require providers to demonstrate that an open disclosure process is used when things go wrong.[148] Open disclosure can prevent complaints from escalating.[149] The principles of open disclosure also provide a guide to responding to complaints.[150]

It is Commissioner Briggs's view that it is clear from the evidence that she heard in many hearings and the stories she heard at community forums in 2019, and from public submissions, that some providers only pay lip service to these principles. Surveys conducted for us by the National Ageing Research Institute confirm the evidence that we have heard about the failings of complaints processes within providers. Only 52.6% of the main concerns experienced by older people in residential aged care facilities were shared with anyone. The main reasons why concerns were not shared were that residents felt they were 'too minor' or residents felt that 'nothing would change' if they were reported. Some of the concerns assessed by residents as being 'too minor' are things others would consider to be clear examples of substandard care, such as being hurt, treated roughly or shouted at by staff. Of the main concerns that residents did discuss with others, 74.7% were officially reported by the resident to staff, management or head office. When an official complaint was made, 66.3% were not resolved to the satisfaction of the resident. The most cited reason was that 'nothing had changed' since the complaint (56.2%).[151]

The situation in home care is of equal or even greater concern to Commissioner Briggs. In the Home Care Packages Program, less than 70% of the main concerns of older people were shared with anyone, and this was even lower in Commonwealth Home Support Programme and residential respite. The main reasons Home Care Package clients did not report concerns were that they 'did not think anything would change' (17%), that the concern was 'too minor' (14%), or that they 'didn't want to be a nuisance or make a fuss' (14%). The most common reasons for not reporting concerns among Commonwealth Home Support Programme respite and residential respite clients were that the client was 'only there for a short time, not worth complaining', the client had 'no capacity to complain', or they 'didn't want to be a nuisance or make a fuss'. In addition, a sizeable proportion of clients indicated that they did not know how to lodge a complaint at all.[152]

Clearly, the system for handling complaints by aged care providers is not working. Many do not know how to lodge a complaint, do not feel confident making a complaint and do not have confidence their complaint will be acted upon. Most official complaints are being left unresolved and are not being reported to official complaints bodies such as the Aged Care Quality and Safety Commission.

However, that is not the view of Commissioner Pagone from the evidence that he has seen. He considers that those providers who could be said to be paying only lip service to these principles are few and the exception, and most seek to discharge their duties diligently. It is true that the survey conducted by the National Ageing Research Institute supports much of the evidence that we have heard but it needs carefully to be evaluated before being fully endorsed. There may well be many concerns that could rightly be described 'too minor' and numerical conclusions drawn from surveys run the risk of treating numbers as the individual people they are intended to represent. What is important is that there was too much complaint rather than whether we describe some providers as paying only lip service. By and large, this does not afford with Commissioner Pagone's evaluation of the commitment which most providers had to these principles.

We consider that there is a need to monitor and promote open disclosure and good complaint handling by providers. Poor complaint handling and a lack of open disclosure can be a reflection of the poor culture of an approved provider, or a particular service.[153] Ms Bethia Wilson AM, former Victorian Health Complaints Commissioner, observed, following meetings with residents, families and carers at Bupa South Hobart, that:

> Contributing factors to the culture appeared to be a lack of understanding of accountability and its benefits. For example the culture is reflected in staff not knowing how to respond positively when people complain. Instead a climate of fear, retribution and obstruction was created leading to family members saying they had to be fierce advocates for their loved ones. Participants said that rather than complaints being welcomed as an opportunity for quality improvements, complaints were not welcome and there was consequently a code of silence.[154]

Open disclosure has been in place in the health system in Australia for over 10 years. Professor Debora Picone AO, Chief Executive Officer at the Australian Commission on Safety and Quality in Health Care, explained that open disclosure requires 'a major change in culture' and that when open disclosure standards were introduced, it was initially quite difficult to entrench this in health organisations.[155]

14.4.2 The role of the Inspector-General

No complaint scheme will get it right all the time. The Inspector-General of Aged Care that we recommend be established, will play an important role in overseeing the Quality Regulator's performance of its complaint functions (see Chapter 2). The Inspector-General's systemic review function should be informed by complaints, as they provide a practical sense of issues facing people receiving aged care and their families.[156]

It is crucial that all complaints are directed to one place. Older people and their families should not have to work out which of the many entities involved in their care can deal with their complaint. There should be a one-stop shop for complaints. Aged care complaints should be made to the Complaints Commissioner in the first instance. A complaint should generally be dealt with by the Complaints Commissioner, unless the Commissioner considers that it would be more appropriately dealt with by the Inspector-General. This will ordinarily include where the complaint is about the performance of the Quality Regulator itself or about any other government body. The Complaints Commissioner and the Inspector-General should consider entering into a memorandum of understanding about complaint handling, including information sharing and reporting arrangements specifying the Inspector-General's access to information on the number and nature of complaints and identification of the sort of complaints that should be referred to the Inspector-General.

The Inspector-General should also be responsible for reviewing a complaint that has been dealt with by the Complaints Commissioner, upon application by a complainant or a respondent. When a complaint is closed, the complainant and respondent should be notified that, if they are not satisfied with the handling or outcome of the complaint, it can be referred to the Inspector-General of Aged Care. On review, the Inspector-General should have the power to affirm the original decision, or to set the decision aside and investigate or attempt to resolve the complaint. A complainant and a respondent should be able to make an application to the Administrative Appeals Tribunal for review of a decision by the Inspector-General to close a complaint dealt with at first instance, or upon review.[157]

The Inspector-General should have the same powers as the Complaints Commissioner to investigate and resolve a complaint, including through making directions to providers to remedy an issue and applying enforceable undertakings.

14.4.3 Expanded scope of complaints

There should be a single authority that can receive complaints from all people interacting with the aged care system, including older people, their family and friends, and workers. It must be as easy as possible for people to make a complaint about aged care, and there must be no risk of complaints falling through the cracks.

Currently, the Aged Care Quality and Safety Commissioner has the power to deal with complaints made, or information given, about an approved provider's responsibilities under the *Aged Care Act 1997* (Cth) or the Aged Care Principles and the responsibilities of a service provider of a Australian Government-funded aged care service under the funding agreement that relates to the service.[158] It does not have powers to deal with complaints about other aspects of the aged care system, such as My Aged Care, a Regional Assessment Service, or the Aged Care Assessment Team.[159] Nor does it appear to have the power to deal with complaints about aged care workers, as the following case study demonstrates.

Sarah Holland-Batt

Ms Sarah Holland-Batt's father was diagnosed with Parkinson's Disease in 2000, and he moved in to residential aged care in 2015.

Ms Holland-Batt gave evidence that in March 2017, a registered nurse at the facility told her mother that Ms Holland-Batt's father was experiencing abuse at the hands of a carer. The registered nurse said the carer 'had deliberately and repeatedly abused' her father on the night shift 'when she was left to deliver his care mostly alone as part of a skeleton staff'. The registered nurse described, as Ms Holland-Batt put it, 'a string of disturbing events she had witnessed in relation to the carer's treatment of Dad'. This included deliberately leaving him wide awake and lying in soiled incontinence pads overnight, and taunting him, laughing at him while saying 'your fresh nappies are out in the hallway—you can get them yourself', despite knowing he was unable to do so. Ms Holland-Batt gave evidence that her father was not able to report the abuse he endured and said 'I am haunted by what else the carer may have done to my father when there were no witnesses present.'

Ms Holland-Batt complained to the former Aged Care Complaints Commissioner about the allegations. She said the complaints officer explained to her that the Commissioner did not have the power to pursue an individual. Instead, the inquiries by the Commissioner 'would be to focus on ensuring that the facility adheres to its obligations, in terms of the standard of care provided to residents'. Ms Holland-Batt said she felt dismayed by this, and said 'How could this body be responsible for complaints about the aged care industry, but have no power to protect the vulnerable people receiving care in that setting?'[160]

We have heard evidence that not all State and Territory agencies responsible for handling complaints about health services have jurisdiction to consider allegations about a personal care worker in aged care, such as those in Ms Holland-Batt's case. In Victoria, for example, there is a gap in the regulation of unregistered aged care workers, and the Aged Care Quality and Safety Commissioner would need to rely on the service provider taking action against their employee.[161] This is unacceptable.

The Complaints Commissioner should be able to deal with a broad range of complaints about aged care, including complaints about approved providers and their staff, and other people working in the aged care system, such as assessors, care finders, and inspectors. Complaints that involve allegations about the professional conduct of a health practitioner should be referred to the relevant professional body. In such cases, the Commissioner should be able to deal with other aspects of the complaint that relate to the conduct of the provider in a way that does not jeopardise any disciplinary investigations.

Having a single authority with the ability to receive a wide range of complaints should make it easier for people receiving aged care and their families and friends. It should also enable the Complaints Commissioner and the Inspector-General to take a holistic view of the aged care system and identify systemic issues for consideration. Such consideration may inform the development of future Quality Standards or future training requirements for care workers.

14.4.4 Better outcomes for complainants

The evidence before us suggests that there is scope for the aged care complaints scheme to meet the expectations of complainants more effectively. At present, the grounds on which the Aged Care Quality and Safety Commissioner can decide to end a resolution process and close a complaint are focused on the provider.[162] While the Commissioner has the power to give directions to a provider during a resolution process, this power is limited to directing a provider to meet its responsibilities.[163] The rules governing the handling of complaints by the Commissioner provide limited guidance on the potential outcomes for complainants.

A 2009 review of the aged care complaints scheme made the following observations, which continue to be relevant today:

> Complainants want explanations, accountability and redress for a particular incident which impacts on them or their relative. Many will also be seeking assurance that the incidence will not be repeated. The current CIS [Complaints Investigation Scheme] focus on its regulatory functions—has there or has there not been a breach of the legislation and whether that breach has been rectified—does not offer complainants accountability for past incidents.[164]

Ms Barnes, who made a complaint about the care her mother received, observed:

> I do not understand how the complaint could have been resolved without there being an acknowledgment of what actually happened to Mum and who was accountable for it.[165]

In a public submission, Mr Rodney Lewis described the aged care complaints system as one that 'has revolved around an alternative dispute resolution system which is utterly devoid of remedies available to the resident as an individual or accessible through their family or delegate'.[166]

Lisa Backhouse

Ms Lisa Backhouse gave evidence that she made a complaint to the Aged Care Quality and Safety Commissioner about the care her mother received in a residential aged care facility. Her complaint was about incontinence care, fall management, pain management, and nutrition and hydration. After an investigation lasting six months, the Commissioner identified failings in all four areas of her complaint.

Ms Backhouse explained that:

> The Commission's response to the complaints outline a raft of remedies such as the provision of further training and check sheets for staff to follow. I have no doubt that remedies such as those offered by the provider and accepted by the Commission, will quickly disappear in the task focussed flurry of an overstretched sector where the chasing of profits consistently overrides care needs. It is beyond belief that further training should need to be provided to Registered Nurses on basic issues such as appropriate medication for severe pain. The failure of qualified staff to provide adequate care is a serious concern and should at the very least be referred to the Australian Health Practitioners Regulation Agency.

Ms Backhouse said that, despite her mother suffering 'pain, indignity, loss of mobility and probably a significant reduction in life span as a result of this incident', there were no direct consequences for the approved provider. She described the Commissioner's emphasis on working with facilities to improve standards as 'a total and absolute failure'. She also gave evidence that legal redress is severely limited, which restricts the ability of residents and families to hold providers to account for negligence and non-compliance issues which cause harm and suffering. According to Ms Backhouse, 'Society's ability to lift overall standards in the sector is currently severely compromised.'[167]

The Complaints Commissioner should be able to respond to complaints in ways that are meaningful to people receiving care and those complaining on their behalf. This should include an ability to direct providers and others to take specified action to remedy an issue that is the subject of a complaint. Such a power will direct the focus of the Complaints Commissioner to the person receiving care, and not only to the respondent's compliance with its legal responsibilities. Appropriate responses by the Quality Regulator could include issuing directives to:

- provide an apology
- provide an explanation for an incident to the complainant
- explain to the complainant the steps the respondent has taken or will take to ensure an incident does not occur again
- require a respondent to take specified remedial action in relation to an incident within a specified period.

The Complaints Commissioner and, where appropriate, the Inspector-General should be required to advise a complainant of the proposed outcome of a complaint and seek their views, before deciding to close that complaint. Mr Geoffrey Rowe, Chief Executive Officer of Aged and Disability Advocacy Australia, told us that he believes there is a 'cultural imperative' at the Aged Care Quality and Safety Commission to close a complaint as quickly as possible.[168] He also gave the following evidence:

> A number of cases that have gone through to ACQSC [Aged Care Quality and Safety Commission] have been closed after receiving a response from the provider with no further consultation with the client. We have had some cases then go to a formal review process where the decision made by the ACQSC has been overturned resulting in positive outcomes for the recipient.[169]
>
> …
>
> In addition, the way the matter is closed is via an email or letter sent to the client explaining what the findings are and so now they will 'close the matter', or in some cases the wording is 'are you then happy for us to then close the matter', without any further consultation or feedback from the client.[170]

Mr Rowe also said that:

> When advocates make the recipient aware of the option to seek a review of the ACQSC's [Aged Care Quality and Safety Commission] finding [in relation to a complaint], recipients are often emotionally drained, fed up and see no value in pursuing the matter any further and thus opt to not use the review mechanism.[171]

We have also heard evidence that the resolution of aged care complaints does not always translate to actual change.[172] Ms Holland-Batt said that she felt the complaints officer 'was driving for a swift resolution of the complaint' and she was not comfortable that there had been a proper resolution of the issue, nor that it could not happen again.[173] Mr Rowe stated that 'feedback to advocates is that despite agreements offered by the provider, the matters subject to complaint are rarely acted upon'.[174]

The Complaints Commissioner should follow up a proportion of complaints that have been closed to assess whether changes have been made, and, if so, whether those changes have addressed the underlying problem or problems. The Complaints Commissioner should also have powers to seek enforceable undertakings. An enforceable undertaking is a legally binding written promise between a regulator and entity or person, the substance of which can go beyond simply requiring compliance with regulations. Circumstances where an enforceable undertaking may be appropriate include where a complainant and a provider have reached an agreement on the basis that the provider will take particular action. Failure to fulfil the obligations in such an undertaking should expose the provider to other sanctions.

14.4.5 Transparency of complaint information

The Aged Care Quality and Safety Commission publishes, in addition to its annual report, a quarterly report on sector performance. The quarterly report contains information on the number of complaints received, the nature of complaints in residential and home care, and the number of notices and directions issued as a result of complaints. While this transparency is commendable, we consider that it could be enhanced by the publication of additional information about complaints, including information about the outcomes of complaints.

There is very little information available publicly about the outcomes of complaints dealt with by the Aged Care Quality and Safety Commissioner. From the 2019–20 annual report, we know that of 8539 complaints received in 2019-20, the majority were finalised by way of early resolution, and 95% were resolved within 90 days.[175] The Commissioner resolved 325 complaints by way of investigation, provider resolution and conciliation.[176] There is limited published information beyond this.

The Aged Care Quality and Safety Commission does not publish information about the number or nature of complaints made about individual providers or services. The Quality Regulator should be required to publish this information so that it is accessible as part of the star ratings system that we have recommended be established in Chapter 3.

Publishing more information about complaint outcomes will provide greater transparency about the extent to which the complaints system is achieving satisfactory outcomes for complainants. A good example is provided by the Western Australian Health and Disability Services Complaints Office, which reports annually on redress outcomes arising from complaints and service improvements implemented as a result of a complaint.[177]

As part of its oversight of the complaints scheme, the Inspector-General should be required to publish a report every six months about the complaints scheme, and the nature and number of complaints. There should be information sharing and reporting arrangements in place between the Complaints Commissioner and the Inspector-General to enable the Inspector-General to provide a holistic picture of aged care complaints.

14.4.6 Timeframe for responding to complaints | Commissioner Briggs

The *2019–20 Annual Report of the Aged Care Quality and Safety Commission* states that the Commission aims to resolve 80% of complaints within 60 days.[178] The Commission met this objective for 75% of complaints in 2019–20.[179] However, this means that fully a quarter of the complaints were not resolved within the targeted timeframe and that some older people may have had to wait for a much longer period before their complaints were addressed.

Aged care services are essential to the lives of older people and their families. Where they have complaints about the quality or safety of those services, it is crucial that their concerns are addressed thoroughly and in a timely manner. Older people who express concerns about their care do not have the time or luxury to wait for a long drawn-out complaints process to work its way through the bureaucracy. Their concerns need to be taken seriously and responded to with some urgency.

Commissioner Briggs considers that the Quality Regulator should aim to resolve complaints within 60 days and should report on performance against this standard. This target should be achievable and is broadly consistent with the position of other regulators. The Australian Securities and Investment Commission, for example, aims to respond to complaints within 28 days of receiving all relevant information.[180]

14.4.7 Role of advocates in complaints handling

In our view, effective advocacy services are a critical part of a robust aged care complaints system.[181] The role of formal advocacy services, including in the complaints process, should be clearly articulated in aged care legislation. This is set out in recommendation 98, and discussed in detail in the section on advocacy below.

Recommendation 98: Improved complaints management

1. Complaints about aged care should be managed by a Complaints Commissioner in the Quality Regulator, who should
    a. be designated to exercise and perform the functions of:
        i. handling complaints about an issue arising in connection with the provision of aged care services
        ii. complaints referral and coordination
        iii. promoting open disclosure and better practice in complaint handling
        iv. consideration and determination of requests to maintain confidentiality of the identity of complainants
    b. in relation to these functions, have powers to:
        i. accept enforceable undertakings, under which the respondent agrees to take certain steps or actions
        ii. issue directions to respondents to remedy an issue
        iii. refer complaints to a more appropriate complaints body or regulator, and to obtain information on the action taken, if any, by that complaints body or regulator

c. before deciding to close a complaint after undertaking a resolution process, have a duty to advise a complainant of the proposed outcome of the complaint, and seek their views on:

   i. the way the process has been handled by the Commission

   ii. the respondent's response to the process

   iii. the proposed outcome of the process.

2. The new Act should provide that complaints may be made to the Quality Regulator. If a complainant or a respondent is not satisfied with the Complaints Commissioner's handing of a complaint or the outcome, the complainant or respondent may refer the matter to the Inspector-General. The Commissioner should refer to the Inspector-General any complaints about the Quality Regulator, its performance of its functions and exercise of its powers.

3. The Inspector-General should have the same powers and be subject to the same requirements as the Complaints Commissioner in relation to complaint handling.

4. The Complaints Commissioner should have a duty to publish a report at least every six months on:

   a. the number of complaints received and dealt with by the Quality Regulator and the Inspector-General at first instance and on review

   b. the subject matter of complaints by general topic

   c. the number of complaints by provider and service

   d. the average time for conclusion of complaints, against the standard of a substantive response within 60 days

   e. the outcomes of complaints

   f. satisfaction with the outcomes of the complaint handling process

   g. requests for review.

5. The new Act should set out the role of advocacy services in the complaint handling processes of approved providers, the Quality Regulator and the Inspector-General.

14.4.8 Protection for whistleblowers

Fear of reprisal is not limited to people receiving aged care services. We have heard that aged care workers may also be reluctant to raise concerns due to a fear of retribution. Ms Holland-Batt became aware of allegations that a carer was abusing her father, a resident in an aged care facility, after a registered nurse spoke to her mother. According to Ms Holland-Batt:

> Because I had formed a view that the ACCC [Aged Care Complaints Commissioner] was powerless to influence the facility to dismiss the abusive carer, Mum and I went to the whistle blower and begged her to come forward. She was extremely worried about doing this. I was told by the whistle-blower that the Facility Manager had been holding staff meetings during which he told staff that whoever had witnessed the abuse was legally obliged to come forward and speak to him, that they were not supposed to speak to families. She was afraid, but eventually Mum and I convinced her to help us.[182]

A nurse who has worked in aged care told us in a public submission that she 'learned over the years not to say anything for fear of repercussions from management'.[183] In another public submission, a former Director of Nursing at a residential aged care facility wrote:

> Many workers I came across…were too scared to make complaints / raise concerns due to fear of retribution, or many just gave up and learnt helplessness as they had previously reported their concerns and nothing had been done, or worse, complaints just shredded and put into rubbish without proper investigation.[184]

This evidence is very concerning. There are limited protections in the Aged Care Act for workers who disclose information about a suspected reportable assault to police, the Aged Care Quality and Safety Commissioner or the provider.[185] Those staff members are protected from any civil or criminal liability, contractual or other remedy, victimisation, detriment or threat.[186] However, these protections only apply to the reportable assaults scheme. They do not apply to complaints or the provision of other information about substandard care. The Charter of Aged Care Rights also provides for the right of residents to complain without reprisal, and to have complaints dealt with fairly and promptly.[187]

Unlike the position in aged care, whistleblower protections in the *Corporations Act 2001* (Cth) have been strengthened by amendments that commenced on 1 July 2019, with respect to certain disclosures to the Australian Securities and Investment Commission, the Australian Prudential Regulation Authority and specified personnel.[188] As a result of these amendments, the protections apply to an expanded range of disclosures, and to a broader range of individuals, including past employees.[189] Similar protections are available under workplace safety law to workers who make complaints about unsafe working conditions.[190]

Comprehensive whistleblower protection provisions should be implemented in aged care legislation to protect people who make complaints or report suspected breaches of legislative requirements to the Quality Regulator, the Inspector-General of Aged Care or key personnel of an approved provider. Responses to Counsel Assisting's final submissions

were generally supportive of this recommendation. The Older Persons Advocacy Network stated that:

> The introduction of whistle-blower protections for people receiving support, their family, carers, independent advocate or significant other may give people the confidence to overcome these fears and report their concerns.[191]

The Australian Medical Association submitted that legislated safeguards may help employees to speak up which may 'lead to earlier identification of concerns and ultimately to the improvement of services provided to older people in aged care'.[192]

Guidance on the form of these provisions may be drawn from the *National Disability Insurance Scheme Act 2013* (Cth), which provides broad protection to certain people who disclose information where they have a reasonable ground to suspect that the information indicates that a National Disability Insurance Scheme provider may have contravened the Act.[193] The protections apply to officers and employees, as well as people with a disability who are receiving a support or service from a National Disability Insurance Scheme provider, or a nominee, family member, carer, independent advocate or significant other of that person.[194]

Aged care whistleblowers should be protected from criminal prosecution, administrative action or civil litigation, such as breach of employment contract or duty of confidentiality. It should also be an offence to cause or threaten detriment to someone because they have made, may have made, or could make a whistleblower disclosure.

A small number of responses to Counsel Assisting's final submissions raised concerns that the proposed whistleblower protections duplicate and potentially expand whistleblower provisions in the Corporations Act.[195] We do not consider that the Corporations Act provisions provide sufficient protection for disclosures about the quality and safety of aged care. We consider that whistleblower protections need to be specifically adapted to the aged care sector. However, the new provisions should be crafted to avoid, to the extent possible, any duplication or inconsistency with existing whistleblower protections that may apply, including those under the Corporations Act.

Recommendation 99: Protection for whistleblowers

The new Act should contain comprehensive whistleblower protections for:

a. **a person receiving aged care, their family, carer, independent advocate or significant other**

b. **an employee, officer, contractor, or member of the governing body of an approved provider**

who makes a complaint or reports a suspected breach of the Quality Standards or another requirement of or under the Act.

14.5 Serious incident reporting

The level of neglect and abuse in aged care is unacceptably high. In 2019–20, residential aged care services reported 5718 allegations of assault, including 851 allegations of sexual assault.[196] We have received 588 submissions mentioning sexual abuse. There were 426 allegations of sexual assault reported to the Australian Department of Health in 2014–15, compared with the 2019-20 figure of 851.[197] This is more than two reports per day on average, every day of the year.

While these figures are extremely concerning, as set out in Volume 2, the actual extent of abuse in aged care is even higher than these figures reveal. The aged care compulsory reporting scheme excludes an alleged assault by a resident with a diagnosed cognitive or mental impairment, where the provider has put in place arrangements to manage the alleged perpetrator's behaviour.[198]

It has been estimated that in 2018–19, there were between 26,960 and 38,898 unreported assaults in residential aged care services.[199] When these estimates are added to the reported 5233 assault allegations for the 2018–19 financial year, the number of alleged assaults in residential aged care was between 32,193 and 44,131. Changes to the current reportable assaults scheme in relation to unlawful sexual contact could result in an additional 1730 incidents of unlawful sexual contact in residential aged care being reported.[200] When that estimate is added to the reported 730 unlawful sexual contact allegations for 2018-19, the estimated number of alleged incidents of unlawful sexual contact in 2018–19 could be as high as 2520 or almost 50 per week.[201] This is a disgrace and should be a source of national shame.

In addition to the effects of assaults and abuse on people receiving aged care and their families and friends, incidents of assault and abuse can have a significant effect on aged care workers. Kathryn Nobes is an aged care worker at a residential aged care facility in New South Wales. She was working at the facility when a resident killed another resident.[202] Ms Nobes described this incident at the Wollongong community forum and gave evidence that the perpetrator had a history of violence towards both staff and residents.[203] Following this incident, Ms Nobes was diagnosed with post-traumatic stress disorder.[204]

A compulsory reporting scheme helps to ensure that approved providers respond appropriately to incidents of abuse and neglect. However, reporting alone will not ensure such an outcome unless measures are taken to address the risk of harm, and people who are abused or neglected receive appropriate medical, psychological and other support.

The existing compulsory reporting scheme in aged care is unsatisfactory for a number of reasons. First, the scope of incidents that must be reported is too limited.[205] Second, the number of reported incidents at each facility and in relation to individual approved providers, is not made publicly available. Third, information reported by approved providers is not used effectively by the regulator to ensure aged care workers who may pose a risk are identified and that appropriate preventative measures are taken.[206]

Before 31 December 2019, all compulsory reports were made to the Australian Department of Health. An officer of the Department gave evidence that the Department's approach to reports before late 2018 was 'mainly focussed on late reporting and low reporting', rather than the care and wellbeing of people receiving aged care services who may be affected.[207] On 1 January 2020, responsibility for the compulsory reporting scheme was transferred from the Department to the Aged Care Quality and Safety Commission.[208] However, while there have been some administrative changes made by the Commission, these changes were not accompanied by any legislative change to the scope or the design of the compulsory reporting scheme.[209]

In 2017, both the Australian Law Reform Commission and the Carnell-Paterson review expressed similar concerns about the existing scheme we have described and recommended that a new serious incident scheme for aged care be introduced.[210] The Australian Government has belatedly recognised that current arrangements for reporting serious incidents should be strengthened. On 2 April 2019, it announced the introduction of a serious incident response scheme, which will commence on 1 July 2021.[211]

The new serious incident reporting scheme will require reporting of a much wider range of incidents than is currently the case. Providers will be required to report:

- unreasonable use of force
- unlawful or inappropriate sexual conduct
- psychological or emotional abuse
- unexpected death
- stealing or financial coercion by a staff member
- neglect
- unlawful use of physical or chemical restraint
- unexplained absence.[212]

The expanded scope of incidents covered by the new scheme is a welcome development and will greatly improve the regulator's oversight of abuse and neglect in residential aged care. The removal of the cognitive impairment exemption is particularly important given that approximately half of the people living permanently in residential aged care have a diagnosis of dementia, and in view of the estimate of the high number of alleged assaults that currently fall within this exemption.[213]

However, expansion of the coverage of the scheme only addresses one of the defects in the current arrangements. Without an expansion of the scheme to home care, purposeful action on the reports of serious incidents and greater transparency around the scheme, the abuse will continue.

14.5.1 Objectives of a serious incident scheme

Neither the Aged Care Act nor the Aged Care Quality and Safety Commission Act set out the objectives of the compulsory reporting scheme, or the functions of the Commission tasked with receiving those reports. The Japara Case Study, in the Brisbane Hearing, illustrated the importance of the purposes of any reporting scheme being clear, and that the scheme should effectively achieve those purposes. Commissioner Briggs found, based on the evidence of the Australian Department of Health's response to reports examined in that case study, that it was not apparent that the scheme was an effective mechanism to ensure the safety and wellbeing of residents.[214]

The objectives of the new Serious Incident Response Scheme should be clearly set out in legislation. This should guide the response of the Quality Regulator to reports of serious incidents. According to the Australian Government, the goals of the new Serious Incident Response Scheme are to strengthen aged care systems, to reduce the risk of abuse and neglect, build providers' skills so they can better respond to serious incidents, and ensure people receiving aged care have the support they need.[215] In our view, however, the central object of any serious incident reporting scheme must be to protect people receiving aged care services from harm.[216]

14.5.2 Serious incidents in home care settings

We consider that the new Serious Incident Response Scheme should be extended to cover allegations of certain serious incidents perpetrated by aged care workers against people receiving aged care in home settings.[217] It is hard to justify the lack of oversight of allegations of abuse and neglect in home settings. As Mr Fitzgerald stated, 'the highest risk for older people in the aged care system is within the home' because 'there is not the line of sight that you normally see in residential services'.[218] In residential care, there is the potential for a line of sight by multiple workers, visitors and health practitioners, that is absent in home settings.[219]

Unlike in aged care, the National Disability Insurance Scheme Quality and Safeguards Commission reportable incidents scheme applies irrespective of setting. As long as there is a connection with service delivery by a registered National Disability Insurance Scheme provider, a reportable incident must be notified to the Commission.[220]

The need for oversight of serious incidents in home settings will increase as more people receive aged care in their homes for longer, and in view of the likely increase in levels of frailty and cognitive impairment in people receiving home care. Frailty is directly linked to vulnerability.[221] Risk can also be increased by factors such as isolation, and a high dependence on aged care services.[222] The risk to older people receiving care in their homes was starkly illustrated by the death of Ms Ann Marie Smith, a National Disability Insurance Scheme participant who received care in her home, as noted above. Ms Smith died in April 2020 'after a substantial period of neglect, having been living in squalid and appalling circumstances'.[223]

There is limited data on the extent of abuse and neglect by aged care workers against people receiving aged care services in their home, in part due to the lack of regulatory oversight of such incidents. The Australian Department of Health is commissioning a study into the prevalence of serious incidents occurring in home and community aged care, which is scheduled to be completed by 30 June 2021. That study will also examine options for extending a serious incident response scheme to home and community care.[224]

In its submissions, the Australian Government supports in principle the application of a serious incident response scheme to home care settings, noting the 'reasonable community expectation that home care settings should generally be subject to the same standards of care as residential aged care'. It noted that the expansion of a reporting scheme into home care should take into account the greater variability of service delivery types, and the degree to which home care providers influence the settings for care.[225] Other submissions suggested that domestic family abuse or neglect should not be included in a Serious Incident Response Scheme but should prompt a referral to an appropriate agency.[226]

We consider that incidents of abuse or neglect that occur within the home, but which do not have a connection with the provision of aged care, should fall outside the scope of the Serious Incident Response Scheme.[227] These matters should be reported to the police or to other State and Territory authorities which can address elder abuse. However, home care providers should have a safeguarding regime. We agree with the NSW Ageing and Disability Commission that:

> Such a regime should explicitly acknowledge the fact that workers may well observe conduct or circumstances that may indicate an older person is, or may be, subject to abuse, neglect or exploitation by another person. Workers should be provided with guidance as to such issues, signs of such abuse, and processes for reporting of such matters within the agency or to external authorities, such as the NSW Ageing and Disability Commission.[228]

Reportable incident schemes need to be sufficiently targeted and funded to ensure that reports can be dealt with in the way that is required. A scheme that is too expansive risks being overwhelmed.[229]

14.5.3 Identifying individuals who may pose a risk

Any serious incident response scheme in aged care must have the capability to detect patterns in reports that indicate an ongoing risk to the safety of people receiving aged care services. Such a scheme should be a critical tool to enable the Quality Regulator to identify risk proactively. When a new report is received by the regulator, those responsible for conducting an initial assessment should be able to identify immediately whether an aged care worker named in that report has been the subject of an earlier report. It is of concern that the compulsory reporting scheme does not currently have this capability.

When it had responsibility for the compulsory reporting scheme, the Australian Department of Health had a limited ability to identify when an aged care worker was the subject of multiple allegations.[230] Until 2018, the names of staff members alleged to have assaulted a resident could not even be recorded in the system. Since 2018, the information has been able to be recorded, but seemingly not in a manner that enables it to be readily searched, or in a form that would trigger a red flag.[231] In the Japara Case Study, there was evidence of the same worker at a Japara facility having been involved in at least three serious incidents.[232]

The Aged Care Quality and Safety Commissioner, who became responsible for the scheme from 1 January 2020, faces similar issues.[233] The names of alleged offenders and their relationship to the alleged victims have been recorded in the system only since 1 January 2020.[234] The ability to search previous reports at a particular service is accordingly limited to reports made since that date.[235] The Commission does not yet have the ability to match alleged offender names in reports across different services.[236] The Commission has advised that it 'continues to work on improvements to its data recording and processing systems to enhance its risk detection capabilities, including in relation to the identification of repeat offenders'.[237]

The Australian Government should ensure that when the new Serious Incident Response Scheme is introduced, the regulator has the capability to undertake this and other basic risk detection. This will enhance the ability of the scheme to make timely and appropriate referrals to the relevant agencies responsible for regulating the conduct of workers.

There should also be appropriate information sharing arrangements in place between the new Serious Incident Reporting Scheme and the disability reportable incidents scheme to enable oversight of workers who may work across the aged and disability sectors or move from one to the other.

14.5.4 Response to serious incident reports

We consider that a provider should be required to provide the Quality Regulator with a plan detailing the action it intends to take in response to a reported incident. A provider should also be required to provide the Quality Regulator with a copy of the report of any investigation the provider has undertaken or caused to be undertaken.

Each of the serious incident reports examined in the Brisbane Hearing were closed on the basis that no further action was required. This occurred without the Australian Department of Health obtaining a copy of the report of any internal investigation conducted by the provider. Where any such documents were provided, this was at the initiative of the approved provider.[238] This is basic information, which should form part of any assessment of whether a provider has responded adequately to a serious incident.

The Quality Regulator should have powers to scrutinise a provider's response to a serious incident, including through obtaining information and imposing reporting obligations in relation to:

- the immediate response to the victim, alleged perpetrator (where relevant) and others who may have been affected by the incident, such as staff members and the victim's family
- an investigation of the incident and whether the allegations were substantiated
- action taken following an investigation
- the processes and systems in place for preventing and responding to serious incidents
- the training of staff in preventing and responding to serious incidents.

Information given by providers should not be simply accepted at face value, which was previously the approach of the Australian Department of Health to compulsory reports.[239] A Departmental officer gave evidence that when the compulsory reporting scheme was operated by the Department, it did not make inquiries with the family members about an incident. He said, 'We believe the service. If they tell us they've done these things, we believe what they've advised us'.[240] The aged care Quality Regulator must be more curious and less trusting in future.

The Serious Incident Response Scheme consultation paper released by the Australian Department of Health in August 2019 recognised that the regulatory powers of the Aged Care Quality and Safety Commissioner may need to be amended for the administration of the new scheme.[241] The Quality Regulator should have powers comparable to those available to the National Disability Insurance Scheme Quality and Safeguards Commissioner for dealing with reportable incidents. These include powers to do one or more of the following:

- require or request the provider to undertake specified remedial action in relation to the incident, including in relation to the health, safety and wellbeing of people with disability affected by the incident
- require the provider to carry out an internal investigation into the incident and provide a report on the investigation to the Commissioner
- require the provider to engage an appropriately qualified and independent expert to carry out an investigation into the incident, and provide a report to the Commissioner
- carry out an inquiry in relation to the incident
- take any other action the Commissioner considers reasonable in the circumstances.[242]

Unlike the position in aged care, the exercise of these powers is not contingent on the Commissioner being satisfied that a provider is not meeting its responsibilities under the relevant legislation.[243]

In addition to these powers, we consider that the Quality Regulator should be able to use the general investigative and enforcement powers we have recommended in Recommendation 103 for the purposes of responding to reports of serious incidents. We note that the Aged Care Quality and Safety Commission has identified a number of potential additional enforcement options to enable it to carry out its anticipated functions in relation to the Serious Incident Response Scheme that is being developed. These include an ability to obtain enforceable undertakings, a capacity to issue directions, and additional information gathering powers.[244]

Recommendation 100: Serious incident reporting

The Australian Government should, in developing a new and expanded serious incident reporting scheme:

a. ensure that the scheme:
    i. addresses all serious incidents, including in home care, regardless of whether the alleged perpetrator has a cognitive or mental impairment
    ii. enables the matching of names of individuals accused of being involved in a serious incident with previous serious incident reports
b. require the Quality Regulator to publish the number of serious incident reports on a quarterly basis at a system-wide level, at a provider level, and at a service or facility level
c. impose a requirement on an approved provider to provide a plan detailing the action it intends to take in response to a reported incident and the report of any investigation of the incident the provider has undertaken or caused to be undertaken
d. confer statutory powers on the Quality Regulator to enable it to:
    i. require a provider to take specified remedial action in relation to an incident within a specified period
    ii. require a provider to investigate an incident in a manner and within a timeframe specified
    iii. oversee the investigation of and response to a serious incident by a provider
    iv. require a provider to take other action in relation to the incident that the Quality Regulator considers reasonable in the circumstances
    v. investigate the circumstances surrounding the incident.

14.6 Enforcement

Enforcement is an important part of ensuring that the regulatory system deters poor quality or unsafe care. It must be credible and effective.

Existing enforcement options do not meet community expectations.[245] In his submission to us, written in the months before his death in a residential aged care facility in Victoria, former Victorian Senator Bernard Cooney made the following comments about the regulation of aged care:

> The objectives of the regulatory framework and the expectations of the Australian community with respect to the quality of care to be provided to some of its most vulnerable members are claimed to be satisfied by what is effectively little more than formal procedural compliance and too often this is unchallenged…there must be substantial improvements made to ensure that the system of performance monitoring of providers operates effectively. Standing behind that must be the likelihood of the imposition of strong sanctions where proper standards are not met. The prospect of genuine and likely accountability of providers for failure to meet such standards is vital.[246]

Professor John Braithwaite, a leading expert in regulation, has described aged care enforcement in Australia as 'enfeebled'.[247] The delivery of substandard care rarely has serious consequences for providers or those in positions of leadership within providers.[248]

The Quality Regulator should be adequately resourced and have an appropriate range of enforcement tools so that it can detect non-compliance. It must be capable of adapting its approach to the particular circumstances surrounding an instance of non-compliance it detects. As Professors John and Valerie Braithwaite and Professor Toni Makkai, also experts in regulation, said:

> What the empirical evidence on regulatory effectiveness and our own Australian aged care research shows is *not* that compliance is driven by how tough sanctions are, but by inspection that assures detection, and by the deployment and use of a varied mix of enforcement tools.[249]

Analysis of the sanctions imposed in relation to residential aged care services between July 2015 and March 2019 reveals a remarkably uniform response to non-compliance. In that period, 76 notices of decisions to impose sanctions were issued.[250] Four sanctions involved the revocation or suspension of places allocated to a particular residential aged care service. In each of the other 72 instances, the same enforcement option was exercised: a sanction restricting the payment of subsidies for new care recipients, and a conditional revocation of approved provider status, unless the approved provider agreed to appoint an adviser and/or administrator and to provide training. The Commissioner took similar enforcement action against the operator of Newmarch House in 2020 after the deaths of 17 residents from COVID-19.[251] Leading Age Services Australia submitted:

> In some respects, the existing enforcement powers are insufficient, but more broadly they are too inflexible. For example, the effect of sanctions such as the ability to no longer receive subsidies for new clients depend heavily on the circumstances of the provider. Penalties also need to be commensurate with the size of organisations. Providers report that on average the cost of a sanction on a residential aged care services exceeds

> $1 million in lost revenue and in the consultancy fees that providers are forced to expend in this process. This is an enormous penalty for a small provider with a turnover of $5 million. However, it is much less severe for a provider with a turnover of more than $100 million.[252]

The 'one size fits all' approach to enforcement suggests a regulator that either lacks an appropriate range of enforcement tools or the necessary flexibility and imagination to deploy the right sanction to fit the individual case. In its 2011 report *Caring for Older Australians*, the Productivity Commission recommended that the regulator be provided with a broader range of enforcement tools 'to ensure that penalties are proportional to the severity of non-compliance'.[253] Although the agency exercising aged care regulatory functions has changed since that time, there have been few substantive changes to its enforcement options. The Productivity Commission's recommendation was echoed by the Aged Care Quality and Safety Advisory Council in 2019. It recommended that the range of enforcement powers be expanded. It also noted that the available sanctions 'cannot be easily tailored to a wide range of provider circumstances' and that restrictions on subsidies are not always effective in promoting sustainable improvements.[254]

We recommend a broader range of enforcement powers to give the Quality Regulator greater scope to impose proportionate penalties, and real deterrence where needed. The additional enforcement powers we recommend below should be subject to conventional safeguards, including procedural fairness. The exercise of these powers should be subject to review by the Administrative Appeals Tribunal on application by a provider.

14.6.1 Civil penalties

Civil penalties are 'sanctions that are imposed by courts in non-criminal proceedings, following action taken by a government agency'.[255] While they resemble fines, a criminal conviction is not recorded and the civil process, including the civil standard of proof, is used.

Civil penalty proceedings are one of the more serious forms of enforcement action available to a regulator. Civil penalties are 'primarily if not wholly protective in promoting the public interest in compliance'.[256] The main purpose of civil penalties is to be a deterrent rather than to be compensatory. There are no civil penalty provisions that relate to the quality and safety of aged care. There is only one civil penalty provision in the Aged Care Act, which relates to providing false or misleading information in appraisals or reappraisals connected with the classification of people receiving care.[257]

We consider that the Quality Regulator should have the option of bringing civil penalty proceedings in response to serious failures in the provision of care. Ms Backhouse, whose mother has spent over a decade in the aged care system, gave evidence that in her view there are 'fundamentally inadequate consequences for providers who fail to meet proper standards in their care of residents'. She said:

> Stronger powers should be bestowed on the regulator to allow for a broader range of punitive measures such as financial ramifications including fines and penalties for providers who fail to deliver adequate care, especially where it results in harm. We need a policeman on the beat, not a social worker.[258]

The most serious enforcement tool available to the Aged Care Quality and Safety Commissioner is the revocation of approval or accreditation. But these powers are rarely used because their use may have a negative impact on those receiving aged care services. As Mr Paul Versteege, Policy Manager for the Combined Pensioners and Superannuants Association of NSW, explained:

> where a residential aged care provider delivers poor care to the point at which revoking their accreditation would be the reasonable compliance response, that response would mean closing down the facility, forcing residents to find a new residential aged care place. Obviously, with the prospect of resident displacement as a result of revocation of accreditation, revocation is likely to only occur in extreme cases, because of the trauma it would cause to residents, particularly if the facility was located in a regional or remote area with few or no alternative facilities to absorb displaced residents. In such areas even a lesser penalty (e.g. the facility not being able to accept new residents for six months) punishes innocent residents and prospective residents along with the guilty provider.[259]

Individual accountability, particularly for those in positions of leadership, is important. As the Aged Care Quality Standards recognise, the governing body of an aged care provider is responsible for delivering quality and safe care.[260] We consider that the Quality Regulator should have the option of commencing civil penalty proceedings against one or more key personnel, in addition to the approved provider, in appropriate cases. A person would only be liable if he or she had knowledge of the essential facts constituting the contravention.[261] A person would not be liable merely because he or she is one of the key personnel of a provider.

Evidence of Barbara and Clive Spriggs

Mrs Barbara Spriggs's husband Robert (Bob) was a patient at Oakden Older Persons Mental Health Service for two short periods in 2016. Mr Spriggs had Parkinson's disease, Lewy body dementia and Capgras Syndrome.

Mrs Spriggs gave evidence that one week after Mr Spriggs was readmitted to Oakden in February 2016, she noticed a huge decline in his health.[262] After her family expressed concern at his deterioration, Mr Spriggs was transferred to hospital. Mr Spriggs: 'had been overmedicated by being given 10 times the dose, 500 milligrams instead of 50 milligrams, of his prescribed antipsychotic drug Seroquel. He was suffering severe bruising on several parts of his body, was dehydrated and suffering from pneumonia.'[263] The events at Oakden were the subject of a number of reviews.[264]

Mrs Spriggs gave evidence that, based on her family's experience, she thought 'there has been no accountability for wrongdoing in the system'.[265] Both Mrs Spriggs and her son Clive told Commissioners Tracey and Briggs that there needs to be more accountability for failings.[266] Mrs Spriggs said: 'To this day, I don't know what happened to Bob at Oakden…I think about those who hurt Bob and I wonder whether they—and I wonder whether they are now employed somewhere else. I wonder if their employers know about their previous conduct.'[267]

The need for accountability in aged care was identified by the South Australian Coroner in 2018 in relation to the death of Mrs Dorothy Baum, a resident who was living with dementia and who died after being physically attacked by another resident.[268] The Coroner concluded that there 'had been a gross dereliction of proper management on the night in question', that Mrs Baum would have been helpless in her bed and unable to escape, and that she lay for at least two hours bleeding in her bed before she was attended to.[269] The Coroner expressed concern that the aged care framework did not 'produce an outcome commensurate with the seriousness of the events that had occurred', and concluded:

> I do not propose to recommend any particular change to the Scheme but I do intend to refer this finding to the Commonwealth Minister for Aged Care and the South Australian Minister for Health and Wellbeing to note my concern that the senior management and the governing bodies of aged care providers should be subjected to a system of personal accountability when standards of care are not met. Only by adopting a scheme in which there is some personal risk to those involved in the management of aged care providers at the highest level could the public be confident that an event such as the appalling treatment of Mrs Baum in life and then in death could not happen again.[270]

We emphasise that civil penalty proceedings, particularly those invoking liability of one or more key personnel as an accessory, will not be appropriate for all instances of non-compliance. They should be reserved for cases of non-compliance that are particularly serious and result in harm, or a reasonably foreseeable risk of harm, to people receiving aged care services.

We do not consider that aged care workers, other than those who are 'key personnel', should be liable for a contravention of a civil penalty provision for a breach of the general duty. We agree with the submission of the United Workers Union that aged care workers are low paid, and 'do not exercise significant decision making power in the workplace'.[271] In addition, we note that aged care workers already have duties under work health and safety legislation.[272] Aged care workers who are registered health practitioners may also be the subject of disciplinary action where they have provided substandard care.

We agree with the submissions of Counsel Assisting that civil penalties should be available for a breach by an approved provider of the new requirements on the use of chemical and physical restraints in residential aged care, and for a breach of the general duty to provide high quality and safe aged care.[273] These submissions received general support. Some responses advocated for criminal penalties as well as civil penalties.[274] Other responses raised concerns about the potential impacts of imposing liability on the directors or key personnel of an approved provider.[275]

We have considered whether a breach of the general duty and restraint requirements should be a criminal offence or give rise to a civil penalty, or both. Conviction of a crime carries with it a range of consequences beyond the immediate penalty imposed by a court.[276] For this reason, the threat of criminal penalties can be more likely to deter than civil ones. However, they carry a higher burden of proof, and can be more difficult to obtain.[277] In addition, enforcement of criminal offences requires proceedings to be brought in State and Territory courts, which can raise additional challenges, such as inconsistent outcomes. By contrast, civil proceedings could be brought in the Federal Court of Australia or the Federal Circuit Court.

We have also considered concerns about imposing accessorial liability for a breach of the general duty. Accessorial liability in this context means that a member of an approved provider's key personnel who is involved in a breach of the general duty by the provider might also be liable for a civil penalty. Such concerns include the potential for this to impact on the capacity of providers to attract and retain board members, the risk that it would deter new providers or workers from entering the sector or workers taking leadership roles, and the potential impact on insurance.[278]

We consider that the introduction of civil penalties and accessorial liability strikes the appropriate balance between these different considerations. It will introduce accountability for serious failings in the provision of aged care and expand the options available to the Quality Regulator for dealing with serious instances of non-compliance. The regulator will be more likely to bring civil proceedings than criminal proceedings for a breach of the general duty or the requirements regulating the use of restraints in residential aged care. The grounds for accessorial liability reflect those in the *Regulatory Powers (Standard Provisions) Act 2014* (Cth).[279] We note that certain conduct in the context of aged care which causes harm to an older person may also constitute a criminal offence.[280] This will not change in the new aged care system we propose. Suspected criminal conduct should be referred to the police.

Recommendation 101: Civil penalty for certain contraventions of the general duty

1. The new Act should provide that, on application by the Quality Regulator to a court of competent jurisdiction, a breach by an approved provider of the general duty to provide high quality safe aged care is a contravention of the Act attracting a civil penalty if:
    a. the act, omission or conduct giving rise to the breach also gives rise to a failure to comply with one or more of the Aged Care Quality Standards, and
    b. the breach gives rise to harm, or a reasonably foreseeable risk of harm, to a person to whom the provider is providing care or engaged under a contract or understanding to provide care.
2. The new Act should also provide that such a contravention attracts accessorial liability for key personnel who:
    a. aids, abets, counsels or procures the approved provider to commit the contravention, or
    b. is in any other way, directly or indirectly, knowingly concerned in, or party to, the contravention by the approved provider.

14.6.2 Compensation

The existing sanctions regime is focused on approved providers and is intended to punish and deter. There are no mechanisms under the aged care legislation by which people receiving aged care services who have been harmed as a result of substandard care can be compensated. Mr Lewis submitted:

> It is of no comfort to the resident or their family, if their comfort, dignity or health have been adversely affected by unlawful restraint, to witness a sanction imposed upon the Provider, even assuming that the sanction arises from harm to just one individual.[281]

The Aged Care Quality and Safety Commissioner has the power to determine that there is an immediate and severe risk to the safety, health and wellbeing of a person receiving care as a result of non-compliance. Such findings are currently taken into account in the Commissioner's decisions to impose sanctions.[282] An example of such a decision was considered in the MiCare Case Study, where it had been concluded following a Review Audit conducted in August 2018 that the safety, health or wellbeing of fourteen residents of an aged care facility had been or may have been placed at serious risk.[283] Although it had reached this conclusion and imposed sanctions on the provider, the Commissioner was unable under the existing law to take further action to compensate or obtain redress for any individual who may have been harmed.

The only option an older person may have to obtain compensation is to undertake private litigation in contract or tort. There are a number of reasons why private civil proceedings may not be feasible or desirable for those who have suffered harm while receiving aged care services, including the cost, the likely duration of such processes and the stressful impact on people involved who may be frail and cognitively impaired.[284] The Australian Lawyers Alliance submitted that:

> the issue of remedies is important. There needs to be power to award compensation for breaches of human rights rather than simply powers to conduct an investigation or revoke accreditation.[285]

We consider that where a provider or person has been found by a court to have contravened a civil penalty provision, the court should be able to award compensation to a person receiving aged care services who has suffered harm as a result of that contravention. The Quality Regulator should be able to make an application for such compensation at the request of the person harmed. An older person who has suffered harm, or someone acting on their behalf, should also be able to make such an application.

We consider that even where the Quality Regulator does not bring civil penalty proceedings, a person receiving aged care services should be able to bring proceedings for damages on the basis that there has been a breach of a civil penalty provision, and the person has suffered loss or damage as a result of that contravention. Any findings or admissions of the contravention in another proceeding, such as related proceedings brought by the Quality Regulator, should be able to be adduced in evidence as proof that the contravention occurred.

We note that the Australian Government supported the imposition of civil penalties enforceable by the Quality Regulator but did not support a private right of action for damages. Noting the potential for unintended consequences, the Australian Government submitted that:

> There is no evidence that individual legal actions will improve outcomes in aged care, and the Commonwealth does not see increasing resort to the courts as a sensible way to promote reform.[286]

The private right of action for compensation that we recommend would require a plaintiff to establish not only a breach of the general duty, but also that the breach gives rise to a failure to comply with one or more of the quality standards and has resulted in harm. Damages will not be available solely on the basis that care has not been of high quality.

Without a private right of action, a person receiving aged care services who has been harmed as a result of a contravention of the civil penalty provision, will either need to rely on the Quality Regulator to institute proceedings to obtain compensation, or will need to bring proceedings in contract or tort. Regulators have limited resources and will not be able to bring proceedings for every suspected contravention of a civil penalty provision. Decisions about enforcement will need to be made based on the regulatory strategy, and other considerations. The introduction of a private right of action will give people receiving aged care and their family and friends an ability to hold providers to account for non-compliance which causes harm and suffering.[287]

Recommendation 102: Compensation for breach of certain civil penalty provisions

The new Act should provide:

a. **that an order may be made on the application of the Quality Regulator to a court of competent jurisdiction that an approved provider that has contravened a civil penalty provision, or a person involved in the contravention, pay damages for any loss and damage suffered by a person receiving aged care services as a direct result of the contravention, and**

b. **for a private right of action for damages in a court of competent jurisdiction by, or on behalf of, a person receiving aged care services who has suffered loss and damage as a direct result of a contravention of a civil penalty provision, in which proceeding any findings or admissions of the contravention in another proceeding may be adduced in evidence as proof that the contravention occurred.**

14.6.3 Enforceable undertakings

An enforceable undertaking is a legally binding written promise by a person or entity to a regulator. It is often a promise to do, or refrain from doing, something for a period of time and is usually made as a result of compliance activity or as part of a complaint resolution process. Enforceable undertakings can be an efficient, effective and flexible tool for responding to potential or actual non-compliance.[288]

The Aged Care Quality and Safety Commissioner has the power to require an approved provider to give an undertaking to remedy non-compliance in certain circumstances. This power can only be used after an approved provider is given a non-compliance notice. The scope of the undertaking is limited to remedying non-compliance. If an approved provider does not give the required undertaking or if it fails to comply with the undertaking, the Aged Care Quality and Safety Commissioner can issue a sanction in relation to the non-compliance.[289]

We consider that this power should be retained and supplemented with a broader and more flexible power to accept an enforceable undertaking. The Quality Regulator should have the power to accept an enforceable undertaking from an approved provider on the basis of alleged or potential non-compliance. This would enable an enforceable undertaking to be used on a proactive or interim basis. As set out earlier in this chapter, we consider that this general power should also be available in the context of the Quality Regulator's complaint handling functions.

Any such undertaking should be enforceable in a court. A court may, if satisfied that the undertaking has been breached, direct the provider to take steps to comply with the undertaking, or make any other order it considers appropriate including an order that the provider compensate a person for loss or damage as a consequence of the breach.[290] This is consistent with the position in the Regulatory Powers (Standard Provisions) Act.

Enforceable undertakings should be published.[291] In addition to promoting transparency about the Quality Regulator's activities and decisions, this can support system-wide learning.

14.6.4 Infringement notices

Infringement notices should be introduced to enable the Quality Regulator to deal efficiently with certain types of non-compliance. This would assist the Quality Regulator to focus its attention and resources on more serious non-compliance.

Infringement notices provide an administrative method for dealing with alleged breaches of the law.[292] If a recipient accepts the notice and pays the penalty, they elect to have the matter resolved administratively, without the need for a determination of liability and a finding of guilt by a court. Alternatively, a recipient of an infringement notice can elect not to pay the penalty. The Quality Regulator can then decide whether to take alternate action.

An infringement notice should only apply to strict or absolute liability offences, and should only be issued where an enforcement officer can easily make an assessment of whether an offence has occurred.[293] Such a notice may be appropriate, for example, where a provider has failed to comply with an obligation to report certain information to the Quality Regulator in the relevant timeframe.[294] Infringement notices will rarely, if ever, be an appropriate way of dealing with offences which have resulted in harm, or a risk of harm, to a person receiving aged care services.

14.6.5 Banning orders

The Quality Regulator should have the ability to ban individuals from providing aged care services, similar to the powers available to the National Disability Insurance Scheme Quality and Safety Commissioner.[295] The circumstances in which a banning order may be appropriate include where the Quality Regulator reasonably believes a person has contravened the Act or is not suitable to provide aged care, or where there is an immediate and severe risk to the safety, health and wellbeing of one or more people receiving care if the person continues to provide aged care services.

The power to issue banning orders would enable the Quality Regulator to take proactive steps to protect those receiving aged care services from individuals who may pose a risk of harm. Professor John Braithwaite gave evidence that, in the face of non-compliance, regulators should impose tougher deterrence measures which, in the context of aged care, may mean 'taking out of the system directors of nursing or administrators who are not capable of providing a safe and effective environment, and a caring environment'.[296] There are currently no such powers available. To be disqualified from being one of the key personnel of an aged care provider, an individual must have been convicted of an indictable offence, be insolvent under administration, or of unsound mind.[297]

Banning orders should be able to be imposed through administrative processes and could be temporary or permanent. A civil penalty should be available if a person engages in conduct that breaches a banning order made against that person. Banning orders will be a targeted enforcement option that can be used alone or alongside other compliance action directed at an approved provider.

We note that a banning order can have a serious impact on an individual's livelihood and will only be warranted in serious and exceptional cases. They will not be appropriate for every breach of standards or instance of non-compliance.[298] A person who is the subject of a banning order should be able to apply to the Administrative Appeals Tribunal for review of the decision.

14.6.6 Appointment of an external manager

The Quality Regulator should have the ability to intervene directly in the management of a service in circumstances where there is an immediate and severe risk to the safety, health and wellbeing of people receiving aged care services, and the governing body is unable or unwilling to take the necessary steps to address that risk.

The most serious enforcement measure currently available to the Aged Care Quality and Safety Commissioner is the revocation of the accreditation of an aged care service or the revocation of the approval of a provider. However, these measures will inevitably lead to the closure of the relevant service (or services). They are rarely used.[299] In circumstances where revocation is under consideration, it will take time to make the necessary arrangements to ensure the impact on people receiving aged care is minimised and managed. As seen in the Earle Haven Case Study, the human cost when residents have to be moved at short notice and without prior planning is unacceptable.[300] Additional powers are needed to ensure that any risk of harm to people receiving care from a non-compliant provider are minimised while appropriate arrangements are put in place.

Where revocation of approval is an option, the Quality Regulator should have a power to seek the agreement of an approved provider to suspend or remove the group of people responsible for the executive decisions of the provider and to appoint an external manager. This is similar to powers the regulator already has pursuant to section 63U of the Aged Care Quality and Safety Commission Act—for example, the power to require a provider to appoint an eligible adviser. This proposed new power goes further than the existing power to require a provider to appoint an eligible advisor. The eligible advisor in the current regime provides assistance to the approved provider rather than becoming a substitute decision-maker as the external manager would be.

The Quality Regulator's additional power to remove or suspend those responsible for executive decision-making and appoint an external manager would only be required in exceptional circumstances where there is a particular urgency, or egregious non-compliance by a provider. The power should only be available where the Quality Regulator considers it is necessary to mitigate an immediate and severe risk to the safety, health and wellbeing of one or more people receiving aged care.

The primary role of the external manager would be to stabilise the provider's aged care services and bring them back to compliance, or to facilitate the orderly exit of the provider from the sector and the transfer of its service or services to a provider capable of delivering safe and high quality care. The external manager should have the rights, title and powers, and be required to perform all the functions and duties, of the people responsible for the executive decisions of the provider.[301] The *Australian Charities and Not-for-profits Commission Act 2012* (Cth) and the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth) provide guidance on how such an enforcement power may operate.[302]

In a case where it appears to the external manager that the provider can be managed into sustainable compliance, the manager might choose to facilitate the appointment of a new executive. The external manager should possess appropriate experience in the provision of aged care and be capable of putting together a highly qualified and experienced team with the range of skills needed to address the issues that have led to the failure of the service.

Recommendation 103: A wider range of enforcement powers

The new Act should confer on the Quality Regulator:

a. a wider range of enforcement powers, including enforceable undertakings, infringement notices and banning orders

b. the power to suspend or remove one or more of the people responsible for the executive decisions of a provider in response to non-compliance, where the Quality Regulator is satisfied that there is an immediate and severe risk to the safety, health and wellbeing of one or more people receiving care, and appoint an external manager

c. the power to impose a sanction revoking the provider's approval unless the provider agrees to the appointment of an external manager.

14.7 The capacity and capability of the regulator

We both consider that the Quality Regulator must ensure that approved providers are providing high quality and safe care to older people. Commissioner Briggs makes additional remarks about the core business of the Quality Regulator.

14.7.1 Core business of the Quality Regulator | Commissioner Briggs

The Quality Regulator should have a clear overarching purpose to safeguard the quality and safety of aged care through a strong focus on gatekeeping, compliance monitoring and enforcement. The Quality Regulator should be independent and unfettered in its capacity to deliver on its core purpose.

The independent Quality Regulator needs to be a rigorous gatekeeper, ensuring that new providers are equipped to deliver high quality and safe care before they are approved to provide services. Once providers are approved, the Quality Regulator needs to be out and about, observing, contacting and visiting approved providers to make sure that they understand their obligations and are meeting them. In the accreditation review processes, the Quality Regulator needs to closely scrutinise the performance of approved providers so that they can provide accurate and meaningful assessments that give a real sense of the quality of an aged care service.

As Professor John Braithwaite said:

> It's when you have a mix of regulatory strategies, we found, in our work evaluating Australian regulation of quality of care, it works very much at the street level. Most of the effective work is done in a very informal, relational way by the assessors who go out and engage with that conversational regulation on site and then send appropriate cases up for more serious enforcement engagement.[303]

The Quality Regulator also needs to be in direct and continuous contact with people receiving care, and to engage with them in assessing the quality of care they receive. It is not good enough to deal only with providers or to engage only with people receiving care through providers. The Quality Regulator should build networks with complainants, advocacy organisations and community visitors, and should supplement the views of these stakeholders with information derived from quality indicators and other sources to build a sense of the quality of care and the risks in the system that may threaten the quality of care in particular providers, regions or areas of care.[304] As Professor John Braithwaite said, the regulator needs to take a 'detective oriented' approach, by using available intelligence in a strategic way to build a picture of possible concerns with an approved provider and the risks they pose to the future delivery of high quality and safe care.[305]

Information and awareness functions are an essential element of the work of an effective regulator. The Quality Regulator should ensure that providers are aware of their obligations and how their performance will be assessed. It needs to communicate in advance about its appetite for risk and the basis on which it will apply sanctions. And when its compliance strategies change, the Quality Regulator should communicate those changes in advance so that providers know what they need to do. At the same time, the Quality Regulator needs to ensure that older people in aged care and their families and advocates are aware of the standards of care that they should expect to be provided and their avenues of redress if the care they receive does not meet those standards.

The Quality Regulator needs to maintain a strong focus on ensuring that older people get high quality and safe care. Professor Paterson said:

> it does feel as if there's still this whole idea that we have a compliance model where we're trying to manage providers back to compliance and we're very reluctant to go to the apex of the triangle.[306]

The focus of the Quality Regulator should not be to educate approved providers and 'manage them back to compliance'. It must be to make sure that older people get the care that they deserve.

There is a broader educative, capacity-building and continuous improvement function that needs to be undertaken with approved providers. Where this has been undertaken at all, it has previously been a function undertaken by the regulator. However, the Quality Regulator should not be expected to perform this industry development function. We heard evidence in the context of the COVID-19 hearing that the role of educator and enforcer can be in conflict.[307] For example, Professor Ibrahim said 'you are not likely to confess your sins or your deficits to the regulator if you expect that you will be sanctioned'.[308] While the Quality Regulator should provide information about regulatory expectations and how it will approach its regulatory task, broader education and capacity-building should be functions of the System Governor.

The Quality Regulator must be prepared to flex its 'regulatory muscle' by moving up the sanction hierarchy and imposing more severe sanctions for non-compliance.[309] The evidence suggests to me that the regulator has very rarely used its strongest powers. Rather than managing underperforming approved providers out of the sector, the regulator appears to have had a disproportionate focus on managing providers back to compliance. During the Perth Hearing, Dr Trigg gave evidence that in her view:

> the new Aged Care Quality Standards will only result in better outcomes if other issues are addressed, for example, the legislative and enforcement powers of the Quality and Safety Commission and the appetite of the Australian government to close poor providers.[310]

The Quality Regulator needs to use the new enforcement powers that we have recommended in appropriate circumstances. Professor Valerie Braithwaite gave evidence that if a regulator has to resort to more serious measures, 'the expectation of improvement is taken more seriously'. She explained:

> If you think you're going to have an enforceable undertaking or something worse, then you listen and act more readily. So—and that's the idea of the enforcement pyramid, that you know that, if you delay and you don't do what you're supposed to do, there are consequences that will hurt you down the track.[311]

In the end, the effectiveness of the Quality Regulator will depend very much on the role played by each of the individuals working within the regulator. They need to be supported to be agile, brave and 'on the ball'.[312] As Professor Paterson said:

> I mean, you shouldn't be in these sorts of roles unless you actually—you know, unless you care about your work. And part of caring about your work—I mean, if you are in a complaints agency, certainly, or if you're in any form of regulator, absolutely you need to be curious. You are a watchdog, you need to prick your ears up and think, 'Hello, what's going on here?' And that, it seems to me, is something that's not always been evident in our system.[313]

A cultural shift is required within the Quality Regulator so that its focus is firmly on the delivery of high quality and safe care to older people. It needs to be empowered—not just with legislated enforcement tools, but with a culture of action—to undertake its compliance and enforcement roles with drive and tenacity.

14.7.2 A capacity and capability review

We both consider that a competent, vigorous and well-resourced regulator is critical to the success of any regulatory regime. The systemic failures set out in Volume 2 raise concerns about the capability, leadership and culture of the Aged Care Quality and Safety Commission.

There was significant support for Counsel Assisting's submission that the Australian Government should conduct a capability review of the Commission.[314] The Australian Public Service Commission describes a capability review as an 'independent, high-level, forward-looking review' of the 'leadership, strategic and delivery capability' of an agency.[315] Responses to Counsel Assisting's submission emphasised the need to review the

resourcing and capability of the assessor workforce. Dietitians Australia submitted that it is 'vital to review the capabilities and training needs of assessors with respect to food and nutrition'.[316] Submissions also pointed to the need to ensure that the assessor workforce has adequate clinical skills, and that they are aware of the needs of Aboriginal and Torres Strait Islander older people and older people who are part of the LGBTI communities.[317] A submission from Hammond Care, an approved provider, stated:

> HC [Hammond Care] strongly agrees with this proposal and recommends that any review considers: the ACQSC's [Aged Care Quality and Safety Commission] performance against its prescribed role and responsibilities; a review of its outputs and their effectiveness; an assessment against their values; the training of its assessor workforce; and the views of key stakeholders such as aged care providers and care recipients. This review must be prioritised and must be completed prior to any consideration for enhanced powers and responsibilities.[318]

The evidence suggests that the Aged Care Quality and Safety Commission's assessor workforce is not sufficiently resourced to perform the tasks for which the Commission is currently responsible, let alone new tasks. For example, in March this year, the Commission advised that the program for increasing the level of compliance activity in home care services led to an increase in 2018–19 compared to 2017–18, but the activity level has since declined significantly. Reasons given for this decline included a high turnover in the assessor workforce, and that the introduction of the new Aged Care Quality Standards in 2019 has meant that assessment and monitoring activities have taken longer to complete.[319]

A submission from the Community and Public Sector Union which has members employed by the Aged Care Quality and Safety Commission, stated that a survey of its members in early 2020 'identified understaffing and resource shortages as critical issues across the Commission, with specific prevalence in the Assessors workforce and the Complaints Resolution Group'.[320] It reported that in response to that survey, 61% of the assessor workforce said they had considered leaving the Commission in the past six months because their workload was unmanageable and 73.5% said they did not think the 20 short-term roles announced in early January 2020 would be sufficient.[321] The NSW Aged Care Roundtable suggested that we consider whether the remuneration of assessors is sufficient to attract professionals with the skills and experience required.[322]

When asked by Senior Counsel Assisting whether it would be of assistance if we made a recommendation for a thorough capability review of the Aged Care Quality and Safety Commission, Ms Anderson replied, 'I certainly would understand if the Royal Commission sought to make that recommendation'.[323] We consider that such a review should occur promptly, and that it should cover regulatory and investigatory skills, clinical knowledge, assessment skills and enforcement skills, all of which are necessary for the regulator to fulfil its responsibilities.

In this chapter and elsewhere in this volume, we recommend that the Quality Regulator be conferred with additional functions. Recommendations we have made are likely to lead to an increase in the regulator's workload. This includes our recommendations in the areas of provider governance, serious incident reports and complaint handling. The introduction of civil penalties will require increased legal capacity within the Quality Regulator. As has been

the experience in the areas of occupational health and safety and environmental regulation, the introduction of the general duty to provide high quality and safe care will require a new focus to the way the Quality Regulator conducts its monitoring and enforcement functions.[324] As Emeritus Professor Arie Freiberg, a leading expert in regulation, has commented, 'a major change in regulatory design requires major changes in the regulator's capacity to give effect to the new design'.[325] There will be an ongoing role for the governing board of the Quality Regulator and the Australian Government to ensure that the regulator has the resources it needs.

Recommendation 104: Aged Care Quality and Safety Commission capability review

1. **By 1 May 2021, the Australian Government should commission an independent review of the capabilities of the Aged Care Quality and Safety Commission.**
2. **By 1 January 2022, the Australian Government should implement the recommendations of the review and provide the resources identified in the review that are needed for the Quality Regulator to engage and develop a skilled and dedicated compliance and enforcement workforce, with the regulatory and investigatory skills, clinical knowledge, assessment skills, and enforcement skills required for it to meet its regulatory mandate.**

14.7.3 Reporting on the performance of the Quality Regulator | Commissioner Briggs

In addition to enhanced public reporting about the aged care sector, Commissioner Briggs considers that there should be much better public reporting about the regulatory outcomes achieved by the Quality Regulator.

The Quality Regulator must have clear performance measures and should report and be assessed against them. Detailed and specific reporting by the regulator is required to enable the community to assess the regulator's ongoing performance against its prescribed role and responsibilities and to assess the effectiveness of its outputs.

At present, it is difficult to assess the performance of the aged care regulator. Professors John and Valerie Braithwaite and Professor Makkai referred to the importance of regulators publishing detailed information about enforcement activities and outcomes for people receiving aged care, and the importance, in particular, that the aged care regulator establishes a link between enforcement and improved quality of care.[326] They commended as exemplars the annual reports of the Australian Competition and Consumer Commission and the Australian Securities and Investment Commission.[327]

The 2019–20 annual report of the Australian Competition and Consumer Commission and the Australian Energy Regulator includes a substantial performance statement, presenting detailed data and analysis aligned to outcome-focused strategies, such as maintaining and promoting competition, consumer protection and fair trading. There are several deliverables per strategy and a suite of key performance indicators per deliverable.[328] Indicators are presented against both targets and results from the previous three years. The report presents enforcement actions against regulated entities in detail. It discusses Commission activities related to consumer groups, such as vulnerable and disadvantaged consumers and Aboriginal and Torres Strait Islander peoples, and topical consumer issues, such as scams and COVID-19. It presents results of stakeholder surveys, including a perceptions survey and an effectiveness survey, and case studies illustrate compliance principles and practices.

The need for the aged care Quality Regulator to have clear performance measures and be assessed against them has been a theme in external reports for almost twenty years.

In 2002–03, the Australian National Audit Office investigated the efficiency and effectiveness of the then Aged Care Standards and Accreditation Agency's management of the residential aged care accreditation process.[329] The audit found that the Agency had implemented an adequate process to meet its legislative responsibilities for accreditation. But the audit was critical of the Agency's focus on activity and output data, which prevented it from assessing its success in achieving its aim of enhancing the quality of life of residents:

> Most of the Agency's accreditation-related management reports…present a summary of Agency activities and outputs at a particular point in time. The Agency makes limited use of qualitative and long-term measures, analysis of accreditation trends over time, comparisons between states, or actual performance against targets.[330]

As such, the Australian National Audit Office found that:

> the Agency does not yet have a way to assess the outcome of its accreditation and monitoring work on the residential aged care industry.[331]

In 2004, the then Australian Department of Health and Ageing commissioned Campbell Research and Consulting to conduct a project to 'evaluate the impact of accreditation on the delivery of quality of care and quality of life to residents in aged care homes'.[332] The resulting 2007 Campbell Report found that while accreditation promoted continuous quality improvement, the Standards at the time were insensitive to improvement over time. This was especially the case when services were already performing at a high standard, with the scale used to assess the Standards incapable of degrees of achievement beyond compliance to a minimum standard.[333] Stakeholder consultations indicated that where services were provided at a high standard, this was likely driven by provider- and service-specific factors, including professionalism and commitment, rather than by the accreditation process.[334]

The Campbell Report recommended three options to measure and therefore drive quality improvement in the sector, including a quality indicator suite and surveys of residents, carers and provider staff.[335]

In 2011, the Australian National Audit Office published a report entitled *Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care Homes*. The objective of this audit was to assess the effectiveness of monitoring by the Aged Care Standards and Accreditation Agency, and compliance activities by the then Australian Department of Health and Ageing, in achieving residential aged care services' compliance with the Accreditation Standards and other responsibilities.[336] Like the earlier audit report, this report was critical of the reliance on activity data, especially when judging service quality and the effects of regulation:

> By its nature, and in isolation, activity-based reporting limits the extent to which stakeholders can develop an appreciation of regulatory performance and its contribution to improvements in the quality of outcomes.[337]

The report encouraged the use of a 'more complete reporting framework' to better serve stakeholders in assessing the contribution of regulators to improved care.[338]

Despite these reports and recommendations, the publicly available performance measures still lack sufficient specificity for assessments to be made about the regulatory outcomes achieved by the regulator.

I acknowledge that this is an area where reform is underway. The Aged Care Quality and Safety Commission Act requires the Commission to report on performance indicators and sanctions imposed. However, the Act is not specific about the form that this reporting should take and leaves considerable discretion about the detail and extent of any reporting.[339]

The performance of the aged care regulators over 2019–20 reported under this framework are presented in the *Report on the Operation of the* Aged Care Act 1997 and the *Annual Report of the Aged Care Quality and Safety Commission*.[340] However, this information is still largely based on outputs and management activities. The most recent report presents 2019–20 data only, which makes tracking of performance over time difficult. Where the Commission's report lists results against a suite of performance measures, it simply indicates 'achieved', 'partially achieved' or 'not achieved'. While some measures have brief commentary, many do not.[341]

The self-assessments might be regarded as generous. Against an aim of implementing end-to-end improvements to strengthen regulation of home services, the Aged Care Quality and Safety Commission regards its result as partially achieved on the basis that 'work has commenced on home services Quality Standards assessment approach'.[342] In reality, little change has occurred. On the focus area of 'consumer experience reports', there is an aim to 'implement new consumer experience reporting questions and methodology…to better inform consumers'. Despite the fact that publication of consumer experience reports ceased in December 2019, the Aged Care Quality and Safety Commission has rated its performance as 'achieved'.[343] This complacent and self-satisfied reporting falls well short of the informed self-reflection based on a sharp and accurate focus on changes in measurable outcomes over time that would be expected of a contemporary regulator.

There is still work to do to embed a culture of transparency and accountability within the regulator. During the course of our inquiry, we have been forced on a number of occasions to seek up-to-date information from the Australian Government on compliance and enforcement outcomes and statistics that should have been readily available from easily obtainable reports published by the Commission.

Given the importance of this issue and the history of poor public reporting in the past, my recommendation is intended to ensure that transparency of the regulatory outcomes achieved by the Quality Regulator is locked in and unavoidable. The recommendation provides clear direction to the proposed new Quality Regulator to make this occur.

Recommendation 105: Transparency around the performance of the Quality Regulator **Commissioner Briggs**

1. By 1 July 2021, the Aged Care Quality and Safety Commission (and from the commencement of a successor body, that body) should provide additional information in its public reporting on the effectiveness of the regulatory system and its performance in safeguarding the quality of life and quality of care provided to people receiving aged care. This reporting should include:
    a. performance against a standard suite of commonly applied measures of regulatory performance, such as complaints, serious incident reports, reviews and inquiries, enforceable undertakings, notices of non-compliance, sanctions including civil penalties, disqualification of individuals, appointment of administrators, withdrawal of accreditation or approved provider status
    b. information on the experience of people receiving care and their families
    c. actions taken to improve the quality and safety of services, including those directed to Aboriginal and Torres Strait Islander people and other vulnerable groups
    d. information on enforcement actions against regulated entities
    e. measurable indicators on the outcomes of the regulatory actions taken by the regulator, and
    f. changes in regulatory outcomes over time.
2. There should be a statutory obligation on the Aged Care Safety and Quality Authority to provide information to the System Governor, for inclusion in the national information service, on compliance and enforcement, serious incident reporting and complaints by provider and service.

14.8 Advocacy

We both agree that one of the best ways to safeguard older people is to make sure that 'their voices are heard and their preferences acknowledged'; that they are active participants in the aged care system.[344] Advocacy services play an essential role in ensuring that this occurs.

The regulator and formal advocacy services share a common interest in protecting and enhancing the quality and safety of care provided to older people. However, their roles are not the same. The role of the regulator is to enforce standards and other statutory requirements. Advocacy services exist to represent the interests of older people. For this reason, advocacy services need to have the scope to act independently of government agencies on behalf of older people, and to be protected from retribution when pursuing their interests.[345] Advocacy services should not be seen as a substitute for an effective and responsive regulator that engages with, and listens to, older people, their families and carers.

Advocates have a critical role in giving a voice to older people confronted by a complex and sometimes intimidating system. Mr Rowe described the role of advocates in aged care as follows:

> We try and give a voice to the older person. The person who is fearful of speaking up. We try not to replace their voice. We are very much about assisting a person to understand their rights, understand that they are able to raise complaints, that there won't be retribution, or there shouldn't be retribution, and giving them the confidence and the skills to raise that and, ideally, after that experience, feeling comfortable, that next time they're faced with a situation where they need to raise a complaint, that they're comfortable to do that.[346]

Advocates are particularly important for certain populations, including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse groups, the LGBTI community, care leavers, veterans, and people with disability. One person's public submission stated:

> Not being able to speak up for myself would be my biggest fear. That's why access to advocacy is crucial—vulnerable people, minority groups and CALD [culturally and linguistically diverse] communities need someone on their side to fight for them. People need to be heard and understood.[347]

All older people who seek or receive aged care services should have access to individually focused advocacy support.

Individual advocacy is one dimension of advocacy. There are two others: education and 'systemic advocacy'.[348] Education refers to the delivery of information and training to older people and their families and representatives, as well as to aged care providers and their staff.[349] Education about the rights of older people, and the responsibilities of aged care providers, can help to build the capacity of older people to raise and resolve issues. Mr Rowe gave evidence that education sessions conducted in services also provide a source of referrals for advocacy services. He said, 'People don't know about us until

we get out there'.[350] The Older Persons Advocacy Network, known as OPAN, submitted that advocacy services are well placed to provide these educative services, including because they 'have the advantage of independence from compliance functions and avoid the perception among some older people of being 'official' or 'government' based.[351] As Mr Rowe explained, 'for advocacy to be fully effective, all stakeholders need to understand the role and value of advocacy'.[352]

'Systemic advocacy' involves raising systemic or widespread issues or problems affecting the rights of older people with providers and with government.[353] As a result of the support they provide to individuals, advocacy services are well placed to identify these issues. Mr Rowe said that advocacy services are 'frequently the only avenue available for the voice of the most vulnerable aged care user to be raised'. In his view, 'Advocacy services have a responsibility to ensure that the voice of the aged care consumer is heard at the service, state and national level.'[354] Professor Paterson gave evidence that in his view:

> The absence of a strong consumer voice in the aged care system is a notable feature of aged care in Australia. The voices of providers are prominent in the Australian system—and appear to be highly influential in policy debates, with Ministers, departments, agencies and officials—but the voices of consumers, families and consumer advocates are relatively weak.
>
> It is unrealistic to expect family members, who are often exhausted from caring for their loved one, or distressed from grief and experiences of poor care, to provide sustained advocacy. Consumer groups are poorly resourced compared to provider groups.[355]

We agree with Professor Paterson that advocacy networks are a mechanism to correct this imbalance. We also agree that advocacy services should extend beyond individual advocacy to information awareness and education programs so that older people are aware of their entitlements and how advocacy can help them. The services should extend to 'systemic advocacy', to advance the interests of older people as a group.

14.8.1 The role of advocates in the formal complaints process

Supporting older people through the formal complaints process is a central function of advocacy services.

We have heard that many people who receive aged care and their family members are fearful of making a complaint.[356] Research carried out on our behalf supports this.[357] One person's public submission stated, 'Dad was never one to make trouble and didn't want us to complain in case he was classed as a trouble maker and would suffer repercussions for it.'[358] Another explained:

> Many family members won't say anything—don't want to speak up because [they] don't want retribution or appear not to appreciate what staff are doing and understand it's a difficult job for the staff. So the residents continue to be treated badly.[359]

A sizeable majority of aged care complaints are made by family members or supporters of an older person on behalf of the older person. We have heard evidence about the ongoing and tireless advocacy of many family members on behalf of older people, particularly those living in residential care.[360] This points to the importance of access to advocates for older people who may not have family or others who are able to advocate on their behalf.[361] Ms Robyn Delahunty told us of the effect of her family's advocacy on her mother's 'generally positive' experiences in aged care:

> We believe that close family contact and our determined advocacy to achieve improved delivery of daily care needs significantly aided her. Residents without family to advocate and speak for their needs may have less fortunate experiences and outcomes in residential Aged Care.[362]

In addition to helping people resolve complaints with providers, advocates can also help people making formal complaints to the regulator. The formal complaints process can be an unfamiliar and daunting experience for older people and their families and friends.

Ms Holland-Batt, who made a complaint about the care provided to her father, gave evidence that she was reliant upon the complaints officer's interpretation of the system and the provider's response and assurances. She said:

> It would be useful to have an officer involved in the process who was not responsible for resolving the complaint; someone more independent from the process that could provide disinterested support.[363]

There should be a role for advocates in supporting people through the formal complaints process, but at present there is considerable uncertainty about the role of advocates in this process. The Aged Care Quality and Safety Commission refers some complaints to advocacy organisations. Aged and Disability Advocacy Australia, which provides aged care advocacy services in Queensland, has reported an increase in referrals for cases that should be within the scope of the Commissioner's functions.[364] Mr Rowe gave evidence that there 'has at times been confusion over this process' because the Aged Care Quality and Safety Commission expects Aged and Disability Advocacy Australia to 'undertake the meeting [between the complainant and provider] without the presence' of the Aged Care Quality and Safety Commission, which leads to 'issues around responsibility and the role of advocacy providing support in the middle of the ACQSC [Aged Care Quality and Safety Commission] complaints processes'.[365]

We agree that the current processes risk undermining the independent role of advocates. As we noted earlier, advocacy services should not be seen as a substitute for an effective and responsive regulator that engages with, and listens to, older people, their families and carers. A clearer delineation of roles in the external complaints process is desirable.

At present, approved providers are required to allow advocates to access their aged care services during normal business hours and as requested by a person receiving aged care.[366] Under the Charter of Aged Care Rights, a person receiving aged care has a right to have a person of their choice, including an aged care advocate, support them or speak on their behalf. The Aged Care Quality Standards require providers to demonstrate that 'consumers' are made aware of, and have access to, advocates for raising and resolving complaints.[367]

However, the role of advocates in the context of aged care complaints is not formally recognised in legislation. Mr Rowe gave evidence about the benefit of having a legislated mandate that can be referred to by an advocacy service which is trying to support someone to raise a concern with a provider, instead of having to use 'powers of persuasion'.[368]

The position in Australia is in contrast with that in New Zealand, where legislation sets out the functions of health and disability services consumer advocates.[369] These functions include receiving complaints, representing or assisting a person for the purposes of trying to resolve the complaint, and providing assistance to those who wish to pursue a complaint formally or informally.[370] There are legislative mechanisms for ensuring that where a complaint is referred to an advocate, the advocate provides a report on the outcome including the terms of any agreement reached and any areas on which no agreement is reached.[371] Mr Rowe said that one of his frustrations is that an advocate can go through the process with an older person and get a resolution, and then be told later that it has not translated into practice.[372] This underscores the benefit of a formal reporting mechanism through which providers account for actions taken in response to complaints.

To avoid any doubt, advocates should be recognised as having standing when making complaints on behalf of older people. In recommendation 98 (above), we recommend that the role of advocacy services in relation to complaints handling be formally recognised in the new Act.

14.8.2 The need for an expanded advocacy program

Older people receiving or applying for subsidised aged care are eligible to receive assistance from a formal advocacy service through the National Aged Care Advocacy Program.[373] The key activities of the program are to provide independent, individual advocacy support and information to older people, including their families or representatives, and to deliver education sessions to older people, aged care providers and staff.[374] The budget for the National Aged Care Advocacy Program has increased in recent years. However, the $10.6 million budgeted for in 2019–20 is less than the $11.2 million spent the previous financial year.[375] We understand that some additional funding has also been provided to the Older Persons Advocacy Network to continue its enhanced advocacy and information support to people during the COVID-19 pandemic.[376]

However, the evidence before us suggests that advocacy funding remains inadequate.

Since 2017, the National Aged Care Advocacy Program has been provided by OPAN, a network comprised of nine service delivery organisations across Australia. The OPAN Annual Report for 2018–19 stated that, despite supporting close to 15,000 people receiving aged care services, this was just over 1% of the number receiving aged care in Australia. It reported a 67% increase in demand for information and advocacy support over the preceding two years.[377] OPAN has also noted that there is an increase in the number of people experiencing complex disadvantage, as well as a greater proportion of older people from culturally and linguistically diverse backgrounds.[378]

Mr Rowe, an OPAN member, said that recent substantial increases in advocacy demand had not led to a commensurate increase in funding.[379] In its submission, Aged and Disability Advocates Australia stated that:

> In the last 6 months alone, the Government has announced an additional 30,000 Home Care Packages. This represents an increase of almost 40% from a cohort heavily dependent on advocacy support to receive a quality service. Many of these people will seek advocacy support to understand, access, negotiate and resolve issues relating to their Home Care Package, and yet the NACAP [National Aged Care Advocacy Program] has received no additional funds to respond to this growth.[380]

Mr Rowe estimated that the Aged and Disability Advocates Australia waiting list for advocacy was around six weeks.[381] That is too long. People will generally seek formal advocacy support for an issue impacting upon the quality or safety of their care, which they may have already spent some time trying to address themselves. In six weeks, their health or wellbeing may have deteriorated to the point that they are less able to lead full and satisfying lives. These figures indicate to us the need for a significant increase in the availability of formal advocacy support.

We consider that a continued and expanded investment in advocacy services is required to ensure that older people, including their families and supporters, are supported to understand their rights and to raise matters of concern.[382] This increased funding must be sufficient to cover current and projected unmet need for advocacy services by people seeking or receiving aged care services. It should also enable advocacy services to fulfil other key advocacy functions, such as education and systemic advocacy and the maintenance of skills and capabilities within advocacy organisations.

Mr Rowe gave evidence that the increased demand for advocacy support 'results in a reduction in our ability to undertake education given the limited financial resources'.[383] The same issue was identified by a 2015 review of aged care advocacy services, which concluded that:

> to avoid waiting lists, advocacy services were favouring individual advocacy at the expense of education, despite the acknowledged quality of the latter and its effectiveness in leading consumers to advocacy services.[384]

Adequate funding is required to ensure that advocacy services do not need to continue to make the difficult choice between meeting the demand for individual advocacy and their education functions.

In the context of an expanded advocacy program, there will also be a need to build capacity within advocacy organisations. Professor Paterson reflected on the strength of New Zealand's publicly funded advocacy program, which he considered a 'jewel in the crown' of the aged care system in that country.[385] In contrast, he saw weakness in Australia's formal advocacy system, describing it as 'a loose network of advocacy services' and in need of strengthening.[386]

Continuing training and professional development of advocates is essential if they are to have the skills and knowledge to advocate effectively. The advocacy network needs to be able to achieve high standards of service based on nationally consistent processes and guidelines. Advocacy services need to be able to maintain accurate records and statistics and have the capacity to use this information to improve their own services and make representations to improve the performance of the system as a whole. If advocacy services are to achieve their potential in representing the interests of older people in aged care, this infrastructure needs to be developed and maintained over time. It needs to be specifically funded.

14.8.3 Formal consultation to determine additional funding requirements

The Australian Government has advised that: 'conversations have begun between the Department and Older Persons Advocacy Network (OPAN) with respect to improving access to individual advocacy, including for people receiving home care services and people with diverse characteristics and life experiences'.[387] This is a welcome development.

However, conversations about improving access do not necessarily lead to additional resources. We consider that the implementation unit responsible for the implementation of the Royal Commission's recommendations should undertake a formal consultation with service providers under the National Aged Care Advocacy Program to determine the extent of unmet need, and the amount of funding required to address this. The Australian Government should then provide the advocacy service with a sustainable funding base that is reasonably related to the level of demand and the full cost of providing these services. Counsel Assisting made a similar recommendation in the Final Hearing, which received broad support.[388]

This consultation should address the need for specialist knowledge and capacity to advocate on behalf of people from diverse backgrounds, including Aboriginal and Torres Strait Islander people, those from culturally and linguistically diverse groups, the LGBTI community, care leavers, veterans, those with disability and those with mental illness.[389] It must also consider the higher costs associated with delivering services to people in regional, rural and remote areas, and the need for equitable access.[390] OPAN has submitted that funding is not currently commensurate with the costs service delivery organisations face in operating in rural and remote locations.[391]

OPAN responded to Counsel Assisting's recommendation that it would 'welcome the opportunity to work closely with the Australian Government to determine the extent of unmet need and unmet demand for individual advocacy services'. It submitted that this examination 'needs to include engagement and consultation with older Australians as to their needs and the advocacy model they desire into the future—any future model must be co-designed with older people'.[392] Mr Rowe submitted that in determining unmet demand, this consultation should 'consider the full range of functions advocates perform'. He noted that 'in addition to resolving complaints, advocates play a vital empowerment role in reminding recipients / carers of their rights and encouragement not to settle for sub-standard care'.[393]

We agree. The consultation should consider not only the need for individual advocacy services, but for education sessions for older people, providers and their staff, as well as systemic advocacy and an appropriate provision for the ongoing infrastructure and capacity to support an effective national network of advocacy services.

14.8.4 An immediate funding increase

In the interim, an immediate funding boost is required to increase the numbers of people who can be supported through the advocacy program, expand the scope of advocacy services, and build the capacity of the advocacy network.

We recommend an increase in funding to enable at least 5% of people receiving aged care to access advocacy services. This is consistent with the submission of OPAN, which proposed an 'immediate funding increase to the National Aged Care Advocacy Program to allow a minimum of 5% of older people receiving Commonwealth aged care to receive Aged Care Advocacy'.[394] This will require considerable additional funding for the advocacy program.

This increase is a necessary response to the limited access to advocacy services currently available to older people. In addition to the evidence that advocacy services only reach about 1% of people receiving aged care, research that we commissioned indicated that only 0.4% of concerns of older people receiving Home Care Packages were reported to an advocacy organisation.[395] In residential care, it is less than 0.4%.[396] When residents raised concerns with an advocacy organisation, the concerns were then officially reported on their behalf 100% of the time.[397]

We recommend an immediate injection of funding to expand the reach and scope of the advocacy program and build the capacity of the advocacy network, pending the outcome of a comprehensive review of the program's long-term funding requirements. The importance of advocacy services, and the history of under-funding, means that an injection of funding cannot wait for the conclusion of the recommended consultation process.

Advocacy organisations are critical to the health of a well-functioning and responsive aged care system. The System Governor has a direct interest in supporting and nurturing the development of a strong, effective and responsive advocacy network. Stewardship of this function should be a core element of its broader system responsibilities.

Recommendation 106: Enhanced advocacy

1. By 1 July 2022, the Australian Government should, through the implementation unit responsible for implementation of the Royal Commission's recommendations, complete a consultation with the contracted provider of services under the National Aged Care Advocacy Program to determine the extent of unmet demand for prompt advocacy services by people seeking or receiving aged care services. The consultation should also consider the need for:
    a. additional funding for the provision of education and systemic advocacy by the contracted provider of services.
    b. capacity building of advocacy services.
2. In light of the conclusions reached by the implementation unit after that consultation, the Australian Government should increase the funding of the National Aged Care Advocacy Program to establish a sustainable funding base that provides for increased coverage of the program to meet currently unmet demand for prompt advocacy services, including education, and systemic advocacy, as well as the infrastructure required to support an effective national network of advocacy organisations.
3. As an interim measure, by 1 July 2021 the Australian Government should provide additional funding and other supports to enable the development of an effective national advocacy network. To this end, the National Aged Care Advocacy Program should be provided with an immediate funding increase to:
    a. enable a minimum of 5% of older people to access advocacy services
    b. enable advocacy networks to
        i. provide education;
        ii. undertake systemic advocacy
    c. support capacity building of the advocacy network through training of formal advocates and the development of clear guidelines and processes to support a nationally consistent advocacy service.

14.9 Conclusion

In the Brisbane Hearing, Counsel Assisting asked Ms Beverley Johnson, a resident in an aged care facility, whether there was anything further she would like to say about the adequacy of resident representation in aged care. She responded, 'Well, I would say, "What representation?" There seems to be very little of it.'[398]

The aged care system needs to ensure that the people who receive aged care services are the central focus of regulatory action. We have recommended that inspections and accreditation processes place greater emphasis on the feedback of those people with direct experience of the quality and safety of aged care. Our recommendations for improved complaint handling, greater clarity around the role of advocates, and avenues for redress and compensation are also directed to ensuring that people with direct experience can play a greater role in the regulation of aged care.

We have recommended that the Quality Regulator be given additional functions, strengthened powers and the resources it needs to perform those functions and exercise those powers. This should give the regulator greater flexibility when responding to risks of harm and non-compliance. However, we agree with the comments of Relationships Australia in its response to Counsel Assisting's final submissions that:

> There is an over-riding imperative to prevent relapse into the incurious 'tick a box' regulatory culture that has been criticised by so many witnesses to this Royal Commission. Conferring a suite of coercive powers on a regulator is not of itself sufficient to promote a culture of responsive regulation that makes nuanced use of the powers conferred on regulators. Further necessary preconditions include adequate resourcing, independence of funding (ie the regulator should not be dependent for its funding on the entities being regulated), a culture of proactive regulation, and leadership that explicitly eschews ritualistic/tick a box regulation.[399]

It is essential that the culture, resourcing and approach of the Quality Regulator are such that the regulator can fulfil its vital role of protecting and enhancing the quality and safety of care provided within the aged care system.

Endnotes

1 Productivity Commission, *Caring for Older Australians (Overview), 2011 (*Exhibit 1-31, Adelaide Hearing 1, RCD.9999.0011.0943); Productivity Commission, *Caring for Older Australians (Volume 1)*, 2011 (Exhibit 1-32, Adelaide Hearing 1, RCD.9999.0011.1031); Productivity Commission, *Caring for Older Australians (Volume 2)*, 2011 (Exhibit 1-33, Adelaide Hearing 1, RCD.9999.0011.1261).
2 K Carnell and R Paterson, *Review of National Aged Care Quality Regulatory Processes*, 2017, pp 108–114 (Exhibit 1-25, Adelaide Hearing 1, RCD.9999.0011.1833).
3 See Volume 2, Chapter 1, on the current system.
4 Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, RCD.9999.0143.0001 at 0002 [14].
5 Transcript, Adelaide Hearing 1, Janet Anderson, 18 February 2019 at T362.44–363.15.
6 Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T9032.15–30; T9035.27–41; T9039.23–24.
7 See Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T9035.16–25.
8 Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T9035.16–25.
9 Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T9035.16–25; Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 41, CTH.4000.0001.2641 at 2653 [42]–2655 [45].
10 See Exhibit 5-7, Perth Hearing, general tender bundle, tab 67, AWF.001.00519 at 0002.
11 Established with effect from 1 January 2019 by section 11 of the *Aged Care Quality and Safety Commission Act 2018* (Cth).
12 Submission of UnitingCare Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0012.0058 at row 754.
13 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, p 14 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).
14 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 70, RCD.9999.0480.0001 at 0005.
15 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 132, RCD.9999.0529.0001 at 0014, 0140.
16 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 73, WIT.0786.0001.0001 at 0010.
17 *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 63D(2)(b), 63D(3).
18 *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63D(4).
19 *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63J(1)(b).
20 *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 63D(3), 63J(3).
21 *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 63D(6), 63J(6).
22 More detail about this case study is included in Volume 4B, Chapter 8, of our report.
23 My Aged Care, *Notices of Non-compliance, Notices to Agree and Sanctions in People Care Pty Ltd (formerly Hibiscus House Nursing House)*, 2019, https://www.myagedcare.gov.au/non-compliance-checker/details-provider/1-DS-531/1-EG-2288, viewed 9 December 2020; My Aged Care, *Notices of Non-compliance, Notices to Agree and Sanctions in People Care*, 2019, https://www.myagedcare.gov.au/non-compliance-checker/details-provider/1-DS-531/1-KLL-157, viewed 9 December 2020.
24 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0028 [12b].
25 Exhibit 2-9, Adelaide Hearing 2, Statement of BE, WIT.0087.0001.0001 at 0003 [17]–[21].
26 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 64, CTH.1000.0004.7448 at 7490.
27 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 64, CTH.1000.0004.7448 at 7480.
28 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 85, RCD.0010.0001.0115 at 0139.
29 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 85, RCD.0010.0001.0115 at 0139.
30 *Aged Care Act 1997* (Cth), ss 42-1, 42-4.
31 *Aged Care Quality and Safety Commission Rules 2018* (Cth), s 52.
32 Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T9035.16–25.
33 Transcript, Sydney Hearing 4, Janet Anderson and Mark Rummans, 2 September 2020, T9032.23–46.
34 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 7, CTH.0001.4001.9469 at Q1-2.
35 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 64, CTH.1000.0004.7448 at 7484. Note that in Sydney Hearing 4, witnesses from the Aged Care Quality and Safety Commission were unable to confirm this. See Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T9033.1–6.
36 See Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 85, RCD.0010.0001.0115 at 0139.
37 *Aged Care Quality and Safety Commission Rules 2018* (Cth), s 29(4)(a).
38 *Aged Care Quality and Safety Commission Rules 2018* (Cth), s 41.
39 See Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T9045.3–19. See also Transcript, Sydney Hearing 4, Michael Lye, 2 September 2020 at T9058.46–9059.3.
40 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 64, CTH.1000.0004.7448 at 7478.
41 Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T9046.3–6.
42 Exhibit 2-9, Adelaide Hearing 2, Statement of BE, WIT.0087.0001.0001 at 0004 [27].
43 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 85, RCD.0010.0001.0115 at 0138–0139.
44 See Submissions of Aged & Community Services Australia, Sydney Hearing 4, 11 September 2020, RCD.0012.0072.0014 at 0029.
45 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 41, CTH.4000.0001.2641 at 2653–2654.
46 See Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 132, RCD.9999.0529.0001 at 0141.

47 See, for example, *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth), s 13.
48 *Aged Care Quality and Safety Commission Act 2018* (Cth), s 16(1)(a).
49 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4587.1–32.
50 Australian Aged Care Quality Agency, *Corporate Plan 2018-19*, 2018, p 6.
51 Exhibit 17-1, Melbourne Hearing 4, general tender bundle, tab 29, CTH.1000.0004.0793 at 0756 [58(a)].
52 Exhibit 8-32, Brisbane Hearing, Statement of Amy Laffan, WIT.0282.0001.0001 at 0006 [33]–0007 [43]; Exhibit 17-1, Melbourne Hearing 4, general tender bundle, tab 29, CTH.1000.0004.0793 at 0758 [59]; Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 41, CTH.4000.0001.2641 at 2653 [42].
53 R Johnstone et al., *Work Health and Safety Law and Policy*, 2012, [8.455]; W Creighton and P Rozen, *Health and Safety Law in Victoria*, 2017, [10.60]–[10.66].
54 Transcript, Sydney Hearing 4, Robert Fitzgerald, 1 September 2020 at T8948.25–30.
55 P Armytage et al., *Independent Inquiry into the Environment Protection Authority,* 2016, pp 221–222; *Environment Protection Amendment Act 2018* (Vic) s 7 (which will come into effect in July 2021).
56 Exhibit 5-40, Perth Hearing, Statement of Lisa Trigg, WIT.0156.0001.0001 at 0018 [105].
57 Exhibit 5-40, Perth Hearing, Statement of Lisa Trigg, WIT.0156.0001.0001 at 0009 [47]; 0018 [106].
58 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 79, CTH.4000.0001.1708 at 1713 [13].
59 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 79, CTH.4000.0001.1708 at 1713 [13].
60 See Transcript, Brisbane Hearing, Debora Picone, 9 August 2019 at T4769.6–10.
61 See Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 79, CTH.4000.0001.1708 at 1717 [29].
62 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 79, CTH.4000.0001.1708 at 1717 [30]–1718 [31].
63 *Aged Care Quality and Safety Commission Rules 2018* (Cth), s 38(2).
64 *Aged Care Quality and Safety Commission Rules 2018* (Cth), ss 40A(2)(c), 57(2)(c).
65 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 79, CTH.4000.0001.1708 at 1714 [16].
66 K Carnell and R Paterson, *Review of National Aged Care Quality Regulatory Processes*, 2017, pp xi, 89 (Exhibit 1-25, Adelaide Hearing 1, RCD.9999.0011.1833).
67 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4595.30–32.
68 See Submission of Older Persons Advocacy Network, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0011.0013 at row 709; Submission of the Australian Nursing and Midwifery Federation, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0013.0162 at row 709.
69 Submission of Dementia Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0012.0130 at row 709; Submission of Aged & Community Services Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0013.0102 at row 710.
70 Submission of Relationships Australia, Response to Counsel Assisting's final submissions, 10 November 2020, RCD.0013.0007.0066 at row 710.
71 Submissions of the Commonwealth of Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0014.0037 at row 709.
72 See Submission name withheld, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0010.0063 at row 710.
73 See Submission of National Seniors Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0014.0299 at row 710.
74 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 79, CTH.4000.0001.1708 at 1719 [34];
75 K Carnell and R Paterson, *Review of National Aged Care Quality Regulatory Processes*, 2017, pp vii–viii (Exhibit 1-25, Adelaide Hearing 1, RCD.9999.0011.1833).
76 See Productivity Commission, *Report on Government Services 2017*, 2017, Table 14A.33; Productivity Commission, *Report on Government Services 2018*, 2018, Table 14A.33; Productivity Commission, *Report on Government Services 2019*, 2019, Table 14A.34. See also K Carnell and R Paterson, *Review of National Aged Care Quality Regulatory Processes*, 2017, p 11 (Exhibit 1-25, Adelaide Hearing 1, RCD.9999.0011.1833).
77 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4582.39–4583.2.
78 Anna Howe, Public submission, AWF.001.01668.01 at 0003.
79 K Carnell and R Paterson, *Review of National Aged Care Quality Regulatory Processes*, 2017, pp 62–63 (Exhibit 1-25, Adelaide Hearing 1, RCD.9999.0011.1833); Exhibit 1-3, Adelaide Hearing 1, Statement of Ian Yates, WIT.0006.0001.0001 at 0009 [33]. See also Transcript, Brisbane Hearing, John Braithwaite, 9 August 2019 at T4787.29–32.
80 Transcript, Melbourne Hearing 2, David Panter, 10 October 2019 at T5662.11–5663.2.
81 Further detail on this case study is in Volume 4B, Chapter 8 of our report.
82 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 6, CTH.4008.1000.2320. See also *Quality of Care Principles 2014* (Cth) ss 10, 11 (as then in force), sch 2. The accreditation standards against which MiCare was judged were replaced with effect from 1 July 2019.
83 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 11, CTH.4007.1000.0003.
84 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 16, CTH.4007.9000.0001. The Aged Care Complaints Commissioner was replaced by the Aged Care Quality and Safety Commission with effect from 1 January 2019.
85 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4352.15–4353.17.
86 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 20, CTH.4007.1000.0598.
87 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 59, CTH.4007.1000.3511.
88 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 136, MIC.5000.0001.0325 a0003.
89 Transcript, Brisbane Hearing, Judith Coombe, 6 August 2019 at T4338.27–31.

90 Exhibit 8-18, Brisbane Hearing, Supplementary Statement of Catherine Rosenbrock, WIT.0359.0001.0001 at 0002 [10]–[11], [14]–[17].
91 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 251, CTH.4007.2000.0632.
92 Submission of AgeWorks Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0010.0150 at row 727.
93 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 79, CTH.4000.0001.1708 at 1726 [61]–[64].
94 Submissions of the Commonwealth of Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0014.0037 at row 727.
95 See, for example, *Coroners Act 2009* (NSW), ss 35, 6; *Coroners Act 2008* (Vic), ss 4, 10–12.
96 See Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 171, RCD.9999.0231.0034 at 0040 [17]; *Coroners Act 2008* (Vic), Preamble.
97 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 85, RCD.9999.0142.0001; Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 171, RCD.9999.0231.0034; Coroners Court of Victoria, *Finding into death with inquest (Broughton Hall Nursing Home) COR 2007 1371*, 2012.
98 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 171, RCD.9999.0231.0034 at 0064 [8].
99 Exhibit 3-70, Sydney Hearing 1, Statement of Joseph Ibrahim, WIT.0115.0001.0001 at 0058 [307]–[308]. L Bugeja et al., 'Frequency and nature of coroners' recommendations from injury-related deaths among nursing home residents: a retrospective national cross-sectional study', *Injury Prevention*, 2018, Vol 24, 6, p 414.
100 Exhibit 3-70, Sydney Hearing 1, Statement of Joseph Ibrahim, WIT.0115.0001.0001 at 0057–0058 [306].
101 See Exhibit 8-26, Brisbane Hearing, Statement of Anthony Speed, WIT.0261.0002.0001 at 0022 [84]–0023 [87].
102 Royal Commission into Aged Care Quality and Safety, *Aged care and COVID-19: a special report*, 2020, p 24; Coroners Court of Victoria, *Finding into death with inquest (Broughton Hall Nursing Home) COR 2007 1371*, 2012, p 57.
103 Royal Commission into Aged Care Quality and Safety, *Aged care and COVID-19: a special report*, 2020, pp 22–24 (Recommendation 5).
104 See Exhibit 8-26, Brisbane Hearing, Statement of Anthony Speed, WIT.0261.0002.0001 at 0022–0023 [84]–[87].
105 Exhibit 3-70, Sydney Hearing 1, Statement of Joseph Ibrahim, WIT.0115.0001.0001 at 0058 [309].
106 *Coroners Act 2008* (Vic), s 72(4). See also Exhibit 3-70, Sydney Hearing 1, Statement of Joseph Ibrahim, WIT.0115.0001.0001 at 0058 [310].
107 See A Robertson SC, *Independent review of the adequacy of the regulation of the supports and services provided to Ms Ann-Marie Smith, an NDIS participant, who died on 6 April 2020: Report to the Commissioner of the NDIS Quality and Safeguards Commission*, 2020.
108 Submissions of the Commonwealth of Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0014.0037 at row 749.
109 *Coroners Act 2008* (Vic), s 72(3); see also Exhibit 3-70, Sydney Hearing 1, Statement of Joseph Ibrahim, WIT.0115.0001.0001 at 0058 [310].
110 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth), ss 27, 29.
111 *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth), ss 29(3), (6); *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth), ss 27(4), (7).
112 See *Aged Care Act 1997* (Cth), ch 4; *Aged Care Quality and Safety Commission Act 2018* (Cth), s 74B; *Regulatory Powers (Standard Provisions) Act 2014* (Cth), s 18.
113 *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 65, 66, 68, 69.
114 *Regulatory Powers (Standard Provisions) Act 2014* (Cth), s 24.
115 *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 67, 70.
116 *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 67, 70.
117 K Carnell and R Paterson, *Review of National Aged Care Quality Regulatory Processes*, 2017, pp 128–129 (Exhibit 1-25, Adelaide Hearing 1, RCD.9999.0011.1833 at 1973–1974).
118 *Aged Care Quality and Safety Commission Rules 2018* (Cth), ss 64(1)(b), 70(3); *Aged Care Quality and Safety Commission Act 2018* (Cth), s 68.
119 *Aged Care Act 1997* (Cth), s 63-1(1)(b).
120 *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63N.
121 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 22, AWF.600.01806.0002 at 0014.
122 *Work Health and Safety Act 2011* (Cth), s 163(1), (2); see also *Occupational Health and Safety Act 2004* (Vic), ss 98–99.
123 *Taxation Administration Act 1953* (Cth), sch 1, s 353-15(1).
124 *Taxation Administration Act 1953* (Cth), sch 1, s 353-15(2).
125 See for example *Taxation Administration Act 1953* (Cth), s 353-15(3).
126 Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020, T9464.1–23. See also Transcript, Sydney Hearing 5, Jaye Smith, 18 September 2020, T9464.25–32.
127 Submissions of the Commonwealth of Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0014.0037; Submission of Anglicare Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0009.0185.
128 Exhibit 8-28, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0012 [75], 0013 [88]; Exhibit 8-39, Brisbane Hearing, Statement of Debra Barnes, WIT.0328.0001.0001 at 0007 [46]; Exhibit 5-9, Perth Hearing, Statement of Noleen Hausler, WIT.1124.0001.0001 at 0005 [46]–0006 [47], 0008 [68]–0009 [70].
129 Exhibit 8-39, Brisbane Hearing, Statement of Debra Barnes, WIT.0328.0001.0001 at 0007 [49].
130 Exhibit 8-24, Brisbane Hearing, Statement of Gwenda Darling, WIT.0329.0001.0001 at 0003 [16]; 0005 [31]; 0009 [54].
131 Exhibit 6-20, Darwin and Cairns Hearing, Statement of Lisa Maree Backhouse, WIT.0221.0001.0001 at 0009 [54]; Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019 at T4710.5–14.

132 National Ageing Research Institute, *Inside the system: aged care residents' perspectives*, A report for the Royal Commission into Aged Care Quality and Safety, Research Paper 13, 2020, pp 8–9, 45. Of the respondents to the survey, not a single resident made a complaint to the Aged Care Quality and Safety Commission, and even taking into account complaints made by another person on a resident's behalf, only 1.8% of such concerns led to a complaint to the Commission.
133 National Ageing Research Institute, *Inside the system: aged care residents' perspectives*, A report for the Royal Commission into Aged Care Quality and Safety, Research Paper 13, 2020, p 47.
134 See Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, RCD.9999.0143.0001 at 0003 [24].
135 Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, RCD.9999.0143.0001 at 0003 [24].
136 See Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4355.42–47.
137 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 78, CTH.4010.9000.0210 at 0210.
138 Exhibit 8-1 Brisbane Hearing, Earle Haven tender bundle, tab 86, CTH.4010.9999.0007.
139 Exhibit 8-1 Brisbane Hearing, Earle Haven tender bundle, tab 79, CTH.4010.9000.0294 at 0294.
140 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 89, CTH.4010.9000.2056 at 2056.
141 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, Earle Haven Case Study, 26 August 2019, RCD.0012.0026.0001 at 0045 [150].
142 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, Earle Haven Case Study, 26 August 2019, RCD.0012.0026.0001 at 0056 [191]–0059 [203].
143 K Carnell and R Paterson, *Review of National Aged Care Quality Regulatory Processes*, 2017, p 82 (Exhibit 1-25, Adelaide Hearing 1, RCD.9999.0011.1833).
144 *Aged Care Quality and Safety Commission Act 2018* (Cth), s 18.
145 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4590.21–24.
146 *Health and Disability Commissioner Act 1994* (NZ), ss 34–35.
147 Aged Care Quality and Safety Commission, *Better Practice Guide to Complaint Handling in Aged Care Services*, 2019, p 12.
148 *Quality of Care Principles 2014* (Cth), sch 2 std 1 (Standard 6–feedback and complaints). See also sch 2 std 8(3)(e) (Standard 8–organisational governance).
149 Aged Care Quality and Safety Commission, *Open disclosure: Framework and guidance*, 2019, p 12.
150 Aged Care Quality and Safety Commission, *Open disclosure: Framework and guidance*, 2019, p 8.
151 National Ageing Research Institute, *Inside the system: aged care residents' perspectives*, A report for the Royal Commission into Aged Care Quality and Safety, Research Paper 13, 2020, pp 8–9.
152 National Ageing Research Institute, *Inside the system: home and respite care clients' perspectives*, A report for the Royal Commission into Aged Care Quality and Safety, Research Paper 14, 2020, pp 10–11.
153 Aged Care Quality and Safety Commission, *Open disclosure: Framework and guidance*, 2019, p 3.
154 Exhibit 13-37, Hobart Hearing, Statement of Bethia Wilson, WIT.0586.0001.0001 at 0005.
155 Transcript, Brisbane Hearing, Debora Picone, 9 August 2019, T4775.42–4776.11.
156 On the synergies between complaint handling and review, see Australian Government Inspector-General of Taxation, *Former IGT Valedictory Speech*, 2018, https://www.igt.gov.au/news-and-publications/other-publications/igt-valedictory-speech, viewed 10 December 2020.
157 See *Aged Care Quality and Safety Commission Rules 2018* (Cth), ss 98–103.
158 *Aged Care Quality and Safety Commission Act 2018* (Cth), s 18.
159 See Australian Department of Health, *How to make a complaint*, 2020, https://www.myagedcare.gov.au/sites/default/files/2020-02/myagedcare-guide-to-making-a-complaint.pdf, viewed 10 December 2020.
160 Exhibit 8-28, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001.
161 Transcript, Shona Reid, Melbourne Hearing 3, 18 October 2019 at T6243.28–30.
162 *Aged Care Quality and Safety Commission Rules 2018* (Cth), s 17.
163 *Aged Care Quality and Safety Commission Rules 2018* (Cth), s 19(1).
164 M Walton, *Review of the Aged Care Complaints Investigation Scheme*, 2009, p 33.
165 Exhibit 8-39, Brisbane Hearing, Statement of Debra Barnes, WIT.0328.0001.0001 at 0007 [46].
166 Rodney Lewis, Public submission, AWF.600.01354.0001 at 0019.
167 Exhibit 6-20, Darwin and Cairns Hearing, Statement of Lisa Backhouse, WIT.0221.0001.0001 at 0007 [42]–0008 [48].
168 Exhibit 8-37, Brisbane Hearing, Statement of Geoffrey Rowe, WIT.0319.0001.0001 at 0024. Ms Shona Reid, the Executive Director of the Complaints Resolution Group at the Australian Aged Care Quality and Safety Commission, disagreed with the proposition that there is an impetus to deal with complaints quickly at the expense of proper due process for the complainants. See Transcript, Brisbane Hearing, Shona Reid, 9 August 2019 at T4761.18–22.
169 Exhibit 8-37, Brisbane Hearing, Statement of Geoffrey Rowe, WIT.0319.0001.0001 at 0024.
170 Exhibit 8-37, Brisbane Hearing, Statement of Geoffrey Rowe, WIT.0319.0001.0001 at 0025.
171 Exhibit 8-37, Brisbane Hearing, Statement of Geoffrey Rowe, WIT.0319.0001.0001 at 0004. See also Submission of the Older Persons Advocacy Network, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0011.0013.
172 Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019 at T4705.46–4706.3; T4715.1–8. See also Exhibit 8-40, Brisbane Hearing, Statement of Shona Reid, WIT.0307.0001.0001 at 0005 [19d].
173 Exhibit 8-28, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0012 [82]. See also Exhibit 8-37, Brisbane Hearing, Statement of Geoffrey Rowe, 8 August 2019, WIT.0319.0001.0001 at 0023; Rodney Lewis, Public submission, AWF.600.01354.0001 at 0021.
174 Exhibit 8-37, Brisbane Hearing, Statement of Geoffrey Rowe, WIT.0319.0001.0001 at 0026.
175 Aged Care Quality and Safety Commission, *Annual Report 2019–20*, 2012, p 35.

176 Aged Care Quality and Safety Commission, *Annual Report 2019–20*, 2020, p 66.
177 See Government of Western Australia, *Health and Disability Services Complaints Office, 2019-20 Annual Report*, 2020, pp 29–30.
178 Aged Care Quality and Safety Commission, *Annual Report 2019-20*, 2020, p 65.
179 Aged Care Quality and Safety Commission, *Annual Report 2019-20*, 2020, p 65.
180 Australian Securities and Investment Commission, *Annual report 2019–20*, 2020, p 67.
181 See Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4597.4–9; Exhibit 8-38, Brisbane Hearing, Statement of the Queensland Public Guardian, WIT.0318.0001.0001 at 0016; Exhibit 8-38, Brisbane Hearing, Statement of Geoffrey Rowe, WIT.0319.0001.0001 at 0022–0023 and 0027.
182 Exhibit 8-28, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0012 [78].
183 Cheryl Axell, Public submission, AWF.001.01858 at 0001.
184 Name withheld, Public submission, AWF.001.04832 at 0001.
185 On the definition of 'staff member' see *Aged Care Act 1997* (Cth), s 63-1AA(9).
186 *Aged Care Act 1997* (Cth), s 96-8.
187 *User Rights Principles 2014* (Cth), sch 1 s 2-12.
188 Those amendments were introduced by the *Treasury Laws Amendment (Enhanced Whistleblower Protections) Act 2019* (Cth). See *Corporations Act 2001* (Cth), pt 9.4AAA.
189 See *Corporations Act 2001* (Cth), s 1317AAA; Explanatory Memorandum, Treasury Laws Amendment (Enhancing Whistleblower Protections) Bill 2017, pp 16–18.
190 *Work Health and Safety Act 2011* (Cth), ss 104–106.
191 Submission of Older Persons Advocacy Network, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0011.0013.
192 Submission of the Australian Medical Association, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0014.0086.
193 *National Disability Insurance Scheme Act 2013* (Cth), ss 73ZA–73ZD.
194 *National Disability Insurance Scheme Act 2013* (Cth), s 73ZA.
195 See Submission of the Governance Institute of Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0012.0112 at 0116–0117.
196 Australian Department of Health, *2019-20 Report on the Operation of the Aged Care Act 1997*, 2020, p 90.
197 Australian Department of Health, *2014-15 Report on the Operation of the Aged Care Act 1997,* 2015, p 115; Australian Department of Health, *2019-20 Report on the Operation of the Aged Care Act 1997*, 2020, p 90.
198 *Aged Care Act 1997* (Cth), s 63-1AA(3); *Accountability Principles 2014* (Cth), s 53(1).
199 KPMG, *Prevalence Study for a Serious Incident Response Scheme (SIRS)*, 2020, pp 4, 37–38.
200 KPMG, *Prevalence Study for a Serious Incident Response Scheme (SIRS)*, 2020, pp 5, 38, 48.
201 Australian Department of Health, *2018-19 Report on the Operation of the Aged Care Act 1997,* 2019, p 84.
202 Exhibit 3-28, Sydney Hearing 1, Statement of Kathryn Nobes, WIT.0143.0001.0001 at 0001 [8].
203 Exhibit 3-28, Sydney Hearing 1, Statement of Kathryn Nobes, WIT.0143.0001.0001 at 0006 [37]–0007 [43].
204 Exhibit 3-28, Sydney Hearing 1, Statement of Kathryn Nobes, WIT.0143.0001.0001 at 0001 [8].
205 Under the compulsory reporting scheme, approved providers are required to notify the police and the Aged Care Quality and Safety Commission in response to an allegation or suspicion of a reportable assault. A reportable assault is defined as unlawful sexual contact or unreasonable force or assault inflicted on a recipient of residential care. See *Aged Care Act 1997* (Cth), s 63-1AA; *Accountability Principles 2014 (Cth), s 53(1).*
206 See Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, Australian Department of Health's response to certain reportable assaults reported by Japara Healthcare Ltd, 26 August 2019, RCD.0012.0025.0001, particularly at 0039 [144h]; Transcript, Brisbane Hearing, Peter O'Brien, 6 August 2019 at T4450.22–25; Exhibit 22-12, Final Hearing, ACQSC Response to NTG-0783 dated 23 September 2020, CTH.4000.0001.2842 at 2848 [24].
207 Transcript, Brisbane Hearing, Peter O'Brien, 7 August 2019 at T4482.19–4483.9.
208 Exhibit 22-12, Final Hearing, ACQSC Response to NTG-0783 dated 23 September 2020, CTH.4000.0001.2842 at 2842 [3].
209 See generally Exhibit 22-12, Final Hearing, ACQSC Response to NTG-0783 dated 23 September 2020, CTH.4000.0001.2842.
210 Australian Law Reform Commission, *Elder Abuse: A National Legal Response*, 2017, pp 111–126 (Exhibit 1-27, Adelaide Hearing 1, RCD.9999.0011.0302); K Carnell and R Paterson, *Review of National Aged Care Quality Regulatory Processes*, 2017, pp 108–114 (Exhibit 1-25, Adelaide Hearing 1, RCD.9999.0011.1833).
211 Exhibit 8-31, Brisbane Hearing, Statement of Amy Laffan, WIT.0279.0001.0001 at 0011 [47]; Australian Department of Health, *Serious Incident Response Scheme (SIRS)*, 2020, https://www.health.gov.au/initiatives-and-programs/serious-incident-response-scheme-sirs, viewed 30 October 2020; Senator the Hon Richard Colbeck, Minister for Aged Care and Senior Australians, Media release, *Serious Incident Response Scheme*, 2020, https://www.health.gov.au/ministers/senator-the-hon-richard-colbeck/media/serious-incident-response-scheme, viewed 9 December 2020.
212 See *Aged Care Legislation Amendment (Serious Incident Response Scheme and Other Measures) Bill 2020* (Cth), s 54-3.
213 See Exhibit 1-44, Adelaide Hearing 1, Statement of Maree McCabe, WIT.0005.0001.0001 at 0003 [19]; KPMG, Prevalence Study for a Serious Incident Response Scheme (SIRS), 2020.
214 See Volume 4B, Chapter 8.
215 Australian Department of Health, *Serious Incident Response Scheme (SIRS)*, 2020, https://www.health.gov.au/initiatives-and-programs/serious-incident-response-scheme-sirs, viewed 4 November 2020.
216 For a comparable example, see *Children's Guardian Act 2019* (NSW), s 9.

217 See Transcript, Sydney Hearing 4, Robert Fitzgerald and Kathryn McKenzie, 1 September 2020 at T8959.9–8960.18; Submissions of Aged & Community Services Australia, Sydney Hearing 4, 11 September 2020, RCD.0012.0072.0014 at 0031.
218 Transcript, Sydney Hearing 4, Robert Fitzgerald, 1 September 2020 at T8950.1–6. See also Transcript, Perth Hearing, Kay Patterson, 26 June 2020 at T2550.19–22; Transcript, Adelaide Hearing 2, Mary Patetsos, 20 March 2019 at T935.30–43; Exhibit 2-37, Adelaide Hearing 2, Statement of Mary Patetsos, WIT.0084.0001.0001 at 0005 [33].
219 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 73, WIT.0786.0001.0001 at 0002.
220 *National Disability Insurance Scheme Act 2013* (Cth), s 73Z; NDIS Quality and Safeguards Commission, *Reportable Incidents: Detailed Guidance for Registered Providers*, 2019, pp 15–16.
221 Transcript, Melbourne Hearing 3, Kathy Eagar, 14 October 2019 at T5773.36.
222 Transcript, Adelaide Hearing 2, Mary Patetsos, 20 March 2019 at T935.30–43; Exhibit 2-37, Adelaide Hearing 2, Statement of Mary Patetsos, WIT.0084.0001.0001 at 0005 [33].
223 Alan Robertson SC, *Independent review of the adequacy of the regulation of the supports and services provided to Ms Ann-Marie Smith, an NDIS participant, who died on 6 April 2020: Report to the Commissioner of the NDIS Quality and Safeguards Commission*, 2020, p 4.
224 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 42, CTH.1000.0005.8506 at 8511 [23]–8512 [28].
225 Submissions of the Commonwealth of Australia, Sydney Hearing 4, 11 September 2020, RCD.0012.0072.0002 at 0007 [17]–[19].
226 See Submissions of Aged & Community Services Australia, Sydney Hearing 4, September 2020, RCD.0012.0072.0014 at 0031; Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 70, RCD.999.0480.0001 at 0006.
227 See Transcript, Sydney Hearing 4, Robert Fitzgerald, 1 September 2020 at T8959.34–8960.18.
228 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 73, WIT.0786.0001.0001 at 0009.
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15. Research and Development and Aged Care Data | Commissioner Pagone

Pursuant to paragraph (f) of our Terms of Reference, we are required and authorised to inquire into 'how best to deliver aged care services in a sustainable way, including through innovative models of care…[and] increased use of technology'. Paragraph (c) requires and authorises us to inquire into 'the future challenges and opportunities for delivering accessible, affordable and high quality aged care services in Australia'.[1] In inquiring into these matters, we are directed to have regard to 'examples of good practice and innovative models in delivering aged care services'.[2]

Understanding how the aged care system works now, and how it might work in the future, requires reliable data and careful research. Data and research will help to inform and evaluate the delivery of aged care, and to support the adoption of improved models of care and new technologies. Throughout our inquiry, witnesses have given evidence about research and development (R&D) and aged care data.[3] We have also commissioned and published research about innovation in aged care.[4] Dedicated investment in aged care research and innovation is needed to seize future opportunities for improved delivery of aged care services.

To that end, Commissioner Briggs and I first recommend the establishment of:

- a fund committed to aged care research and innovation
- an independent council, the Aged Care Research and Innovation Council, to make recommendations to the System Governor on expenditure from that Aged Care Research and Innovation Fund.

Recommendations made to the System Governor by the Council should reflect the Council's strategy for aged care research and innovation, and should relate to a range of areas, including but not limited to:

- the delivery of aged care, including workforce-related matters
- prevention and treatment of ageing-related health conditions
- application of technological developments in aged care
- better governance of aged care providers
- the socioeconomics of ageing.

The Council's research and innovation strategy should provide for research that is co-designed with older people and their families and with aged care providers and the aged care workforce. The strategy should have a focus on the translation of research into practice.

Second, Commissioner Briggs and I recommend that the Australian Institute of Health and Welfare should perform various aged care data governance and management functions. Among other things, the Australian Institute of Health and Welfare should establish, store, manage, and refine for presentation and publication a National Aged Care Data Asset. In doing so, the Australian Institute of Health and Welfare should develop, in consultation with the Australian Bureau of Statistics and the Australian e-Health Research Centre, specialised statistical standards and classifications relevant to aged care, including national minimum datasets for aged care.

With some exceptions in the detail, Commissioner Briggs and I agree on these recommendations. The exceptions of detail are as follows. First, Commissioner Briggs and I differ on the proportion of funding to be allocated from the Aged Care Research and Innovation Fund to each of the abovementioned areas of research. Second, I consider that, for the purposes of managing the development of national minimum aged care datasets, a management group should be established and chaired by the System Governor, and that management group should have members with relevant expertise from the Australian Institute of Health and Welfare, the Pricing Authority, the Australian Commission on Safety and Quality of Health and Aged Care, and the Australian Bureau of Statistics. Commissioner Briggs does not support the establishment of such a management group.

Commissioner Briggs also makes a third recommendation relating to investment by the Australian Government in technology. Having regard to the evidence before us, I am unable to join Commissioner Briggs in making a recommendation in those terms. Some of the matters the subject of Commissioner Briggs's recommendation are addressed in part in our second recommendation. I consider that the System Governor should support the development of information and communications technology capability in the aged care sector. Among other things, the System Governor should facilitate the development of software and systems to enable automatic reporting by approved providers on:

- mandatory reporting obligations
- quality indicators
- prudential arrangements
- data for the Aged Care National Data Asset
- other responsibilities.

We address these topics in separate chapters notwithstanding the substantial overlap in the recommendations and the text that we adopt in support of them. Commissioner Briggs has additional observations and text in support of the recommendations that relate more naturally to her view than to mine.

Fundamental to the view which I seek to outline below is a broader approach to the R&D for which funding should be available. It is important in this sector for funding on R&D to go well beyond the pure research of the kind we have seen in the past. In this sector, it may need to extend to the kind of research that might ordinarily be undertaken by market participants in putting the product of their R&D in the market. Considerations of this kind led me to adopt a different proportion of the amounts recommended than Commissioner Briggs.

15.1 Aged care research and development

We have been told that given the number of people accessing aged care services and the challenges facing the aged care sector, aged care research is not given sufficient priority and there is relatively little funding. This needs to change. A new approach to aged care research and its funding is required.

Recommendation 107: Aged Care Research and Innovation Fund

1. The new Act should provide for the establishment of an Aged Care Research and Innovation Fund to be administered by the System Governor.
2. The Australian Government should provide funding equal to 1.8% of total Australian Government expenditure on aged care to the Aged Care Research and Innovation Fund each year, without derogating from the amount of funding available for research and innovation through the Australian Research Council and the National Health and Medical Research Council. Researchers in ageing and aged care should continue to have equal right of access to the funds administered by these other research councils.
3. By 1 July 2022, the Australian Government should establish and fund a dedicated Aged Care Research and Innovation Council.
4. The Aged Care Research and Innovation Council should be funded to:
    a. make recommendations to the System Governor on expenditure from the Aged Care Research and Innovation Fund
    b. set the strategy and agenda for:
        i. research into, and innovation in, the delivery of aged care, including workforce-related research and technology
        ii. research into the socioeconomics of ageing
        iii. research into, and innovation in, the prevention and treatment of ageing-related health conditions

c. facilitate networks between research bodies, academics, community organisations, industry, government and the international community for research, technology pilots and innovation projects, to assist with the translation of research into practice to improve aged care and to address issues associated with ageing in Australia

d. work with the Australian Research Council, the National Health and Medical Research Council, participants in teaching aged care programs, and health and research networks to facilitate the sharing and application of research outcomes with policymakers, research bodies, health care bodies, approved providers and the community.

5. The Aged Care Research and Innovation Council should be chaired by a member appointed by the majority of Council members. The Council should consist of eight members appointed by the Australian Government for (renewable) periods of up to three years on the basis of their distinguished research records or achievements in research and development. The remuneration of the members of the Aged Care Research and Innovation Council should be determined by the Remuneration Tribunal.

6. On the advice of the Aged Care Research and Innovation Council, the System Governor should make grants from the Aged Care Research and Innovation Fund to support:

   a. research into, and innovation in, the delivery of aged care, including through co-funding arrangements with industry and aged care providers, and through workforce-related research and technology

   b. research into the socioeconomics of ageing

   c. research into, and innovation in, the prevention and treatment of ageing-related health conditions.

7. The Aged Care Research and Innovation Council and the System Governor should, in performing their functions in relation to grants from the Aged Care Research and Innovation Fund, be guided by the following aims:

Commissioner Pagone

   a. about half of the funding allocated at any given time should be for research into, and innovation in, the delivery of aged care, with:

      i. about half of that funding allocated to projects supported by substantial co-funding arrangements with industry and aged care providers, and

      ii. priority given to research and innovation that involves co-design with older people, their families and the aged care workforce

b. about 10% of the funding allocated at any given time should be for research into the socioeconomics of ageing

c. about 20% of the funding allocated at any given time should be for research into, and innovation in, the prevention and treatment of ageing-related health conditions.

8. The Aged Care Research and Innovation Council and the System Governor should, in performing their functions in relation to grants from the Aged Care Research and Innovation Fund, be guided by the following aims:

Commissioner Briggs

a. the total funding allocated to the Aged Care Research and Innovation Fund should be split equally between ageing-related health research and aged care-related research

b. the aged care-related research funding should be allocated in the following way:

i. about two-thirds of the funding allocated at any given time should be for research into, and innovation in, the delivery of aged care, with:

A. about half of that funding allocated to projects supported by substantial co-funding arrangements with industry and aged care providers, and

B. priority given to research and innovation that involves co-design with older people, their families and the aged care workforce, and

ii. about one-third of the funding allocated at any given time should be for research into the socioeconomics of ageing.

15.1.1 Aged Care Research and Innovation Fund

There are four main sources of public funding for aged care research in Australia:

- two dementia-specific funds (the Dementia and Aged Care Services Fund and the Boosting Dementia Research Initiative) [5]
- a health and medical research fund (Medical Research Future Fund)[6]
- a fund which covers every field of research other than health and medical research (Australian Research Council).[7]

There is no dedicated funding for research into the delivery of high quality and safe aged care.

Professor Steven Wesselingh, Chair of the Research Committee of the National Health and Medical Research Council, told us that, while a large amount of money has been allocated to research projects relevant to the health and clinical aspects of ageing, comparatively less has been allocated to projects addressing aged care quality and safety. By way of illustration, he said that:

> In the last 10 years, in terms of aged care and the quality of aged care, NHMRC [the National Health and Medical Research Council] has spent about $86 million over 10 years. In contrast, in neurological disease we have spent $1.8 billion. So working hard on neurological disease, that's all part of aged care, you know, Parkinson's disease, dementia, etcetera, so really good research. The actual questions about aged care quality and safety that you are addressing have received relatively little funding.[8]

Professor Briony Dow, Director of the National Ageing Research Institute, told us that there has been a lack of investment in research into delivery of aged care due to a societal view that aged care is not 'particularly important'. She said that the problem is circular: societal attitudes filter down, aged care research is not seen as a particularly attractive area by educators and researchers, and this is 'reinforced by a lack of funding'.[9] Professor Johanna Westbrook, Director of the Centre for Health Systems and Safety Research, Australian Institute of Health Innovation at Macquarie University, stated that funding for research focused on aged care services and their effectiveness is very limited.[10]

A deficiency with the existing funding for research is that it is too focused upon 'pure research' and insufficiently upon innovation and development. Research and development (R&D) is defined by the Organisation for Economic Co-operation and Development standard as 'creative and systematic work undertaken in order to increase the stock of knowledge—including knowledge of humankind, culture and society—and to derive new applications of available knowledge', and includes the activities undertaken to innovate and to introduce new products and services, or to improve existing offerings.[11]

R&D covers (a) basic research, (b) applied research and (c) experimental development. At its core, R&D funding should be aimed at activity that is:

- novel
- creative—that is, based on original, not obvious, concepts and hypotheses
- uncertain of final outcome
- systematic, for planning and budgeting
- reproducible and transferable.

Such R&D is typically undertaken by market participants to obtain competitive advantages, but providers in the aged care sector lack the resources to invest in risky R&D.

InteliCare, an Australian company that develops smartphone predictive analytics technology, responded to Counsel Assisting's final submissions with an example of the need for government investment when the Western Australian Government invested in InteliCare's Artificial Intelligence-based system which had been developed for, and deployed to, regional areas. InteliCare asked that we recommend the establishment of a dedicated innovation and technology grant program for aged care service delivery that promotes the development and adoption of evidence-based assistive technology options for the sector.[12] The Aged Care Research and Innovation Fund should be able to undertake such a task, including upon the basis of joint funding by private operators.

Other submissions we received indicated a need for a coordinated program to support the development of new technologies in aged care. Humanetix Ltd made one such submission.[13] It had been the recipient of an ad hoc grant from the Australian Government to re-engineer the processes needed to support better quality, safety and sustainability in aged care at the Jindalee Aged Care Residence in the Australian Capital Territory.

It is instructive to look at the experience of programs in the United Kingdom. Innovate UK is a government-backed scheme that supports innovation and improvement in many areas of public life, including long-term care. It does this by providing opportunities for United Kingdom businesses to innovate. Innovate UK seeks to address the challenges of delivering care sustainably by exploring how new products and services can lead to changes in outcomes. Its Independent Living Innovation platform explores how technologies enable service delivery for older people and those living with long-term conditions. There is also value in the approach taken by the NHS Innovation Accelerator (NIA), which aims to give more equitable access to cutting edge, high-impact products, processes and technologies by focusing on the conditions and cultural change needed to enable the adoption of innovations that matter to patients at scale and pace.[14] The NIA invites leading health care pioneers from around the world to bring their tried and tested innovations to the NHS. The program aims to select a broad range of innovations to be more rapidly deployed and scaled across the health service to improve patient care and to reduce costs.

Both Commissioner Briggs and I recommend that to ensure an enduring focus on the needs of the aged care system, a dedicated Aged Care Research and Innovation Fund should be established. This fund should be administered independently of existing research funds and have a much wider focus. The establishment of this new fund should be additional and separate to, and have no impact on, the amount of money available in existing research funds.[15] Researchers in ageing and aged care should continue to have the same ability to access those other research funds.

The amount of investment in aged care research and development needs to reflect the Australian Government's expenditure on aged care, the importance of high quality and safe care for vulnerable older people, and the research work necessary to support the new aged care system. I consider that annual aged care research funding should be fixed and equal to 1.8% of the Australian Government's total expenditure on aged care. That figure reflects the general level of expenditure on research and development across the Australian economy which varied between 2.25% in 2008–09 and 1.79% in 2017–18.[16] The Australian Government should adopt this figure in the short to medium term and then revise it up or down as required.

In addition to dedicated funding, new administrative infrastructure is required to ensure that the public investment in aged care research and innovation is directed to practical and beneficial outcomes.

15.1.2 Aged Care Research and Innovation Council

Both Commissioner Briggs and I recommend that an Aged Care Research and Innovation Council should be established.

We have been told about the need for:

- coordination of aged care research and development in Australia and internationally
- research that pays proper regard to the priorities of end-users, including older people, members of the community, families and informal carers
- a research body governed by a range of people with different experience and expertise
- funding of research and development into existing and new models of aged care that are not otherwise the subject of funding by the National Health and Medical Research Council and other similar bodies.[17]

The new Council should set the strategy and agenda for aged care research and development. It should make recommendations to the System Governor on expenditure from the Aged Care Research and Innovation Fund. Under the Independent Commission model recommended by me, the System Governor will be the Australian Aged Care Commission from 1 July 2023 onwards. Research and development the subject of those recommendations should not be focused only on health-related, clinical or medical matters relating to aged care. It should extend to research on, for instance, the delivery of aged care, application of technological developments in aged care, better governance of aged care providers, and the socioeconomics of ageing. It should also extend to workforce-related research and technology, including translation from conception to market, to improve workforce productivity and quality of care.

The Aged Care Research and Innovation Council should recommend funding for, among other things, research that is co-designed with older people and their families, and with aged care providers and the aged care workforce. Professor Alison Kitson, Vice-President and Executive Dean of the College of Nursing and Health Sciences, Flinders University, and Foundational Director, Caring Futures Research Institute, told us that co-design is a relatively recent phenomenon in the area of clinical trials and research. She explained that accepting co-design required a change in thinking 'because it challenges the paradigm of what objectivity is' through allowing input from those using the services the subject of the research. Her opinion was that if the aim of research is to translate knowledge into practice, then 'involving stakeholders right at the beginning is the most important factor for success'.[18]

Professor Dow explained that 'co-design type work' is outcomes focused and is 'not the type of research that lends itself to higher level academic publications'. She said that an unavoidable consequence of co-design with end-users is a loss of ultimate control over research design. She also said that if you are researching for quality of care or quality of life outcomes, these matters are not capable of being flawlessly measured, as compared to blood pressure, for example, which is capable of objective measurement.[19]

Dr Robert Grenfell, Director of Health and Biosecurity at the Commonwealth Scientific and Industrial Research Organisation, told us that research should be for solving problems that need to be solved.[20] I agree. The Aged Care Research and Innovation Council should adopt a priority-driven approach to research. In adopting such an approach, the allocation of funding is strategically directed to identified problems and gaps to ensure that funded research delivers the greatest benefit for end-users. The focus on priority-driven co-design will distinguish the new Aged Care Research and Innovation Council from some other research bodies. For example, Professor Wesselingh told us that the National Health and Medical Research Council has tended to allocate funding on the basis of investigator-driven, rather than priority-driven, research. He said that, in investigator-driven research, investigators come to the National Health and Medical Research Council with their ideas for research projects. Those ideas are assessed by peer review, and the highest quality research proposals get funded.[21] Professor Dow told us that research supported by the National Health and Medical Research Council 'lends itself to much more basic science and clinical trials'.[22]

As part of its coordination function, the new Council should facilitate networks to assist the translation of research into practice to improve aged care and to address issues associated with ageing. This should include working with the Australian Research Council, the National Health and Medical Research Council, and participants in teaching aged care programs.

The new Aged Care Research and Innovation Council should have eight members appointed by the Australian Government. The Council should be chaired by a person determined by a majority of members of the Council. The Chair and the other members should be appointed for (renewable) periods of up to three years. Members should be appointed on the basis of their distinguished research records or their achievements in research and development. The remuneration of the members of the Aged Care Research and Innovation Council should be determined by the Remuneration Tribunal.

We have been told that the National Ageing Research Institute or the National Health and Medical Research Council could take on this role.[23] Some responses to Counsel Assisting's final submissions, including from the Australian Government, suggested that aged care research should be the responsibility of an existing body. It was submitted that establishing a separate Council might duplicate administrative roles performed by, for instance, the National Health and Medical Research Council, and might fragment research, funding and capacity.[24]

The approach preferred by Commissioner Briggs and myself is for the Aged Care Research and Innovation Council to remain outside of the National Health and Medical Research Council and other existing research bodies. I consider that the Aged Care Research and Innovation Council would maximise its effectiveness, and minimise any inefficiency and

duplication, by working with bodies such as the National Health and Medical Research Council. However, the role and functions of the new Council should remain independent.

I also consider that there is little risk that additional research funding and capacity will fragment existing funding and capacity. The role and functions of the Aged Care Research and Innovation Council are new and extend beyond those of the National Health and Medical Research Council. For example, research funded through the Aged Care Research and Innovation Council would not be limited to health and medical research. I also consider that the approach to be taken by the Aged Care Research and Innovation Council, often based on co-design and priority-driven research and development, is more appropriate for aged care research and development. That approach is different to the approach taken by the National Health and Medical Research Council.

The National Health and Medical Research Council supports basic research in health but most of the investment in the development of innovative health products, such as pharmaceuticals or technologies, is funded by the private sector for competitive advantage. In contrast, the Australian Government is overwhelmingly the funder of aged care and will need also to provide additional funds needed for innovative development and research as well as basic research. This will be a key role for the Aged Care Research and Innovation Fund.

I otherwise consider that the Council should be guided by the following aims when recommending allocations of funds from the Aged Care Research and Innovation Fund:

- about half of the funding allocated at any given time should be for research into, and innovation in, the delivery of aged care, with:
    - about half of that funding allocated to projects supported by substantial co-funding arrangements with industry and aged care providers
    - priority given to research and innovation that involves co-design with older people, their families and the aged care workforce
- about 10% of the funding allocated at any given time should be for research into the socioeconomics of ageing
- about 20% of the funding allocated at any given time should be for research into, and innovation in, the prevention and treatment of ageing-related health conditions.

15.1.3 Evaluation of research and its translation into practice

The 2018 report of the Aged Care Workforce Strategy Taskforce noted that, despite the number of existing research bodies and funding sources, the aged care sector is slow to adopt research. The Taskforce attributed this to the absence of a 'research translation pipeline' and said that this 'discourages government and private sector investment'. While these comments were directed to 'research and translation priorities…firmly focussed on the needs of contemporary workforce-related needs', we consider that this problem affects aged care research and innovation more generally.[25]

Commissioner Briggs's and my approach to aged care research and innovation, including on workforce-related needs, will support translation of research outcomes into practice and include evaluation of new research and innovations. The Australian Government has taken steps to establish a Centre for Growth and Translational Research focusing on workforce-related issues and their translation to market, but progress has been too slow.[26] An Aged Care Research and Innovation Council with a broader focus is needed to contribute to the delivery of high quality and safe care in the aged care system of the future. If the Council is established and other recommendations made by Commissioner Briggs and myself, such as enhanced arrangements for workforce planning, are implemented, it will not be necessary to proceed with a separate Centre for Growth and Translational Research.

Professor Sue Gordon, Strategic Professor – Chair of Restorative Care at Flinders University, suggested that cooperative research centres are one way to bring information, technology and evidence together to help researchers understand perspectives of people receiving care and providers.[27] Cooperative research centres are designed to help industry partner with the research sector to solve industry-identified issues and are supported by an Australian Government program.[28] 'Living labs' are another type of partnership between researchers, care staff, care providers and educators that are used for research translation in aged care.[29] Some responses to Counsel Assisting's final submissions urged the use of living labs.[30]

As described in Chapter 18 of Volume 4 of this report, we have heard a lot of evidence about ideas that have been translated into innovative technologies used in parts of the aged care sector. Those technologies include:

- digital health and clinical information systems
- technological tools that can provide predictive data and decision support
- assistive and healthy ageing technologies
- monitoring technologies
- physical robotic technologies
- social networking applications to help address social isolation
- virtual care and telehealth
- human resources technologies, including scheduling, rostering and feedback systems.

There is considerable scope for further translation of aged care research into innovative practice.

15.2 Data governance and a National Aged Care Data Asset

I am concerned that reliable, accessible and comprehensive data on safety and quality is not available in the aged care sector. At a system level, there is 'no comprehensive data on the outcomes of care'.[31] This cannot continue. The Australian Government cannot effectively regulate, or develop responsive policy for, a system about which it remains partially ignorant. The Australian public is entitled to expect comprehensive, up-to-date and de-identified data to be available to them on a regular basis to help them evaluate the safety and quality of the aged care system.

It is not merely a matter of collecting missing data. Rather, all data must also be of a high quality and the capacity must be built to use it effectively. Data systems need to be able to work together and share information—also called being 'interoperable'—and the infrastructure must be sufficient to serve the purposes of collecting data.

Recommendation 108: Data governance and a National Aged Care Data Asset

1. By 1 July 2022, the *Australian Institute of Health and Welfare Act 1987* (Cth) should be amended to require and empower the Australian Institute of Health and Welfare to perform the below functions, which should be funded from the Aged Care Research and Innovation Fund.
2. The new functions of the Australian Institute of Health and Welfare will be:
    a. to collect (directly or in association with other bodies or people), store and manage aged care-related information and statistics (including information on the aged care workforce, the economics of aged care, the operation of the aged care market, and the delivery of aged care services), in consultation with the Australian Bureau of Statistics if necessary
    b. to coordinate the collection and production of aged care-related information and statistics by other bodies or persons
    c. to publish aged care-related information and statistics, whether by itself or in association with other bodies or persons
    d. subject to the enactment and commencement of the proposed *Data Availability and Transparency Act* (Cth), to develop and enter into data sharing agreements, in accordance with that proposed Act, with accredited users and data service providers to obtain and provide access to the use of aged care-related data

e. to develop methods and undertake studies designed to assess the provision, use, cost and effectiveness of aged care services and aged care technologies

f. to conduct and promote research into aged care services in Australia

g. to develop, in consultation with the Australian Bureau of Statistics and the Australian e-Health Research Centre, specialised statistical standards and classifications relevant to aged care services (including national minimum datasets), and to advise the Bureau on the data to be used by it for the purposes of aged care-related statistics

h. to oversee the development of a standard format for presentation of aged care data, including consideration of data interoperability with the health care sector

i. to curate and make publicly available a National Aged Care Data Asset, which should at a minimum include data on:

    i. the demographics, clinical characteristics and care needs of aged care recipients, and the aged and health care services they use

    ii. the demographics, skills and wages and conditions of the aged care workforce

    iii. the financial performance of aged care providers, the quality of care provided, and their ownership types, operating segments, size and any other characteristics deemed relevant by the Australian Institute of Health and Welfare to analyse the aged care sector's functioning

j. to publish information about the quality and safety of aged care services at facility or service level

k. to ensure that Australian Government entities with responsibility for or involvement in aged care, researchers, and other bodies as appropriate, have access to aged care-related information and statistics held by the Institute or by bodies or persons with whom contracts or arrangements have been entered into by the Institute

l. to publish methodological and substantive reports on work carried out by or in association with the Institute under this recommendation

m. to make recommendations to the System Governor, as well as to the responsible Minister, on the improvement and promotion of aged care services in Australia.

3. The Australian Institute of Health and Welfare should have appropriate government funding and resourcing for the employees and information and communications technology needed to perform its functions, including 'business to government' and 'government to government' data sharing in or near real time.

4. For the avoidance of doubt, nothing in the above is intended to prevent the System Governor or the Quality Regulator from collecting and analysing data in administering the aged care system, or commissioning research on the aged care system.
5. The new Act should require that:
    a. the System Governor
    b. the Quality Regulator
    c. the Pricing Authority, and
    d. approved providers of aged care

    provide data to the Australian Institute for Health and Welfare in accordance with its requirements within three months of the end of the relevant reporting period, and that they respond to other requests for aged care-related data by the Australian Institute for Health and Welfare in a timely manner.
6. The Australian Institute of Health and Welfare should store, manage and refine for presentation, and regularly publish, the National Aged Care Data Asset, with the first such publication by 1 July 2025. The Institute is to accredit software used for collection of data for the data asset, quality indicator data and data relating to compliance with the Aged Care Quality Standards.
7. The System Governor should be responsible for the following additional functions:
    a. to facilitate the development of software and Information and Communications Technology systems to enable automatic reporting by approved providers on mandatory reporting obligations, quality indicators, prudential arrangements, data for the Aged Care National Data Asset and other responsibilities
    b. to establish arrangements consistent with the 'collect once, use many times' principle, including:
        i. information and communications technology interoperability arrangements between the System Governor and the Australian Commission on Safety and Quality in Health and Aged Care to enable the sharing of data related to aged care
        ii. ensuring administrative data relevant to approved providers, such as assessment data, is made available to providers
        iii. ensuring a mechanism exists for approved providers to transfer, in an effective and secure manner, information about an individual when the individual changes service providers.

8. **In carrying out its functions, the Australian Institute of Health and Welfare should be guided by the principle that de-identified data is to be made publicly available to support research into, and scrutiny of, the provision of aged care services, but personal information must not be released.**

9. **From 1 July 2022, the System Governor should establish and chair a 'management group' of senior representatives from:**

Commissioner Pagone

   a. **the Australian Institute of Health and Welfare**

   b. **the Pricing Authority**

   c. **the Australian Commission on Safety and Quality in Health and Aged Care**

   d. **the Australian Bureau of Statistics**

   to manage the development of a framework for the national minimum aged care datasets, informed by reference to the aged care quality indicators that are to be developed by the Australian Commission on Safety and Quality in Health and Aged Care, and the development of the datasets themselves.

Ms Glenys Beauchamp PSM, then Secretary of the Australian Department of Health, acknowledged that access to data was a key reform that the Department needed to look at.[32] A lack of access to data leads to very practical problems. For example, Dr Nicholas Hartland PSM, First Assistant Secretary of the In Home Aged Care Division in the Australian Department of Health, told us that integration of the Home Care Packages Program and the Commonwealth Home Support Programme had been delayed because the Department does not have a good understanding of what is funded for whom under these programs. He described this lack of understanding as one of the major blockers of this important work.[33]

Where data is collected, it may be collected multiple times unnecessarily. Ms Elizabeth Cosson AM CSC, Secretary of the Australian Department of Veterans' Affairs, told us that she would like to see the mainstream aged care information system and the veterans' affairs information system interface to allow automatic population of information across both systems, so that people would only have to tell the Australian Government about their circumstances once.[34] Professor Westbrook said that the aged care sector, including approved providers and government, tends 'to collect the same information in multiple different places in different datasets and this really limits our ability to use that data or to improve the quality of that data'.[35] The Australian Institute of Health and Welfare acknowledged that current aged care data is fragmented and incomplete:

> There is limited integration across data sets to enable a person centred view of pathways and outcomes across aged care, health and other support systems. There are also notable data gaps (e.g. workforce, finance, regular assessment of care needs, quality of life, quality of care) and no agreed common data definitions in use across the aged care sector.[36]

I recommend that the Australian Institute of Health and Welfare should be required and empowered to:

- collect, store and manage aged care-related information and statistics
- coordinate the collection, production and publication of that material, whether by itself or in association with others
- oversee the development of a standard format for presentation of aged care data, including consideration of interoperability with the health care sector
- develop a National Aged Care Data Asset, including, among other things, a number of national minimum aged care datasets.

The Australian Institute of Health and Welfare should be funded to do this work through the Aged Care Innovation and Research Fund because it will provide certainty for future funding needs. The Australian Institute of Health and Welfare will require this additional funding to complete the work of curating and publishing data for a National Aged Care Data Asset.[37] The importance of accurate and timely published data for the aged care system is also such that the activity needs to be independent of political influence.

The System Governor should determine what national minimum aged care datasets should be included in the National Aged Care Data Asset. The datasets should include data on:

- the demographics, clinical characteristics and care needs of people receiving aged care
- the demographics, skills and wages and conditions of the aged care workforce
- the financial performance of aged care providers, the quality of care provided by them, their ownership types, operating segments, size and any other characteristics relevant to the analysis of how the age care sector is functioning.

I recommend that the System Governor should establish and chair a management group to support this function. Under the Independent Commission model recommended by me, the System Governor will be the Australian Aged Care Commission from 1 July 2023 onwards. The group should include senior representatives of the Australian Institute of Health and Welfare, the Pricing Authority, the Australian Commission on Safety and Quality in Health and Aged Care, and the Australian Bureau of Statistics. The group would manage the development of the national minimum aged care datasets by the Australian Institute of Health and Welfare.

15.2.1 National Aged Care Data Asset

A National Aged Care Data Asset will bring together data from multiple sources. It will provide a better understanding of the life experiences, pathways and outcomes of people receiving aged care and the operation and performance of the aged care system, including on quality and safety. The data asset would be made up of a number of national minimum aged care datasets.

The National Aged Care Data Asset should link or be linkable with data, including other national minimum datasets, collected on primary and acute health care as well as disability care. Ms Louise York, Head of Community Services Group, Australian Institute of Health and Welfare, explained that the data should be useful for looking at both the individual service provider level and the system level. She said that a lot of that data is in the system at the moment, but it needs to be made available sooner and linked more regularly to produce a better overall picture of the aged care system.[38]

Ms York told us that 'there's great potential of linked up data to provide information about the risks that are being experienced' by people using aged care. She considered that data about hospitalisations, prescribing rates, complaints and accreditation status could be linked.[39] Associate Professor Maria Inacio, Director of the Registry of Senior Australians at the South Australian Health and Medical Research Institute, said that compliance and accreditation information would be 'incredibly valuable' in the future to understand the performance of facilities.[40]

The National Aged Care Data Asset should involve the collection and de-identified publication of at least the following linkable data:

- aged care program administration data, including need assessments, funding claims and payments, care provision, and expenditure by service types, including mapping to region and other characteristics (this information should cover the same data currently provided for in the National Aged Care Data Clearinghouse)
- other Australian Government administrative data with likely linkages with existing Pharmaceutical Benefits Schedule and Medicare Benefits Scheme data
- regulatory data, including provider applications for approval to be a provider, complaints, consumer experience, compulsory reporting, quality compliance, prudential compliance, and quality indicators
- select provider internal data, including data about clinical care, staffing and rostering, staff training, provision of care, quality of life, and financial characteristics
- demographic data, including the background of users of aged care, and the number, skills, wages and conditions of the aged care workforce
- primary and acute health care data, involving separate collection or linkages with hospital admissions and health care treatments, including general practice and allied health.

A data asset of this type is being developed for the disability sector by the Australian Government and State and Territory Governments. The purpose of that data asset is to 'improve outcomes for people with disability, their families and carers, by sharing de-identified data to better understand the life experiences and outcomes of people with disability in Australia'.[41]

The development of the National Aged Care Data Asset should be informed by the National Disability Data Asset pilot and consider design features which will enable the data assets to be interoperable and complementary.

The Australian Institute of Health and Welfare has relevant expertise and structures to manage the proposed National Aged Care Data Asset. It should be given the functions, powers and resources to do so.

Governance and leadership of aged care data

Dr Grenfell told us that the Australian Institute of Health and Welfare should be responsible for data curation, but that data governance should sit with an independent entity.[42] Ms York emphasised the importance of separating curation and governance.[43] Several responses to Counsel Assisting's final submissions emphasised the importance of the independence of curation of data to ensure that data meets the needs of all users.[44]

I consider that the new management group should identify the information required for a National Aged Care Data Asset and develop the strategy and agenda for aged care data.

Ms York said that the Australian Institute of Health and Welfare 'has a legislated function of designing datasets in conjunction with relevant stakeholders'. She said what the Australian Institute of Health and Welfare would normally do is:

> work with clinicians, policy makers, academics, people involved, consumers, customers, older people and potentially the ICT [information and communications technology] sector, workforce, to work through…what they want to know, what's already available and then how we would go through the painstaking work of working out how to actually isolate those core pieces of information that need to be collected to really get that regular measurement over time of what we're trying to achieve.[45]

I encourage the Australian Government to engage with the State and Territory Governments to agree on what components of health care data collected by them should be incorporated into the National Aged Care Data Asset either directly through new collections, or through linking existing datasets provided regularly to the Australian Institute of Health and Welfare.

15.2.2 Data standards for aged care

We received a number of submissions that supported implementation of standardised data collection and the 'collect once, use many times' principle.[46] This should be a fundamental principle for data management in aged care. In order to use data many times, the original collection must be high quality and reliable. This means that aged care data, and its collection, must meet minimum standards. As SA Health submitted, 'good data collection is fundamental to setting a solid foundation for monitoring the performance of the system, its interfaces and to inform future reform'.[47]

Data about aged care comes from several different government agencies that do not have common data standards and systems.[48] Minimum datasets must be based on common data standards so that they yield meaningful and reliable information.[49] Having these standards means that aged care providers know what digital recordkeeping systems will be suitable for the data that they need to capture and transmit. Mr Ben Lancken, Head of

Transformation at Opal Aged Care, said that standards would enable providers like Opal to 'build our systems to enable the collection of the data'.[50]

The Aged Care Industry Information Technology Council stated in 2017 that 'the absence of common standards, sector-level policies and common data collection…means it is difficult for individual organisations to benchmark their performance and identify needed improvements'.[51]

An important task for the aged care data authority is to establish a 'common language' for aged care data. Attention should be paid to the intersection between aged care, health care and disability services, and the importance of common data properties to enable the systems to communicate.

To support the development of the National Aged Care Data Asset, the new Act should require relevant government entities and approved providers of aged care to provide data required by the Australian Institute for Health and Welfare within three months of the end of the relevant reporting period for the type of data being reported. They should also be required to respond, in a timely manner, to other requests for aged care-related data made by the Australian Institute of Health and Welfare.

The Australian Government announced the 'Aged Care Data Compare' project in June 2020. This project aims to resolve technical difficulties with the standardisation and sharing of valuable data recorded as part of everyday practice in residential aged care. This includes assessment of the Health Level Seven International (HL7) Fast Healthcare Interoperability Resources Specification and the possible use of aged care data interoperability standards and protocols. The Australian Department of Health should continue its involvement in this work and make sure that it is resourced adequately and given priority.

Collection of personal or protected information

Data and information collected under Australian and State and Territory legislation are frequently subject to statutory protections limiting disclosure other than for the purpose they were collected. The *Privacy Act 1988* (Cth) may also prevent the disclosure and publication of data and information.

These protections exist for a reason. However, to establish a National Aged Care Data Asset that can be made available to researchers and stakeholders in a way that does not identify individuals, I consider that limited exceptions should be enacted.

The Australian Government, together with the State and Territory Governments, should work to identify and remove legislative barriers to collection and linkage of data about individuals by the Australian Institute of Health and Welfare. Data that does not identify individuals should be made available for research and policy purposes through publication of aggregate data, including service-level data.

Authority to release data

A key issue for future research will be to ensure timely access to data. Data custodians are responsible for approving access to, and use of, the data collections for which they have authority. They have to manage privacy issues and ensure that data held by them is only used in research in a manner consistent with its approved use.[52] These processes can cause delay in accessing data.

Associate Professor Inacio described the administrative burden of obtaining access to data from the Australian Institute of Health and Welfare and, in particular, the lack of timely access to valuable data. She told us that there was 'absolutely no excuse' for aged care eligibility assessment data not having been made available since 2016, and that this delay represented a missed opportunity for research during those four years.[53]

Associate Professor Gillian Caughey, also of the Registry of Senior Australians, said that long delays in securing access to data had adversely affected the ability to monitor trends in care quality and to provide timely information about risks in the health and aged care sectors.[54]

Ms York described a vision for the future with 'enduring and regularly linked information where all of those approvals have already been given upfront' as long as the use of the data fits within agreed principles and outcomes.[55] This vision should become a reality. Delays in accessing aged care data from the Australian Institute of Health and Welfare must be minimised in future.

15.3 Information and communications technology

Dr George Margelis, the Independent Chair of the Aged Care Industry Information Technology Council, said:

> Apart from the need to enable open but secure business to business (B2B) digital exchange, there is also a need to enable business to government (B2G) information sharing. Consequently, it is timely to develop a holistic government strategy for the Aged and Community Care sector that supports interoperability, secure and ready data exchange, with appropriate underpinning systems. The absence of such B2G interfaces is impeding the ability to enforce vendor best practice, and to create an open ecosystem of secure data exchange.[56]

I consider that the System Governor should facilitate the development of software and systems to enable automatic reporting by approved providers on mandatory reporting obligations, quality indicators, prudential arrangements and other responsibilities. It should also establish arrangements consistent with the 'collect once, use many times' principle, including:

- integrating Australian Government systems to enable sharing of aged care data[57]
- ensuring mechanisms exist for the transfer of clinical records where required for the continuity of care (these issues are discussed in our chapter on better access to health care)
- investment in new infrastructure to support that principle being put into practice.

Arrangements should also be established by the System Governor to:

- ensure relevant administrative data, such as assessment data, is available to providers
- ensure a mechanism exists for approved providers to transfer information about an individual effectively and securely when the individual changes service providers.

The System Governor should support the development of information and communications technology capability in the aged care sector. This includes the secure use of data throughout the system and solutions to reduce the administrative burden of data collection. Real-time or near real-time data sharing should be standard within government, with the capacity for approved providers to upload data.[58]

Professor Westbrook gave evidence about technology barriers that can limit providers taking advantage of research. She referred to: electronic information systems with limited functionality; variable information technology literacy of staff; and a lack of systems interoperability. For example, she described how a lack of interoperability between a residential aged care facility's medication systems and a general practitioner's electronic prescribing system increases the risk of errors.[59] The Australian Government has agreed that all residential aged care services should move to digital electronic care records.[60]

Information and communications systems used by approved providers of aged care should operate so that information that is routinely collected for their own purposes can assist them to meet responsibilities to provide data, including for the National Aged Care Data Asset.

I recommend that the Australian Institute of Health and Welfare should accredit software for compatibility with the National Aged Care Data Asset to enable the efficient collection of quality data. Responses from providers to Counsel Assisting's final submission were reluctant to support software accreditation by the Australian Institute of Health and Welfare if that would involve additional cost or lost investment.[61] The purpose of software accreditation would be to reduce the costs of data collection and ensure that quality data was being collected. Accreditation should be of parameters or standards only, and occur in a way that does not adversely impact on innovation.

Endnotes

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16. Data, Research, Innovation and Technology | Commissioner Briggs

Understanding how the aged care system is working now, and how it might work in the future, requires reliable data and careful research. Data and research will help to inform and evaluate the delivery of aged care, and to support the adoption of improved models of care and new technologies.

There is a lot of research and technology development occurring in Australia of potential benefit to older people. However, many older people miss out on the benefits because research findings and technological developments are not translated into the everyday practice of aged care. Researchers and technology developers, the aged care sector itself and the Australian Government have a shared responsibility to address this, so that older people can have a better quality of life.

16.1 Data governance and a National Aged Care Data Asset

16.1.1 Being smart with data

Providers routinely collect data about their clients and services, but that data is not adequately integrated and analysed at sector and provider levels to inform how to achieve improvements in care. Professor Johanna Westbrook, Director of the Centre for Health Systems and Safety Research, Australian Institute of Health Innovation at Macquarie University, said that:

> we do lots of collection of items of information but really it doesn't become meaningful information until you start bringing it together in some sort of holistic way. And at the moment we have got lots of different data collections going on but as a sector we really aren't able to use that data.[1]

Data is of little value unless it is transformed into insights and intelligence that can be used to determine how well the aged care system is functioning and where it needs to improve. With increased automation and the use of electronic records, there are great opportunities to use data to identify, predict, and target problems, monitor the effectiveness of policies, and drive continual improvement. The collection and analysis of data about older people and the aged care system have enormous potential to support high quality and safe care and to drive reform in aged care.

Witnesses described the immense power and opportunities in data to produce a comprehensive picture of changes in an older person's health, service use and wellbeing. It can support comparisons of providers across the sector, through benchmarking and star ratings. It can improve the safety of medicine use, promote accountability, and improve decision-making within the aged care sector.

Associate Professor Lee-Fay Low, an ageing and health policy researcher from the University of Sydney, described several benefits of improved data capture for aged and health care providers and the aged care regulator:

> Data collected during routine home support processes as part of assessment, support plan reviews, funding reporting should be incorporated into regulation and system monitoring processes. Development of data systems would need substantial user involvement to maximise utility and efficiency (ie use time and help providers in their client facing, reporting and governance work), the ability to interface between home support data systems and health departments and the aged care regulator, and e-health records should be maximised.[2]

We make the following recommendation on data governance. Unlike Commissioner Pagone, I do not consider it necessary to form another management group to oversee data management. I am confident that existing data management groups could be extended and adjusted to cover these wider functions of the Australian Institute of Health and Welfare.

Recommendation 108: Data governance and a National Aged Care Data Asset

1. By 1 July 2022, the *Australian Institute of Health and Welfare Act 1987* (Cth) should be amended to require and empower the Australian Institute of Health and Welfare to perform the below functions, which should be funded from the Aged Care Research and Innovation Fund.
2. The new functions of the Australian Institute of Health and Welfare will be:
    a. to collect (directly or in association with other bodies or people), store and manage aged care-related information and statistics (including information on the aged care workforce, the economics of aged care, the operation of the aged care market, and the delivery of aged care services), in consultation with the Australian Bureau of Statistics if necessary
    b. to coordinate the collection and production of aged care-related information and statistics by other bodies or persons
    c. to publish aged care-related information and statistics, whether by itself or in association with other bodies or persons
    d. subject to the enactment and commencement of the proposed Data Availability and Transparency Act (Cth), to develop and enter into data sharing agreements, in accordance with that proposed Act, with accredited users and data service providers to obtain and provide access to the use of aged care-related data

e. to develop methods and undertake studies designed to assess the provision, use, cost and effectiveness of aged care services and aged care technologies

f. to conduct and promote research into aged care services in Australia

g. to develop, in consultation with the Australian Bureau of Statistics and the Australian e-Health Research Centre, specialised statistical standards and classifications relevant to aged care services (including national minimum datasets), and to advise the Bureau on the data to be used by it for the purposes of aged care-related statistics

h. to oversee the development of a standard format for presentation of aged care data, including consideration of data interoperability with the health care sector

i. to curate and make publicly available a National Aged Care Data Asset, which should at a minimum include data on:

    i. the demographics, clinical characteristics and care needs of aged care recipients, and the aged and health care services they use

    ii. the demographics, skills and wages and conditions of the aged care workforce

    iii. the financial performance of aged care providers, the quality of care provided, and their ownership types, operating segments, size and any other characteristics deemed relevant by the Australian Institute of Health and Welfare to analyse the aged care sector's functioning

j. to publish information about the quality and safety of aged care services at facility or service level

k. to ensure that Australian Government entities with responsibility for or involvement in aged care, researchers, and other bodies as appropriate, have access to aged care-related information and statistics held by the Institute or by bodies or persons with whom contracts or arrangements have been entered into by the Institute

l. to publish methodological and substantive reports on work carried out by or in association with the Institute under this recommendation

m. to make recommendations to the System Governor, as well as to the responsible Minister, on the improvement and promotion of aged care services in Australia.

3. The Australian Institute of Health and Welfare should have appropriate government funding and resourcing for the employees and information and communications technology needed to perform its functions, including 'business to government' and 'government to government' data sharing in or near real time.

4. For the avoidance of doubt, nothing in the above is intended to prevent the System Governor or the Quality Regulator from collecting and analysing data in administering the aged care system, or commissioning research on the aged care system.
5. The new Act should require that:
    a. the System Governor
    b. the Quality Regulator
    c. the Pricing Authority, and
    d. approved providers of aged care

    provide data to the Australian Institute for Health and Welfare in accordance with its requirements within three months of the end of the relevant reporting period, and that they respond to other requests for aged care-related data by the Australian Institute for Health and Welfare in a timely manner.
6. The Australian Institute of Health and Welfare should store, manage and refine for presentation, and regularly publish, the National Aged Care Data Asset, with the first such publication by 1 July 2025. The Institute is to accredit software used for collection of data for the data asset, quality indicator data and data relating to compliance with the Aged Care Quality Standards.
7. The System Governor should be responsible for the following additional functions:
    a. to facilitate the development of software and Information and Communications Technology systems to enable automatic reporting by approved providers on mandatory reporting obligations, quality indicators, prudential arrangements, data for the Aged Care National Data Asset and other responsibilities
    b. to establish arrangements consistent with the 'collect once, use many times' principle, including:
        i. information and communications technology interoperability arrangements between the System Governor and the Australian Commission on Safety and Quality in Health and Aged Care to enable the sharing of data related to aged care
        ii. ensuring administrative data relevant to approved providers, such as assessment data, is made available to providers
        iii. ensuring a mechanism exists for approved providers to transfer, in an effective and secure manner, information about an individual when the individual changes service providers.
8. In carrying out its functions, the Australian Institute of Health and Welfare should be guided by the principle that de-identified data is to be made publicly available to support research into, and scrutiny of, the provision of aged care services, but personal information must not be released.

9. From 1 July 2022, the System Governor should establish and chair a 'management group' of senior representatives from: **Commissioner Pagone**

a. the Australian Institute of Health and Welfare

b. the Pricing Authority

c. the Australian Commission on Safety and Quality in Health and Aged Care

d. the Australian Bureau of Statistics

to manage the development of a framework for the national minimum aged care datasets, informed by reference to the aged care quality indicators that are to be developed by the Australian Commission on Safety and Quality in Health and Aged Care, and the development of the datasets themselves.

16.1.2 Current data collections and integration projects

Australia has a number of data collections which together contain information on health services and aged care. The existing datasets and data integration projects show that there has been a great deal of concurrent effort to bring together data from different sources to get better insight into older people and the health and aged care systems they use.

The Australian Institute of Health and Welfare Aged Care Data Clearinghouse

The National Aged Care Data Clearinghouse is an independent and centralised aged care data repository, located at the Australian Institute of Health and Welfare. It provides aged care data to a range of stakeholders, including policymakers, researchers, service providers, community groups and people who use services.[3]

The Data Clearinghouse holds data in relation to people who were receiving aged care from 1997 onwards, as well as some data prior to 1997.[4] The data received by the Data Clearinghouse consists of more than 80 datasets, including data relating to:

- demographics of people in aged care
- services provided and facilities / outlets
- aged care services received
- payments to aged care providers
- amount and level of care provided
- admission, separation, length of stay and reason for leaving care.[5]

The Data Clearinghouse data is from the following sources:

- the Australian Department of Health, which provides information on aged care services, providers, places and people receiving care
- the Aged Care Assessment Program Minimum Data Set, which captures assessments undertaken by Aged Care Assessment Teams at the time people begin to use services
- Services Australia, which provides information on payments and related details
- the Commonwealth Home and Community Care Program Minimum Data Set, which comprises statistical information about people using the program and the help they receive
- the Australian Bureau of Statistics, which supplies statistical and reference details relating to population and locations.[6]

Complete details of the data measures are provided within the National Aged Care Data Clearinghouse data dictionary.[7]

Some of the datasets within the Data Clearinghouse can be used to prepare larger linked datasets, which 'support analysis of aged care recipients' pathways of people receiving aged care across systems and time'.[8]

There is a lot of relevant aged care data that is not part of the Data Clearinghouse. In a submission to us, the Australian Institute of Health and Welfare indicated that:

> There is also a large volume of administrative data which relate to aged care that are not part of the Data Clearinghouse. For example, people using aged care may receive the Aged Pension, pay income tax, use health services (e.g. primary and allied health care, hospital care) and medicines or participate in the National Disability Insurance Scheme, and, eventually, they die. Given that aged care service use can be influenced by people's health, disability, social support, housing arrangements and income, as well as the availability of suitable aged care services, integration with these sources has high potential value.[9]

Registry of Senior Australians project

The Registry of Senior Australians, previously known as the Registry of Older South Australians, was established in 2017 by the Healthy Ageing Research Consortium, a cross-sectoral partnership of researchers, clinicians, aged care providers and consumer advocacy groups.[10] The Registry of Senior Australians is a data platform designed to monitor the quality and safety of care provided to people receiving aged care services in Australia.[11] The Registry's model leverages existing information. It brings together datasets such as the Aged Care Assessment Program, Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and State hospitalisation records, collected by organisations throughout the country, to provide 'a full picture of ageing and aged care pathways'.[12]

The Registry uses data linking to draw insights about different programs and services within the health and aged care systems.[13]

Aged Care Data Compare project

The Aged Care Data Compare project is a two-year project is funded by the Digital Health Cooperative Research Centre, the Bupa Health Foundation, the Centre for Health Services Research, University of Queensland, and the Australian Department of Health. The Australian e-Health Research Centre is providing technical expertise.

The project started in June 2020 and aims to resolve the technical challenges that make it hard to compare data about aged care quality and performance between facilities. The project is designed to facilitate sharing of information 'across aged care providers that use different IT systems' with a view to being able to benchmark the care that they provide.[14]

The project will produce and validate a prototype data authority or 'data hub' to that will 'calculate quality indicators and prepare reports from standardised data'.[15]

The project aims are to:

- Survey types of information currently recorded in software solutions to judge suitability for standardisation.
- Create an agreed standardised data inventory that software solutions can draw on.
- Configure data items and develop protocols that allow sharing between organisations and software platforms.
- Construct a prototype 'data hub' to support a quality benchmarking platform.
- Identify a suite of quality indicators that can be calculated from the standardised data.
- Ultimately enable residential aged care providers to understand, compare and improve their quality of care.[16]

Individually, these projects are incomplete responses to what is really missing in the aged care sector—a single, reliable and accessible source of data on older people, aged care providers, the aged care and health services they use and the outcomes for them, of using those services. Without this single reliable source of data, the capacity of the Australian Government and aged care providers to monitor and evaluate the quality and safety of health and aged care services will remain limited.

16.1.3 Limitations of existing data collections and systems

Reliable, accessible and comprehensive data on safety and quality is not available in the aged care sector. At a system level, there is 'no comprehensive data on the outcomes of care'.[17] This cannot continue. The Australian Government cannot effectively regulate, or develop responsive policy for, a system about which it remains partially ignorant. The Australian public are entitled to expect comprehensive, up-to-date and de-identified data to be available to them on a regular basis to help them evaluate the safety and quality of the aged care system.

The Australian Institute of Health and Welfare acknowledges that current aged care data is fragmented and incomplete:

> There is limited integration across data sets to enable a person centred view of pathways and outcomes across aged care, health and other support systems. There are also notable data gaps (e.g. workforce, finance, regular assessment of care needs, quality of life, quality of care) and no agreed common data definitions in use across the aged care sector.[18]

It is not merely a matter of collecting missing data. Rather, all data must also be of a high quality and the capacity must be built to use it effectively. Data systems need to be designed to share information—also called being 'interoperable'—and the infrastructure must be sufficient to serve the purposes of collecting data.

Ms Glenys Beauchamp PSM, then Secretary of the Australian Department of Health, acknowledged that access to data was a key reform that the Department needed to look at.[19] A lack of access to data leads to very practical problems. For example, Dr Nicholas Hartland, First Assistant Secretary of the In Home Aged Care Division in the Australian Department of Health, told us that integration of the Home Care Packages Program and the Commonwealth Home Support Programme had been delayed because the Department does not have a good understanding of what is funded for whom under these programs. He described this lack of understanding as one of the major blockers of this important work.[20]

Where data is collected, it may be collected multiple times unnecessarily. Ms Elizabeth Cosson AM CSC, Secretary of the Australian Department of Veterans' Affairs, told us that she would like to see the mainstream aged care information system and the veterans' affairs information system interface to allow automatic population of information across both systems, so that people would only have to tell the Australian Government about their circumstances once.[21] Professor Westbrook said that the aged care sector, including approved providers and government, tends 'to collect the same information in multiple different places in different datasets and this really limits our ability to use that data or to improve the quality of that data'.[22]

The existing data sources and repositories about the aged care system are varied in terms of scope, purpose, accessibility and usefulness in assessing the performance of the aged care sector. Despite the number and sophistication of these existing data sources and integration projects, no single reliable source exists that is accessible to all who have a need or a right to know about the quality and safety of aged care services in Australia. The Australian Institute of Health and Welfare explained that the data that is captured about aged care comes from several different government agencies that do not have common data standards and systems.[23]

16.1.4 Aged care data authority

Australia does not have a national aged care dataset to inform assessment of how the aged care sector performs for the benefit of older people. This is because there is no funding for such a dataset, and because no entity has responsibility to develop and maintain it.

There is currently no body in Australia that has the authority and the technical capabilities to establish a national data asset for aged care. An aged care data asset based on national minimum aged care datasets should be managed by an independent body with legislated authority, technical capabilities and funding certainty to:

- obtain, integrate and share de-identified data needed for transparent performance monitoring and research of the system
- publish reports on the quality and safety of aged care services, at the individual provider level, to help people make informed choices about their care arrangements
- supply aged care providers with benchmarking information to help them see how they can improve the quality of their services
- support research and innovation in aged care by providing researchers with free and timely access to comprehensive, de-identified data
- inform the development and evaluation of the Australian Government's aged care policies, and
- provide the Quality Regulator with information that supports risk-based regulation and early identification of quality and safety risks.

In order to derive the best value from funded research, aged care researchers should be able to draw on a national data system rather than having to capture or create project-specific datasets. This will require data governance arrangements and information and communications systems reform to enable the secure transmission of data, through data science and analysis capabilities. It will also require reforms to improve the availability and use of data about the aged care system and people receiving aged care.

I recommend that the Australian Institute of Health and Welfare be required and empowered to:

- collect, store and manage aged care-related information and statistics
- coordinate the collection, production and publication of that material whether by itself or in association with others
- oversee the development of a standard format for presentation of aged care data, including consideration of interoperability with the health care sector
- develop a National Aged Care Data Asset, comprising a number of national minimum aged care datasets.

The Australian Institute of Health and Welfare should be funded to do this work through the Aged Care Innovation and Research Fund because it will provide certainty for future funding needs. The Australian Institute of Health and Welfare will require additional funding to complete the work of curating and publishing data for a National Aged Care Data Asset.[24] The importance of accurate and timely published data for the aged care system is such that the activity needs to be independent of political influence.

The System Governor should determine the national minimum aged care datasets. The datasets should include data on:

- the demographics, clinical characteristics and care needs of people receiving aged care
- the demographics, skills and wages and conditions of the aged care workforce
- the financial performance of aged care providers, the quality of care provided by them, their ownership types, operating segments, size and any other characteristics relevant to the analysis of how the age care sector is functioning.

16.1.5 National Aged Care Data Asset

A National Aged Care Data Asset will bring together data from multiple sources. It will provide a better understanding of the life experiences, pathways and outcomes of people receiving aged care and the operation and performance of the aged care system, including on quality and safety. The data asset would be made up of a number of national minimum aged care datasets.

The National Aged Care Data Asset should link or be linkable with data, including other national minimum datasets, collected on primary and acute health care as well as disability care. Ms Louise York, Head of Community Services Group, Australian Institute of Health and Welfare, explained that the data should be useful for looking at both the individual service provider level and the system level. She said that a lot of that data is in the system at the moment, but it needs to be made available sooner and linked more regularly to produce a better overall picture of the aged care system.[25]

Ms York told us that 'there's great potential of linked up data to provide information about the risks that are being experienced' by people using aged care. She considered that data about hospitalisations, prescribing rates, complaints and accreditation status could be linked.[26] Associate Professor Maria Inacio, Director of the Registry of Senior Australians at the South Australian Health and Medical Research Institute, said that compliance and accreditation information would be 'incredibly valuable' in the future to understand the performance of facilities.[27]

The National Aged Care Data Asset should involve the collection and de-identified publication of at least the following linkable data:

- aged care program administration data, including need assessments, funding claims and payments, care provision, and expenditure by service types, including mapping to region and other characteristics (this information should cover the same data currently provided for in the National Aged Care Data Clearinghouse)
- other Australian Government administrative data with likely linkages with existing Pharmaceutical Benefits Schedule and Medicare Benefits Scheme data
- regulatory data, including provider applications for approval to be a provider, complaints, consumer experience, compulsory reporting, quality compliance, prudential compliance, and quality indicators

- select provider internal data, including data about clinical care, staffing and rostering, staff training, provision of care, quality of life, and financial characteristics
- demographic data, including the background of users of aged care, and the number, skills, wages and conditions of the aged care workforce
- primary and acute health care data, involving separate collection or linkages with hospital admissions and health care treatments, including general practice and allied health.

A data asset of this type is being developed for the disability sector by the Australian and State and Territory Governments. The purpose of that data asset is to 'improve outcomes for people with disability, their families and carers, by sharing de-identified data to better understand the life experiences and outcomes of people with disability in Australia'.[28]

The development of the National Aged Care Data Asset should be informed by the National Disability Data Asset pilot and consider design features which will enable the data assets to be interoperable and complementary.

The Australian Institute of Health and Welfare has relevant expertise and structures to manage the proposed National Aged Care Data Asset. It should be given the additional functions, powers and resources to do so.

Governance and leadership of aged care data

Dr Robert Grenfell, Director of Health and Biosecurity at the Commonwealth Scientific and Industrial Research Organisation, told us that the Australian Institute of Health and Welfare should be responsible for data curation, but that data governance should sit with an independent entity.[29] Ms York emphasised the importance of separating curation and governance.[30] Several responses to Counsel Assisting's final submissions emphasised the importance of the independence of curation of data to ensure that data meets the needs of all users.[31]

Ms York said that the Australian Institute of Health and Welfare 'has a legislated function of designing datasets in conjunction with relevant stakeholders'. She said what the Australian Institute of Health and Welfare would normally do is:

> work with clinicians, policy makers, academics, people involved, consumers, customers, older people and potentially the ICT [information and communications technology] sector, workforce, to work through…what they want to know, what's already available and then how we would go through the painstaking work of working out how to actually isolate those core pieces of information that need to be collected to really get that regular measurement over time of what we're trying to achieve.[32]

The Australian Government should engage with the State and Territory Governments to agree on what components of health care data collected by them should be incorporated into the National Aged Care Data Asset either directly through new collections, or through linking existing datasets provided regularly to the Australian Institute of Health and Welfare.

Data standards for aged care

We received a number of submissions supporting implementation of standardised data collection and the 'collect once, use many times' principle.[33] This should be a fundamental principle for data management in aged care. To use data many times, the original collection must be high quality and reliable. This means aged care data, and its collection, must meet minimum standards. As SA Health submitted, 'good data collection is fundamental to setting a solid foundation for monitoring the performance of the system, its interfaces and to inform future reform'.[34]

Data about aged care comes from several different government agencies that do not have common data standards and systems.[35] Minimum datasets must be based on common data standards so that they yield meaningful and reliable information.[36] Having these standards means that aged care providers know what digital recordkeeping systems will be suitable for the data that they need to capture and transmit. Mr Ben Lancken, Head of Transformation at Opal Aged Care, said that standards would enable providers like Opal to 'build our systems to enable the collection of the data'.[37]

The Aged Care Industry Information Technology Council stated in 2017 that 'the absence of common standards, sector-level policies and common data collection…means it is difficult for individual organisations to benchmark their performance and identify needed improvements'.[38]

An important task for the aged care data authority is to establish a 'common language' for aged care data. Attention should be paid to the intersection between aged care, health care and disability services, and the importance of common data properties to enable the systems to communicate.

To support the development of the National Aged Care Data Asset, the new Act should require relevant government entities and approved providers of aged care to provide data required by the Australian Institute for Health and Welfare within three months of the end of the relevant reporting period for the type of data being reported. They should also be required to respond, in a timely manner, to other requests for aged care-related data made by the Australian Institute of Health and Welfare.

The Australian Government announced the 'Aged Care Data Compare' project in June 2020. This project aims to resolve technical difficulties with the standardisation and sharing of valuable data recorded as part of everyday practice in residential aged care.[39] This includes assessment of the Health Level Seven International (HL7) Fast Healthcare Interoperability Resources Specification and the possible use of aged care data interoperability standards and protocols.[40] The Australian Department of Health should continue its involvement in this work and make sure that it is resourced adequately and given priority.

Collection of personal or protected information

Data and information collected under Australian and State and Territory legislation are frequently subject to statutory protections limiting disclosure other than for the purpose they were collected. *The Privacy Act 1988* (Cth) may also prevent the disclosure and publication of data and information.

These protections exist for a reason. However, to establish a National Aged Care Data Asset that can be made available to researchers and stakeholders in a way that does not identify individuals, limited exceptions should be enacted.

The Australian Government, together with the State and Territory Governments, should work to identify and remove legislative barriers to collection and linkage of data about individuals by the Australian Institute of Health and Welfare, and to make aggregated, non-identifiable data available for research and policy purposes, including service level data.

Authority to release data

A key issue for future research will be to ensure timely access to data. Data custodians are responsible for approving access to, and use of, the data collections for which they have authority. They have to manage privacy issues and to ensure that data held by them is only used in research in a manner that is consistent with its approved use.[41] These processes can cause delay in accessing data.

Associate Professor Inacio, of the Registry of Senior Australians, described the administrative burden of obtaining access to data from the Australian Institute of Health and Welfare and, in particular, the lack of timely access to valuable data. She told us that there was 'absolutely no excuse' for aged care eligibility assessment data not having been made available since 2016, and that this delay represented a missed opportunity for research during those four years.[42]

Associate Professor Gillian Caughey, also of the Registry of Senior Australians, said that long delays in securing access to data had adversely affected the ability to monitor trends in care quality and to provide timely information about risks in the health and aged care sectors.[43]

Ms York described a vision for the future with 'enduring and regularly linked information where all of those approvals have already been given upfront' as long as the use of the data fits within agreed principles and outcomes.[44] This vision should become a reality. Delays in accessing aged care data from the Australian Institute of Health and Welfare must be minimised in future.

16.2 Aged care research and innovation

We have been told that, given the number of people accessing aged care services and the challenges facing the aged care sector, aged care research is not given sufficient priority and there is relatively little funding. This needs to change. A new approach to aged care research and its funding is required.

Continuous improvement and innovation should become part of everyday practice, for the aged care sector to provide high quality care. In my opinion, innovation must be informed by the best available evidence from research and the means to apply it to the everyday practice of care. This will help foster curiosity in the people who work in aged care. A heightened sense of curiosity should make aged care workers and providers alert to risks or problems and their potential solutions. Curiosity about how to do things better should help lead to further improvement, innovation and an ambitious pursuit of better practice care.

This was reaffirmed in evidence given by Professor Briony Dow, Director of the National Ageing Research Institute, who stated that:

> there is a great deal of evidence regarding models of care, appropriate environments, workforce training needs and so on relating to aged care. However, much of the evidence is not known and/or not taken up by the aged care sector.[45]

Research activities relevant to ageing and aged care are of little value, unless they lead to practical solutions that support healthy ageing and high quality aged care services. Above all, research and innovation must make a difference to the things that older people care about. This highlights the importance of strong partnerships between researchers, aged care providers, older people receiving care and their families. When aged care providers, their staff and the aged care sector as a whole start to look collectively for best practice solutions, this will support the translation of research into practice and, in turn, into high quality and safe care.

We make the following recommendation to establish an Aged Care Research and Innovation Fund, and I make a particular recommendation on the allocation of research funds at 107.8, which differs from that of Commissioner Pagone at 107.7.

Recommendation 107: Aged Care Research and Innovation Fund

1. **The new Act should provide for the establishment of an Aged Care Research and Innovation Fund to be administered by the System Governor.**
2. **The Australian Government should provide funding equal to 1.8% of total Australian Government expenditure on aged care to the Aged Care Research and Innovation Fund each year, without derogating from the amount of funding available for research and innovation through the Australian Research Council and the National Health and Medical Research Council. Researchers in ageing and aged care should continue to have equal right of access to the funds administered by these other research councils.**

3. By 1 July 2022, the Australian Government should establish and fund a dedicated Aged Care Research and Innovation Council.

4. The Aged Care Research and Innovation Council should be funded to:

    a. make recommendations to the System Governor on expenditure from the Aged Care Research and Innovation Fund

    b. set the strategy and agenda for:

        i. research into, and innovation in, the delivery of aged care, including workforce-related research and technology

        ii. research into the socioeconomics of ageing

        iii. research into, and innovation in, the prevention and treatment of ageing-related health conditions

    c. facilitate networks between research bodies, academics, community organisations, industry, government and the international community for research, technology pilots and innovation projects, to assist with the translation of research into practice to improve aged care and to address issues associated with ageing in Australia

    d. work with the Australian Research Council, the National Health and Medical Research Council, participants in teaching aged care programs, and health and research networks to facilitate the sharing and application of research outcomes with policymakers, research bodies, health care bodies, approved providers and the community.

5. The Aged Care Research and Innovation Council should be chaired by a member appointed by the majority of Council members. The Council should consist of eight members appointed by the Australian Government for (renewable) periods of up to three years on the basis of their distinguished research records or achievements in research and development. The remuneration of the members of the Aged Care Research and Innovation Council should be determined by the Remuneration Tribunal.

6. On the advice of the Aged Care Research and Innovation Council, the System Governor should make grants from the Aged Care Research and Innovation Fund to support:

    a. research into, and innovation in, the delivery of aged care, including through co-funding arrangements with industry and aged care providers, and through workforce-related research and technology

    b. research into the socioeconomics of ageing

    c. research into, and innovation in, the prevention and treatment of ageing-related health conditions.

7. The Aged Care Research and Innovation Council and the System Governor should, in performing their functions in relation to grants from the Aged Care Research and Innovation Fund, be guided by the following aims:

Commissioner Pagone

   a. about half of the funding allocated at any given time should be for research into, and innovation in, the delivery of aged care, with:

      i. about half of that funding allocated to projects supported by substantial co-funding arrangements with industry and aged care providers, and

      ii. priority given to research and innovation that involves co-design with older people, their families and the aged care workforce

   b. about 10% of the funding allocated at any given time should be for research into the socioeconomics of ageing

   c. about 20% of the funding allocated at any given time should be for research into, and innovation in, the prevention and treatment of ageing-related health conditions.

8. The Aged Care Research and Innovation Council and the System Governor should, in performing their functions in relation to grants from the Aged Care Research and Innovation Fund, be guided by the following aims:

Commissioner Briggs

   a. the total funding allocated to the Aged Care Research and Innovation Fund should be split equally between ageing-related health research and aged care-related research

   b. the aged care-related research funding should be allocated in the following way:

      i. about two-thirds of the funding allocated at any given time should be for research into, and innovation in, the delivery of aged care, with:

         A. about half of that funding allocated to projects supported by substantial co-funding arrangements with industry and aged care providers, and

         B. priority given to research and innovation that involves co-design with older people, their families and the aged care workforce, and

      ii. about one-third of the funding allocated at any given time should be for research into the socioeconomics of ageing.

16.2.1 The nature of aged care research

Research is investigation undertaken to gain knowledge and understanding.[46] Aged care research can be difficult to define and classify because it tends to sit in a space somewhere between health, medical or social research. A cross-disciplinary approach to research is often necessary in fields as complex as ageing and aged care.

Research on aged care quality and safety may include consideration of medical health, technological, organisational, environmental, cultural and social issues. Research may draw on a variety of methods, including experimental, qualitative and co-design approaches to explore the inputs, processes and outcomes of aged care practices and systems.

In addition to research, quality assurance and evaluation contribute to continuous improvement and innovation. Quality assurance and evaluation usually involve the application of research methods. While research aims to gain knowledge, quality assurance aims to monitor and improve processes or activities, and evaluation aims to identify the impact or outcomes of a process or activity.[47]

The creation of knowledge through research does not in itself lead to positive change. The knowledge must be translated through changes in policy, practice and product development where appropriate. This entails bringing together researchers and representatives from industry and the education and training sectors to achieve good health, economic, environmental, and social or other outcomes from research.[48]

Regardless of whether an activity is research, quality assurance or evaluation, its potential benefit to the welfare and individual wellbeing of people may require consultation with those very people.[49] Co-design in aged care quality research is valuable because it is conducted in 'real world' settings with a view to understanding what works for older people in their specific contexts—and in the real world more generally. It also enables researchers to understand how to improve the uptake of new products and services.[50] Co-designed research is similar to action research in that it aims to build a body of knowledge, find practical solutions to problems, and enhance professional and community practices to benefit people's everyday lives.

Some Australian leaders in the field of aged care research told us about the practical value of co-design. They explained that it ensures that their research questions address issues of importance to older people and maximises the likelihood of the research producing tangible benefits. Ms Julianne Parkinson, the Chief Executive Officer at the Global Centre for Modern Ageing, said:

> Co-design, when best performed, brings together the existing or the aspirational end users who would consume a product or service, alongside a suite of professionals and they could include many stakeholders. So by way of example, they could be those that are involved in the regulation of a product or service to market.
>
> And when it's done very well, this actually informs, by the end users—it is an equal playing field and equal platform of power and co-development that means that the product probably will meet the end user's real needs and wants.[51]

16.2.2 Aged care innovation

Innovation is critical for aged care to adapt to the evolving needs of older people. I have heard it is difficult to innovate in the aged care sector due to cautious governance processes and a low appetite for financial risk. Aged care providers that struggle to deliver a decent standard of care from day to day are unlikely to be looking over the horizon to explore tomorrow's possibilities.

The suggestion that the current system inhibits innovative service delivery was a common theme throughout the inquiry. For example, Mr Matthew Richter, Chief Executive Officer of the Aged Care Guild, said:

> The primary concern is policy and regulatory instability and then financial vulnerability of the sector overall is a concern as well. The sector isn't performing very well from a financial perspective and that has material implications, I believe. When you have any industry that is returning on its assets a negative return, you don't tend to see broad-based innovation.[52]

In reflecting on how well the current aged care system provides incentives for innovation, a number of witnesses expressed a generally despondent view. According to Ms Jennifer Lawrence, Chief Executive Officer of Brightwater Care Group:

> Look, I don't think it incentivises innovation, and I think that that is a problem for providers in terms of being able to afford to do anything that's innovative is actually quite difficult.[53]

Approved providers have raised concerns about a lack of funding available to innovate. For example, Ms Jennene Buckley, Chief Executive Officer, Feros Care, argued that the current residential service funding models do not allow providers to innovate.[54] Professor Sue Gordon, Strategic Professor and Chair of Restorative Care at Flinders University, acknowledged the need for adequate financial support to incorporate any new requirements on providers:

> We're talking about a sector where 51 per cent of aged care providers are in the red. So there needs to be support to basically incorporate anything.[55]

There are some small Australian Government grants currently available for providers to apply for to assist with innovative practices. However, this funding is generally short-term. Some schemes, such as the Cooperative Research Centres Program, require applicants to secure in-kind private funding.

There is a reluctance in the aged care industry to embrace innovation, even when the costs of doing so are low. According to Dr Tanya Petrovich, Business Innovation Manager, Centre for Dementia Learning at Dementia Australia:

> there are things that can be implemented now that would make a significant difference to aged care and it doesn't require a lot of money.[56]

An example she gave was removing nurses' stations in residential facilities. She suggested that residential facilities needed to be encouraged to be more innovative, suggesting that there is a reluctance in the industry to innovate.[57] Dr Petrovich explained:

> I just think there's a mindset there that is just not open enough to innovation…I think that the industry as a whole in general is risk-averse and is not open to innovation in residential aged care…They need to be encouraged to be more innovative.[58]

We commissioned a 'Review of Innovative Models of Aged Care', which identified a number of existing innovative approaches to providing aged care for older people, both in Australia and internationally.[59] The report from that review highlights that:

> there are many innovative approaches to supporting older people requiring long-term care both in the community and residential care. National regulations and funding can either support approaches or limit their implementation or uptake.[60]

The examples of the many efforts to innovate in the report show what may be possible when providers have a vision, appetite for risk and some incentives. The aim of our proposed approach to stimulating innovation is that more Australian aged care providers will try and succeed at finding better ways of meeting the evolving needs and expectations of older people and those who care for them.

16.2.3 Aged Care Research and Innovation Fund

There are several main sources of public funding for aged care research in Australia:

- two dementia-specific funds (the Dementia and Aged Care Services Fund and the Boosting Dementia Research Initiative)[61]
- a health and medical research fund (Medical Research Future Fund)[62]
- a fund which covers every field of research other than health and medical research (Australian Research Council).[63]

There is no dedicated funding for research into the delivery of high quality and safe aged care.

There is very little funding allocated to projects that explore aged care quality and safety. Funding is more widely available for research focused on how to prevent and manage health conditions associated with ageing, which is important and valuable. However, research and evaluation projects that explore how to improve the quality and safety of services and technological support for older people are also valuable. Much more work is needed in these areas, as they do not attract much research funding.[64]

Professor Steven Wesselingh, Chair of the Research Committee of the National Health and Medical Research Council, told us that, while a large amount of money has been allocated to research projects relevant to the health and clinical aspects of ageing, comparatively less has been allocated to projects addressing aged care quality and safety. By way of illustration, he said that:

> In the last 10 years, in terms of aged care and the quality of aged care, NHMRC [the National Health and Medical Research Council] has spent about $86 million over 10 years. In contrast, in neurological disease we have spent $1.8 billion. So working hard on neurological disease, that's all part of aged care, you know, Parkinson's disease, dementia, etcetera, so really good research. The actual questions about aged care quality and safety that you are addressing have received relatively little funding.[65]

Professor Dow told us that there has been a lack of investment in research into delivery of aged care due to a societal view that aged care is not 'particularly important'. She said that the problem is circular: societal attitudes filter down, aged care research is not seen as a particularly attractive area by educators and researchers, and this is 'reinforced by a lack of funding'.[66] Professor Westbrook said that funding for research focused on aged care services and their effectiveness is very limited.[67]

I recommend that, to ensure an enduring focus on the needs of the aged care system, a dedicated Aged Care Research and Innovation Fund should be established. This fund should be administered independently of existing research funds and have a much wider focus. The establishment of this new fund should be additional and separate to, and have no impact on, the amount of money available in existing research funds.[68] Researchers in ageing and aged care should continue to have the same ability to access those other research funds.

The amount of investment in aged care research and development needs to reflect the Australian Government's expenditure on aged care, the importance of high quality and safe care for vulnerable people, and the research work necessary to support the new aged care system. Annual aged care research funding should be fixed and equal to 1.8% of the Australian Government's total expenditure on aged care. It reflects the general level of expenditure on research and development across the Australian economy which varied between 2.25% in 2008–09 and 1.79% in 2017–18.[69] The Australian Government should adopt this figure in the short to medium term and then revise it up or down as required.

In addition to dedicated funding, new administrative infrastructure is required to ensure that the public investment in aged care research and innovation is directed to practical and beneficial outcomes.

16.2.4 Aged Care Research and Innovation Council

I recommend that an Aged Care Research and Innovation Council be established.

We have been told about the need for:

- coordination of aged care research and development in Australia and internationally
- research that pays proper regard to the priorities of end-users, including older people, members of the community, families and informal carers
- a research body governed by a range of people with different experience and expertise
- funding of research and development into existing and new models of aged care that are not otherwise the subject of funding by the National Health and Medical Research Council and other similar bodies.[70]

The new Council should set the strategy and agenda for aged care research and development. It should make recommendations to the System Governor on expenditure from the Aged Care Research and Innovation Fund. Research and development the subject of those recommendations should not be focused only on health-related, clinical or medical matters relating to aged care. It should extend to research on, for instance, the delivery of aged care, application of technological developments in aged care, better governance of aged care providers, and the socioeconomics of ageing. It should also extend to workforce-related research and technology, including translation from conception to market, to improve workforce productivity and quality of care. Commissioner Pagone and I make different recommendations for how money within the Aged Care Research and Innovation Fund should be allocated.

The Aged Care Research and Innovation Council should recommend funding for, among other things, research that is co-designed with older people and their families, and with aged care providers and the aged care workforce. Professor Alison Kitson, Vice-President and Executive Dean of the College of Nursing and Health Sciences, Flinders University, and Foundational Director, Caring Futures Research Institute, told us that co-design is a relatively recent phenomenon in the area of clinical trials and research. She explained that accepting co-design required a change in thinking 'because it challenges the paradigm of what objectivity is' through allowing input from those using the services the subject of the research. Her opinion was that if the aim of research is to translate knowledge into practice, then 'involving stakeholders right at the beginning is the most important factor for success'.[71]

Professor Dow explained that 'co-design type work' is outcomes focused and is 'not the type of research that lends itself to higher level academic publications'. She said that an unavoidable consequence of co-design with end-users is a loss of ultimate control over research design. She also said that if you are researching for quality of care or quality of life outcomes, these matters are not capable of being flawlessly measured, as compared to blood pressure, for example, which is capable of objective measurement. [72]

Dr Grenfell told us that research should be for solving problems that need to be solved.[73] I agree. The Aged Care Research and Innovation Council should adopt a priority-driven approach to research. In adopting such an approach, the allocation of funding would be strategically directed to identified problems and gaps to ensure that funded research delivers the greatest benefit for end-users. The focus on priority-driven co-design will distinguish the new Aged Care Research and Innovation Council from some other research bodies. For example, Professor Wesselingh told us that the National Health and Medical Research Council has tended to allocate funding on the basis of investigator-driven, rather than priority-driven, research. He said that, in investigator-driven research, investigators come to the National Health and Medical Research Council with their ideas for research projects. Those ideas are assessed by peer review, and the highest quality research proposals get funded.[74] Professor Dow told us that research supported by the National Health and Medical Research Council 'lends itself to much more basic science and clinical trials'.[75]

As part of its coordination function, the new Council should facilitate networks to assist the translation of research into practice to improve aged care and to address issues associated with ageing. This should include working with the Australian Research Council, the National Health and Medical Research Council, and participants in teaching aged care programs (Recommendation 107.4(d)).

The new Aged Care Research and Innovation Council should have eight members appointed by the Australian Government. The Council should be chaired by a person determined by a majority of members of the Council. The Chair and the other members should be appointed for (renewable) periods of up to three years. Members should be appointed on the basis of their distinguished research records or their achievements in research and development. The remuneration of the members of the Aged Care Research and Innovation Council should be determined by the Remuneration Tribunal.

We have been told that the National Ageing Research Institute or the National Health and Medical Research Council could take on this role.[76] Some responses to Counsel Assisting's final submissions, including from the Australian Government, suggested that aged care research should be the responsibility of an existing body. It was submitted that establishing a separate Council might duplicate administrative roles performed by, for instance, the National Health and Medical Research Council, and might fragment research, funding and capacity.[77]

My preferred approach is for the Aged Care Research and Innovation Council to remain outside of the National Health and Medical Research Council and other existing research bodies. The Aged Care Research and Innovation Council would maximise its effectiveness, and minimise any inefficiency and duplication, by working with bodies such as the National Health and Medical Research Council. However, the role and functions of the new Council should remain independent.

There is little risk that additional research funding and capacity will fragment existing funding and capacity. The role and functions of the Aged Care Research and Innovation Council are new and extend beyond those of the National Health and Medical Research Council. For example, research funded through the Aged Care Research and Innovation

Council would not be limited to health and medical research. I consider the approach to be taken by the Aged Care Research and Innovation Council, often based on co-design and priority-driven research and development, is more appropriate for aged care research and development. That approach is different to the approach taken by the National Health and Medical Research Council.

The National Health and Medical Research Council supports basic research in health but most of the investment in the development of innovative health products (such as pharmaceuticals or technologies) is funded by the private sector for competitive advantage. In contrast, the Australian Government is overwhelmingly the funder of aged care and will need also to provide additional funds needed for aged care research and innovation. This will be a key role for the Aged Care Research and Innovation Fund.

Many people expressed their broad support for a dedicated body to lead and fund aged care research, and offered views as to the benefits, purpose and design. In particular, they are seeking a research agenda that is influenced by researchers, aged care providers and the interests of the people who receive aged care services.[78] Research projects must have potential to improve the quality and safety of aged care services, and the usefulness of technological supports for older people and those who care for them.

The Aged Care Research and Innovation Council should be careful to ensure that health-related research does not dominate its agenda. I recommend that no more than 50% of the funds allocated be devoted to ageing-related health research. I further recommend that the Aged Care Research and Innovation Fund apportion the remaining 50% of funds for aged care-related research as follows:

- two-thirds for research into, and innovation in, the delivery of aged care, with:
    - about half of that funding allocated to protects supported by substantial co-funding arrangements with industry and aged care providers
    - priority given to research and innovation that involves co-design with older people, their families and the aged care workforce
- about one-third for research into the socioeconomics of ageing.

16.2.5 Translation of research into practice

The 2018 report of the Aged Care Workforce Strategy Taskforce noted that, despite the number of existing research bodies and funding sources, the aged care sector is slow to adopt research. The Taskforce attributed this to the absence of a ‘research translation pipeline’ and said that this ‘discourages government and private sector investment’. While these comments were directed to ‘research and translation priorities…firmly focused on the needs of contemporary workforce-related needs’, this problem affects aged care research and innovation more generally.[79]

My approach to aged care research and innovation, including on workforce-related needs, will support translation of research outcomes into practice and include evaluation of new products and services. The Australian Government has taken steps to establish a Centre for Growth and Translational Research focusing on workforce-related issues and their translation to market, but progress has been too slow.[80]

Up to $34 million has been allocated for the Centre for Growth and Translational Research, and the Centre is expected to be operational in early 2021. Its purpose is to: develop new models of care and develop assistive technologies to support the independence of older people receiving care; link older people, aged care researchers and workforce educators to support co-design of research priorities and projects; educate the sector on how to use new innovations in practice; and complement other aged care research bodies to facilitate aged care research translation.[81]

The Centre for Growth and Translational Research is a good initiative that has potential to boost the tempo, scale and impact of research and development into how to get better aged care services. The current concept for the Centre, however, has a number of limitations and risks. A somewhat different approach is needed to: achieve better strategic coordination of research and collaboration on projects; ensure that research and innovation funding is allocated to projects with the best potential to have a sector-wide impact; and have a complete, end-to-end, research to innovation pipeline.

I am of the view that these desired outcomes could be better achieved by a dedicated aged care research and innovation funding body, which together with the teaching aged care network can improve the Australian aged care sector's means and capacity to drive innovation and continuous improvement through a nationally coordinated aged care research agenda and dedicated funding. I consider that, to genuinely support older people as they age, there must be:

- strategic coordination of co-designed research that is designed to create and evaluate models of care and other support for people as they age
- an avoidance of small, ad hoc studies of limited scale and impact
- the upscaling of successful initiatives into the broader sector
- sharing of research outcomes within the aged care and health sectors, and with the public.

An Aged Care Research and Innovation Council with a broader focus is needed to contribute to the delivery of high quality and safe care in the aged care system of the future. If the Council is established—and our other recommendations, such as enhanced arrangements for workforce planning, are implemented—it may not be necessary to proceed with a separate Centre for Growth and Translational Research. The developmental work underway, funded by the Australian Government, could support the creation of the Aged Care Research and Innovation Council with its broader scope and remit, as I have recommended.

The Aged Care Research and Innovation Council should be responsible for peer reviews of research proposals and should prioritise projects for funding, if they have one or more of the following features:

- the project intends to develop or evaluate new care models
- the project features co-design with older people, carers and aged care workers and providers in its methodology
- the project entails evaluation or quality assurance of technological supports for older people
- the project team includes one or more early career researchers
- the project has high potential to influence government policy or the policies and practices of aged care and health service providers
- the project is inclusive of older people in regional and remote locations or people who are traditionally under-represented in aged care or other research.

As described in Chapter 18 of Volume 4 of this report, we have heard a lot of evidence about ideas that have been translated into innovative technologies used in parts of the aged care sector. Those technologies include:

- digital health and clinical information systems
- technological tools that can provide predictive data and decision support
- assistive and healthy ageing technologies
- monitoring technologies
- physical robotic technologies
- social networking applications to help address social isolation
- virtual care and telehealth
- human resources technologies, including scheduling, rostering and feedback systems.

I firmly believe that people receiving aged care and their carers should fully benefit from existing and emerging technologies. My preferred approach is that aged care research and innovation should drive the increased use of those technologies and the adoption of better care models through a nationally coordinated aged care research agenda and dedicated funding.

16.3 Information and communications technology

The aged care system we envisage for the future will need to operate in a technology-enabled environment for efficient clinical, business and operational systems. These need to be designed to identify older people's needs and preferences, and to provide care tailored to their needs.

The implementation of our recommendations for a data asset and a body to serve as the data authority, is dependent on information and communication systems that can harness data and information across the aged care system—from individuals, aged care providers and government agencies—and coordinate that information to support the new aged care system.

The current state of information and communications systems used across the aged care sector has significant deficiencies and gaps that severely impact the way aged care is provided.[82] The Aged Care Industry Information Technology Council argues that the sector's technological readiness is underdeveloped, due to inadequate sector-wide planning and workforce training and development, as well as the absence of incentive schemes to encourage investment in technological systems.[83] According to Professor Westbrook:

> Few IT vendors in the aged care sector have been willing to invest and actively collaborate with researchers and clients to substantially improve the sophistication of their systems.[84]

The System Governor should facilitate the development of systems to enable automatic reporting by approved providers on mandatory reporting obligations, quality indicators, prudential arrangements and other responsibilities. It should also establish arrangements consistent with the 'collect once, use many times' principle, including:

- integrating Australian Government systems to enable sharing of aged care data[85]
- ensuring mechanisms exist for the transfer of clinical records where required for the continuity of care (these issues are discussed in our chapter on better access to health care)
- investment in new infrastructure to support that principle being put into practice.

I also consider that arrangements should be established by the System Governor to:

- ensure relevant administrative data, such as assessment data, is available to providers
- ensure a mechanism exists for approved providers to transfer information about an individual effectively and securely when the individual changes service providers.

The System Governor should support the development of information and communications technology capability in the aged care sector. This includes the secure use of data throughout the system and solutions to reduce the administrative burden of data collection. Real-time or near real-time data sharing should be standard within government, with the capacity for approved providers to upload data.[86]

Professor Westbrook gave evidence about technology barriers that can limit providers taking advantage of research. She referred to: electronic information systems with limited functionality; variable information technology literacy of staff; and a lack of systems interoperability. For example, she described how a lack of interoperability between a residential aged care facility's medication systems and a general practitioner's electronic prescribing system increases the risk of errors.[87] The Australian Government has agreed that all residential aged care services should move to digital electronic care records.[88]

Information and communications systems used by approved providers of aged care should operate so that information that is routinely collected for their own purposes can assist them to meet responsibilities to provide data, including for the National Aged Care Data Asset.

I recommend that the Australian Institute of Health and Welfare accredit software for compatibility with the National Aged Care Data Asset to enable the efficient collection of quality data. Responses from providers to Counsel Assisting's final submission were reluctant to support software accreditation by the Australian Institute of Health and Welfare if that would involve additional cost or lost investment.[89] The purpose of software accreditation would be to reduce the costs of data collection and ensure that quality data was being collected. Accreditation should be of parameters or standards only, and occur in a way that does not adversely impact on innovation.

16.3.1 Architecture and investment in technology

There are several problems with the current technology infrastructure and architecture.

First, there is variable use of digital record keeping for clinical and administrative information management.[90] My Health Record is 'not extensively used across the aged care sector'.[91] General practitioner Dr Paresh Dawda spoke about this issue and how it duplicates record keeping efforts for general practitioners who service aged care facilities:

> Record keeping in RACFs [residential aged care facilities] is challenging and variable. Most of the RACFs I visit are using electronic systems but there are some that use paper system or hybrid system.
>
> I believe it is important at our team keeps a record of the encounters in our clinical system to maintain sovereignty of the record but also to enable us to deliver proactive care. This means we enter records in two places, as the RACF and in our clinical system, resulting in duplicated effort.[92]

Second, the current systems that are supposed to support the aged care sector are either designed to support specific administrative and financial reporting requirements or are program-centric.[93] They are not focused on the person. For aged care providers and older people, 'there are too many interfaces to access because of the lack of seamless connection between service systems'.[94]

Third, information and communications systems across government, aged care services, hospitals and other health care providers are not interoperable.[95] This affects people receiving aged care as they access aged care, hospitals, other health care and government services. Professor Westbrook said that

> Lack of inter-operability of IT systems is a significant and major issue. For example the lack of interoperability between RACFs [residential aged care facilities] medication systems and GPs' electronic prescribing systems increases the risk of errors.[96]

The problem is exacerbated because My Health Record is not widely used across the aged care sector and does not interact with My Aged Care to provide consistent and integrated information about people receiving aged care.

Fourth, there is also a lack of interoperability of information systems between Australian Government bodies that provide services to older people.

The new aged care system needs an information and communications system that is vastly evolved from that which currently exists, details of which are covered in the recommendation below.

Recommendation 109: ICT Architecture and investment in technology and infrastructure **Commissioner Briggs**

1. From 1 July 2022, the Australian Government should invest in technology and information and communications systems to support the new aged care system. That investment should have the following elements:
    a. systems that are designed to enable better services for older people, including
        i. a new service-wide client relationship management system interoperable with My Health Record for care management, case monitoring and reporting systems built around older people's care, that would move progressively to real-time and automated reporting within five years
        ii. data and information that is accessible, complete, accurate and up to date, and
        iii. standardised systems and tools to make the user experience easy and efficient, with minimal separate portals and a single point of entry for older people and approved providers
    b. pre-certified assistive technologies and smart technology to support both care and functional needs and manage safety, and to support the quality of life of older people. These technologies are to:
        i. be universally available and enabled through internet and wifi access, and funded by the Australian Government
        ii. be put into older people's homes to help in the provision of care and improve older people's level of social engagement, and
        iii. support the development and use of mobile care finder and mobile assessment applications

c. interoperability of information and communications systems to enable the sharing of data and information about people receiving care between aged care and health care providers and relevant government agencies. Where appropriate, this interoperability should be enabled by expanding the scope of the Aged Care Data Compare project to encompass care in the home so that a full set of Fast Health Care Interoperability Resources data standards is developed for aged care assessment and services.

2. By July 2022, the System Governor should develop an Aged Care Information and Communications Technology Strategy in consultation with older people and various stakeholders to provide a road map to implement these and related initiatives.

Dr George Margelis, the Independent Chair of the Aged Care Industry Information Technology Council, said:

> Apart from the need to enable open but secure business to business (B2B) digital exchange, there is also a need to enable business to government (B2G) information sharing. Consequently, it is timely to develop a holistic government strategy for the Aged and Community Care sector that supports interoperability, secure and ready data exchange, with appropriate underpinning systems. The absence of such B2G interfaces is impeding the ability to enforce vendor best practice, and to create an open ecosystem of secure data exchange.[97]

As outlined elsewhere in this report, the aged care sector needs comprehensive strategic planning for its workforce and a nationally coordinated plan to harness the value of data and research on aged care system and processes. Information and communications systems are critical enablers of the new aged care system that we envision, and are worthy of their own strategic plan.

By July 2022, the Australian Government should complete a comprehensive review of information and communication systems within the aged care sector and within government bodies that provide services to people receiving aged care. The review should culminate in a future state information and communications architecture and roadmap to enable:

- the use of digital records for case management
- data transmission and information sharing between aged care providers, health care providers and government bodies that provide services to older people
- the use of assistive and smart technologies by people receiving care.

The review should consider the initial analysis and findings from the Architecture Practice, which was commissioned by the Royal Commission to undertake a review of the information, communications and technology architecture in aged care.

Dr Hartland, from the Australian Department of Health, told us that to get better data about aged care will require investment in information communications technology.[98] He explained that the ability to use data was not only dependent on the form in which it is collected but also how the data is transferred within and beyond the aged care and health systems:

> the issue is getting access to that data from that system, understanding exactly how it's constructed and then transferring it to another system in a structured way so the other system can accept it. So it's not only the problem that whether or not the form works, it's actually the underlying system.[99]

Government bodies that form part of the aged care system need to have sufficiently developed information and communication systems so that they can use the information effectively. The Aged Care Quality and Safety Advisory Council has already acknowledged that for it to receive and analyse large volumes of data for regulatory intelligence, it will need significant investment in its information and communications systems.[100]

Better systems for older people

Professor Westbrook said that:

> better use of electronic data collection systems which interface with external providers (GPs, pharmacists, hospitals), allowing sharing of timely health information, could contribute to improved care for residents, reduce adverse events and reduce care staff workloads by preventing redundant data collection...[101]

The new aged care system needs a data collection system based on the 'collect once, use many times' principle. This means the information and communication systems need to be built around the individual people who use aged care services. A central feature of this should be a case management system that guides people through the steps to establish their needs, assess eligibility, develop a care plan and engage a provider or providers to deliver the services in the care plan. The case management system should be a digital record that is anchored on each person's identity. It should be accessible to all who are involved in their care management. According to Dr Margelis:

> The adoption of My Health Record and its eventual alignment with My Aged Care means that Aged and Community Care providers need to prepare their data collection to support electronic health record sharing now, including providing details of assessment findings, care plans, advanced care directives and a timeline of service interventions for each consumer. They will also need to ensure that their data collection systems include unique identifiers to support the linking of consumer records and provider information with My Health Record in particular, and with the health sector more generally. Their workforce must be enabled to access these consumer records via mobile devices.[102]

The former Secretary of the Australian Department of Health, Ms Beauchamp, agreed that all residential aged care services should move to digital electronic care records.[103] This needs to happen quickly as providers of aged care and health care services need a reliable method of accessing clinical and care information, linking this to the older person receiving aged care and making it securely available at all points where health care for the person is administered.

As set out in the *Healthcare Identifiers Act 2010* (Cth), every person enrolled in Medicare or registered with the Australian Department of Veterans' Affairs has an individual Healthcare Identifier. There are two other types of Healthcare Identifiers: a Healthcare Provider Identifier for individual health practitioners and a Healthcare Provider Identifier for organisations. Organisations need to have a Healthcare Provider Identifier to access My Health Record.[104]

The Architecture Practice, which we commissioned to assist us with information technology in aged care, proposes that the Australian Digital Health Agency extend the use of My Health Record so that it captures information about aged care.[105] The Architecture Practice also notes that the Healthcare Identifiers Service for health professionals is the key means by which information about people receiving aged care can be shared between aged care and health care providers. Healthcare Identifiers already support digital information exchange sharing and management in the Australian health sector. If the uptake of My Health Record in aged care is increased, Healthcare Identifiers could be the unique identifier to link information about people receiving aged care and the health and aged care services that they receive.[106]

Linking the aged care and health care systems through a unique identifier and My Health Record will improve the way in which older people, aged care and health care providers are guided, connected and supported through the process of receiving and delivering care.

Systems that talk to each other

Aged care providers do not need to have identical information and communication technology systems, but some standardisation is needed for systems to be compatible.[107] This is where identifying interoperability standards for aged care is important. These are an essential building block for consistent and standardised information exchange between parts of the aged care system.

The Aged Care Data Compare project, referenced earlier in this chapter, is an important development because it is attempting to develop these data interoperability standards. The project is a key step not only to enabling the exchange of data but it is also critical to the development of a national Aged Care Data Asset.

The Architecture Practice recognises this and proposes that this project should continue to be supported to achieve its aims.[108] I agree. It is important for its potential to enable data sharing between aged care and health care providers and to develop a prototype hub for data sharing between aged care providers and government bodies.

The Aged Care Data Compare project is assessing the suitability of Fast Healthcare Interoperability Resources as an aged care data standard. This is a standard that enables the exchange of electronic health records between systems.[109] Fast Healthcare Interoperability Resources are seeing broad adoption overseas and the feasibility of Fast Healthcare Interoperability Resources should be further investigated in Australia.

It is encouraging that the Australian Government is investing in digital transformation in several ways so that government bodies that provide services to older people can readily manage and share information to reduce administrative burden and improve the reliability of their services. The new data availability and transparency legislation needs to make it easier for Australian Government bodies to share its data about people receiving aged care with the Department of Health, Services Australia, the National Disability Insurance Agency and the Department of Veterans' Affairs.

Seamless systems for reporting

Information and communication systems used by approved providers of aged care should operate so that information that is routinely collected for their own purposes can assist them to meet responsibilities to provide data, including for the National Aged Care Data Asset.

The aged care sector needs the capability for reporting on the day-to-day activities of providers in a way that does not detract from the core business of care and support, and so that the information is transmitted efficiently. Details regarding the workforce, finance, operational matters, and quality and safety indicators data can provide a critically valuable snapshot of home care—space that currently has little to no coverage.

Real-time reporting of aged care data enables responsive and proactive regulation. It also enables operational monitoring of services that can build an evidence-based risk profiling model for continuous improvement. It will also help identify residential aged care services at risk of providing poor quality care.

Pre-certified assistive technologies and smart technology

Chapter 4 of this volume, on program design, includes a recommendation that there be an assistive technology and home-based modifications category within the aged care program. Likewise, The Architecture Practice suggests that the Australian Government should fund providers to enable them to include assistive technologies and sensors as a standard offering.[110] It found that, across the aged care sector, there is little to no use of assistive technologies, wearable devices and sensors for:

- monitoring the environment for safety issues
- managing an older person's health conditions
- supporting the enjoyment of life
- measuring the time spent on activities critical to the mental health of older people.[111]

Assistive technologies which are enabled through the Internet or wi-fi have the potential to positively impact health outcomes through their use.

The low level of digital literacy in the aged care workforce is a barrier to broader adoption of assistive technology within the aged care sector.[112] Aged care staff should receive training to improve their digital literacy and proficiency with technological devices and systems used in aged care setting.

Direct care technology should also be used to support the process of assessing care. A mobile care finder application should be developed that allows for a care finder to start an individual's digital record for a client with information from relevant government systems. A mobile assessor's application should also be built to allow for an assessor or assessment team to undertake the eligibility assessment with rules built into it for ease of use, automation and interoperability.

16.4 Conclusion

Most modern and progressive industries use data, research, innovation and technology to meet their customer's expectations, optimise their business performance, comply with legislation and regulations, and to maintain their competitive position. The aged care sector should be no different. To provide higher quality and safer care to those people who use its services, it should strive to use create opportunities to continuously improve and innovate. As Mr Sean Rooney, Chief Executive Officer of peak body Leading Age Services Australia said

> Providers of aged care have to respond to a wide range of challenges such as the aged care reform agenda, new technologies and changing consumer preferences resulting in evolving market opportunities. These factors form a set of challenges of ever-increasing complexity that disrupt the age services industry as it is now. However, these challenges also open up opportunities.[113]

During our inquiry, we heard that some providers have invested in technology and embraced new and creative ways of providing their services. I urge aged care providers to build on this existing work as they embark on a significant era of reform. I acknowledge that this will require work and investment, but it simply must be done if the Australian Government and aged care providers are genuinely committed to creating a system that meets the needs and expectations of older people and those who care for them.

Building a National Aged Care Data Asset will bring together data from multiple sources. It will provide a better understanding of the life experiences, pathways and outcomes of people receiving aged care and the operation and performance of the aged care system, including on quality and safety. The capture of comprehensive data and transforming it into intelligence about the aged care sector and older people will help to evaluate the delivery of aged care. It will also support the adoption of technology and innovative models of care.

Endnotes

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Overview | Funding and Financing in the New Aged Care System | Commissioner Pagone

In the next four chapters, I set out reform proposals for:

- the funding arrangements for the provision of aged care (including private co-contributions and means testing)—Chapter 17: Funding the Aged Care System
- how residential aged care providers should access investment for construction and refurbishment of accommodation infrastructure—Chapter 18: Capital Financing for Residential Aged Care
- the regulatory arrangements that should apply to risks associated with approved providers' financial performance and management of public funds and deposits from aged care—Chapter 19: Prudential Regulation and Financial Oversight
- the financing of public expenditure on the aged care system—Chapter 20: Financing the New Aged Care System.

The importance of these topics to the successful reform of aged care in Australia is difficult to overstate. The design of these elements is crucial to ensuring that the aged care system can deliver the safe and high quality care that older people deserve and expect.

These matters are relevant to various aspects of our Terms of Reference. This includes: the requirement to inquire into 'causes of any systemic failures, and any actions that should be taken in response' in paragraph (a); 'what the Australian Government…can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe' in paragraph (d); 'how to ensure that aged care services are person-centred' in paragraph (e); and 'how best to deliver aged care services in a sustainable way' in paragraph (f).[1]

Commissioner Briggs and I agree on many of the recommendations in the four chapters that follow, but we do not agree on all aspects of the mechanisms for funding, prudential regulation and financing. In some respects, there are substantial differences between us which we set out separately for coherence and readability of our respective views and recommendations.

My proposals on these matters are integral to the overall vision outlined in earlier chapters of this report. It is a vision that is largely shared with Commissioner Briggs. The most salient points are that the future of aged care in Australia should be built upon the following key foundational reforms:

- There should be a universal entitlement to receive high quality and safe aged care in accordance with each person's assessed needs. This should be regarded as a right, similar to the right to adequate publicly funded health care. Commissioner Briggs and I share this vision, which we introduce in Chapter 1: Foundations of the New Aged Care System.
- If that vision is to be realised, it will be necessary that funding levels be determined by a process independent of government direction and conducted by an independent body on the basis of data about costs of provision of high quality care. This will support a larger and better paid workforce and many of the other improvements we recommend. Commissioner Briggs and I agree on this principle, although there are differences between us on the appropriate body to be chosen for the task. We address this matter in Chapter 2: Governance of the New Aged Care System.
- It will also be necessary that the rationing of subsidies to a certain percentage of the population will need to come to an end. Commissioner Briggs and I agree on this matter, which we address in Chapter 4: Program Design.
- The setting of standards of safety and quality that service providers will be required to meet in providing funded aged care should be placed in the hands of an independent body. Commissioner Briggs and I agree on this matter, which we address in Chapter 3: Quality and Safety.
- The other important aspects of the day-to-day governance and administration should, in my view, be decoupled from the fiscal policies and day-to-day business of the Australian Government, and placed in the hands of an independent, specialist statutory body governed in the interests of people who need aged care. On this point, Commissioner Briggs and I differ markedly in our views. We explain our respective positions in Chapter 2: Governance of the New Aged Care System.

Consistently with these key reforms, responsibility for the funding and financing of aged care should be decoupled and insulated from the day-to-day pressures and political needs of the Australian Government. The importance of this is evident from an examination of the origins of the current system. In my view, the current state of the aged care system results directly and foreseeably from structural aspects of its funding and financing arrangements. There is nothing accidental about this. The system is designed to be subject in every way to whatever the fiscal imperatives of the government of the day may happen to be.

There is not an effective market through which aged care is supplied to 'consumers'. In an ideal market economy, the role for government in developing public policy in the provision of aged care could be limited to putting in place a framework where market forces could provide individuals with care choices that matched their needs while ensuring an effective safety net for those with little ability to pay. However, there is not such an effective market for aged care and government must have a greater role as the active System Governor because of the vulnerability of many of the people who need aged care and who are poorly placed to exercise choice or switch between services, and because of other challenges and instances of market failure.

The Australian Government already intervenes extensively in the activities of the sector. It controls the number, composition and location of the residential care places made available. That is, it rations places and limits access to those rationed places through a process of assessing and classifying needs. The Government also determines the levels of funding that aged care providers receive for the care that they deliver and regulates the prices that providers can levy on their residents. The Government limits the number and value of packages provided for the funding of home care, and limits the grants for home support.

The history of the Australian Government's involvement in aged care—up to, including and after the introduction of the current Aged Care Act in 1997—has shown a focus of legislative arrangements on the financial relationship between the Commonwealth and providers, and on restraining expenditure, rather than on the rights of older people to the care that they need. In my preface to Volume 1 of this report, and in Chapter 2: Governance of the New Aged Care System, I referred to a Cabinet Memorandum at the time of introduction of the current system in 1997, which illustrates this point. The memorandum explained that 'capping or limiting' supply produced 'enormous savings' but that these savings could be lost if the Australian Government did not retain 'total control over all of its parameters – the number of care classifications, the number of residence in each of them and the amount of funding that attaches to each classification – and so total control of its theoretical cost'.[2] Staff assisting us estimate that the collective decisions of successive governments amount to a total cut of more than $9.7 billion from the budget for aged care in 2018–19.[3] The memorandum even referred to the potential for government to change 'service provision benchmarks' if necessary to protect against budgetary impacts.[4]

This is why I recommend that the governance arrangements for the aged care system should be independent of Ministerial direction. An independent Australian Aged Care Commission should be appointed that can give undivided attention and focus to its task of being an effective system governor of aged care. Australia's aged care system, and most importantly the people who rely on it, should not have to face the risk that the decisions about their needs will be based directly on the Australian Government's fiscal position. The focus of system governance should be on the continuity, quality and safety of aged care in the interests of people who need it. The independence of a Commission will enable it to put forceful arguments to secure what is needed to ensure that older people get the high quality care they need rather than needing to justify, and at times obscure, compromises between conflicting or competing demands.

This is also why I recommend that the future funding and financing of aged care should also, as far as possible, be independent of Ministerial direction. This too is an area where older people need greater certainly.

In Chapter 17: Funding the Aged Care System, I set out the recommendations which both Commissioner Briggs and I make about funding arrangements, and recommendations about contributions and means testing. We are in agreement about the arrangements that should apply to fund the suite of different services we describe in Chapter 4: Program Design, about independent determination of the necessary levels of funding that will apply, and about urgent interim measures aimed at securing the financial viability of the sector until independent pricing commences. Both of us agree that older people should not be required to make a contribution to the costs of their health care and personal care. For the last 35 years, Australians have received medical and hospital care through Medicare without compulsory co-payments. There is no reason why older people should be required to make compulsory contributions towards the cost of the health care and personal care they receive through the aged care system. In my view, provided the Australian Government and the Parliament adopts the proposal for a new aged care levy, this principle should in due course be extended so that people who have paid that levy and who eventually need residential care should not have to pay more than the current level of contribution toward their ordinary costs of living in an aged care facility (pegged at 85% of the single basic age pension), and that all residents should receive the same public contribution toward the costs of their accommodation in residential care.

In Chapter 18: Capital Financing for Residential Aged Care, I set out my conclusions on the flaws that affect the current approach by which residential care providers access financing for capital expenditures. That approach is heavily reliant on interest-free loans—Refundable Accommodation Deposits—obtained from residents, and which insulates investments in accommodation from the ordinary rigours and disciplines of the capital markets. Like Commissioner Briggs, I incline to the view that the sector's reliance on this approach should be modified. Rather than making a firm recommendation about achieving this now, however, I suggest that it be addressed after the sector has gone through the extensive program of reforms included in our other recommendations.

In Chapter 19: Prudential Regulation and Financial Oversight, I set out recommendations for strengthening the arrangements for financial oversight and prudential regulation of aged care service providers so that the Australian Government has the means to identify providers that may be at risk of financial distress, and for monitoring of the use of proceeds of accommodation deposits.

In Chapter 20: Financing the New Aged Care System, I address the options the Australian Government has for raising the money necessary to fund the provision of aged care services sustainably into the future. For many decades, aged care in Australia has been financed by a mix of: public funding, sourced through the general taxation system; private contributions in the forms of means tested fees and co-payment for certain services; and public and private capital financing. Putting aside capital financing of accommodation infrastructure, at the moment the bulk of aged care recurrent operational funding is provided by the Australian Government through consolidated revenue. As a result, the financing of aged care has been tied to the annual budget cycle, and fiscal priorities of the day have been allowed to take precedence.

When introducing the *Invalid and Old-age Pensions Bill 1908* into the Australian Parliament, the then Treasurer, John Forrest, stated, 'No one is to receive an old-age pension unless he is unable to maintain himself.'[5] This approach has led to two fundamental principles of the current pension arrangements: first, the maximum level of pension is not generous; and second, there needs to be means testing. These two principles still largely guide income support arrangements and have strongly influenced the current aged care financing arrangements. However, they are not the right approach for an essential service, akin to health care, for which there should be a right of universal access based on need.

If the aged care system is to deliver that right of universal access, it will be necessary for the funding and financing of the future system to have a secure, predictable and reliable foundation. The Australian community must be confident that funds will be available to ensure any assessed need for high quality aged care will be met if and when called upon. In my view, this is likely to mean a system of financing based upon a hypothecated levy on taxable income. In Chapter 20: Financing the New Aged Care System, I recommend that the Productivity Commission should inquire into this matter. I also outline my guidance and suggestions for development of proposals for such a levy. An approach of this kind draws on international best practice, and would engender stability and confidence. It would involve the adoption of insurance-based (actuarial) principles in the future financing of the system. In essence, it is a proposal that aged care should be financed as a form of social insurance with all contributors pooling their risks and paying according to their means. Dispelling any concerns that such an approach would involve imposing an inequitable burden on the current generation of taxpayers, a financing arrangement of this kind should be designed in a manner that would not involve the accrual of significant reserves. It would be what is known in insurance circles as a 'pay-as-you-go' rather than a 'pre-funded' scheme.

Much has been said during this inquiry about the need to place the people who require aged care at the centre of the system. The proposals in the next four chapters are an important element in my vision to achieve exactly that. Piecemeal adjustments and improvements are unlikely to achieve what is required. Structural change and a philosophical shift is required, placing the people seeking and receiving care at the centre of all service models, regulation, funding, and financing. This means a new system empowering them and respecting their rights. An independent Aged Care Commission with guaranteed funding though a hypothecated aged care levy will, in my view, create the foundation upon which this change can flourish.

Endnotes

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3 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 114, RCD.9999.0522.0001 at 0009.
4 Australian Departments of Health and Family Services and Finance, *Cabinet Memorandum: Residential Aged Care - Long Term Outlays and Issues for Funding Structures*, 1997, pp 3 [4], 4 [9], 5 [11], 8 [33] (Exhibit 22-1, Final Hearing, RCD.9999.0539.0001).
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17. Funding the Aged Care System | Commissioner Pagone

17.1 Introduction

Public funding is critical to the aged care system. Private sources of funding also play a significant role. The Australian Government spent $19.9 billion on aged care in 2018–19.[1] This funding was directed to various programs, the principal of which were:

- $13 billion spent on residential aged care, supplemented by payments by residents to residential aged care providers of $4.8 billion[2]
- $2.5 billion spent on home care, supplemented by contributions paid by Home Care Packages Program package holders of $107 million
- $2.5 billion to Commonwealth Home Support Programme providers, supplemented by out-of-pocket contributions of $252 million.[3]

If financial support for carers and miscellaneous other programs that benefit older people are taken into account, including those administered by the Departments of Social Services and Veterans' Affairs, Australian Government expenditure in 2018–19 was over $23 billion.[4]

As we explain in Volume 2 of this report, the current system delivers services which are all too often substandard, and sometimes unsafe. Other people do not receive the care that they need because of the current rationing arrangements. In many instances, due to insufficient funding, the current system fails to deliver services to people in accordance with assessed needs.

This brings us to an important point of tension in the task we are required to perform. By paragraphs (a) and (d) of our Terms of Reference, we are required and authorised to inquire into actions that should be taken in response to systemic causes of substandard care, and what the Australian Government and others can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe. We recommend numerous reforms, almost all of which have funding implications. For example, we make recommendations for the removal of planning limits in favour of providing publicly-funded care based on assessed need (Recommendation 41), more generous funding of care at home (Recommendation 118 and Recommendation 119), and higher levels of staffing of residential care facilities (Recommendation 86). At the same time, we are acutely conscious that by paragraph (f) of our Terms of Reference, we are also required and authorised to inquire into 'how best to deliver aged care services in a *sustainable* way'.[5]

We have given careful consideration to ways in which funding arrangements should be improved to ensure the economic sustainability of the aged care system as whole. This includes the need to ensure value and accountability for public expenditure and a sufficient number of providers to supply the increasing aged care needs of our community.[6] In my chapter on financing the new aged care system, I have also given consideration to options for sustainable public financing of the system into the future.

17.1.1 Design approach

In 2019, the Aged Care Financing Authority identified what it considered to be the characteristics of 'a viable and sustainable aged care system'. These include:

> confidence and trust in policy settings; stable, predictable, efficient, equitable and effective arrangements for allocating Government funding; appropriate overall funding; funding arrangements that are flexible and adaptable to changing demographics and demands; equitable contribution to costs by consumers; effective prudential oversight; and sound management and governance arrangements.[7]

Subject to the need to consider the principle of contributions from 'consumers' in light of the universal entitlement to aged care that we recommend, we agree that the design of the funding arrangements for a reformed aged care system should have these attributes. In particular, the following analysis by the Aged Care Financing Authority in 2019 resonates with the evidence:

> The overriding challenge facing the Government is maintaining confidence and trust in the quality of aged care services and the funding and financing arrangements for the industry. Towards achieving trust, the regulatory and funding arrangements have to be stable, understood, and transparent. Trust is essential because while the Government is the main source of funding for aged care, the services are primarily delivered by the non-government sector: for-profit and not-for-profit providers. These providers will not invest in the industry, nor will they be able to attract the required staff, unless they understand the basis of regulation, the Government's approach to the funding of the industry, and they have confidence in the adequacy and stability of Government policies. From the consumer perspective, there needs to be trust in the quality of care people will receive from the aged care system for this will influence the preparedness of consumers and their families to seek the support that they need. [8]

17.1.2 Reform of co-payments and means testing

The current regime of co-payments (or co-contributions) and means testing is also in need of significant reform. In our view, aged care should be a universal entitlement, and it follows that the care component of aged care services should not be subject to fees. Most likely, older people have contributed to the Consolidated Revenue Fund through their lives as taxpayers, and there is no warrant for them to be required to contribute means tested fees towards the cost of the care they need in their old age. As I explain in more detail below, Commissioner Briggs and I differ to some degree in our view of what should be regarded as 'care' for the purposes of applying this principle to the costs of accommodation and the ordinary costs of living in residential care. But this is not a difference of view about the soundness of the principle itself. In any event, the means testing arrangements that currently apply are patently inequitable, and have a disproportionately harsh impact on people of modest means but

whose income or assets, or the form in which those assets are held, leave them exposed to mandatory contributions to the aged care system. If, and to the extent that, means testing is to be retained in the future aged care system, it requires a substantial overhaul.

17.2 Current financial pressures

In recent years, the aged care sector has been under significant and increasing financial pressure. Evidence from experts, banks, approved providers, chartered accounting firm StewartBrown, and the Australian Department of Health indicates that the financial performance of approved providers has been deteriorating over a period of several years, and that the continued viability of a significant number of residential care providers is doubtful under current funding levels and arrangements.[9] StewartBrown conducts surveys of aged care sector financial performance. Their 2019-20 report was based on detailed reporting from a sample of 187 approved provider organisations which, StewartBrown states, represents 22% of the residential care segment and 44% of residential aged care homes, as well as 33% of Home Care Packages.[10] Even allowing for the likelihood that analysis of the results of survey participants do not represent the performance of providers who do not participate in it, the StewartBrown data indicates that a significant number of approved providers are currently not receiving revenue streams which cover their expenses. StewartBrown's report for financial year 2019–20 estimates that the 'bottom 75%' of aged care homes participating in the survey (835 residential care facilities) are making an average operating loss of $20.31 per resident per day.[11]

Issues of provider viability and the adequacy of funding levels are not new. In his 2002 *Review of Pricing Arrangements in Residential Aged Care*, which undertook the first comprehensive analysis of sector viability, Professor Warren Hogan, economist, found that 29% of residential aged care services were making an operational (Earnings Before Interest, Tax, Depreciation and Amortisation) loss.[12]

We obtained our own analyses of profitability and viability of the sector, based principally on data reported by approved providers to the Australian Department of Health up to the end of financial year 2018–19.[13] These comprised a report analysing those financial data from accountancy firm BDO, and a report on industry returns from Frontier Economics.[14] BDO focused primarily on 2017–18 and preceding years because data for 2018–19 was incomplete. In any event, BDO considered that because of limitations in the way financial data was reported by the aged care sector, it could not reach firm conclusions about 'true' returns:

> It is possible to calculate a reported profit margin, return on assets and return on equity from the data provided. However, our view is that consideration should also be given to any gains or losses made by related parties to the extent that they can be attributed to capital obtained from the sector (for example, how RADs are used to make gains). It is possible that such gains or losses are quite significant given the total value of RADs in aged care ($28.4Bn in FY2018).
>
> In our view, shareholders of individual Approved Providers would consider such benefits when evaluating their investment in the sector. The data that would be required to develop this more holistic, true return, is not available within the ACFR [Aged Care Financial Report]. Approved Providers do not have an obligation to report it.[15]

In quoting from the BDO report, I do not suggest that providers have not provided accurate data, or that any related party transaction was not properly undertaken upon arms' length consideration and in accordance with proper accounting and regulatory standards. Australia has a robust fiscal and regulatory system designed to prevent fiscal distortions, and there was no evidence to suggest that, in this case, they were not working as intended. The point made by BDO about 'true' returns is narrower and reflects upon the economic incentives in the system as designed. To date, the system has allowed providers to fund the capital cost of facilities by measures that have included the Refundable Accommodation Deposits. The figures and information sought from providers have not aimed to capture the economic profits which the providers have been able to make through their holding of the capital over time.

Notwithstanding this limitation, as one of the authors of the report explained, some of the top 25% of financial performers reported that they had made a good return in recent financial years.[16] A table presented in the report indicated that the top quartile of for-profit residential care providers made a return (calculated as Earnings Before Interest, Tax, Depreciation and Amortisation over Assets) of 7.61% in financial year 2017–18.[17]

Frontier Economics reported that industry returns over several years to 2016–17 appeared sufficient to attract investment:

> Average returns in Residential Aged Care were reasonably constant in FY2015, FY2016 and FY2017. Because these returns are averaged over for-profits, not-for-profits and government entities it is not clear that returns covered the cost of capital for all entities. However, the substantial investment in the sector in FY2015 to FY2017 suggests that returns for many providers did cover their cost of capital in these years. Average returns to the sector have decreased in each of the last two financial years.[18]

Aged care providers are diverse and complex, which also makes any kind of overall assessment of the financial state of the sector challenging. Most are privately owned organisations run as a commercial business ('for-profits') or organisations owned by community, charity or religious organisations ('not-for-profits' even though they may or may not be run like a commercial business).

Table 1: Number of providers by ownership and program, 2018–19[19]*

	For-profit	Not-for-profit	Government	Total
Residential	288	488	97	873
Home Care Packages (at 30 June 2019)	335	479	114	928
Commonwealth Home Support Programme	102	1006	350	1458

Source: Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, 2020.

* Providers can operate in more than one program

The risk of financial failure by residential care providers is particularly acute in regional, rural and remote areas.[20] There are also valid concerns about the effect of a deterioration in occupancy in Victorian residential aged care facilities during the COVID-19 pandemic.[21] Home care providers have also experienced some declines, although these appear to be stabilising.[22]

In my view, there appear to be several factors contributing to the financial pressures felt by many providers, including inflexible and outdated funding models and inadequate indexation arrangements. The funding of aged care requires significant reform. These reforms need to address both short-term threats to continuity of suitable aged care and the need for stable funding in the longer term that will deliver high quality care into the future. The current funding system does not deliver funding levels based on actual costs of delivering high quality and safe aged care services, and is inadequately indexed.

17.3 Proposed reforms

The need for some of these reforms has been recognised by the Australian Government. The Australian Department of Health accepts that 'the level of indexation has not been sufficient to cover the increasing cost of service delivery inputs' and that 'if this is not addressed…over time, it will result in pressure being put on service delivery'.[23] The Department also identified that 'the evidence available indicates financial performance across the residential aged care sector has deteriorated in recent years'.[24] It has also acknowledged that the Aged Care Funding Instrument is not an appropriate funding tool and that the use of the Aged Care Funding Instrument 'has resulted in a history of unpredictable and unstable funding outcomes for providers and Government'.[25]

Both Commissioner Briggs and I recommend a revolution in the way that funding levels are determined for aged care. The key reform should be the introduction of independent pricing of aged care services, based on analysis of the costs of providing high quality and safe aged care. Independent pricing would provide a foundation underpinning a new form of casemix funding for residential care, appropriate staffing levels and skills-mixes in residential care, and appropriate calibration of funding for aged care services in other settings. Pending the commencement of independent pricing, there should be immediate changes in the annual indexation method for aged care services and targeted increases to certain funding streams for the provision of residential aged care. The additional funding should come with additional responsibilities for approved providers. We recommend the introduction of new accountability measures, to ensure that funding is directed towards the high quality and safe aged care to which older people are entitled.

17.3.1 Indexation of funding to aged care providers

We recommend the following short-term measures to address the inadequacy of indexation of aged care funding levels in the next few years, pending the commencement of independent pricing of aged care services. Once independent pricing commences, it should generate annual revisions of funding levels that take into account estimated inflation in cost inputs, dispensing with the need for the application of an indexation formula.

However, until then, there is a pressing need for immediate action, as I explain below.

Recommendation 110: Amendments to residential aged care indexation arrangements

1. Commencing with effect on 1 July 2021, the Australian Government should amend the indexation arrangements for residential aged care so that all care subsidies, and the viability supplement, are increased on 1 July each year by the weighted average of:
    a. 60% of the yearly percentage increase to the minimum wage for an Aged Care employee – Level 3 under the *Aged Care Award 2010* (clause 14.1) that is determined by the Fair Work Commission immediately prior to 1 July as part of the annual review of award minimum wages
    b. 30% of the yearly percentage increase to the minimum wage for a Registered nurse Level 2 – pay point 1 under the *Nurses Award 2010* (clause 14.3) that is determined by the Fair Work Commission immediately prior to 1 July as part of the annual review of award minimum wages
    c. 10% of the yearly percentage (to the 31 March immediately preceding the indexation date) increase to the Australian Bureau of Statistics Consumer Price Index.
2. Whenever the Fair Work Commission makes a change to a minimum wage in either the *Aged Care Award 2010* or the *Nurses Award 2010* other than as part of the annual review of award minimum wages, subsidies should be indexed from the operative date of those increases by the weighted average of:
    a. 60% of the percentage increase to the minimum wage for an Aged Care employee – Level 3 under the *Aged Care Award 2010* (clause 14.1) that is determined by the Fair Work Commission
    b. 30% of the percentage increase to the minimum wage for a Registered nurse Level 2 – pay point 1 under the *Nurses Award 2010* (clause 14.3) that is determined by the Fair Work Commission.
3. The increases based on these arrangements should apply to the financial year commencing 1 July 2021 and continue until such time as the Pricing Authority has commenced independent determination of prices for residential care.

Recommendation 111: Amendments to aged care in the home and Commonwealth Home Support Programme indexation arrangements

1. Commencing with effect on 1 July 2021, the Australian Government should amend the indexation arrangements for home care and the Commonwealth Home Support Programme so that subsidy rates are increased on 1 July each year by the weighted average of:
    a. 55% of the yearly percentage increase to the minimum wage for a Home Care employee – Level 3 pay point 1 under the *Social, Community, Home Care and Disability Services Industry Award 2010* (clause 17.3) that is determined by the Fair Work Commission immediately prior to 1 July as part of the annual review of award minimum wages
    b. 15% of the yearly percentage increase to the minimum wage for a Registered Nurse Level 2 – pay point 1 under the *Nurses Award 2010* (clause 14.3) that is determined by the Fair Work Commission immediately prior to 1 July as part of the annual review of award minimum wages
    c. 30% of the yearly percentage (to the 31 March immediately preceding the indexation date) increase to the Australian Bureau of Statistics Consumer Price Index.
2. Whenever the Fair Work Commission makes a change to a minimum wage in either the *Social, Community, Home Care and Disability Services Industry Award 2010* or the *Nurses Award 2010* other than as part of the annual review of award minimum wages, subsidies should be indexed from the operative date of those increases by the weighted average of:
    a. 55% of the percentage increase to the minimum wage for a Home Care employee – Level 3 pay point 1 under the *Social, Community, Home Care and Disability Services Industry Award 2010* (clause 17.3) that is determined by the Fair Work Commission
    b. 15% of the percentage increase to the minimum wage for a Registered Nurse Level 2 – pay point 1 under the *Nurses Award 2010* (clause 14.3) that is determined by the Fair Work Commission.
3. The increases based on these arrangements should apply to the financial year commencing 1 July 2021 and continue until such time as the Pricing Authority has commenced independent determination of prices for aged care in the home.

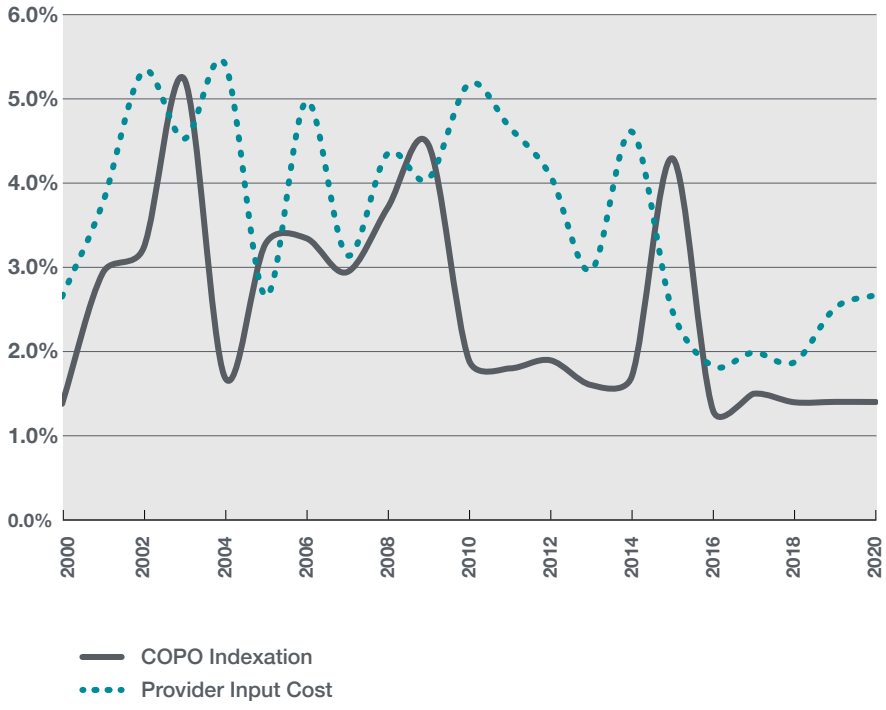
The Australian Government's approach to indexation of funding levels for aged care services has been inadequate to keep up with real cost increases over many years. Since 2012, the indexation of funding levels has contributed to volatility in decision-making about the funding made available for residential care.

The annual indexation that is applied to aged care funding levels is a composite index constructed by the Australian Department of Finance that comprises a wage cost component (weighted at 75%) and a non-wage cost component (weighted at 25%).[26] For all Wage Cost Indices the value of the wage cost component is based on the dollar increase in the national minimum wage, as determined annually by the Fair Work Commission, expressed as a percentage of the latest available estimate of average weekly ordinary time earnings published by the Australian Bureau of Statistics as at November of each year. The value of the non-wage cost component of Wage Cost Index 9 is based on changes in the Consumer Price Index between the March quarters each year.[27]

This indexation formula has been applied in aged care since 1996–97. The component of the indexation formula relating to staff costs assumes an ongoing reduction of staffing costs as a proportion of total costs. It achieves this by using the dollar value of the increase to the minimum wage, and discounting it by converting it into a percentage of the average adult weekly wage, which is more than double the minimum wage.[28] The minimum wage at the time of writing is $753.80 a week, compared with the average weekly ordinary time earnings of $1713.90.[29] The effect of the wage component is to undercompensate the aged care sector where the average wage in the sector is below the average weekly ordinary time earnings.

Figure 1 illustrates how subsidy levels have been consistently indexed each year at a lower rate than provider input costs, measured as the weighted (25/75) average increase in the Consumer Price Index and Average Weekly Ordinary Time Earnings.

Figure 1: Comparison of the rates of growth of subsidy levels and provider input costs



Source: Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 114, RCD.9999.0522.0001 at 0009, Figure 8.

Mr Michael Callaghan AM PSM, the Former Chair of the Aged Care Financing Authority, drew our attention to the relationship between indexation and the declining financial performance of the residential aged care sector.[30] Evidence given during a panel of major lending institutions also identified inadequate indexation compared with wage rises as a driver of declining financial performance of the sector.[31] Mr Nicolas Mersiades, the Director of Aged Care at Catholic Health Australia, told us there was 'no chance that the current system is going to be able to match cost increases' that are incurred by approved providers.[32] Between 1999–2000 and 2018–19, the input costs for approved providers increased by 116.9%, but the subsidy level increased by 70.3%.[33] Mr Mersiades was one of a number of witnesses to criticise the indexation arrangements and clearly articulated that what providers are paid does not keep up with their costs.[34] He said that funding is 'predicated on an indexation formula which is based on a labour productivity expectation which is not sustainable' and 'involves a significant discount on the minimum wage adjustments'.[35]

As mentioned above, the Australian Department of Health accepts that indexation has been inadequate. Dr Brendan Murphy, Secretary of the Department of Health, said that there was a need to address the level of indexation and for indexation to be determined in a more evidence-based way in the future.[36]

It was suggested in the evidence before us that inadequate indexation might have contributed to decisions that introduced volatility into the funding of residential aged care. The Australian Department of Health claimed that low indexation 'arguably encourages providers to make higher than appropriate funding claims' under the Aged Care Funding Instrument model.[37] The suggestion that providers were making 'higher than appropriate claims' is a controversial one. The Department has identified higher than forecast expenditure under the Aged Care Funding Instrument at various times since 2011, and has claimed that this has been driven by higher than appropriate claiming.[38] But it is also possible that average resident acuity has been gradually increasing, leading to what Mr Mersiades described as 'frailty drift'.[39] Some combination of these factors is also possible.

This topic has generated mistrust between the aged care sector and the Australian Department of Health.[40] The Department made decisions to 'pause' or 'freeze' indexation of funding levels under the Aged Care Funding Instrument in 2012 and in 2016 to 2018. The Department said that in 2012, the Australian Government 'paused indexation for twelve months' and made changes to the Aged Care Funding Instrument tool 'to address concerns of over claiming and to bring growth more in line with estimated sustainable funding levels'.[41] The Department again perceived higher than expected claiming growth in 2014–15 and 2015–16.[42] In response to these perceived issues, the Australian Government again paused indexation of Aged Care Funding Instrument funding for a year (2017–18), as well as applying a 50% reduction in indexation of the Complex Health Care domain under the Aged Care Funding Instrument for the preceding and succeeding financial years.[43]

The Australian Government submitted to us that:

> The intention of the indexation freeze was to respond to the unjustified spike in claims, and to mitigate the impact of actual and potential overclaiming behaviour of providers; it was not to entirely withhold or withdraw funding to the sector. [44]

Mr Callaghan said the changes to indexation in 2016–17 'led to this almost-zero growth in the revenue of providers while the costs were going up'.[45] He described the situation following his involvement in consultations undertaken by the Aged Care Financing Authority in 2018 following these pauses:

> It was a very strong view of mistrust between both parties. From the provider's point of view, all of them, the message they were hearing from Department, from the Government, I suppose, was that they were involved in what they were interpreting as unethical claiming behaviour with ACFI…From the Department's point of view, they just didn't have confidence that what was—what they were seeing in terms of the ACFI truly represented the underlying growth in acuity…[46]

The Australian Department of Health conceded that government action in relation to the indexation and ongoing use of the Aged Care Funding Instrument 'has resulted in a history of unpredictable and unstable funding outcomes for providers and Government'. [47] It has recognised that the Aged Care Funding Instrument is not an appropriate funding tool.[48] It has also recognised that the Aged Care Funding Instrument itself facilitated the alleged over-claiming behaviour.[49]

As already noted, the financial performance of a significant number of providers in the sector—particularly in rural, regional and remote locations—is now very poor. Mr Samuel Morris of the Australia and New Zealand Banking Group identified smaller 'single site operators' as being at particular financial risk in the current environment, stating that 'they're less able to offer a competitive service at a lower cost with this declining margin because with scale comes diversity, and we've found larger operators are able to weather those types of risks in this environment'.[50]

It is difficult to quantify the proportion of approved providers that might be at risk of financial failure. The report from accountancy firm BDO indicated that the viability of a significant number of residential care providers was doubtful under current funding arrangements. BDO's report was based on financial data reported for the year 2017–18 and a methodology for assessing viability on the basis that no more than 80% of a residential care provider's balance of outstanding Refundable Accommodation Deposits should treated as a non-current liability and at least 20% as a current liability.[51]

In itself, financial failure is not necessarily a systemic problem, and to some extent it must be expected and permitted to occur, subject to certain safeguards. It is normal for businesses to operate at losses for periods, and improve the operations and eventually recover and become profitable or fail and exit the market. A consistently poorly-performing service provider should not remain in business. However, there are special considerations in aged care. Prolonged financial pressure due to inadequate funding could generate risks to the quality of people's care, the sudden collapse of a provider would harm the interests of people in its care, and even an orderly exit of a provider in a location where services are scarce could have serious consequences for the availability of care in that location.

Both Commissioner Briggs and I recommend that changes to the indexation arrangements for home care and residential aged care services should commence at the beginning of the 2021–22 financial year to deliver immediate increases, on the basis of a rough estimate of annual changes in significant cost inputs. This is an interim measure pending the introduction of regular independent pricing of aged care services. These recommendations will go some way to ensuring the revenue increases available to approved providers more adequately match their increasing costs to ensure the short-term viability of the sector pending the introduction of independent pricing.

We have developed two indexation formulas, one for residential care funding and the other for Home Care Package levels and Commonwealth Home Support Programme funding. Both are imprecise, but we consider them to be appropriate as interim measures.

The formula for residential care funding indexation was derived in the following way. It is clear that wages and wage growth are easily the most significant drivers of input costs for approved providers of residential care. According to recent StewartBrown Aged Care Performance Survey Sector Reports, in residential care, direct care labour costs make up something between 80% and 90% of direct care costs.[52] For the purposes of this recommendation, we estimate that labour costs make up about 90% of direct care costs, which is very close to the figure derived from StewartBrown's June 2020 report.

The 90% labour cost component should no longer be based on dollar value of changes in the minimum wage divided by average weekly ordinary time earnings. It should be pegged to some appropriate estimate of increases in wages in the residential care segment. The remaining 10% component should be pegged to general inflation, represented by movement in the Consumer Price Index. As for the 90% wage component, based on care time data included in the StewartBrown reports, multiplied by the relevant award rates, direct care labour costs are composed of about 66% by value in wages for personal care workers and 34% in wages for nurses and others; that is, proportions of two-thirds to one-third.[53] We therefore recommend an indexation formula that will include a two-thirds weighting of the labour component by reference to increases in the minimum wages of personal care workers, and a one-third weighting based on increases in the minimum wages for nurses. Following this approach, we propose that one-third of the 90% labour cost component of the indexation formula should be apportioned (that is, 30% of overall indexation) to movement in the award wage for nurses and two-thirds (60% of overall indexation) to movement in the relevant award wages for personal care workers.

The evidence we have heard demonstrates that while home care providers are not subject to the same volatility between funding model and indexation arrangements, home care basic care subsidies and the majority of supplements are indexed by the same method used for residential aged care.[54] The Australian Department of Health has also conceded that the level of indexation 'appears to have been insufficient to cover the increasing cost of service delivery', which has resulted in a reduction of hours of care in Home Care Packages over time.[55]

This concession from the Australian Department of Health leads us to conclude that indexation arrangements for home care should also be amended to dispense with indexation based on dollar value increase in minimum wages divided by average weekly ordinary time earnings. Instead, we consider that indexation reflecting the increase to the minimum wage, and in the wages for nurses, will be more a more accurate of increases in the costs of providing home care. Again, our recommendations are informed by StewartBrown data. They include a 30% component pegged to general inflation, represented by movement in the Consumer Price Index. As for the 70% wage component, our recommendations will peg indexation to the major categories of wages in the sector on a rough allocation of 15% to nurses and 55% to personal care workers, based on calculations using care times estimated from StewartBrown survey data for the home care segment award wages for nursing staff and care managers, and for personal care workers.[56] We recommend that the same indexation method be applied to funding levels under the Commonwealth Home Support Programme.

The Health Services Union told us it does not support the connection between Award rates and funding.[57] Similarly, the United Workers Union does not support funding being linked to Award wages. The United Workers Union said:

> not all aged care workers are covered by the Award, some workers are covered by enterprise agreements. Enterprise bargaining is difficult in the aged care sector, as some providers argue against above Award wages, stating that they are funded only to pay Award rates.[58]

The United Workers Union submitted that the modern Award system is meant to represent a minimum safety net of terms and conditions. However, Award wages for residential care and home care workers are inadequate. In its view, 'tying indexation rates to increases in Award rates further entrenches the minimum Award rates as actual wage rates in aged care'.[59] The points made by the Health Services Union and United Workers Union are important for the Pricing Authority to take into account in the future processes of independent pricing. However, our recommendations on indexation are interim measures prior to the commencement of independent pricing by the new proposed Pricing Authority. In the absence of a more detailed cost study, we regard the decisions of the Fair Work Commission as to movements in minimum wages as the best available evidence of the changes required to the labour components of funding levels.

As with our indexation recommendation in residential care, our quantum of indexation is based on the fact that wage growth is the most significant driver of input costs for approved providers.

17.3.2 Urgent interim funding measures

In addition to indexation, there are three further areas where we propose urgent interim action to ensure the financial viability of approved providers of residential care. The first of these recommendations is an urgent measure to increase the revenues available to meet residents' basic living needs, the second is continuation of an increased amount of Viability Supplement, the additional subsidy that payable under certain conditions to approved providers in regional and remote locations. The third is a measure guaranteeing that the costs of certain additional staff training will be reimbursed by additional public funding.

Recommendation 112: Immediate changes to the Basic Daily Fee

1. The Australian Government should, no later than 1 July 2021, offer to provide funding to each approved provider of residential aged care adding to the base amount for the Basic Daily Fee by $10 per resident per day, for all residents. The additional funding should be provided only on a written undertaking that:
    a. the provider will conduct an annual review of the adequacy of the goods and services it has provided to meet the basic living needs of residents, and in particular their nutritional requirements, throughout the preceding 12 months, and prepare a written report of the review
    b. the review report will set out:
        i. details of the provider's expenditure to meet the basic needs of residents, especially their nutritional needs, and will include spending on raw food, pre-processed food, bought-in food, kitchen staff (costs and hours), and the average number of residents
        ii. changes in expenditure compared with the preceding financial year
        iii. the number of residents who have experienced unplanned weight loss or incidents of dehydration
    c. by 31 December each year, commencing in 2021, the governing body of the provider will attest that the annual review has occurred, and will give the review report and a copy of the attestation, to the System Governor
    d. the System Governor should make the annual review report publicly available — **Commissioner Briggs**
    e. in the event of failure to comply with the above requirements, the provider will be liable to repay the additional funding to the Australian Government, and agrees that this debt may be set-off against any future funding as a means of repayment.
2. The Australian Government will commence payment of the additional funding to a provider within one month of the provider giving its written undertaking.
3. The results of any review may be taken into account in any reviews of the compliance of the provider with the Aged Care Quality Standards.
4. This measure should continue until such time as the Pricing Authority has commenced its independent determination of prices for aged care.

I note that the recommendations by Commissioner Briggs on this matter also include a recommendation that the annual review reports to be submitted by approved providers should be made publicly available. I do not join in that recommendation because in my view there is a risk that such a requirement may distort the flow of information that should

properly be going to the System Governor. It is of fundamental importance that the flow of information from providers to the System Governor should be full, free, frank, candid and confidential, without generating concerns about collateral use by others. It is for reasons such as those that regulators frequently have secrecy obligations in relation to information they gather from those they regulate. Such secrecy provisions are designed to facilitate the full flow of information for the proper purposes of regulation, without the person regulated being exposed to external risks.

As I noted at the start of this chapter, the funding the Australian Government pays for residential aged care is supplemented by certain payments from residents to residential aged care providers. The most significant as a component of overall revenue is the Basic Daily Fee. In 2018–19, payments by residents amounted to $4.8 billion, $3.4 billion of which comprised payments of the Basic Daily Fee for residents' living expenses.[60]

The Basic Daily Fee is capped at 85% of the basic single age pension and is intended to cover everyday living expenses such as food, laundry, cleaning, and utilities.[61] This currently equates to about $52 a day.[62] The level of the Basic Daily Fee operates as a price cap on the amount an approved provider may lawfully charge a resident for the services that represent basic daily living needs, as set out in Part 1 of Schedule 1 to the *Quality of Care Principles 2014* (Cth). StewartBrown has identified that for the year ended 30 June 2020, the costs of providing everyday living services exceeded revenue by $9.11 a bed a day (an average across all providers participating in their survey).[63]

We have heard that approved providers may be compelled either to reduce the quality of goods and services provided to meet everyday living needs or their levels of staff provision because of the inadequacy of the Basic Daily Fee revenue stream.[64] The Australian Government accepts that the subsidy given to providers through the Basic Daily Fee is insufficient.[65] The insufficiency of the Basic Daily Fee revenue to meet minimum living needs appears to have been a systemic weakness in the funding and sustainability of residential aged care for some time. The issue was noted by Mr David Tune AO PSM in his 2017 review of the *Living Longer, Living Better* reforms.[66] The goods and services that depend on this revenue stream, such as nutrition and sanitation, are not only essential to meet everyday living needs, but have clear potential impact on the delivery of high quality and safe aged care. Inaction by government on the inadequacy of the revenue stream supporting these goods and services is another example of inadequate system governance and systemic weakness that could contribute to poor aged care outcomes. Mr Tune recommended that the Basic Daily Fee should be uncapped for 'non-low-means' residents subject to safeguards such as review by the Aged Care Pricing Commissioner of amounts about a certain threshold, but should remain capped at 85% of the single age pension for low-means residents.[67] Mr Tune did not explain whether he considered this might result in cross-subsidisation by residents paying the uncapped form of the fee of those paying the capped form of the fee.

Under current arrangements, according to StewartBrown, residential care providers who participate in StewartBrown's survey are underspending their Aged Care Funding Instrument revenue on care at the average level of $15.22 per resident per day, after inclusion of administration overhead costs.[68] This is probably in order to meet shortfalls in other areas and perhaps to earn a profit margin. In short, money which would be used to

provide high quality care, including additional staffing or better training and qualifications, is being directed to meet other costs because the price cap that is imposed to permit recovery of those costs is too low.

In Recommendation 127 below, we recommend that the Pricing Authority, once established, should ascertain the costs of meeting basic living needs of residents, and determine the cap on the price that may be charged by residential care providers to meet those needs accordingly (the **Services Fee Amount**). The independently determined Services Fee Amount may well be in excess of 85% of the single basic age pension. To the extent that it is, and residents are charged accordingly, for supported residents we recommend that the Australian Government should fund the gap, ensuring that a supported resident will only contribute to the level of 85% of the single basic age pension.

The Australian Department of Health accepts that revenue from the current Basic Daily Fee is not meeting these costs and that it would be desirable to have additional funding come into the sector.[69] It will take some time before independent pricing is in operation. Until these longer-term arrangements are in place, it is necessary that the Australian Government provide additional interim funding.

In constructing a plan for additional interim funding for basic daily needs, it is necessary to balance urgency, the desirability of simplicity and minimising administrative burden, and accountability. Balancing these considerations, we recommend an immediate conditional increase in the Basic Daily Fee of $10 per resident per day, to be funded by the Australian Government.

We are conscious that some providers will already be spending appropriately on nutrition and other basic living needs and absorbing the costs of doing so, perhaps contributing to losses. The conditions for the payment therefore do not include a prescriptive requirement to spend the additional revenue in a particular manner.

I am also conscious that our recommendation for an extra $10 a day a resident is a very imprecise estimate of what is needed, but consider it to be justified as an interim measure. I am concerned to ensure that approved providers are encouraged to use the additional revenue that would flow from this measure appropriately in light of their circumstances, and having reviewed in detail the adequacy of the goods and services they provide to meet residents' basic living needs, particularly nutrition. It is necessary, in my view, that approved providers who wish to receive this additional revenue be put to the trouble of an enhanced accountability measure demonstrating the levels of expenditure they have had in the recent past on basic living needs of residents, and the changes in expenditure that result from the receipt of this additional revenue. The reports conducted by approved providers under this recommendation would be available to the regulator during audits. In short, improved accountability is a necessary condition of receiving this uplift in funding, and there will be an increased expectation that high quality goods and services are provided to meet basic living needs, particularly nutrition. We therefore recommend that approved providers should only be provided with the additional $10 per resident per day funding, on condition that the provider will give a written undertaking in the form described in Recommendation 112, by the end of each year.

The Health Services Union supported the proposed $10 increase and the direction for providers to demonstrate the quality of nutrition and other basic living needs to a higher standard. The Health Services Union said that the catering and food services workforce must be supported to understand and deliver higher standards of nutrition, where this is not already occurring, and that relevant segments of the workforce must be trained and supported to record and report food expenditure.[70]

Aged & Community Services Australia, a national peak body for aged care providers, submitted that the annual review should be incorporated in financial reporting instead of being a separate requirement.[71] I disagree. Improved accountability for the spending of care subsidies is a separate issue to the financial reporting requirements and should be treated as a quality of care issue. It is not suitable for incorporation in the financial reporting regime. Aged & Community Services Australia also did not support the recommendation that the results of any review may be considered in any compliance reviews. It submitted that the standards review already incorporates the services provided.[72] However, I consider that this specific additional funding justifies further accountability to the System Governor about expenditure on residents' basic living needs.

Advocacy group Aged Care Crisis Inc. did not support this recommendation and submitted there would be a lack of deterrence in merely requiring providers to repay the additional funding without imposing a penalty.[73] I disagree. Having to repay the additional funding will be incentive enough. The reporting requirements should foster a culture of compliance.

Recommendation 113: Amendments to the Viability Supplement

1. **With immediate effect, the Australian Government should continue the 30% increase in the Viability Supplement that commenced in March 2020, as paid in respect of each residential aged care service and person receiving home care, until the Pricing Authority has determined new arrangements to cover the increased costs of service delivery in regional, rural and remote areas and has commenced independent determination of prices.**
2. **The increased indexation arrangements proposed in Recommendations 110 and 111 should apply in addition to the measure in this recommendation.**

The costs of goods and services are higher in regional, rural and remote Australia. We have heard uncontested evidence that this negatively impacts the financial performance of approved providers in these areas, and that these providers are experiencing deteriorating financial performance and risks to viability in higher proportions than their major city counterparts.[74] Our recommendations on regional, rural and remote aged care can be found in Chapter 8.

Currently, the Australian Government pays a Viability Supplement to residential and home care providers in these areas.[75] For residential aged care services, the Viability Supplement is based on the remoteness and size of the service and on the acuity of the resident

population.[76] For home care, the Supplement is based on the place of residence of the person receiving care, and is available to people living in remote areas and smaller, more isolated regional areas.[77]

There was a 30% increase to this Supplement announced on 17 December 2018, and an additional temporary 30% announced on 31 March 2020.

We recommend the increases to the Viability Supplement be maintained, as this is imperative to support the viability of providers in these areas. This Supplement must be maintained until such time that the Pricing Authority is established and commences its independent cost analysis and pricing processes, including the cost of delivering aged care in regional, rural and remote areas.

Mr Glenn Bunney, a member of the public, submitted that he believed the indexation increases recommended to us by Counsel Assisting (Recommendations 110 and 111) combined with the recommendation to maintain the Viability Supplement (Recommendation 113) would be 'woefully inadequate' to adequately fund aged care services.'[78] Based on the evidence presented to me and the numerous research projects undertaken by staff of the Royal Commission, I appreciate Mr Bunney's concern but am of the view that the recommendations will ensure the adequate funding of the aged care sector in the immediate term—with the Pricing Authority (Recommendation 115) being responsible for the sufficiency of funding into the future.

Recommendation 114: Immediate funding for education and training to improve the quality of care

1. **The Australian Government should establish a scheme, commencing on 1 July 2021, to improve the quality of the current aged care workforce. The scheme should operate until independent pricing of aged care services by the Pricing Authority commences. The scheme should reimburse providers of home support, home care and residential aged care for the cost of education and training of the direct care workforce employed (either on a part-time or full-time basis, or on a casual basis for employees who have been employed for at least three months) at the time of its commencement or during the period of its operation. Eligible education and training should include:**
    a. **Certificate III in Individual Support (residential care and home care streams) and Certificate IV in Ageing Support**
    b. **continuing education and training courses (including components of training courses, such as 'skill sets' and 'micro-credentials') relevant to direct care skills, including, but not limited to, dementia care, palliative care, oral health, mental health, pressure injuries and wound management.**
2. **Reimbursement should also include the costs of additional staffing hours required to enable an existing employee to attend the training or education. The scheme should be limited to one qualification or course per worker.**

We heard evidence across our hearing program that made it very clear to us that the training of staff was a key issue for the delivery of quality care in aged care.[79] Not only that, but as explained above in relation to our Recommendation 112, it seems that funds which could be used to provide high quality care, including on better training and qualifications for staff, is being directed to meet other costs because the price cap that is imposed to permit recovery of those costs is too low.

It is therefore essential that the Australian Government provide funding for the training of the direct care workforce in aged care, pending the commencement of independent pricing for aged care. As a simple accountability measure, that funding should be provided on a reimbursement basis.

17.3.3 Independent Pricing Authority

As we each outlined in Chapter 2: Governance of the New Aged Care System, both Commissioner Briggs and I consider the introduction of independent pricing of aged care services to be a critical reform.

The general concept of introducing some form of independent review of costs is uncontroversial. The Secretary of the Australian Department of the Treasury, Dr Steven Kennedy, gave evidence that an aged care system based on an independent assessment of costs would contribute towards a government being able to trust and fund that system.[80] Dr Murphy indicated his support for independent pricing.[81] A number of eminent economists spoke in favour of the general concept of independent pricing. Professor Flavio Menezes, Chair of the Queensland Competition Authority and former Head of the School of Economics at the University of Queensland, characterised the current arrangements as involving a conflict of interest for the Australian Government, whereby it is simultaneously trying to enforce quality standards and constrain costs.[82] Dr Kenneth Henry AC, the former Secretary of the Treasury, explained that adopting independent pricing would improve efficiency and remove distortions caused by cross-subsidisation.[83] Professor Michael Woods of the Centre for Health Economics Research and Evaluation at the University of Technology Sydney, and former Deputy Chairman of the Productivity Commission, said that an independent agency advising the Australian Government on costs, prices and funding was an important design principle for aged care.[84]

A wide range of aged care providers and their peak representative organisations have told us that independently assessed funding levels are important for ensuring they are adequately funded to deliver high quality care. This includes Leading Aged Services Australia, the Aged Care Guild, Aged & Community Services Australia, Catholic Health Australia, Regis Aged Care, Estia Health, the Whiddon Group, Ryman Healthcare, ECH and Group Homes Australia.[85] Mr Mersiades of Catholic Health Australia told us:

> While recognising that there's a large number of reforms which would be a dead heat for coming second, I would prioritise the creation of a reform—independent pricing authority to administer a new funding system as a means to increasing the number of staff, planning them better and up-skilling them more and which will be required if we're going to be able to meet community expectations about quality of care.[86]

Mr Paul Versteege, Policy Manager for the Combined Pensioners and Superannuants Association of NSW Inc,, also described the importance of this type of change:

> The need for independence in the setting of a national price for aged care services, both residential aged care and home-based aged care, cannot be overstated. Price setting of aged care services needs to be free of undue influence by Government, who will be paying the aged care subsidies based on this price, and by aged care providers, who will be receiving these subsidies.[87]

We consider that the introduction of independent pricing into the system is critical to restore or instil confidence and trust between the sector and the Australian Government, and thus to instil confidence in the sustainability of the system in the wider community. We differ on the detail of how this should be achieved.

Commissioner Briggs recommends expansion of the functions of the Independent Hospital Pricing Authority, its renaming as the Independent Hospital and Aged Care Pricing Authority, and the conferral on it of cost review and benchmarking functions, functions relating to design of funding arrangements and data collection, and the function of publishing a schedule of prices for aged care services, which would be a disallowable instrument.

I recommend the establishment of a new pricing authority specifically for aged care, to exercise a broader set of functions. In the following recommendation, I set out more detail as to the functions of the form of Pricing Authority I propose, the Aged Care Pricing Authority.

Recommendation 115: Functions and objects of the Pricing Authority

Commissioner Pagone

1. **Before the commencement of independent pricing of aged care services by the Pricing Authority, preliminary work on estimating the costs of providing high quality aged care should be undertaken by or at the direction of the implementation unit or taskforce referred to elsewhere in these recommendations.**
2. **Upon its establishment, by 1 July 2023, under the new Act, the Pricing Authority should take over that work and all resources developed by the implementation unit.**
3. **The functions of the Pricing Authority should include:**
   a. **providing expert advice to the System Governor on optimal forms for funding arrangements for particular types of aged care services and in particular market circumstances**
   b. **reviewing data and conducting studies relating to the costs of providing aged care services**

c. determining prices for particular aged care services based on estimates of the amounts (whether constituted by government subsidies or user payments or both) appropriate to the provision of high quality and safe aged care services

d. evaluating, or assisting the System Governor to evaluate, the extent of competition in particular areas and markets

e. advising on appropriate forms of economic regulation, and, where necessary, implementation of such regulation.

4. In undertaking its functions, the Pricing Authority should be guided by the following objects:

a. ensuring the availability and continuity of high quality and safe aged care services for people in need of them

b. ensuring the efficient and effective use of public funding and private user contributions in the provision of high quality and safe aged care services, taking into account the principles of competitive neutrality

c. promoting efficient investment in the means of supply of high quality and safe aged care services in the long-term interests of people in need of them

d. promoting the development and retention of a highly motivated and appropriately skilled and numerous workforce necessary for the provision of high quality and safe aged care services in the long-term interests of people in need of them.

My recommendation for the establishment of a new pricing body (Recommendation 6) is based on a proposed recommendation in Counsel Assisting's final submissions. There was widespread support for the establishment of a Pricing Authority in the submissions received in response to Counsel Assisting's final submissions. The Australian Government said in response:

> The Commonwealth supports the proposed Aged Care Pricing Authority (ACPA), however considers it should provide independent and transparent advice to Government regarding prices and funding arrangements rather than determining prices. This would ensure Government remains accountable for pricing and funding decisions.[88]

And:

> the Commonwealth supports in principle the creation of a body such as the proposed ACPA on the express qualification that the function of the ACPA is advisory only.
>
> …
>
> The Commonwealth supports the functions proposed for the new body in relation to cost estimation, advice on funding arrangements, conducting data and cost studies, evaluating market competition and advising on economic regulation. The Commonwealth only disagrees with the recommendation in so far as it proposes that the ACPA will determine prices, rather than make recommendations to government with respect to prices. [89]

A binding or advisory pricing function

We heard competing views from certain witnesses about whether the pricing function should be determinative or advisory. The Australian Government clearly expressed its view that prices for services and subsidy levels should not be 'determined' or set independently, but should be recommended to government. The Government position is that the government of the day should be free to accept or reject the advice of the independent Pricing Authority. Dr Murphy expressed concerns that otherwise the Government would be 'locked into delivering a price'.[90] As Senior Counsel Assisting said in final submissions: 'that might be the point. It might be important that the Government be locked into delivering a particular price determined by experts on the best available information'.[91] Dr Murphy said 'price needs to be transparently determined and recommended to Government, but whether Government should have the fiscal right to determine how that's manifested is a matter for debate'.[92] Professor Woods expressed a similar reservation.[93] On the other hand, Professor John Piggott AO, Director of the Australian Research Council Centre of Excellence in Population Ageing Research at the University of New South Wales, and Scientia Professor of Economics, supported a binding price-setting role for the independent body.[94] Professor Henry Cutler, Director of the Macquarie University Centre for the Health Economy, said that 'there are good reasons why price should be set by an independent authority', including removing 'volatility to provider revenue' caused by policy change and ensuring transparent price setting.[95]

We also heard from approved providers on this subject. For example, Mr Mamarelis of the Whiddon Group spoke of the need for independent pricing from the perspective of an approved provider:

> I believe we need independent price setting. I think the examples of the past when we are caring for older Australians, and in Whiddon's case, we have thousands of people we care for annually, we can't operate in an environment where the Government just decides, for example, to put a funding pause on our revenues when we are planning around people's lives, we are planning around the people who care for those individuals and our funding is just withdrawn from us and literally at a minute's notice.[96]

Dr Marie dela Rama of the University of Technology Sydney did not support the determination of prices being undertaken by the Pricing Authority. She submitted, in response to Counsel Assisting's recommendations, that bodies like the Aged Care Financing Authority are not independent of the aged care sector and therefore cannot independently determine prices.[97]

We both consider that the Pricing Authority should be established on the basis of governance arrangements that ensure it is independent from both the sector and the government. Commissioner Briggs considers that the most appropriate balance is to be struck by conferring determinative pricing power on the Pricing Authority, but by making the price schedule setting out those determinations an instrument that is disallowable in Parliament.

Consistently with the submission made to us by Counsel Assisting, I consider that the functions of the Pricing Authority should include the power to set prices for aged care services on a binding basis, and not merely to provide advice to the Government.[98]

I consider that the functions of the Pricing Authority should include the power to set prices for aged care services on a binding basis, and not merely to provide advice to the Government. I consider that a binding power to set prices is necessary in order to insulate the funding of the aged care sector in Australia from the influence of broader fiscal considerations on the government of the day, as well as to ensure a thoroughly transparent pricing process. In light of the history of mistrust between Government and approved providers discussed earlier in this chapter, and the need to restore and instil confidence in funding arrangements, it is appropriate to confer a determinative pricing function on the Aged Care Pricing Authority. In short, the Aged Care Pricing Authority's power to determine prices should be binding on the Australian Government. This will provide confidence for older people and their families, and allow providers to undertake long-term planning and make the necessary investment decisions to ensure access to high quality aged care services.

Costing and pricing considerations

In costing and pricing aged care services, the Pricing Authority should, in my view, be guided by the following factors in exercising its pricing functions:

- The cost of providing the aged care services concerned.

  The costing process needs to encompass the full range of direct and indirect costs of providing aged care services. For example, Mr Grant Corderoy, Senior Partner of StewartBrown Chartered Accountants, told us that there is no allowance for administration costs within the current funding arrangements for residential aged care, and that these costs are increasing due to increasing compliance requirements.[99] In his view, the failure to provide for these indirect costs of providing care is weighing down the financial performance of residential care providers.

  The costing process also needs to be sensitive to the fact that there may be different cost drivers in different situations, and that these will need to be reflected in the funding models and prices. For example, we have heard significant evidence about the increased costs of delivering aged care services in regional, rural and remote Australia.[100] Similarly, delivering aged care services to groups with diverse needs also has cost implications.[101]

  The different types of aged care services—care, activities of daily living, and accommodation—should be costed separately. Dr Henry told us about the importance of unbundling different types of aged care services in the costing process. It avoids the potential for cross-subsidisation to create perverse incentives.[102] It enables governments to apply different funding, means testing and co-contribution arrangements to different types of aged care services.[103] It also promotes allocative efficiency, in that a particular type of service is not undersupplied or oversupplied.[104]

- The aim of promoting competition, where reasonably practicable. This includes promotion of competition in the supply of the services concerned to protect individuals needing aged care services from abuses of monopoly power in terms of prices, pricing policies and standard of services.

For example, this consideration might lead the Pricing Authority to use loadings and to recommend commissioning of services to address gaps in service delivery, particularly in regional, rural and remote Australia. I consider that these approaches might appropriately be adopted more broadly to promote competition in aged care service delivery and where needed.

- The appropriate rate of return on assets used to provide aged care services.

  Professor Kathy Eagar, Director at the Australian Health Services Research Institute, University of Wollongong, told us that she supports a 'no profit on care' requirement, which would require providers to remit any funding provided for care that was unspent.[105] Under this arrangement, providers would be able to make a profit from accommodation, hotel and other auxiliary services. The Australian Nursing and Midwifery Federation submitted there should be greater detail in reports prepared by providers concerning the financial acquittal of funds applied to direct care and that we should propose an acquittal and return mechanism. The Australian Nursing and Midwifery Federation considered that providers ought to demonstrate that any funding received has been used for its intended purpose or otherwise must repay those funds.[106]

  However, Professor Menezes's evidence was that this type of rate of return regulation introduces the risk of moral hazard, in that a provider has no incentive to reduce their costs in order to outperform the benchmark price.[107] Professor Woods also pointed out that:

  > But I do think you need to be explicit to recognise that for the consumers to receive quality services they need to have viable providers, and if providers are not able to generate a return on their investment, they won't invest.[108]

  I am sympathetic to Professor Eagar's views, and believe that our recommendations for a minimum staff time quality and safety standard (Recommendation 86) and acquittal of staffing hours (Recommendation 122) will largely address this issue in residential care. Ultimately, though, I am persuaded by Professor Woods's argument that to get providers to invest in the high quality aged care services that older people deserve, providers will need to be able to make a return on that investment. To do anything else would compromise both quality and access.

  The Pricing Authority will need to recognise an explicit rate of return on assets in setting prices for aged care services.

- The effect on general price inflation over the medium term.

  In Volume 2, we highlight the inadequacies of the current indexation arrangements as a significant cause of the systemic failures in aged care. Earlier in this chapter, we sought to remedy that issue in the short term with a change to the indexation arrangements for aged care pending the establishment of a Pricing Authority and implementation of new funding models. The Pricing Authority will need to develop an appropriate indexation methodology to reflect the lag between the costing data provided and the period for which prices are set.

- Efficiency in the supply of aged care services so as to reduce costs for the benefit of individuals making user contributions and for the benefit of taxpayers.

  The process of independent pricing is intended to encourage technical efficiency.[109] Setting prices based on benchmarked costs will encourage providers to examine their costs and take steps to reduce them.[110]

- Constraints in labour supply and the need for development of a motivated, skilled and appropriately remunerated workforce.

  As we noted above, labour costs are the single largest cost component in delivering aged care services. The size of the aged care workforce has been projected to grow substantially in the coming years as demand increases for aged care services. In addition, we make a series of recommendations in Chapter 12: The Aged Care Workforce, to improve the quality and further increase the size of the aged care workforce. These include measures to improve rates of pay, introduce mandatory qualification and registration requirements for personal care workers, and require residential care providers to meet a minimum staff time standard. Providers will need to be resourced in order to implement those measures.

- Standards of quality and safety of the services concerned.

  We have consistently heard that costing aged care services requires a clear definition of the quality and safety standards providers will be required to meet.[111] In Chapter 3: Quality and Safety, we recommend that the Australian Commission for Safety and Quality in Health Care should be responsible for defining those standards, and throughout Volume 3 we have outlined what those standards should incorporate.

The Health Services Union submitted that the Pricing Authority needs to ensure the total cost of quality care is captured, including costs of a well remunerated, well trained, stable workforce.[112] Pricing must include consultation mechanisms with diverse stakeholder groups.[113]

The United Workers Union supports the establishment of an Aged Care Pricing Authority, in principle. The United Workers Union submitted that it is critical that such an authority takes into account the full cost of providing quality care, including workforce issues, when making pricing decisions. The United Workers Union represents workers in disability services in several States and Territories, and told us that its members have experienced difficulty with enterprise bargaining under the National Disability Insurance Scheme. However, the way that price regulation operates under the National Disability Insurance Scheme ensures that the minimum rate is effectively the going rate in disability services. The United Workers Union submitted that any pricing authority in aged care must avoid these issues by properly costing for a well remunerated, well trained and secure aged care workforce.[114] We recommend in Chapter 12: The Aged Care Workforce, at Recommendation 85, that the Pricing Authority should take into account the need to attract sufficient staff with the appropriate skills to the sector, noting that relative remuneration levels are an important driver of employment choice. In pricing aged care services, the Pricing Authority will need to consider the remuneration levels for similarly skilled employees in other sectors, such as the health care and disability support sectors.

The Victorian Government notes that funding needs to ensure that the needs of all people, including people with complex needs, are appropriately met. Particular cohorts should not be disadvantaged under the new funding arrangements and those arrangements should not make it more difficult for people to access care for affordability reasons.[115]

Economic regulation

I recommend an economic regulation function for the Aged Care Pricing Authority. Professor Menezes described the role of the economic regulator as being twofold: to identify the failure and why there is a need for intervention, and to determine the best way to intervene.[116]

Under the current arrangements, the primary forms of economic regulation are price caps or other restrictions on how much providers can charge older people for particular types of aged care services. Older people with a Home Care Package or living in residential care are required to pay a Basic Daily Fee. For those on a Home Care Package, the amount of the Basic Daily Fee is linked to 17.5% of the single basic age pension.[117] For older people living in residential care, the Basic Daily Fee—also known as the standard resident contribution—is linked to 85% of the single basic age pension.[118]

In addition to those legislatively established price caps, the *Aged Care Act 1997* (Cth) also establishes a role for the Aged Care Pricing Commissioner in regulating the fees that residential aged care providers can charge. The functions of the Aged Care Pricing Commissioner include:

- reviewing and approving Extra Service Fees for a higher than average standard of accommodation, food and services
- reviewing and approving applications to charge Refundable Accommodation Deposits above the maximum amount determined by the Minister, which is currently $550,000.[119]

The Aged Care Pricing Commissioner, Mr John Dicer, said in his submission to us that the Commission's role:

> was established to ensure that accommodation prices represent value for prospective aged care residents and that higher prices reflect the standard of accommodation rather than a resident's capacity to pay.[120]

In his *Legislated Review of Aged Care 2017*, Mr Tune concluded that the Aged Care Pricing Commissioner's role will remain a necessary regulatory mechanism in the medium term.[121] Mr Tune made two recommendations for reform of the Aged Care Pricing Commissioner's role:

- retain the cap on the Basic Daily Fee in residential care for supported and partially support residents but to allow providers to charge a higher Basic Daily Fee to non-supported residents, with amounts over $100 a day to be approved by the Aged Care Pricing Commissioner[122]
- increase the maximum value that can be charged for a Refundable Accommodation

> Deposit before approval from the Aged Care Pricing Commission must be sought to $750,000, and implement an automatic link to changes in the maximum amount based on median house prices.[123]

The Australian Government has not implemented either of these recommendations.

Generally, residential aged care providers have supported increased flexibility in the accommodation prices they charge to older people. For example, Mr Sean Rooney, Chief Executive Officer of peak body Leading Age Services Australia, told us that:

> In residential care, accommodation charges for non-supported residents are really the only place where there is a reasonable degree of flexibility over fees being charged. While the need to make applications to the Pricing Commissioner for charges above the cap is cumbersome—and LASA supports the Tune Review recommendation that the cap be indexed—it supports a reasonable degree of price flexibility to respond to local factors, and changes in the economy.[124]

COTA Australia argued for stronger consumer protections for older people accessing aged care services. In a submission in response to Counsel Assisting's funding, financing and prudential regulation propositions, they told us that:

> There must be regulation of private pricing. All costing information must be published. Consumers have provided us with numerous examples of providers charging 'additional service' or 'extra service' fees the basis for which is not revealed to them or is opaque and confusing.
>
> There must be strong regulatory responses to providers who engage in improper pricing practices.
>
> COTA recommends that the Royal Commission propose greater transparency in private pricing by ensuring that consumers cannot be charged for a service or resource unless its printed by the provider on their website in a private pricing schedule.[125]

Mr Callaghan agreed that there was a need to provide appropriate consumer protections for older people accessing aged care.[126] At the same time, there is a real risk that the imposition of price caps could discourage investment and limit older people's access to aged care.

At present, for residents who are not supported by the Australian Government, approved providers may ask for an accommodation payment in excess of the Accommodation Supplement, but there are some consumer protections in place.[127] If an approved provider wishes to obtain a Refundable Accommodation Deposit, or corresponding Daily Accommodation Payment, above a prescribed ceiling or threshold, application for a higher limit to be set must be made to the Aged Care Pricing Commissioner.[128] Professor Menezes described the current limit of $550,000 on the value of Refundable Accommodation Deposits above which approval must be sought from the Aged Care Pricing Commissioner as a 'coarse instrument', but did not recommend abandoning it.[129] The consensus between Professor Menezes and Professor Cutler was that this form of economic regulation is reasonably appropriate to protect the interests of unsupported residents from approved providers' market power, and that heavier forms of regulation such as fixed price caps would not be justified. [130]

In Recommendation 115.3(e) above, we propose that the Pricing Authority should be empowered to advise on economic regulation, which would include identifying circumstances in which economic regulation is appropriate, and the form that economic regulation should take. The Pricing Authority should be able to employ a suite of economic regulatory tools, including but by no means limited to price caps. The economic regulatory functions of the Pricing Authority should include determining whether and what mode of economic regulation or other intervention is appropriate in the absence of service availability or a workably competitive market for particular services, and where necessary implementing the appropriate forms of economic regulation, advising the System Governor on implementation of such economic regulation, or advising the Minister on any statutory amendments required to implement economic regulation. I consider that the Aged Care Pricing Authority should also carry on the work of the current Aged Care Pricing Commissioner with respect to accommodation charges.

The Australian Government supports the conferral on the Aged Care Pricing Authority of economic regulatory principles, and supports in principle the objects of the Aged Care Pricing Authority identified in Recommendation 115.4, above.[131]

Advice on funding arrangements

We both consider that the Pricing Authority will need to work closely with, and support, the System Governor to implement and provide advice on the funding arrangements and models for aged care services.

I think this advisory role of the new Pricing Authority will be substantially broader than the role of the current Aged Care Financing Authority. The Aged Care Financing Authority was established in 2012 in response to the Productivity Commission's *Caring for Older Australians* report.[132] Its functions include:

> (a) at the request of the Minister , to provide advice to the Minister, in relation to any specific issues relating to the funding and financing of aged care services;
>
> (b) to provide advice to the Minister, by 30 June of each year, on the impact of funding and financing arrangements on:
>
> (i) the viability and sustainability of the aged care sector, and
>
> (ii) the ability of care recipients to access quality aged care, and
>
> (iii) the aged care workforce...[133]

The Aged Care Financing Authority plays an important role in the current arrangements, and I have found its work very useful in supporting our deliberations. There will continue to be a need for the type of advice that the Aged Care Financing Authority has provided, and its functions should be incorporated into the Pricing Authority. However, the Pricing Authority will need to take on a larger role working with the System Governor in transitioning to the new funding arrangements for aged care services. Part of the Pricing Authority's role should be to provide expert advice to the System Governor on the appropriate funding arrangements for use in aged care services. This should involve development of any associated data standards to support the implementation and operation of those funding arrangements.

Additional specific roles

As mentioned in detail elsewhere in this chapter, the Pricing Authority should have responsibility for ascertaining costs and determining prices not only for the funding to be paid for care, but also for a number of other aged care services. These include determining the permissible charges for aged care residents' ordinary costs of living, and the permissible charges for accommodation for people who, on the basis of a means test, are eligible for financial support for their accommodation, known as the Accommodation Supplement.

We consider that the advisory function of the Pricing Authority should apply to details of the future arrangements for these services and charges. For example, in addition to the provision of the Accommodation Supplement itself, the framework of delegated legislation under the Aged Care Act imposes two associated mechanisms to give incentives to residential care providers to admit sufficient numbers of supported residents to their facilities. First, there is a discount of 25% that is applied to the maximum rate of the Accommodation Supplement payable in facilities when the resident mix of the facility includes 40% or fewer low-means, supported, concessional and assisted residents.[134] Second, there is a responsibility imposed on approved providers to comply with the applicable 'supported resident ratio' for their region, which requires a provider to ensure that its facilities provide care to at least a specified percentage of lower-means residents. These regional supported resident ratios currently vary between 16% and 40%.[135] In the future, the Pricing Authority will be well placed to provide advice on any appropriate refinements of these arrangements.

Requirements to participate in Pricing Authority activities

Recommendation 116: Requirement to participate in Pricing Authority activities

1. **By 1 July 2022, the *Accountability Principles 2014* (Cth) should be amended to require participation by approved providers in cost data reviews.**
2. **By 1 July 2023, the new Act should require that as a condition of approval or continued approval, aged care providers are required to participate in any activities the Pricing Authority requires to undertake its functions, including transmitting cost data in a format required by the Authority for the purposes of costing studies. The Authority should take costs associated with these activities into account when determining funding levels.**

To support the pricing function, it will be necessary for the Pricing Authority to obtain cost data from the sector, necessitating wide-ranging powers to obtain financial information from approved providers and their participation in costs studies and standard form cost surveys.

Costing studies will be critical to the Authority's functions. Mr James Downie, the Chief Executive of the Independent Hospital Pricing Authority, explained:

> Annual costing studies ensure that the ABF [activity based funding] system is self-correcting. For example, if there is a wide spread practice of increasing the coding complexity of patients, then over time the price weight will reduce, and as such the incentive to over code complexity is ameliorated.[136]

The Australian Department of Health agreed that upon implementation of an activity based funding model such as the Australian National Aged Care Classification, costing studies would need to 'be undertaken to ensure that the cost weights attached to each class remain relevant'.[137]

The exact scope of the required activities we recommend should be left to the determination of the Pricing Authority.

17.4 Specific funding arrangements for particular services

As Professor Eagar told us, funding system design is not a set of free choices and not an end in itself. It cannot be separated from program design and should be seen as the best means to achieve the aged care system that Australia should have into the future.[138]

In broad terms, the components of funding system design for aged care can be described as:

- **Assessment:** the process and tools by which people's needs are assessed for their eligibility for services, and the type and amount of those services. This also includes a process for reassessing people's needs when they change.
- **Needs categorisation:** the model that categorises people's needs and allocates resources to support those needs.
- **Funding methods:** the basis on which funds are paid to providers for service provision.

These components are interrelated, often complex, and must operate together to achieve a set of diverse objectives, for the person, providers and the broader aged care system.

As Professor Cutler told us:

> There is no perfect funding model for residential aged care. All funding models have their advantages and disadvantages. Selecting a funding model will require trade-off between complexity and the ability to incentivise good quality care. For example, historical block funding is relatively easy to administer, but it does not incentivise better care quality or efficiency improvements. It will also lead to inequitable access to care if funding fails to reflect population need.[139]

In making recommendations about funding arrangements for aged care services, I have had regard to the need to put people first, and to strive as far as possible for arrangements that are simple, practical, equitable, efficient, consistent, and responsive or 'agile'. I have also had regard to the need to create explicit relationships between people's needs, costs, prices and outcomes.[140]

In Chapter 4: Program Design, we set out recommendations for a new design for the aged care system. As explained in that chapter, we recommend that the Australian Government simplify and streamline the aged care program. There should be one aged care program, with supports and care that can build as people's needs increase over time. At the heart of our recommendations is an integrated system with a single assessment process where people receive an entitlement to the care they need. Providing an entitlement to aged care will mean that people will know what aged care services they can expect to receive, and that they will receive them in a timely manner.

We have heard a wide range of evidence on the preferred way in which aged care services should be funded. For example, Dr David Panter, Chief Executive Officer of aged care provider ECH Incorporated, argued that providers should be funded on the basis of the outcomes they achieve. He told us:

> An ideal system would be user-focused and goal-orientated so that it is measured by the outcomes achieved rather than inputs. So for example, if an older person's desire is to stay living independently at home for as long as possible, which it is for by far the majority, then the system should be structured to incentivise providers to achieve this goal. In this context length of tenure in a HCP [Home Care Package], supported by 'quality of life' indicators, is a critical measure of success (outcome). However, home care provider performance does not get measured on these factors, instead they are measured on inputs, e.g. hours of service provided.[141]

However, I believe it would take some time for the outcomes monitoring recommendations we have made in Chapter 3: Quality and Safety to mature to the point where they could be relied upon for funding purposes. As a result, we do not believe that an outcomes-based funding model is appropriate at this time.

We have also heard about the advantages of block funding for providers, which are currently used for the Commonwealth Home Support Programme.[142] Providers are paid quarterly in advance and have to report on the level of activity they perform. However, providers do not receive any additional funds if the budgeted activity level is exceeded.[143]

Block funding provides more confidence about the expected funding stream. This encourages establishment and retention in areas of thin markets—that is, those that are not workably competitive—and allows the flexibility to provide greater levels of service to people, and in places where they are needed.[144] This level of flexibility is particularly important when people need to access services at short notice or in response to a crisis.

A block funding approach is used under the National Health Reform Agreement for smaller public hospitals in regional areas. Mr Downie, told us:

> So, for those smaller hospitals, they're block-funded. So they receive a fixed amount of funding each year. So the National Efficient Cost is used for that and the current model consists of two parts. There's a fixed amount, it covers the fixed cost of opening—or keeping that hospital open, and there's a variable amount based on the National Efficient Price that recognises that the more activity a hospital does, the more costs it incurs but importantly, that's a fixed amount for the year based on historical activity trends.[145]

However, there are also drawbacks to block funding. Generally speaking, funding through grant rounds tends to confer an advantage on existing contract holders, creating barriers to new entrants and potentially reducing competitive pressures on incumbents to innovate.[146] There are also issues with transparency and choice, as there is limited publicly available information on how grants are reconciled and potentially less choice for people receiving care.[147] As a matter of logic, it seems that providing block funding irrespective of activity and performance could generate a perverse incentive to reduce service delivery.

We believe that there are significant lessons for the funding of aged care services that can be drawn from the introduction of the activity based funding for public hospitals in 2011. The objects of the National Health Reform Agreement state that, among other things, it will:

> (a) improve patient access to services and public hospital efficiency through the use of activity based funding (ABF) based on a national efficient price
>
> …
>
> (c) improve the transparency of public hospital funding through a National Health Funding Pool and nationally consistent approach to ABF[148]

Professor Cutler argued that there are benefits in combining approaches to funding model design. He told us:

> Funding models can also be combined to mitigate disadvantages or introduce further advantages associated with using only one funding model. While this increases the administrative burden, benefits associated with better targeted funding and subsequent improved outcomes can outweigh these costs.[149]

I agree. The primary approach for funding providers for the aged care services they deliver should be based on the volume of activity each provider performs. Activity based funding should be supplemented with block funding where required to ensure area coverage, continuity of service, and service viability objectives. This approach combines the access, efficiency, transparency, and competition advantages of activity based funding, with the greater confidence provided by block funding.

Below, I outline the funding arrangements that would apply to each of the five service categories, to support older people once they have been assessed.

Elsewhere in this Volume, we make recommendations for alternative funding arrangements to those outlined here. In those cases, our view is that the specific circumstances justify a different approach. For example, in regional, rural and remote areas and other thin markets, it may be appropriate to commission aged care providers to ensure there is adequate service coverage (Recommendation 54). Similarly, the nature of delivering aged care services to Aboriginal and Torres Strait Islander people requires a high degree of funding security and flexibility (Recommendations 52 and 53). The rationale for these different approaches is outlined in the relevant chapters.

In designing the key elements of that new program, we have attempted to retain the best of what the current programs have to offer, while integrating them and striving for simplicity. Our design takes 17 Commonwealth Home Support Programme services, 11 forms of respite care, four levels of Home Care Packages, and residential aged care, down to just 5 categories:

1. **Social supports:** reduce isolation and loneliness (see Recommendation 33). These supports should be funded by direct grant agreements, which will include a combination of block funding and activity based funding.
2. **Respite supports:** recognise and help informal carers to take time to do what they need to do, away from the caring role, and to give both the person receiving care and the carer breaks to help sustain the caring relationship (see Recommendation 32). Again, these supports should be funded by direct grant agreements, which will include a combination of block funding and activity based funding.
3. **Assistive technologies and home modifications:** help people remain independent and safe (see Recommendation 34). The service providers of these goods and services should be funded by direct grant agreements, which will include a combination of block funding and activity based funding.
4. **Care at home:** more personal care, more allied health care where needed, more nursing; living supports and palliative care and end-of life-services that can help people to age and die with dignity at home (see Recommendations 35 and 36). The funding models that will apply to these services may include, but are not confined to, direct grant agreements. I elaborate on this topic later in this chapter.
5. **Care at a residential home:** ensures care is available for people who can no longer live at home due to their frailty, vulnerability or behavioural and psychological symptoms of dementia, or other reasons (see Recommendations 37 and 38). The funding of the care that is received in aged care homes should be activity based casemix funding, as I explain below.

I set out our recommendations for the funding arrangements for each in turn, in the sections that follow.

17.4.1 Social supports, respite, assistive technologies and home modifications

Recommendation 117: Grant funding for support services to be funded through a combination of block and activity based funding

1. The Pricing Authority should advise the System Governor on the combination and form of block and activity based grants that should be adopted for social supports, respite, and assistive technology and home modifications, having regard to the characteristics of these services and market conditions where they are delivered.
2. Growth funding of 3.5% should continue to be provided for these service categories until a demand-driven planning regime is in place.
3. The Australian Government should grant fund these services from 1 July 2022.

Commissioner Briggs

A key objective behind our recommendation for grant funding of social supports, respite supports and home modification and assistive technology is to ensure area coverage across Australia. That is, grant funding should ensure that everyone who needs to access these types of supports can do so, irrespective of how widely dispersed the population might be or how scarce the number of organisations willing to supply services might be. Meeting that objective will require a robust planning regime, active system management, and providers having a degree of certainty over their funding. In my view, grants with a block-funded component are the appropriate mechanism to achieve this objective. However, for the reasons I have outlined above, the grants for social supports should contain an activity based component.

While area coverage is also an important consideration, capacity and service availability are also significant issues.

Older people and their carers often need to make urgent use of respite support to ensure the long-term continuity of care without an older person being forced to enter residential care. Respite providers should be grant funded and sufficiently numerous to ensure that there is capacity to meet the needs of older people in the areas they live. To achieve that outcome, a combination of block and activity based grants should also be used for respite supports. However, in this care it may be appropriate for a higher proportion of the funding to be paid through the block funded component to ensure respite providers' viability and access for older people if usage patterns fluctuate. This approach will also encourage residential care providers to allocate permanent beds for respite care.

In Chapter 4: Program Design, we outline how support for assistive technologies and home modifications has been inconsistently funded between States and Territories, and that the market for the provision of these supports for older people is underdeveloped. We highlight the need to actively foster and grow the development of this category of supports, and for System Governor to develop a needs-based planning framework for assistive technologies and home modifications. Providers should be grant funded, at least until the provision of assistive technologies and home modifications for older people matures. Providers should, where possible, be funded through a combination of block and activity based payments.

As part of its advisory function on funding arrangements for aged care services, the Pricing Authority should advise on the appropriate combination of block and activity based payments in the grants for social supports, respite, and assistive technologies and home modifications. The block funding component will cover the fixed costs of operating the service plus a minimum number of services that must be delivered. This will give both providers and people requiring care some certainty that a minimum level of services will be provided.

As outlined above, the justification for block funding is likely to vary between service types. It is also likely to vary based on the geographic location in which the service is being provided. The Pricing Authority should be empowered to provide this advice on the basis of all the relevant factors in the circumstances.

I believe that the Pricing Authority will best placed to determine how activity based funding is allocated by setting out the prices for individual services and any additional weightings that should be applied. The precise mix of block and activity based funding needs to be considered further so that there is the right mix of security, flexibility, accountability and incentives. It is ultimately a matter for the Pricing Authority and the System Governor, having regard to the type of services and the state of any relevant markets.

For respite, where accommodation is provided, the applicable grant funding arrangements will need to ensure an appropriate return on capital investment in the relevant premises. We consider that funding for respite accommodation should be determined by the Pricing Authority based on the reasonable costs of providing that form of accommodation. Further, it may be necessary for the Pricing Authority to vary its approach to take account of higher cost inputs for certain kinds of respite accommodation. For example, there may be forms of respite that have a higher required rate of return but that should be incentivised because of their effectiveness in sustaining care at home. Several witnesses told us about the benefits of cottage respite. The Aged Care Financing Authority has described cottage respite, or overnight community respite, as providing 'overnight care delivered in a cottage-style respite facility or community setting other than in the carer, care recipient or host family's home'.[150] Dr Meredith Gresham, Senior Consultant to Dementia Centre, HammondCare, and Post-Doctoral Research Fellow at the University of New South Wales, told us about a study that HammondCare completed into cottage respite, emphasising its advantages in delaying entry into permanent residential care.[151] It will be open to the Pricing Authority to evaluate the costs and benefits of cottage respite, and advise the System Governor on funding arrangements suitable for cottage respite. In doing so, the Pricing Authority will be able to apply appropriate loadings to incentivise respite providers to develop and support cottage-based respite services sufficiently to ensure their availability.

We recommend that growth funding of 3.5% should continue to be provided for these service categories until a demand-driven planning regime is in place. Historically, under the Home and Community Care program, these supports grew at 6% per annum. The growth rate was cut to 2.8% in 2015–16, 1.5% in 2016–17, and 2.4% in 2017–18. In 2018–19, the growth rate was increased to 3.5%, which aligned with the annual growth in the population aged over 65 years.[152] This growth is in addition to annual indexation for home support funding.

17.4.2 Care at home service category

In addition to the three grant-funded categories of services recommended above, we propose a 'care at home' category of services, to be provided upon assessment of need and assignment of some appropriate form of entitlement such as a personalised budget reflecting the individual's assessed needs, or else a standard amount or bundle of services based on a particular casemix classification of the individual.

Recommendation 118: New funding model for care at home

1. **By 1 July 2024, the Australian Government should pay subsidies for service provision within the care at home category through a new funding model that takes the form of an individualised budget or casemix classification. The new funding model should provide an entitlement to care based on assessed need across the following domains:**
    a. **care management**
    b. **living supports—cleaning, laundry, preparation of meals, shopping for groceries, gardening and home maintenance**
    c. **personal, clinical, enabling and therapeutic care, including nursing care, allied health care and restorative care interventions**
    d. **palliative and end-of-life care.**
2. **The funding model should be developed as part of the development of the new care at home category (see Recommendation 35). Ongoing evidence-based reviews should be conducted thereafter to refine the model iteratively, and ensure that it provides accurate classification and funding to meet assessed needs.**

The Australian Department of Health told us that it is currently developing a model for assessing, classifying and funding a unified home care program, combining the existing Home Care Packages Program and the Commonwealth Home Support Programme.[153]

The System Governor should be in a position to commence payment of subsidies for service provision within a new 'care at home' category by 1 July 2024. The details of the service arrangements should be developed and iteratively refined in consultation with older people and the aged care sector. The starting point for this consultation, development and refinement process is set out in Chapter 4: Program Design. The Department's work on these issues should continue. However, I outline the key features we consider are required.

The first step is a process by which the needs of older people would be assessed and classified. Each classification would be linked to an entitlement to care that would be expressed in terms of the hours of support that would be provided within specified domains—care management; living supports; personal and clinical care; and palliative and end-of-life care—and a budget (or budgets) associated with those services.

Consistent with Recommendation 123, on payment on an accruals basis for care at home, providers would submit invoices for payment by the System Governor against the budget for each older person receiving care at home. The older person should be able to exceed temporarily their budget to respond to a period of increased need—for example, to access additional support temporarily while the person is recovering from a fall. Where the older person exceeds their budget for over three months, this would act as an automatic trigger for reassessment.

I expect that under this arrangement grant funding would only be used to commission care at home providers to service thin markets. This is discussed further in Chapter 8: Aged Care in Regional, Rural, and Remote Australia.

Upper limit on funding for care at home

Recommendation 119: Maximum funding amounts for care at home

1. **With effect from 1 July 2024, the Australian Government should provide funding for a person receiving care at home in accordance with their assessed needs, subject to the following limitation.**
2. **The funding available for a person receiving care at home should be no more than the funding amount that would be made available to provide care for them if they were assessed for care at a residential aged care service.**

Older people overwhelmingly prefer to remain in their home.[154] To allow this to occur, significantly more funding should be available to older people to allow them to access more care in the home. The limit on the funding a person should receive for care at home should be no more than the care component of the funding that the Australian Government would provide for them in a residential care setting.

In the current system, however, people are not well supported in this preference. The Home Care Packages Program has its own assessment processes and four levels of funding available depending on the outcome of the assessment. They are Level 1 basic needs which runs to approximately $9000 a year; Level 2 low-care needs, about $15,750 a year; Level 3 intermediate care needs, about $34,500 a year; and Level 4 high-care needs, about $52,250 a year.[155]

In the current system, the highest package—a Level 4—offered only eight hours and 45 minutes of care a week, on average, in 2018–19.[156] Each week, this allows for an average of three hours of personal care and less than 20 minutes of clinical care.[157] A maximum of less than nine hours of care a week may not be enough to support someone with high needs at home. The March 2020 StewartBrown *Aged Care Financial Sector Report* indicated that the average direct care hours for a person receiving care per week declined by 13% from March 2019 to March 2020 and that the total staff hours provided across all Home Care Package levels appears to be declining.[158] The fact that direct care hours are declining is at odds with evidence about the needs of older people, especially those with higher acuity.[159] Mr Versteege, said:

> Something is not quite right where HCP level 2 funding of $15,500 p.a. is available to buy two hours a week of cleaning and an accompanied weekly trip to the supermarket for grocery shopping and an HCP level 4 funding of more than $50,000 p.a. only funds nine hours of care per week.[160]

As we have recommended, there should be a universal entitlement to aged care, that is, an entitlement to receive high quality and care to meet ageing-related needs. This is not an absolute right to have that care delivered in a particular setting. Care provided to a person in a congregate setting may be more cost-effective in certain circumstances than care provided to that person in their own home. In cases where the person can no longer safely continue to receive subsidised care at home, the provider may have to decide whether it is willing to continue to provide services to the person at home, given its duty to ensure the person receives high quality care. The *User Rights Principles 2014* (Cth) currently contemplate this scenario and reserve the right of the provider to discontinue home care under certain conditions.[161] This should continue to be the case.

The most appropriate limit to be placed on the funding a person should be entitled to receive for care at home is the care component of the funding that the Australian Government would provide for them in a residential care setting. If the person is prepared and able to supplement that funding with their own resources, and if an approved provider of home care is prepared to assume responsibility for care of the person in those circumstances, this may mean the person will be able to remain longer at home, and may be able to remain at home until the end of their life.

Mr Paul Sutton, the Victorian Operations Manager of Ryman Healthcare (Australia), submitted that Ryman was concerned that a person receiving care in residential aged care has direct access to care on demand 24 hours a day, and will receive more minutes of care a day than a person living at home. Home care, he submitted, cannot provide the same level of care on demand as provided in residential care.[162] We acknowledge this point. However, I strongly prefer the position that a universal entitlement to aged care requires

people to be able to receive the care they require in the setting they prefer to receive it to the extent possible. No Australian should be prevented from receiving care at home because of an arbitrary lower limit on what can be funded in the home. We know that the vast majority of Australians would prefer to receive care at home.

The *Legislated Review of Aged Care 2017* included a recommendation for the introduction of an additional level of Home Care Package to the four existing levels.[163] We do not recommend the introduction of a new level of Home Care Package given the prospect of more comprehensive re-ordering of the service arrangements for care in the home and community in the near future—by mid-2024, as we have recommended in Chapter 4: Program Design.

Under a casemix funding model for residential aged care, there is an issue concerning how the maximum funding amount for home care is to be calculated. For example, if the Australian National Aged Care Classification model is the casemix model for residential aged care, an issue arises because the estimated comparison base tariff varies with features of the facility.[164] The calculation of the maximum amount of home care funding involves a counterfactual scenario—a determination of the care funding that would be payable if the person was receiving residential care. There being no actual facility, a notional amount based either on a national average or regional average for the base tariff would be required, and this would be added to the individualised care payment. The adjustment tariff would not apply.

17.4.3 Residential care

Revenue for approved providers of residential care is currently configured into three streams:

- care
- daily living needs
- accommodation[165]

Both Commissioner Briggs and I consider that this approach should continue under the future system.

As explained in more detail below, I do not consider that residents' ordinary costs of living or costs of accommodation should be subject to means testing in the future aged care system.

Care

As to the funding provided for care in residential facilities, it is clear that the Australian Department of Health supports a transition away from the Aged Care Funding Instrument.[166]

It is clear that such a transition needs to be implemented at the earliest reasonable opportunity.

We recommend a new model for funding of care in residential aged care settings which will take into account the 'activity' of the approved provider at a given time (that is, how many residents it is caring for) and the 'casemix' of that activity (that is, the variation in needs of the residents). The model is to be based on assessment of needs and classification of individuals to one of a number of funding categories, each of which reflects the costs of caring for a person classified to that level of need.

Recommendation 120: Casemix-adjusted activity based funding in residential aged care

By 1 July 2022, the Australian Government should fund approved providers for delivering residential aged care through a casemix classification system, such as the Australian National Aged Care Classification model. The classification system should take into account the above recommendations for high quality aged care. Ongoing evidence-based reviews should be conducted thereafter to refine the model iteratively, for the purpose of ensuring that the model provides accurate classification and funding to meet assessed needs.

This model of funding found broad support when tested with witnesses.[167] This support was found across representatives of both for-profit and not-for-profit residential aged care providers.

A team from the University of Wollongong, led by Professor Eagar, has been working on the replacement of Aged Care Funding Instrument by an appropriate casemix model since 2017. In their Resource Utilisation and Classification Study, they developed a proposal for a new casemix-adjusted activity based funding model for residential aged care, the Australian National Aged Care Classification. Under this model, providers would receive:

- a base tariff payable daily to meet the costs of care delivered equally to all residents (such as clinical supervision and training, facility clinical management and shared care activities such as night supervision and resident observation during social activities and meal times), with the level of the base tariff varying by remoteness, and facility size and type
- an individualised care payment based on each resident's casemix classification to meet the costs associated with the care of residents with different needs
- an adjustment tariff payable during the first 28 days of care to meet the costs of settling residents into new arrangements.[168]

The payment model is structured in this way 'to recognise the fact that a large proportion (approximately 50%) of care costs within a facility are driven not by the individual care needs of the residents but by care delivered equally to all residents'.[169]

There are also additional costs incurred when a resident first transitions into residential aged care relating to:

- time spent getting to know the resident and their family
- individualised care planning
- behaviour management
- health care assessments
- facilitating health care arising from assessments, including pain management, dental care, palliative care and other issues that need attention
- developing an advanced care directive in partnership with the resident and their family.[170]

Under this model, each payment is expressed as a National Weighted Activity Unit, which describes the relative value of each payment to the national average.[171] My view is that this payment structure should be adopted for residential aged care facilities, and updated as required in line with changes to the Australian National Aged Care Classification itself. Prior to implementation, the Pricing Authority will need to set a price and update Relative Value Units for the base care tariff, individualised care payment, and adjustment tariff. These will need to reflect changes in costs that have occurred since the Resource Utilisation and Classification Study was completed, including those brought about from our recommendations. In particular, the introduction of a minimum staff time quality and safety standard (Recommendation 86) and improvements to aged care workers pay (Recommendation 84) will need to be factored in.

Prior to the commencement of independent pricing by the Pricing Authority, an estimated National Weighted Average Unit for an interim application of a casemix-adjusted funding model, such as the Australian National Aged Care Classification model, should be calculated and applied to fund approved providers of residential care.

The final recommendations of the Resource Utilisation and Classification Study also recommended:

> That, in residential care facilities in remote areas (MMM [Modified Monash Model] 6 or MMM 7), the base tariff be based on approved beds (capacity) with all other base tariffs being based on occupancy.[172]

This recommendation effectively provides a guaranteed or block funded component for eligible residential aged care facilities. The size of the block funded component would increase based on the size of the facility. In line with the approach to funding I have outlined above, I believe it should be open to the Pricing Authority to adopt this approach in other circumstances where required to meet service continuity and viability objectives. This could include residential aged care facilities in regional and remote areas, or to ensure the viability of specialist facilities if required.

The Australian National Aged Care Classification is currently in trials. It, or some variant, may be an appropriate casemix model for adoption by the future Pricing Authority.

The Australian National Aged Care Classification model incorporates costs associated with a range of existing supplements, including for specialist homeless services and facilities in regional, rural and remote areas, as well as for facilities catering for Aboriginal and Torres Strait Islander people. It does not account for the cost of the enteral feeding, oxygen, and veterans' supplements.[173]

If the Australian National Aged Care Classification model is implemented in residential aged care, it will be important that these supplements be continued until they can be considered, and their costs ascertained, by the Pricing Authority.

The Australian Nursing and Midwifery Federation was supportive of the proposal for casemix-adjusted funding for residential care, such as Australian National Aged Care Classification or similar. The Federation was of the view that such a funding model will allow providers the flexibility to enhance the quality of life and wellbeing of residents.[174] The Health Services Union supported in principle the casemix-adjusted activity based funding proposal for residential care.[175]

The United Workers Union expressed cautious support for the Australian National Aged Care Classification model, while noting some concerns.[176] One of its main concerns is that the funding model design is based on current practice within residential aged care facilities, which does not necessarily reflect best practice because it does not adequately take into account the social and emotional needs of residents. Further, staff time data collected for the study to determine fixed and individual costs was based on what happens now in residential facilities, in a context where providers may be struggling to provide high quality care. In the United Workers Union's view, there is a risk that 'this will result in one flawed system being replaced by another'.[177] Another significant concern stated by the United Workers Union is the approach to pricing under the Australian National Aged Care Classification. The Australian National Aged Care Classification does not take into account the true cost of providing quality care. The United Workers Union submitted that any casemix-adjusted model that is adopted must take into account the true cost of providing quality care.[178] I agree, noting that our recommendation of a casemix-adjusted funding model is an interim measure pending the views of the Pricing Authority on the funding model for residential aged care.

The Victorian Government said that:

> Further consideration could be given to how the Australian National Aged Care Classification might prejudice access for people with complex needs and people within smaller rural and regional communities. There needs to be further consideration of options available to create incentives to drive development of new services including through the viability supplement. Implementing the recommendations concerning multipurpose services will provide more flexibility to deliver aged care and other services that meet the needs of smaller communities.[179]

Similarly, the National Advisory Group for Aboriginal and Torres Strait Islander Aged Care said that the Australian National Aged Care Classification funding model is as yet almost entirely untested in remote and very remote settings and has not been piloted in any remote services.[180] We note these concerns but do not consider that the Aged Care Funding Instrument providers a better model of funding for services providing to older people in rural, regional and remote places. The transition to a casemix-adjusted funding model will need to be monitored carefully in regional, rural and remote locations to ensure that it is operating properly. We also note that we have recommended that the Pricing Authority be empowered to introduce funding models which operate differently in 'thin' markets (those that are not workably competitive), to ensure that there is no prejudice to older people in rural, regional or remote locations.

The Victorian Government submits that people with very complex care needs can find access to aged care challenging, and it is unclear how the model proposed will address this and incentivise reablement or improved quality of care. The Victorian Government note the potential for gaps with the Australian National Aged Care Classification because part of the service system was excluded from the first study examining resident needs, and not all resident needs were considered. It indicates that the Australian National Aged Care Classification will result in a significant redistribution of funding across the system. The Australian National Aged Care Classification was informed by a cost weights study rather than a cost of care study, and it did not include all care needs or the small proportion of people with very complex needs that are common in, for example, Victorian public sector residential aged care services. There is a risk that the model will not provide the funds necessary to meet these needs.[181]

The Aged Care Guild supports the Australian National Aged Care Classification. It stated the importance of incorporating appropriate administration costs and 'lifestyle'.[182]

Ordinary costs of living

As I noted earlier in this chapter, the price an approved provider of residential care is permitted to charge a resident for basic living is the Basic Daily Fee, currently set at 85% of the single basic age pension. The Basic Daily Fee operates as a price cap for the bundle of goods and services set out in Part 1 of Schedule 1 to the Quality of Care Principles.

As outlined above, the evidence indicates that the Basic Daily Fee is inadequate to meet the costs of providing an adequate level of goods and services to meet basic living needs.

However, while the price cap is set at an incorrect level, this does not mean that prices for essential living needs should be uncapped. Residents in aged care facilities would be vulnerable to price gouging if this were to be the case. Consistent with the evidence of Professors Menezes and Cutler, the amount approved providers may charge residents for daily living needs should continue to be price capped, but the cap should not be limited to 85% of the single basic age pension.

The Pricing Authority should set the cap from time to time on the basis of cost data and benchmarking. It is possible that the cap will vary between regions, or depending on remoteness. Pensioners and any others who after means testing are deemed unable to

pay the full amount of the Basic Daily Fee should contribute 85% of the single basic age pension, and the Australian Government should pay an Ordinary Cost of Living Top-up Subsidy representing the gap between the regulated price for ordinary living costs and 85% of the single basic age pension. The Ordinary Cost of Living Top-up Subsidy would vary for each resident to reflect the outcome of the means test, with providers receiving the full supplement for supported residents, a part supplement for partially supported residents, and no supplement for non-supported residents.

Accommodation

To provide residential aged care, an approved provider must be able to provide accommodation to its residents in premises accredited as a residential aged care service. The approved provider might lease or own the premises. Either way, significant capital investment is incurred in acquiring and constructing the premises and refurbishing them as required from time to time. In this sense, residential aged care is capital intensive by comparison with other modes of aged care. Residential aged care providers require a funding stream and means of financing capital investment in accommodation that accounts for this.

The current funding arrangements for residential aged care accommodation can be grouped into two categories, the arrangements that apply for residents who are eligible to receive subsidised accommodation (often called 'supported' residents), and those that apply for residents who are not eligible to receive subsidised accommodation. For eligible residents, the Australian Government pays, in whole or part, the Accommodation Supplement. The Accommodation Supplement applies as a price cap on the amount that an approved provider is permitted to receive for the accommodation of an eligible resident.

Other residents are subject to different arrangements, which we each consider separately when we address Capital Financing, later in this volume. Some approved providers raised concerns about the adequacy of the level at which the Accommodation Supplement is set. Uniting NSW.ACT told us that:

> The Accommodation Supplement (particularly the significantly refurbished supplement) is constrained by government regulation. Apart from the requirement of the level of expenditure to uplift from the base level of accommodation supplement, the full supplement is only paid when the supported resident ratio in a home is greater than 40%. The higher supplement amount paid would cover a build cost $345,000 over 30 years (with no allowance for refurbishment or cost of land). The less than 40% supported resident ratio accommodation supplement would cover a build cost of $260,000—no refurbishment or land.[183]

We commissioned Frontier Economics to report on the required revenues to support investment through debt or equity in residential aged care, including the potential use of a building block model incorporating a Weighted Average Cost of Capital.[184] Professor Stephen Gray, Director and Chairman of Frontier Economics and a Professor in finance at the University of Queensland, explained to us how such a model for estimating appropriate returns could be designed to account for facility-specific or provider-specific factors, or could be applied in a general way. These could include differences in land values, facility age and quality, whether capital grants were used to fund construction, and other factors such as whether a provider is tax exempt.[185] There was support for the level of

accommodation funding to reflect the Weighted Average Cost of Capital from peak bodies Aged & Community Services Australia and Leading Age Services Australia.[186] Mr Mamarelis supported the principles underpinning the Weighted Average Cost of Capital, but had some reservations about how it would be applied in practice.[187] Some providers disputed Frontier Economics' estimate of the applicable Weighted Average Cost of Capital. [188]

In my view, the approach outlined by Frontier Economics is a reasonable starting point for estimating the return on capital and determining the appropriate level (or levels) for the Accommodation Supplement. I do not, however, consider that there is a justifiable case for regulating the accommodation prices charged by approved providers for unsupported residents to any greater extent than already applies.

We both recommend that the Pricing Authority should determine the level, or levels, of the Accommodation Supplement, and should keep this matter under review and update the Accommodation Supplement when required (as set out in Recommendation 128, below.

Prices for accommodation for unsupported residents should continue to be subject to oversight by the Aged Care Pricing Commissioner. This role should be taken over by the Pricing Authority, once that body is established.

17.4.4 Assessment principles—incentives for an enabling approach

Recommendation 121: Incentives for an enablement approach to residential care

From 1 July 2022, the following incentives should be incorporated into the rules, principles and guidelines for assessment and funding eligibility:

a. **an approved provider should be paid retrospectively from the date when a reassessment was requested where it is determined on reassessment that a person is entitled to a higher level of funding, and the provider can demonstrate that it has been providing the higher level of care**

b. **a resident should not be required to be reassessed for funding eligibility if their condition improves under the care of a provider.**

The aged care system should help people to maintain independence. The funding mechanism that subsidises the provision of residential aged care should be aligned with this goal. The cornerstone of the current funding arrangement, the Aged Care Funding Instrument, is defective. It lacks incentives towards reablement and instead generates incentives that reinforce dependency.[189] Under the Aged Care Funding Instrument, if a person regains some of their independence, a provider receives less funding after that person is reassessed.[190] The Aged Care Funding Instrument does not provide the

proper incentive for a provider to improve the condition of older people in their care. The assessment process should therefore be reformed to reward providers where residents become less dependent. Professor John McCallum, Chief Executive Officer of National Seniors Australia, told us that this approach would be a 'great positive'. [191]

Providers should be regularly testing whether the services they are providing are meeting the older person's needs, supporting their independence and helping them to achieve their goals. If that process shows that services could be improved, providers should revise their care plans. In some cases, the older person may require additional care to manage an episode or for a short period of time. For example, the person may benefit from a short-term reablement intervention. If providers do increase care, and if the reassessment process finds that a higher level of funding is required, providers should be eligible for back payment to the date that the reassessment was requested.

At the same time, there should be an explicit incentive for providers to invest in restorative care and reablement.[192] I expect that this will encourage more providers to focus on improving the quality of life of older people receiving aged care. However, Allied Health Professions Australia submitted that this may not be sufficient:

> The proposal for a new aged care funding instrument has specifically identified the need to remove such disincentives for improving the health and wellbeing of aged care residents, allowing aged care homes to retain any difference between the level of funding the resident is assessed for and the actual cost of providing care to a resident that has benefited from reablement and restorative care.
>
> Unfortunately, it is not clear that removing the disincentive in the funding model will be sufficient to improve quality and may need to be enhanced through additional funding aimed at investing in improving the health and wellbeing of the resident. The costs of reablement and restorative services as well as preventive care may not be covered by the potential difference in funding and care costs and may mean aged care providers do not choose to spend limited funds in this way.[193]

We do not propose to rely solely on this incentive to promote reablement. In Chapter 4: Program Design and Chapter 9: Better Access to Health Care, we make recommendations that would lead to the increased provision of allied health and promote restorative care.

17.4.5 Accountability

We make a number of recommendations to enhance accountability for the appropriate expenditure of government funding. These measures are complementary to financial reporting and prudential regulatory requirements, which we address in separate chapters on prudential regulation and financial oversight.

Reporting of staffing expenditures

Recommendation 122: Reporting of staffing hours

1. **From 1 July 2022, the *Accountability Principles 2014* (Cth) should be amended to require all approved providers of residential aged care to report, on a quarterly basis, setting out total direct care staffing hours provided each day at each facility they conduct, specifying the different employment categories (including personal care workers, enrolled nurses engaged in direct care provision, registered nurses engaged in direct care provision, and allied health care professionals engaged in direct care provision).**
2. **The System Governor should assess the reports against the minimum staffing requirements, and initiate appropriate action in cases of non-compliance.**

The current aged care system is not well designed to ensure that the care being provided meets people's needs. Residential care providers receive approximately $11.7 billion each year in total Australian Government care subsidies, and approximately $12.4 billion in overall care-related revenue, including contributions from residents.[194] Despite this, there is no specific requirement on residential aged care providers to spend any portion of the money they receive on care. Recommendation 122 will provide transparency as to the staff deployed in residential care facilities, which will do a great deal to ensure that approved providers are accountable for the funding they receive.

Transparency and accountability should be critical goals of the new aged care system. Witnesses who gave evidence about this issue, including experts, providers, the Australian Department of Health, and consumer advocates, supported increased transparency and accountability in the spending of public money for care.[195] Professor Woods was of the view that:

> An approach worthy of further analysis is to require a clear level of specification of care service levels, including both clinical and care staffing standards, as well as ring-fencing of the funding for care services to ensure that the public and consumer funds are not sources of excess profits. Such ring-fencing should include very high levels of transparency and public accountability for expenditure on those care services.[196]

We do not recommend a formal ring-fencing requirement for expenditure of particular amounts of funding on care. That would be administratively burdensome and may distort operations.[197] In my view, a requirement to report on staffing levels strikes an appropriate balance between administrative burden and accountability. Ideally, in order to ensure the quality of services, the measurement of outputs rather than inputs would be more appropriate.[198] Measuring outcomes focuses on whether the approved provider is meeting the required benchmarks of quality. However, I have become convinced that it is appropriate to require the reporting of staff hours as well.

The Health Services Union emphasised the importance of transparency. It is concerned that providers:

> will manipulate staffing models and subsequent reporting by having duties and responsibilities of care staff absorbed by other direct and non-direct care roles. We strongly support measures to improve transparency around staffing and inform best practice and quality standards in the future. We reiterate our support of the proposed legislation currently before the Senate, dealing with financial transparency. Providers should have to report on all staffing categories including those outlined here, as well as catering and food services, cleaners, laundry staff, and contract and agency workers and external consultants.[199]

The United Workers Union stated similar concerns, including the risk of exaggerated claims to the amount of direct care work provided to residents by transferring non-direct care duties, such as cleaning, laundry, kitchen work and so on, onto personal care workers.[200] The form in which reporting requirements are imposed should be tailored to preclude such practices.

The Victorian Government submitted that more transparent reporting of staffing hours will enhance transparency and accountability to the wider community.[201]

In Chapter 12: The Aged Care Workforce, we recommend the introduction of a quality and safety standard mandating minimum staffing levels and skills mixes for residential aged care.

Payment on an accruals basis for home care

Recommendation 123: Payment on accruals basis for care at home

The Australian Government should pay home care providers for services delivered or liabilities incurred from Home Care Packages on accrual.

Recommendation 124: Standardised statements on services delivered and costs in home care

1. **The Australian Government should develop and implement a standardised statement format for home care providers to record services delivered and costs incurred on behalf of Home Care Package holders.**
2. **From 1 July 2022, providers should be required to issue completed statements in the standardised format to people receiving their care on a monthly basis.**

3. **From 1 July 2022, providers should be required to provide reports on a quarterly basis in a standard format setting out total direct care staffing hours provided each day at each home they service, specifying the different employment categories (including personal care workers, enrolled nurses engaged in direct care provision, registered nurses engaged in direct care provision, and allied health care professionals engaged in direct care provision).**

Commissioner Briggs

The current payment system for home care lacks transparency and accountability. Home care providers are paid subsidies for each month in advance, regardless of the services actually provided.[202] This means the Australian Government is wholly reliant on approved providers for accurate reporting and reconciliation of funds. This arrangement has several undesirable effects, including the accumulation of 'unspent funds' and a lack of clarity regarding what services are delivered. This practice is complex and has inherent prudential risk. To increase efficiency, transparency and accountability in the system, providers should be paid after they have delivered services.

Under the current Home Care Payment arrangements, any amount that is not spent providing care and services in any given month is held by the provider as available funds to be used by the person receiving the package in the future. These funds are commonly referred to as 'unspent funds'.[203] According to StewartBrown, unspent funds in home care average $8250 per person, totalling in excess of $1.1 billion of public funds residing with approved providers as a liability.[204]

Approved providers of home care hold and use unspent funds in a variety of ways. Some treat unspent funds as part of their working capital, reducing the need to access other sources. Some quarantine unspent funds in a separate account and use them only to pay for care and services. Some have the money held by a third party, effectively in trust.[205] The Australian Government does not give guidance to providers on whether interest may be earned and does not require interest to be paid to the Australian Government if it has been earned.[206] Due to the high level of unspent funds by people receiving care, there is a reluctance by some providers to levy, and by consumers to be charged, a client contribution in home care because it would effectively only add to the quantum of unspent funds. This practice distorts the overall funding model.[207]

The Australian Government has little visibility over what goods and services are provided to people on Home Care Packages. Home care providers are not required to report to the Australian Government what kinds of goods and services are provided with the Home Care Package subsidies the Australian Government supplies, which amount to about $2.5 billion per year (based on 2018–19 data).[208] Results of a study of home care providers conducted by the Australian Department of Health disturbingly showed that in 2018–19, only 15 minutes a fortnight was spent on each of nursing and allied health care.[209]

In the 2019–20 Budget, the Australian Government announced that payment arrangements in home care are to be changed from payment in advance to payment upon delivery of service. One of the intentions of this change is to avoid Australian Government funding being held as unspent funds by providers. The *Aged Care Legislation Amendment (Improved Home Care Payment Administration No. 1) Bill 2020* has passed the House of Representatives and received a second reading in the Senate on 9 November 2020. Together with the *Aged Care Legislation Amendment (Improved Home Care Payment Administration No. 2) Bill 2020*, introduced in the House of Representatives on 21 October 2020, these Bills change the payment of home care subsidies to approved providers from being paid in advance to being 'paid in arrears'.[210] They also amend the arrangements relating to the payment of the home care subsidy to approved providers by providing that the Australian Government will retain, on behalf of people receiving home care, any subsidy that may be in excess of the care and services provided, to be drawn down as care and services are provided in future.[211] This legislation would implement Phase 1 of a broader package of reforms to home care payment arrangements by changing monthly subsidy payments from payment in advance to in arrears. Phase 2 would see payments based on services provided to people receiving a Home Care Package. Phase 3 would act to reduce the total amount of unspent funds by drawing down on those funds for services delivered.[212]

In December 2019, at the request of the Minister for Senior Australians and Aged Care Services, the Aged Care Financing Authority examined the potential approved provider and consumer impact of the 2019–20 Budget measure. It concluded:

- in relation to Phase 1, most home care providers should be able to accommodate the cash flow impact of the Phase 1 change. However, it is possible that some small providers operating in 'thin or difficult markets and under financial pressure may face challenges'. Short-term assistance should be available to support such providers and any provider seeking financial assistance should first use the Business Advisory Service operated by PricewaterhouseCoopers on behalf of the Australian Government
- in relation to Phase 2, a range of actions need to be taken, including determining how the new payment arrangements would operate, the timeframe for trailing and implementation, and considering financial support to providers who may find it particularly challenging to adjust their systems to deal with the new payment arrangements
- in relation to Phase 3, providers should have a choice to either a) return the unspent funds when the phase commences, or b) retain the unspent funds and allow those to be drawn down or returned to the Australian Government when the person leaves home care.[213]

We recommend that significant weight be placed on the conclusions of the Aged Care Financing Authority in relation to the implementation of the reforms. We note that the Bills remain before the Australian Parliament. Work should continue to implement the arrangements as soon as possible having regard to the need for an orderly transition. Arrangements for Phase 2 should be in place no later than 1 September 2021, consistent with the Australian Government's recent budget announcement.[214]

In light of these factors, we recommend a measured approach that ensures a reasonable level of transparency about expenditure on care. This approach should not be administratively burdensome. Under a proposal for accruals-based invoicing of funds from packages, providers of home care will effectively be under more stringent requirements.

17.5 Who should pay? Co-contributions and means testing

17.5.1 Overview

Under current arrangements, older people who use aged care services pay for slightly over one-quarter of the cost of those services (28.5% in 2018–19).[215] Older people make these contributions through a complex mix of co-contributions and means tested fees.[216] Subject to means testing, people contribute to the costs of their care in residential aged care, and can be asked to do so in both the Home Care Packages Program and the Commonwealth Home Support Programme.

We heard a lot about the existing co-contribution and means testing arrangements in the aged care system during our inquiry. Witnesses described these arrangements as inequitable and confusing.[217] Some considered that they contributed to perverse incentives around the types of aged care services people accessed.[218] The Productivity Commission's 2011 *Caring for Older Australians Inquiry* report stated that the system of co-contributions was 'often arbitrary in nature, lacking any obvious rationale and relationship to a person's capacity to pay'.[219] A number of changes have been made since that landmark report.[220] However, problems persist and the arrangements need fundamental reform.

During Adelaide Workshop 1, we heard that means testing needs to be 'simplified and equitable', 'fair and sustainable' and 'robust and consistently applied'.[221] In my view, reforms in this area must go further.

As we set out in Chapter 1: Foundations of the New Aged Care System, fundamental to our vision of aged care in the future is a system of universal entitlement to high quality aged care based on assessed need. The entitlement to aged care has particular implications for the system of contributions and means testing for aged care. In the new aged care system, there should be no requirement to pay a co-contribution toward care in any community setting, home care or residential aged care, including respite. Consistent with the provision of health care to public patients in public hospitals, personal care services and clinical care services should be available free of service charges. In our view, because all Australians should have an entitlement to aged care, the costs of care should be distributed equitably across the community. It should not be imposed disproportionately on the people who need and receive aged care services. This represents a significant departure from current arrangements.

In making this recommendation, we acknowledge that the current co-contribution arrangements for care contribute to the financing of the system. Our recommendation will place an additional burden on financing the system from public sources. For example, in 2018–19, people receiving Home Care Packages paid basic daily fees worth $66 million (2.6% of total funding for providers).[222] In the same financial year, people receiving residential aged care made contributions of $586 million to their care. This amounts to 4.9% of total care revenue. [223] We have each addressed aged care financing more broadly, including raising the additional money to cover the costs that people would otherwise contribute through the current arrangements, in our respective chapters on financing the new aged care system.

Counsel Assisting's final submissions proposed that 'nominal' contributions and fees should be charged for social support (including transport), home modifications and assistive technologies, and domestic assistance (including cleaning and gardening).[224] Where these services are being supplied as elements of aged care provided to a person who has been assessed as needing that aged care, we both disagree. We do not recommend that any contributions or fees, nominal or otherwise, should be charged in such circumstances.

Likewise for respite, as in other forms of aged care, people should not be required to pay for the care they receive. In addition, people receiving respite should not be required to pay for accommodation. The rationale for this is connected with the purpose of respite. Respite should sustain the long-term capability of a person to remain in their own home and to receive care there. Further, the people receiving respite may already have accommodation-related costs of their own to bear. Where people and their carers have been assessed as needing respite, it is important to make access to respite easy and affordable, because of the important role it can play in sustaining the care relationship and delaying or preventing entry to permanent residential care.

We both propose that the amount that may be received by an approved provider of residential aged care for the ordinary living costs of its residents—that is, food, cleaning, laundry, utilities and other things associated with living generally—should be set by the Pricing Authority, and that the Pricing Authority should set the maximum subsidy the Australian Government will pay for accommodation—known as the Accommodation Supplement.

Commissioner Briggs considers that, consistent with the current arrangements, accommodation costs and the ordinary costs of living should be primarily the responsibility of the person receiving care, subject to the Australian Government paying a subsidy for these things to the extent that the individual cannot, as assessed by a means test. That is because, in our society, it has long been generally accepted that these costs are a personal expense normally met by individuals in the community (Recommendations 127, 140 and 141).

I consider that means testing for the ordinary costs of living and the Accommodation Supplement should be phased out altogether, subject to whether the Australian Government implements a levy to finance aged care expenditure along the lines I propose for detailed inquiry by the Productivity Commission in Chapter 20: Financing

the New Aged Care System. Means tested contributions for ordinary costs of living and accommodation should only apply for people who are (at the time of commencement of the aged care levy I propose) currently aged 65 years or over. In the longer term, for people who are under 65 years, I consider this arrangement should transition to an arrangement whereby older people only contribute to their ordinary living costs to a maximum amount corresponding to 85% of the single basic age pension, and should only pay a contribution to accommodation if, and to the extent that, they choose accommodation that is more expensive than the level of the Accommodation Supplement. That is because those goods and services should be seen as care for which those younger age cohorts will already have made their financial contribution, through the income tax system over the prime income-earning years of their lives. In this regard, I consider that the Australian Government should design an appropriate transition mechanism that takes account of the extent to which particular age cohorts are forecast to contribute to the financing of the new aged care system through payment of the aged care levy, based on analysis of tax and demographic data. For example, it would be appropriate that a person aged 64 years at the time of commencement of the aged care levy should, if it becomes necessary for them to receive residential aged care, contribute more to means tested fees to meet their costs of ordinary living and accommodation than a person who is aged 40 years at the time of commencement of the levy.

Irrespective of whether my recommendation about a transition away from means testing of fees for ordinary living costs and accommodation is adopted, Commissioner Briggs and I both make recommendations to refine the way accommodation funding is determined and to improve the funding available to meet ordinary costs of living, by the setting of the Services Fee Amount mentioned earlier in this chapter. These recommendations change the means testing arrangements by which the charges associated with these goods and services are determined for people receiving them, to iron out inequities in the current means testing arrangements. These recommendations should be implemented as soon as practicable.

17.5.2 Current arrangements

Underlying principles

Aged care lies at a nexus between Australia's health care and social welfare systems. It is a unique type of service that has some of the characteristics of heavily subsidised health care. However, the main component of the cost of the service is provision of personal care, which has traditionally been provided within the household and therefore mostly unsubsidised. As a result, in almost all Organisation for Economic Co-operation and Development countries, the family is still the main provider, and implicitly the funder, of aged care.[225]

In Australia, the financing principles for aged care, which were originally based on those operating in the health care system, have been heavily influenced most recently by those operating in the social welfare system.[226] The most significant relevant feature of the welfare system for older people is the means tested age pension. Unlike most other Organisation for Economic Co-operation and Development countries, the age pension

is universally available. Eligibility does not depend upon past contributions and there is no discretion as to the form or amount of the pension. The role of private contributions in health care funding arrangements is highly complex, and vary in different areas of the system. For example, public hospital services are available free of charge but, at the same time, individuals contribute 22.0% of the total costs of public and private hospitals through out-of-pocket costs and private health insurance (net of the government rebate).[227] Medical services are subsidised, but the level of government subsidy is fixed and the co-payments paid by users of these services are set by the provider of the services. Bulk billed services account for 80.1% of services delivered through the Medicare Benefits Schedule, but private fees account for 21.5% of all expenditure on Medicare Benefits Schedule-subsidised services.[228] Broadly speaking, the financing arrangements for aged care currently blends a means testing approach with a rationed entitlement approach.

Commonwealth Home Support Programme

There are no formal means testing arrangements for the Commonwealth Home Support Programme, although there are non-mandatory co-payments. There is significant flexibility around the fees that people are charged for services under this program. This is a result of the guidance and principles set out in the *Client Contribution Framework* and the *National Guide to the CHSP Client Contribution Framework.*[229] The basic principles of the framework are that:

- people in similar circumstances receiving similar services should pay similar fees
- people who can afford to contribute to the cost of their care should do so
- access to care should not be determined by the ability to contribute.

Access to services is based on need and the availability of funding for the service provider. This means that in practice, individuals who have similar support needs may be charged different fees by different providers for the exact same service.[230]

The *Legislated Review of Aged Care 2017* recommended that mandatory contributions based on an individual's financial capacity be introduced for services under the Commonwealth Home Support Programme.[231] This would bring the fees more in line with those under other aged care programs. The Australian Government has not responded to this recommendation.

In 2018–19, co-contributions through this program totalled around $252 million, which represented 9.9% of total program expenditure (9.3% in 2017–18).[232] The average co-contribution paid was about $300 per year.[233] This average co-contribution is lower than the co-contributions seen in other aged care programs and reflects the entry level nature of the program.

Home care

Current arrangements in the Home Care Packages Program require people to contribute to the cost of their care. They can be asked to pay both:

- a non-compulsory basic daily fee up to 17.5% of the single basic age pension
- a contribution towards the cost of their care through an income tested fee.

The package amount paid by the Australian Government to providers on behalf of an older person is reduced by the amount of the income tested fee regardless of whether the fee is collected by the provider or not.[234] The income tested fee arrangements are subject to annual and lifetime caps and do not apply to older people who were receiving a Home Care Package on or before 30 June 2014. These fees are determined by providers, up to the maximums specified by the Australian Government.[235] There is strong evidence that many providers do not charge the full basic daily fee allowable, and some evidence that some providers do not always charge the income tested fee.[236]

In 2018–19, people receiving Home Care Packages paid basic daily fees worth $66 million (2.6% of total funding for providers). That equates to an average of about $700 a year a person.[237] The maximum allowable fee at 30 June 2019 was $3836.56 per year.[238]

In addition, individuals paid $42 million (1.7% of total funding for providers) in income tested fees in 2018–19. That equates to an average of about $450 a year per person.[239]

Residential aged care

In residential aged care, amounts paid by people receiving aged care to approved providers made up over a quarter of total provider funding in 2018–19 (26.7% or $5.2 billion), but only a fraction of this was for care.[240]

People in permanent residential aged care can be asked to pay four types of fees:

- a basic daily fee up to 85% of the single basic age pension
- a contribution towards the cost, or the full cost, of their accommodation on a means tested basis
- a contribution towards the cost of their care through a means tested fee. The subsidy amount paid by the Australian Government on behalf of an older person is reduced by the amount of the fee regardless of whether the fee is collected by the provider or not
- the full cost of any additional or extra services they receive.[241]

The evidence suggests that, unlike in the home care sector, people who receive residential aged care are generally asked for, and are paying, the basic daily fee. In 2018–19, this amounted to $3.4 billion in basic daily fees. This means that the average basic daily fee paid in 2018–19 was about $18,250 per year, which is close to the maximum permitted amount for the fee.[242]

People receiving residential aged care also bear the majority of their accommodation costs. In 2018–19, this consisted of $828.7 million in accommodation payments, excluding lump sum deposits.[243] Imputing the interest notionally earned on lump sum deposits as accommodation fees increases the amount spent on accommodation by older people in permanent residential aged care to $2.3 billion.[244] By comparison, Australian Government expenditure on Accommodation Supplements was $1.159 billion.[245]

People receiving care made a much smaller contribution to care costs through the means tested care fee. This comprised $586.0 million in 2018–19, which was only 4.9% of all care costs.[246] Additional and extra services represented the smallest fee category, with $319.8 million in fees paid in 2018–19.[247]

17.5.3 Reforms

Services where no contributions or means testing required

Recommendation 125: Abolition of contributions for certain services

1. **Individuals who are assessed as needing social supports, assistive technologies and home modifications, or care at home should not be required to contribute to the costs of that support.**
2. **Individuals who are assessed as needing residential care should not be required to contribute to the costs of the care component of that support.**

As I set out above, consistent with the universality of entitlement to aged care, we recommend that people should not be required to pay a contribution towards the care services that they receive in the community, their home or in residential aged care, including for respite. In my view, this principle should extend to social supports, home modifications and assistive technology, and domestic support for people who are assessed to need these things because of ageing-related infirmity. There is societal expectation of a universal health care obligation, to a reasonably high minimum standard, for nursing care and, to a lesser extent, for allied health services. If a person is unable to care for themselves through disability or age-related frailty, the same principle applies.

I acknowledge that there are differing views about whether people should be required to contribute to the cost of care services that they receive. The prevailing approach in the aged care system is that people should contribute, according to their means. That prevailing approach received support from witnesses called before us. For example, Professor Woods stated that fees for care at home needed to be means tested, and that this should be consistent with the means testing for residential care.[248] Mr Callaghan suggested that the current contribution that comes from consumers for home care services is too small compared to the Australian Government's contribution.[249] The Australian Department of the Treasury also supported the continuation of a system of private contributions towards the costs of care, while noting the need for reform of the means testing arrangements.[250]

Regis Healthcare stated their belief that individuals of high means should contribute to the costs of social supports, assistive technology and home modifications. Regis submitted that subsidising the costs of people of high means leaves less funding available for those of low means. Regis also contended that the Australian Government should be responsible for collecting any nominal fees rather than passing that burden onto approved providers.[251]

Feros Care noted that the single program for community care services could establish and enforce a system of co-payments and fees that was standardised, and as such indicated a degree of uncertainty as to why these particular supports had been identified as needing separate co-payments.[252]

Mr Craig Gear of the Older Person's Advocacy Network opposed co-payments. He noted that there are no co-payments for this type of support under the National Disability Insurance Scheme and submitted that it is inequitable to suggest that co-payments should be required of people with disability over the age of 65 years.[253]

Relationships Australia supported universal access to social supports, assistive technology and home modifications.[254]

Both Commissioner Briggs and I have decided to recommend that contributions for these services be dispensed with. In my view, the risks and burdens of retaining some form of modest contribution outweigh any advantage, and in principle they should not be levied. All the relevant services should be regarded as care. This should including those services, such as home modifications, cleaning, gardening and transport, that might be regarded as having inherent or objective value to people irrespective of need, and which could therefore be thought to raise a risk of a 'moral hazard' risk of a person accessing more services than they require. This risk will not arise because services are only subsidised based on assessed need. There is also a likely benefit to the Australian Government from these early investments.[255] Attempting to impose a system of means tested fees is likely to involve administrative burden and cost that is disproportionate to the value of the services, and might impose a disincentive on people taking up these services.

Respite care

Recommendation 126: Fees for respite care

1. **Individuals receiving respite care under the new Act should only be required to contribute to the costs of the services that they receive associated with ordinary costs of living (as defined in Recommendation 127, below) up to a maximum of 85% of the single basic age pension, and any additional services they choose to receive. They should not be required to contribute to the costs of the accommodation and care services that they receive.**
2. **The level of the maximum amount that respite providers may recover for the ordinary costs of living should be determined by the Pricing Authority.**

3. **The new Act should also contain provisions that ensure that individuals who are unable to pay the co-payments toward the ordinary costs of living are not denied access to the high quality respite care that they have been assessed as needing.**

4. **The Australian Government should pay each approved provider of respite to a person an amount representing the difference between the contribution the person makes to their ordinary costs of living in accordance with paragraph 126.1 and the amount that the respite provider may recover (which may not exceed the amount calculated by the Pricing Authority in accordance with paragraph 126.2).**

Respite care is defined within the Aged Care Act as an alternative care arrangement with the primary purpose of giving a carer or care recipient a short break from their usual care agreement. In my view, respite care should also serve as an opportunity to sustain the long-term capability of people to remain in their own home and receive care there. This rationale underpins our recommendations relating to respite care.

At present, people are able to access respite care through a range of aged care programs, including the Commonwealth Home Support Programme, Home Care Packages Program and residential aged care.[256]

People who access respite care through the Commonwealth Home Support Programme may be charged a contribution towards their care, but this is not mandatory and there is no fixed value. In comparison, fees for respite care through a Home Care Package have a capped maximum value. These fees include the home care basic daily fee set at 15% of the age pension and an income tested fee.[257] However, as I outline above, these fees are not compulsory. People who access respite care in a residential setting can be charged a basic daily fee that is set at 85% of the aged pension.[258] Unlike people who receive permanent residential care, respite residents do not need to pay any means tested care fees or accommodation payments. A 2018 review carried out by the Aged Care Financing Authority identified that fees for residential respite care can be a barrier to access, with a disparity in fees for different types of respite care across the different programs.[259]

As I outline above, respite should sustain the long-term capability of people to remain in their own home and to receive care there. The Australian Government benefits from the delivery of respite services, through a reduction in the long-term cost of care. If, and to the extent that, the deferral or prevention of entry into residential care can be achieved, this will represent a saving to the Australian Government on the costs of permanent residential care, including Accommodation Supplement payments, and so can be justified as a probable good 'investment' by the Australian Government. It is important, therefore, not to provide a disincentive to the uptake of these services through co-payments or means tests. As mentioned above, we recommend that there be no such co-payments or means tests for the care component of respite.

Accommodation costs, although normally a personal responsibility, should continue to be met by the Australian Government as the older person will need to meet the accommodation costs of their usual place of living while they are receiving respite. This is in line with the arrangements that currently operate in residential respite care. Residential respite care should be priced by the Pricing Authority taking into account reasonable returns on capital investment. However, ordinary costs of living should be borne by the person in respite, to the level of 85% of the single basic age pension, in line with the current arrangements.

The amount that respite providers may recover for ordinary costs of living associated with respite should be determined by the Pricing Authority. The Australian Government should pay the difference between that amount and the contribution people are required to make, which is based on 85% of the single basic age pension. There should be no means testing, which would be too administratively burdensome to justify in the context of respite. As with other fees, hardship arrangements should be available for people who cannot afford the co-payment.

Other fees charged in residential aged care

Ordinary costs of living

Recommendation 127: Fees for residential aged care—ordinary costs of living

1. Individuals receiving residential aged care under the new Act should be required, subject to the other parts of this recommendation, to contribute to the costs of the goods and services that they receive to meet their ordinary living needs, comprising all the goods and services currently specified in Part 1 of Schedule 1 of the *Quality of Care Principles 2014* (Cth) (the ordinary costs of living).
2. The Pricing Authority should determine the maximum amount payable for residents' ordinary costs of living based on an analysis of the efficient costs of delivering high quality goods and services to meet their ordinary living needs (the Services Fee Amount).
3. The maximum level of the fee that an individual resident can be asked to pay toward the ordinary costs of living (Basic Daily Fee) should be determined in accordance with provisions in the new Act and should equal the sum of:
    a. a base fee equal to 85% of the maximum amount of the basic age pension, and
    b. a means tested amount determined in accordance with Recommendation 129 or 141,

    and must not exceed the Services Fee Amount most recently determined by the Pricing Authority in accordance with Recommendation 127.2 above.

4. **The new Act should contain provisions that ensure that individuals who are unable to pay the Basic Daily Fee are not denied access to high quality residential aged care.**

5. **The new Act should also provide that where:**

   a. **an approved provider provides residential care to an individual and charges an amount for that individual's ordinary costs of living, and**

   b. **the amount charged does not exceed the Services Fee Amount most recently determined by the Pricing Authority in accordance with Recommendation 127.2, and**

   c. **the Basic Daily Fee payable by the individual is below the amount charged by the approved provider for the individual's ordinary costs of living,**

   then

   d. **the Australian Government will pay the approved provider the difference (Ordinary Cost of Living Top-up Subsidy) between:**

      i. **the Basic Daily Fee for the individual, and**

      ii. **the amount charged by the approved provider for the individual's ordinary costs of living.**

While we both consider that people who receive aged care should not be responsible for their care costs, they should be required to contribute according to their means to their ordinary costs of living. This includes meeting costs related to food, cleaning, laundry, utilities, and any additional services. In the general community, the ordinary costs of living are funded in their entirety by individuals who live in their own home, with any Australian Government assistance provided through the age pension. If and to the extent that some people might be assessed as needing domestic assistance to enable them to continue to live independently at home, this represents an exceptional case where government subsidy is justified as a good investment to delay or prevent entry into more costly residential care.

In order to cover these costs, people who receive residential care should still be required to contribute a fee that consists of 85% of the single basic age pension. However, more is needed. As we discussed earlier in this chapter, information provided by StewartBrown suggests that the current level of the uniform Basic Daily Fee, set at 85% of the single basic age pension, is insufficient to cover ordinary living costs. We have made a number of recommendations to address this in the short term, pending the commencement of independent pricing by the Pricing Authority. These measures include a temporary increase in the Australian Government supplement for the Ordinary Costs of Living in return for a written undertaking from approved providers on certain matters.

In this section, I describe a longer-term solution to address the shortfall in revenue designed to meet ordinary living costs. The Pricing Authority should from time to time review and reset the maximum level which a residential aged care provider may charge to provide the goods and services necessary to provide safe and high quality goods and services for the essentials of ordinary living (Services Fee Amount). An approved provider will be permitted to charge up to but not exceeding the Services Fee Amount. Assuming that the approved provider charges the Services Fee Amount, then to the extent that an individual has the means, as determined by a means test to pay over the level of 85% of the single basic age pension and up to the Services Fee Amount, then that individual must pay a fee (**Basic Daily Fee**). To the extent that there is a shortfall between the Services Fee Amount and the Basic Daily Fee, the Australian Government will pay a subsidy (**Basic Daily Top-up Subsidy**).

This arrangement will ensure an adequate funding stream for high quality goods and services to meet essential living needs, and will allow for greater levels of contributions from people receiving care, according to their means.

Ordinary living costs are a personal expense normally met by individuals. Given the stapling (bundling) of the goods and services that meet basic living needs to care that people receive in residential care, it is important that the prices for these ordinary living goods and services are regulated. This is especially true in residential aged care where there can be a degree of provider capture after a resident has moved into an aged care home due to the difficulties in moving.

The price set by the Pricing Authority should reflect any additional costs of these services in residential aged care when compared with the community. These arrangements would not preclude providers from offering additional or premium daily living goods and services (above an already high minimum) through additional service charges, if the resident chooses to purchase such additional services.

We envisage that the new means tested fee would be calibrated to achieve progressively greater contributions from people who have greater levels of assets and income. For example, people who are in receipt of the full pension should not be required to pay the means tested fee. Hardship arrangements should be available for people who cannot afford the co-payment. These changes will require reform of existing means testing arrangements, which I discuss in detail in the following section.

There is a difference between Commissioner Briggs and me in our support for means testing. On the face of the above recommendation, it might appear that the means tested element of these arrangements should apply indefinitely. However, I support the continuation of the means tested element as a transitional arrangement, subject to the introduction of an aged care levy. If an aged care levy is introduced, paragraph 127.3(b) in the above recommendation should only apply to people who are, at the time of commencement of the aged care levy, currently 65 years or older. For people who are then aged under 65 years, the formula in paragraph 127.3 should transition to an arrangement whereby all older people, irrespective of their means, pay no more than the base fee equal to 85% of the maximum amount of the basic age pension toward their ordinary costs of living, and the Australian Government pays the Ordinary Cost of Living Top-up Subsidy for all older people.

My reasons are as follows. I consider that all residents should contribute toward the costs of their daily living needs to the level of 85% of the single basic age pension. I also consider that the funding of any additional amount required to meet the ordinary costs of living in residential aged care should be determined in light of the long-term financing of the aged care system. As I explain in more detail in Chapter 20: Financing the New Aged Care System, I propose that in due course, subject to proper inquiry and development, a hypothecated levy should be imposed through the taxation system to generate a stable source of financing for the aged care system. I anticipate that, by the time people who are (at the commencement of the implementation of the levy) currently under 65 years are likely to need and receive aged care, they will have contributed to the financing of the system through this levy, and younger cohorts will have done so for many years. I consider that for such people, their excess costs of ordinary living in residential aged care (over the level of 85% of the single basic aged pension) should be regarded as part of the universal entitlement to aged care for which they have contributed as taxpayers. As such, the Australian Government should pay the Ordinary Cost of Living Top-up Subsidy for them, without imposing any means testing. I further consider that requiring such people to pay the gap between the price for ordinary living cost set by the Pricing Authority and 85% of the single basic age pension would amount to a double impost, because those people will already have contributed according to their means to the financing of the aged care system through the aged care levy, and I consider that they should not in effect be required to pay twice.

Accommodation

Recommendation 128: Fees for residential aged care accommodation

Commissioner Pagone

1. Individuals receiving residential aged care under the new Act should be required, subject to the other parts of this recommendation, to contribute to the costs of their accommodation.

2. The new Act should recognise two categories of residents for the purposes of regulation of amounts payable for accommodation: residents for whose accommodation the Australian Government will pay or contribute (eligible residents) and residents for whose accommodation the Australian Government will not make anv contribution.

Eligible residents

3. The Pricing Authority should from time to time determine the maximum amount or amounts payable for the accommodation of eligible residents, based on an analysis of the efficient costs of delivering high quality accommodation and a reasonable rate of return on capital investment (Accommodation Supplement). In doing so, the Pricing Authority may at its discretion determine one uniform amount to apply in all cases, or a number of different amounts based on factors such as the date of construction or refurbishment of the facility, the size or other features of the room, and the region or degree of remoteness of the location of the facility.

4. Subject to Recommendation 128.6, the new Act should provide that the maximum amount an approved provider may receive for the accommodation of a resident should be the Accommodation Supplement determined by the Pricing Authority in Recommendation 128.3 above, payment of which will comprise:

    a. a means tested fee for accommodation determined in accordance with Recommendation 129, payable directly by the individual resident, and

    b. funding of the difference between the means tested fee for accommodation and the maximum level determined by the Pricing Authority in Recommendation 128.3 above, payable by the Australian Government (Accommodation Top-up Supplement).

5. The new Act should contain provisions that ensure that individuals who are unable to pay for accommodation are not denied access to high quality residential aged care.

Other residents

6. Where an individual is determined in accordance with Recommendation 129 to have a means tested fee for accommodation greater than the Accommodation Supplement determined by the Pricing Authority in accordance with Recommendation 128.3 above, then

    a. no Accommodation Top-Up Supplement is payable in respect of such a resident, and

    b. the fee that the individual may be charged is not limited to the Accommodation Supplement, but subject to Recommendation 128.7 should be subject to a provisional upper limit (to be determined by the Pricing Authority from time to time) (Provisional Accommodation Charge Limit).

7. The Pricing Authority:

    a. should from time to time determine the Provisional Accommodation Charge Limit, based on an analysis of the efficient costs of delivering high quality accommodation and a reasonable rate of return on capital investment, being either a uniform amount that will apply in all cases, or a number of different amounts that will apply in different cases, based on factors such as the date of construction or refurbishment of the facility, the size or other features of the room, and the region or degree of remoteness of the location of the facility

    b. may, on the application of an approved provider, and after consideration of factors including the cost of investment and any particular constraints on supply of residential aged care services in the relevant area, determine that the Provisional Accommodation Charge Limit for one or more rooms of a facility should be varied to a different amount.

Like the ordinary costs of living, accommodation has been regarded by many as primarily the responsibility of the person receiving care, provided they have the means to pay for it.[260] Currently, an Accommodation Supplement is paid by the Australian Government to approved providers for eligible residents. Since 1 July 2014, eligibility for a full or partial accommodation supplement is subject to asset and income means testing arrangements.[261]

The means testing arrangements applicable to qualification for full or partial accommodation supplement should be reformed to ensure they do not have a disproportionately harsh impact on people who do not meet the requirements for full support by the Government, but who nevertheless are positioned at the lower end of the wealth spectrum. I discuss this further below. As already noted, for residents who receive no support from the Government, the existing arrangements constraining providers from charging above a provisional ceiling, subject to application for the ceiling to be lifted in particular cases, should be retained.

I consider that, like the ordinary costs of living, the allocation of the costs of accommodation in residential aged care should be considered in light of the proposals for the long-term financing of the aged care system, and in particular my proposal that a hypothecated levy should be imposed through the taxation system to generate a stable source of financing for the aged care system. Just as in the case of ordinary costs of living, in my view the means testing arrangements for eligibility for the Accommodation Supplement should only apply to people who are, at the time of commencement of the aged care levy, currently 65 years or older. For people who are then under 65 years, these arrangements should transition to an arrangement whereby the Australian Government pays the Accommodation Supplement for all older people, means testing is discontinued, and older people only pay a contribution toward their accommodation costs if they choose accommodation that is more expensive than the level of the Accommodation Supplement. The same reasoning applies. I anticipate that, by the time people who are (at the time the levy commences) currently under 65 years are likely to need and receive aged care, they will have contributed for many years to the financing of the system through this levy. I consider that for such people, the costs of accommodating them in residential aged care should be regarded as part of the universal entitlement to aged care for which they have contributed as taxpayers, and that the Australian Government should pay the Accommodation Supplement for all such people, irrespective of means. I consider that requiring such people to pay the Accommodation Supplement would amount to a double impost, and that they should not in effect be required to pay through taxation and then again through means testing. In this regard, it is important to note the inherent 'progressivity' of the income tax system. Wealthier taxpayers pay tax at progressively higher rates for those parts of their income that falls within higher brackets of value. This means that the wealthier people will already have contributed more, progressively with their income levels, to the tax revenue which is used to finance the aged care system. In effect, the income tax system will already have imposed a means test on the level of those contributions.

Changes to the operation of the means test

Recommendation 129: Changes to the means test

Commissioner Pagone

1. For each individual receiving residential aged care under the new Act, a means tested amount should be determined in accordance with the following parts of this recommendation.
2. If the individual is in receipt of an *income support payment* or a *service pension* or an *income support supplement* or a *veteran payment* (as defined in the *Social Security Act 1991* (Cth) and the *Veterans' Entitlements Act 1991* (Cth)), then their means tested amount is zero.
3. If the individual is not in receipt of an *income support payment* or a *service pension* or an *income support supplement* or a *veteran payment*, then their means tested amount is determined as the maximum of the following two amounts:
    a. the *income tested amount* referred to in Recommendation 129.4 below, and
    b. the *asset tested amount* referred to in Recommendation 129.5 below.
4. The *income tested amount* for the individual is calculated as follows:
    a. the income tested amount is equal to 50% of the difference between the individual's *total assessable income* and the individual's *total assessable income-free area*

    where:

    b. the individual's *total assessable income* is the amount that would be worked out as the care recipient's ordinary income for the purpose of applying Module E of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991* (Cth)
    c. the individual's *total assessable income-free area* is the maximum level that a person's ordinary income could be for the purpose of applying Module E of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991* (Cth) where that person remains eligible for a pension.
5. The *asset tested amount* is calculated as follows:
    a. The annual *asset tested amount* is equal to 7.8% of the difference between the individual's *total assessable assets* and the individual's *total assessable asset free area*

where:

b. the individual's *total assessable assets* is the amount that would be worked out as the care recipient's ordinary income for the purpose of applying Module G of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991* (Cth)

c. the individual's *total assessable asset free area* is the maximum level that a person's assessable assets could be for thepurpose of applying Module G of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991* (Cth) where that person remains eligible for a pension.

6. Where that means tested amount is less than or equal to the maximum rate of the Ordinary Cost Of Living Top-up Subsidy (as determined under Recommendation 127) then:

   a. the individual is required to pay a means tested ordinary cost of living fee for the purpose of Recommendation 127.3 equal to the means tested amount

   b. the individual is not required to pay a means tested accommodation fee for the purpose of Recommendation 128.4

   c. the approved provider receives an Ordinary Cost of Living Top-up Subsidy equal to the difference between the maximum rate of the top-up subsidy and the means tested amount, and

   d. the provider receives the maximum rate of the Accommodation Top-up Supplement.

7. Where that means tested amount is greater than the maximum rate of the Ordinary Cost of Living Top-up Subsidy (as determined under Recommendation 127) and less than or equal to the sum of the maximum rates of the Ordinary Cost of Living Top-up Subsidy and the Accommodation Top-up Supplement then:

   a. the individual is required to pay a means tested ordinary cost of living fee for the purpose of Recommendation 127.3 equal to the maximum rate of the Ordinary Cost of Living Top-up Subsidy

   b. the individual is required to pay a means tested accommodation fee for the purpose of Recommendation 128.4 equal to the means tested amount minus the maximum rate of the Ordinary Cost of Living Top-up Subsidy

   c. the provider receives no Ordinary Cost of Living Top-up Subsidy, and

   d. the provider receives an Accommodation Top-up Supplement equal to the difference between the sum of the maximum rates of the Ordinary Cost of Living Top-up Subsidy and the Accommodation Top-up Subsidy and the means tested amount.

8. **Where that means tested amount is greater than sum of the maximum rates of the Ordinary Cost of Living Top-up Subsidy and the Accommodation Top-up Supplement then:**
    a. **the individual is required to pay a means tested ordinary cost of living fee for the purpose of Recommendation 127.3 equal to the maximum rate of the Ordinary Cost of Living Top-up Subsidy, and**
    b. **the individual's accommodation fees are subject to Recommendations 128.6 and 128.7 above, and**
    c. **the provider receives no Ordinary Cost of Living Top-up Subsidy, and**
    d. **the provider receives no Accommodation Top-up Supplement.**

Means testing should ensure that services and payments are directed towards those that need them the most. However, existing aged care means testing arrangements are not progressive. They are regressive. They have an adverse impact on people in certain income or asset bands, particularly those on the lower end of these bands. Not only is this inequitable, but it also reduces the amount of funding available to the aged care system that could be better directed towards delivering high quality care. Below, I provide a summary of the existing aged care means testing arrangements, along with examples that illustrate the issues within these arrangements. It is clear that existing means testing arrangements require reform.

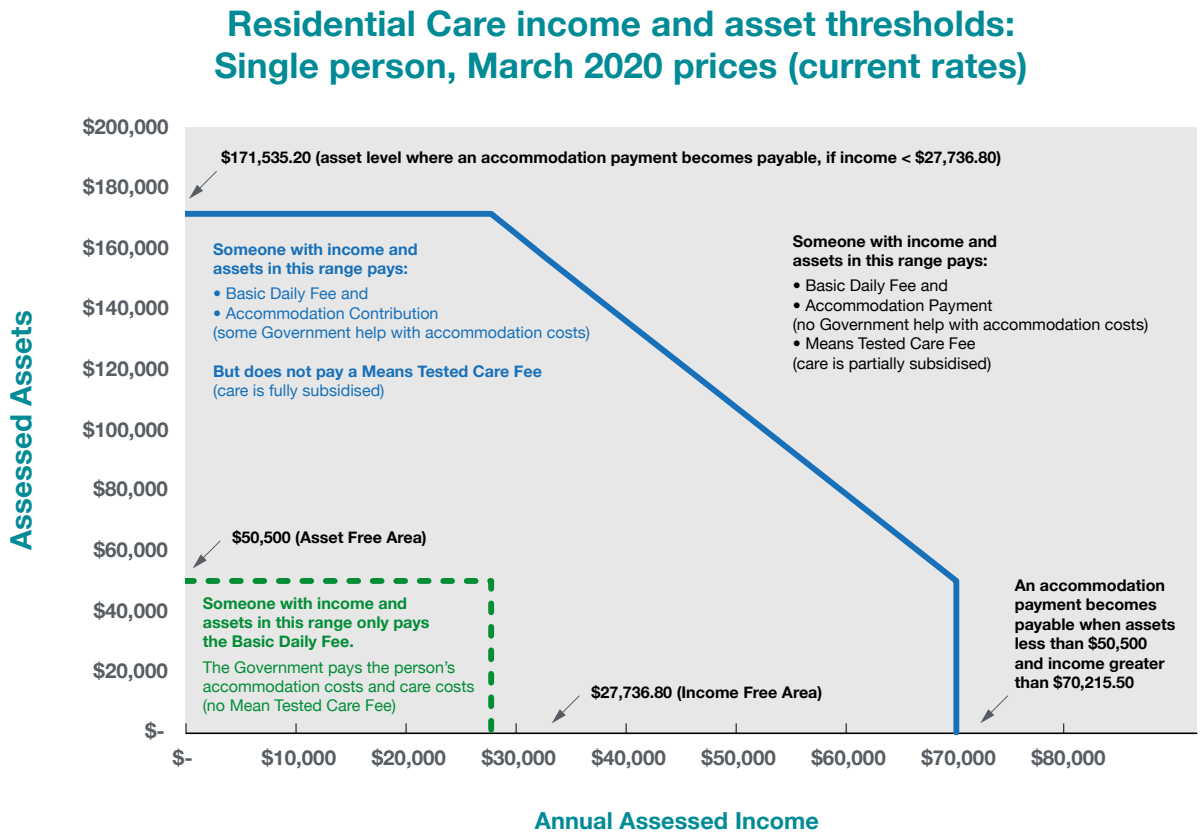
The Australian Government currently applies means testing to two payments applicable to residential aged care—the accommodation payments and the means tested care fee.[262] Both income and assets are assessed in the residential aged care means test.[263] The amount payable by the Australian Government as a subsidy in respect of an individual is reduced by the sum of the result of these two tests:

- The income test reduces the amount of subsidy payable by 25% for every dollar in excess of the maximum income for a full pensioner.
- The assets test reduces the amount of subsidy payable by:
    - 17.5% of assets between the asset free threshold ($50,500) and the first asset threshold ($171,535)
    - plus 1.0% of assets between the first asset threshold and the second asset threshold ($413,606)
    - plus 2.0% of assets above the second assets threshold.[264]

The means test first reduces the level of the Accommodation Supplement payable by the Australian Government when a person exceeds the existing thresholds. Thereafter, it reduces the level of care subsidy payable by the Australian Government.

The effect of these means tests is illustrated below in Figure 2, where we can see that means testing results in essentially three tiers of payment.

Figure 2: Operation of the aged care income and assets tests[265]



Source: adapted from Figure E.2, Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, 2020.

Residents who are eligible to receive subsidised accommodation may be either fully or partially supported. In the passage that follows, I refer to people who are not eligible to receive subsidised accommodation as 'unsupported' residents.

People within the green box are fully supported residents. These residents have income below $27,736.80 and assessable assets below $50,500. They do not need to contribute to their accommodation costs or their care costs. About a quarter of all residents are in this category.

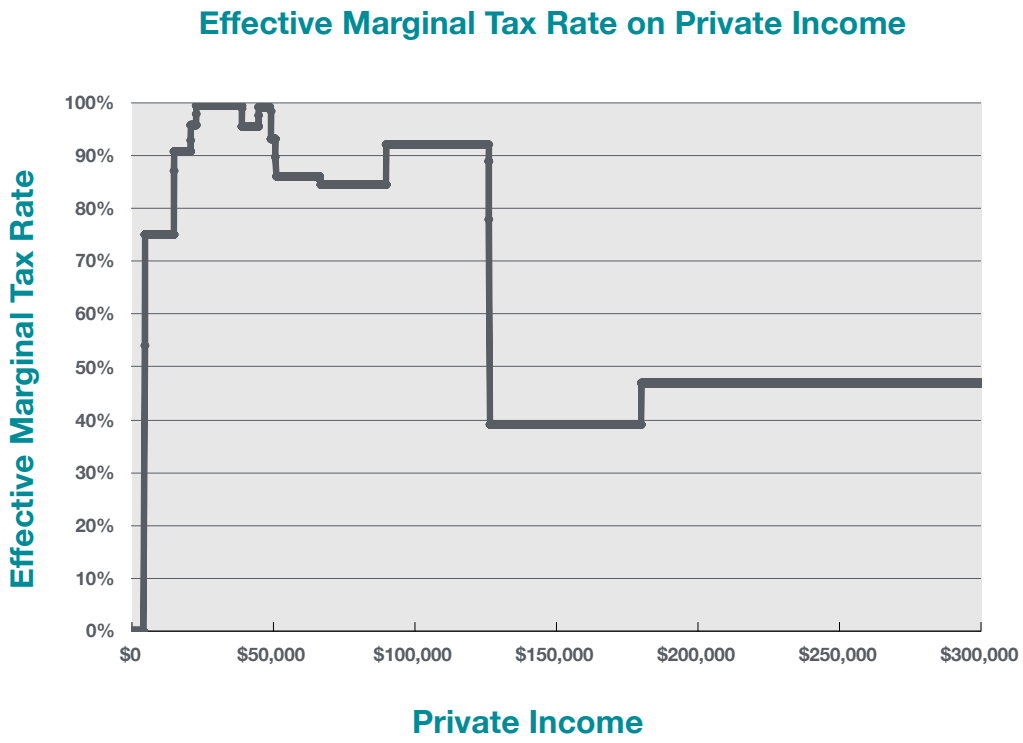
Partially supported residents are those within the blue area of Figure 2 and are required to pay for some of their accommodation costs. Partially supported residents are not required to contribute to their care costs through a means tested care fee. About a quarter of all residents are partially supported residents.

Unsupported residents fall outside the blue line and have income above $70,320 or assets above $171,535. Unsupported residents have to pay for the full cost of their accommodation and contribute to their care costs. About half of all residents are unsupported residents.[266]

The information provided to us suggests that partially-supported residents, and unsupported residents who just fall into this category, are disproportionally affected by the asset and income tests. Professor McCallum referred to this as a 'means test trap'.[267] As an example, a pensioner who is a partially supported resident would need to pay both a Basic Daily Fee and a means tested contribution towards their accommodation. These fees are likely to consume the value of their age pension and could potentially leave them with negative income.[268]

Figure 3 illustrates how the residential aged care income test operates and how it affects the marginal tax rate. The effective marginal tax rate is significantly higher for people who are on a private income of below $130,000, and is greatest for people who have a private income of between $20,000 and $50,000. This shows that people who have some of the lowest private incomes are facing the highest effective marginal tax rates.

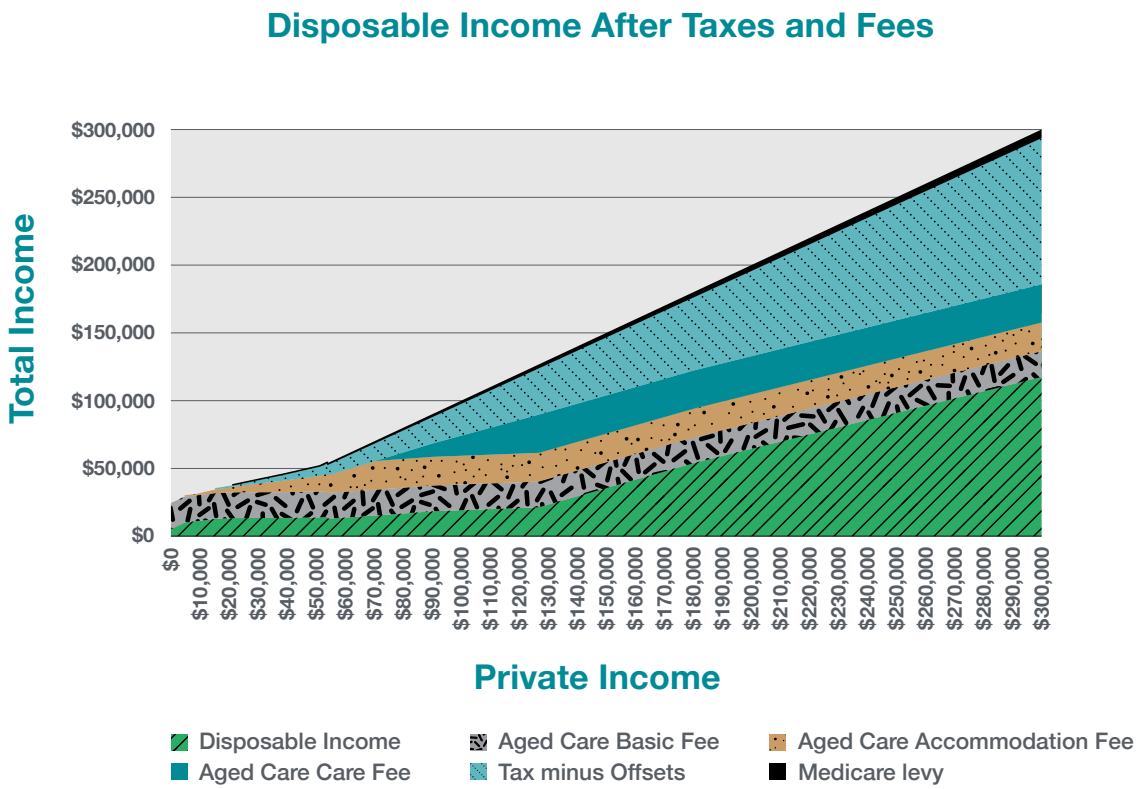
Figure 3: Operation of the residential aged care income test on effective marginal tax rate



Source: Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0016.

Another way of demonstrating this effect is to consider the amount of disposable income a person has following application of the income test, which is illustrated in Figure 4. This shows that the amount of disposable income available to a person increases rapidly after they have a private income of $130,000 or greater.

Figure 4: Operation of the aged care income test on disposable income



Source: Exhibit 21-2, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0017.

People who are very wealthy are shielded from the effects of the income and asset tests by the existence of means testing caps which can be applied on a daily, annual and lifetime basis. These caps ensure that the means tested fees that a person pays cannot be greater than the sum of the maximum value of the accommodation supplement and the amount of care subsidy that they would otherwise pay. On July 2020, the maximum means tested fee a person could be charged in a single day was $281.33.[269] The maximum yearly cap during this period was $28,087 and the lifetime cap was $67,410.[270] These caps are fixed, irrespective of a person's wealth. I consider that this does not align with the evidence we received from witnesses which suggested that people should make contributions to services in line with their capacity to pay.[271]

A fairer approach would commence to means test for aged care purposes after the age pension means test had reduced the amount of the age pension a person received to zero. This would mean the aged care means test would not interfere with the means test for the age pension. On this approach, in essence, the Australian Government assistance available to the individual would be treated as the sum of:

- the age pension
- the Ordinary Cost of Living Top-up Subsidy
- the Accommodation Top-up Supplement.

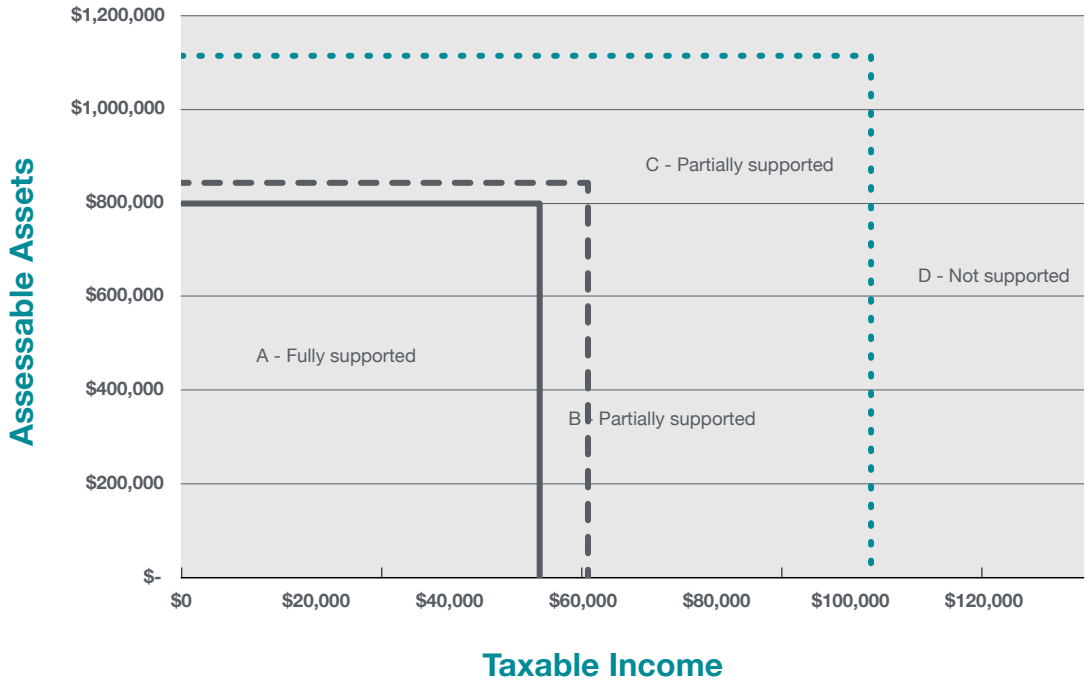
Commissioner Briggs and I propose that the pension means test should be applied to this total and progressively reduce the three amounts to zero. As a result, all full and part pensioners would receive the maximum amounts of the Ordinary Cost of Living Top-up Subsidy and the Accommodation Top-up Supplement.

Self-funded retirees with assets or income above the pension cut-offs would receive progressively less assistance with these two payments. I recommend that the taper rate at which government assistance reduces for self-funded retirees should be the same as the taper rate that applies to reduce eligibility for the age pension as assets and income increase, namely 7.8% for the assets test and 50% for the income test.

Figure 5 below shows how the proposed means test would work for single non-homeowners.

- Full and part-pensioners would be fully supported and would only pay 85% of the single basic age pension towards the cost of their residential aged care. The Australian Government would pay for the cost of their care and accommodation and the full amount of the Ordinary Cost of Living Top-up Subsidy (Resident A in Figure 5).
- These residents have private income less than $53,732 per annum and assessable assets worth less than $797,500.
- Non-pensioners with a small amount of income or assets above the thresholds for part-pensioners would pay 85% of the single basic age pension and a means tested contribution towards Ordinary Cost of Living Top-up Subsidy. The Australian Government would pay for the cost of their care and accommodation and the rest of the Ordinary Cost of Living Top-up Subsidy (Resident B in Figure 5).
- These residents have private income between $53,732 and $61,032 per annum and assessable assets worth between $797,500 and $844,295.
- Non-pensioners with slightly more income or assets above the thresholds for part-pensioners would pay 85% of the single basic age pension, the full value of the Ordinary Cost of Living Top-up Subsidy, and a means tested contribution towards their accommodation. The Australian Government would pay for the cost of their care and some of their accommodation of the costs, but would not pay any of the Ordinary Cost of Living Top-up Subsidy (Resident C in Figure 5).
- These residents have private income between $61,032 and $103,394 per annum and assessable assets worth between $844,295 and $1,115,848.
- Non-pensioners with more income or assets above the thresholds for part-pensioners would pay 85% of the single basic age pension, the full value of the Ordinary Cost of Living Top-up Subsidy and the cost of their accommodation as agreed by them and their provider. The Australian Government would pay for the cost of their care. (Resident D in Figure 5).
- These residents have private income of more than $103,394 per annum or assessable assets worth more than $1,115,848.

Figure 5: Fully supported, partially supported and non-supported residents under the proposed revised residential aged care income test (single non-home owner)



Different thresholds would apply for single non-homeowners, single homeowners, partnered non-homeowners and partnered homeowners in line with the pension means test. Whether or not the home is counted as an asset for the purposes of the means test would be determined by the same rules as currently apply for the pension means test. Under the pension means test, a person's principal residence is an exempt asset if either they, their partner, or both of them are living in it.[272] If a person enters residential aged care and their partner is not living in the home, for pension purposes the principal residence is not counted in the assets test for two years. After that time, the value of the principal home is counted in the assets test and the person is treated as a non-homeowner for pension purposes.[273] I propose that the same treatment should apply in aged care. Aligning these arrangements in aged care with those that apply in the pension context involves an approach that is generally more 'generous' to people receiving aged care, but also involves a limitation on the extent to which the principal residence is currently exempt from the aged care assets test. Under the current aged care assets test, the principal residence is exempt provided a 'protected person' resides there, and the definition of 'protected person' is broader than the exemption that applies for the age pension.[274]

Figure 6 illustrates how the proposed new residential aged care income test operates and how it affects a person's marginal tax rate. By comparison to the current income test, the effective marginal tax rates faced by pensioners are much more reasonable and overall effective marginal tax rates are more progressive.

Figure 6: Operation of the revised residential aged care income test (at 50%) on effective marginal tax rate

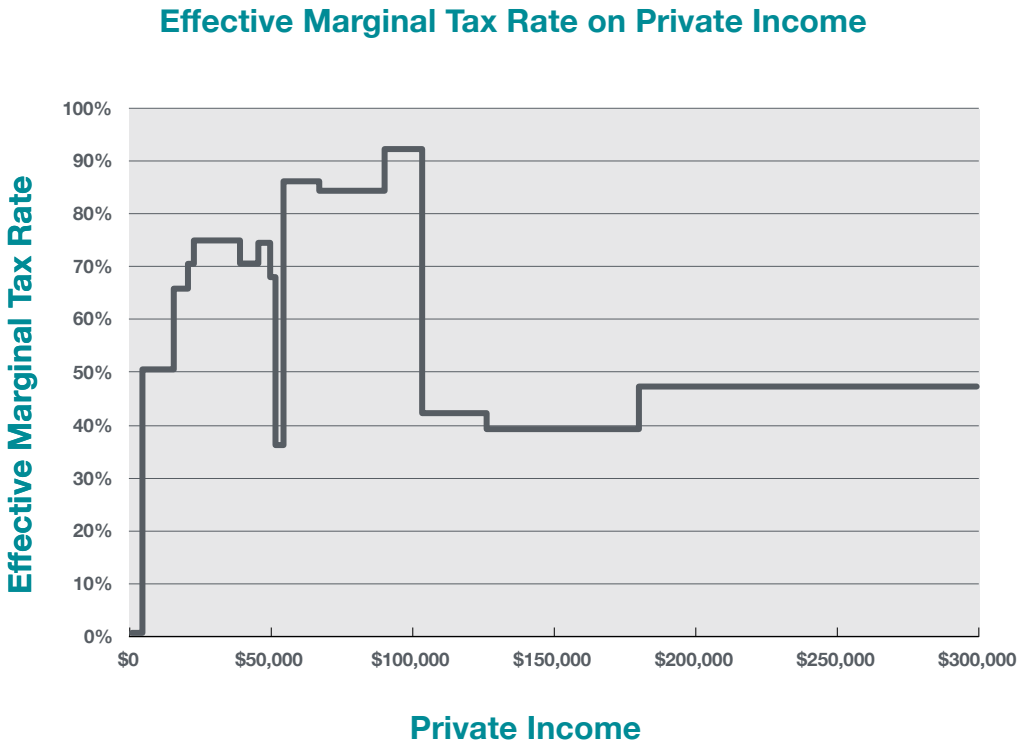
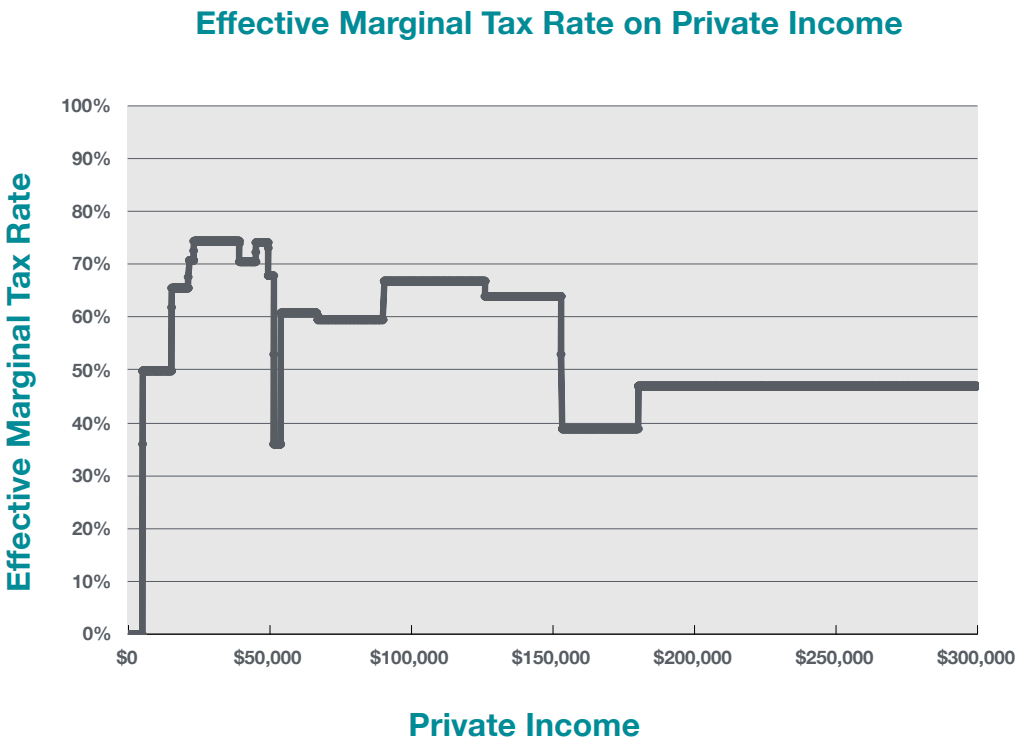


Figure 7: Operation of the revised residential aged care income test (at 25%) on effective marginal tax rate



These proposed changes to the means test should, in addition to being generally more equitable than the current arrangements, remove a particular distortion in the current aged care means test. The current aged care means test counts both assets and the income derived from those assets as contributing toward the reduction of eligibility of assistance. This 'double counting' effect is not present in the pension means test, and should be removed from the aged care means test.

Commissioner Briggs recommends lower taper rates for the aged care income and asset tests in part because she is concerned that higher taper rates will result in effective marginal tax rates that are too high. I do not agree. First, the taper rates I recommend dovetail with those in the current age pension means tests. Second, and most importantly, much of the income of self-funded retirees is income tax free, so the effective marginal income tax rates may not be as high as would appear.

17.6 Conclusion

The key conclusions Commissioner Briggs and I have reached about the funding arrangements that should be adopted for aged care services in the future are set out in the table that follows. The table sets out who should pay for what, and how. There are two overarching principles which have influenced our recommendations on the level of funding to be provided:

- the amount of funding should be sufficient to meet the independently assessed needs for these services of all older people
- the funding should be sufficient to allow providers of those services to deliver them sustainably, safety and at a high level of quality.

Category	Government funding	Fees and co-contributions
Social supports	The Australian Government should provide grant funding for social supports. The grants should involve a combination of block and activity based payments.	Older people should not be required to make any co-contributions to the cost of social supports that they have been assessed as needing.
Respite supports—care	The Australian Government should provide grant funding for the care component of respite. The grants should involve a combination of block and activity based payments.	Older people should not be required to contribute to the cost of care provided in respite that they have been assessed as needing.

Category	Government funding	Fees and co-contributions
Respite supports—ordinary costs of living	The maximum total amount which a respite provider may receive for ordinary costs of living should be determined by: the Pricing Authority (Commissioner Pagone) the Pricing Authority, by disallowable instrument (Commissioner Briggs). The Australian Government should pay the difference between this amount and the amount payable by each individual (which will generally be 85% of the single basic age pension).	Older people with the means to do so should be required to contribute an amount to the cost of services associated with the ordinary costs of living provided in respite that they have been assessed as needing equal to 85% of the single basic age pension. There should be no requirement for an older person to contribute more than 85% of the single basic age pension, irrespective of the person's means, because the administration of a means-testing regime for this purpose is not justifiable for short duration services like respite.
Respite supports—accommodation	The Australian Government should provide block funding for the accommodation costs of respite. The unit costs of accommodation should be determined by the Pricing Authority based on an appropriate model for estimation of required revenues to support investment in respite.	Older people should not be required to contribute to the cost of accommodation provided in respite that they have been assessed as needing.
Respite supports—additional services	The Australian Government should not make any contribution for additional services in respite.	Older people should be required to pay fees for any additional services they choose to obtain in respite.
Assistive technologies and home modifications	The Australian Government should provide grant funding for assistive technologies and home modifications. The grants should involve a combination of block and activity based payments.	Older people should not be required to make any co-contributions to the cost of assistive technologies and home modifications.
Care at home	The Australian Government should introduce a classification system for funding care at home, covering care management, personal and clinical care, domestic assistance, and palliative and end-of-life care.	Older people should not be required to contribute to the cost of care at home.
Care at a residential care service—care	The Australian Government should introduce a casemix-adjusted activity based funding model for residential care.	Older people should not be required to contribute to the cost of care provided through residential care.

Category	Government funding	Fees and co-contributions
Care at a residential care service—ordinary costs of living	The maximum total amount which a residential care provider may receive for ordinary costs of living should be determined by: • the Pricing Authority (Commissioner Pagone) • the Pricing Authority, by disallowable instrument (Commissioner Briggs). The Australian Government should pay an 'Ordinary Cost of Living Top-up Subsidy' in respect of those residents where the amount the person is required to pay (as determined by a means test) falls short of the amount charged by the provider. Commissioner Pagone: In the longer term, for people who are under 65 years, this funding arrangement should transition to an arrangement whereby the Australian Government pays the Ordinary Cost of Living Top-up Subsidy for all, irrespective of their means.	Older people should be required to pay a Basic Daily Fee for ordinary costs of living associated with care at a residential care home. The Basic Daily Fee should be: • 85% of the single basic age pension, and • a means tested fee for ordinary living costs o provided that the sum of these two components will not exceed the maximum total amount which residential care provider may receive, as determined by the Pricing Authority. Commissioner Briggs: the means testing arrangements for ascertaining the levels of contribution should be determined by the responsible Minister from time to time. Commissioner Pagone: In the longer-term, for people who are under 65 years, this funding arrangement should transition to an arrangement whereby older people only pay a contribution of 85% of the single basic age pension, irrespective of their means.

Category	Government funding	Fees and co-contributions
Care at a residential care service—accommodation	The maximum total amount that a residential care provider may receive for providing accommodation to fully or partially supported residents should be determined based on an appropriate model for estimation of required revenues to support investment in residential aged care by: • the Pricing Authority (Commissioner Pagone) • the Pricing Authority, by disallowable instrument (Commissioner Briggs). The maximum amount will be the level of the 'Accommodation Supplement'. The Australian Government should pay the Accommodation Supplement for the accommodation costs of fully supported residents, and should pay an 'Accommodation Top-up Supplement' for partially supported residents, where the amount the person is required to pay (as determined by a means test) falls short of the level of the Accommodation Supplement. Commissioner Pagone: In the longer term, for people currently under 65 years (who are expected to contribute to additional financing of the aged care system via the Aged Care Levy), this funding arrangement should transition to an arrangement whereby the Australian Government pays the Accommodation Supplement for all residents.	Fully supported residents are not required to contribute to their accommodation costs. Partially supported older people should be required to pay rent for their accommodation in the form of a Daily Accommodation Payment as determined by the means test. Commissioner Briggs: the means testing arrangements for ascertaining the levels of contribution should be determined by the responsible Minister from time to time. Unsupported residents can pay for their accommodation as they agree with the provider. This might include the provision of a Refundable Accommodation Deposit if they choose. • The means test will operate so that pensioners will not pay a means tested payment for accommodation. Commissioner Pagone: In the longer-term, for people who are under 65 years, this funding arrangement should transition to an arrangement whereby older people only pay a contribution if they choose accommodation that is more expensive than the level of the Accommodation Supplement.
Care at a residential care service—additional services	The Australian Government should not make any contribution for additional services in residential care.	Older people should be required to pay fees for any additional services they choose to obtain in residential care. This applies to services the person is not assessed as needing.

Endnotes

1 Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry,* 2020, pp 12–13 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).

2 This figure of $4.8 billion comprised $3.4 billion towards residents' living expenses, $822 million towards accommodation costs by residents who chose to pay through a Daily Accommodation Payment and $513 million towards care costs: Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, p 13 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).

3 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, p 13 [Table 2.2] (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).

4 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 134, RCD.9999.0530.0002; Office of the Royal Commission analysis of Productivity Commission, *Report on Government Services 2020, F Community Services, 14 Aged Care Services,* 2020; Aged Care Financing Authority, *Seventh Report on the Funding and Financing of the Aged Care Industry*, 2019; Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, 2020; Australian Department of Social Services, *Annual Report 2018-19*, 2019; Australian Department of Social Services, *DSS Demographics*, 2019.

5 Commonwealth of Australia, *Letters Patent*, 6 December 2018, paragraph (f), emphasis added.

6 See D Cullen and Office of the Royal Commission into Aged Care Quality and Safety, *Medium- and long-term pressures on the system: the changing demographics and dynamics of aged care*, Background Paper 2, 2019.

7 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 46, CTH.9100.0001.0001 at 0011–0012. See also Aged Care Financing Authority, *Seventh report on the Funding and Financing of the Aged Care Industry*, 2019, pp 119–122 (Exhibit 10-1, Melbourne Hearing 2, general tender bundle, tab 118, RCD.9999.0220.0001).

8 Aged Care Financing Authority, *Seventh report on the Funding and Financing of the Aged Care Industry*, 2019, p 120 (Exhibit 10-1, Melbourne Hearing 2, general tender bundle, tab 118, RCD.9999.0220.0001).

9 See, for example, Exhibit 21-25, Sydney Hearing 5, Statement of Henry Cutler, RCD.9999.0380.0001 at 0004 [24]–[25]; Exhibit 2-86, Adelaide Hearing 2, Statement of Hjalmar Swerissen, WIT.0085.0001.0001 at 0003 [16]; Transcript, Sydney Hearing 5, Chris Williams, 21 September 2020 at T9491.27–9492.5; Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0011–0019; Exhibit 21-23, Sydney Hearing 5, Statement of Chris Mamarelis, RCD.9999.0335.0001 at 0004 [25]–0006 [36]; Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0009; Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9421.43–9422.18.

10 At the time of preparation of this chapter, the most recent full year published report was the StewartBrown *Aged Care Financial Performance Survey Sector Report*, June 2020, which was a report on a full year of data for financial year 2019–20. See StewartBrown, *Aged Care Financial Performance Survey Aged Care Sector Report*, 2020, p 3.

11 StewartBrown, *Aged Care Financial Performance Survey Aged Care Sector Report*, 2020, p 10.

12 WP Hogan, *Review of Pricing Arrangements in Residential Aged Care*, 2004, p 34.

13 BDO, *Report on the Profitability and Viability of the Australian Aged Care Industry*, A report prepared for the Royal Commission into Aged Care Quality and Safety, Research Paper 12, 2020, p 50 (Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 10, RCD.9999.0388.0044).

14 BDO, *Report on the Profitability and Viability of the Australian Aged Care Industry*, A report prepared for the Royal Commission into Aged Care Quality and Safety, Research Paper 12, 2020 (Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 10, RCD.9999.0388.0044); Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 12, RCD.9999.0388.0223.

15 BDO, *Report on the Profitability and Viability of the Australian Aged Care Industry*, A report prepared for the Royal Commission into Aged Care Quality and Safety, Research Paper 12, 2020, p 33 (Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 10, RCD.9999.0388.0044).

16 Transcript, Sydney Hearing 5, Fahim Khondaker, 14 September 2020 at T9163.34–38.

17 BDO, *Report on the Profitability and Viability of the Australian Aged Care Industry*, A report prepared for the Royal Commission into Aged Care Quality and Safety, Research Paper 12, 2020, p 34 (Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 10, RCD.9999.0388.0044).

18 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 12, RCD.9999.0388.0223 at 0228.

19 Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, 2020, pp 38, 43, 59 [Tables 5.1, 6.2, calculated from Chart 4.1] (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).

20 Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9137.13–16; Transcript, Sydney Hearing 5, Chris Williams, 21 September 2020 at T9495.37–42; Exhibit 21-16, Sydney Hearing 5, Statement of Westpac Banking Corporation, WPC.9999.0002.0001 at 0020; Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9569.45–9570.5.

21 Transcript, Sydney Hearing 5, Campbell Ansell, 18 September 2020 at T9474.18–9475.2; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 39, RCD.9999.0477.0001 at 0003.

22 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry,* 2020, pp v, 42 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).

23 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9218 [103].

24 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9193 [16].

25 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9193–9194 [18]; Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0014 [45a]; Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9428.30–37.

26 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, pp 66–67 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017). The indexation approach for residential care and home care is known within government as 'WCI-9'. A similar approach, known as 'WCI-3', is used for the Commonwealth Home Support Programme, by which the wages component is weighted at 60% and the non-wage component at 40%: Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, p 39 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).
27 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, pp 66–67 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).
28 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0008 [49].
29 Fair Work Ombudsman, *Minimum wages,* 2020, https://www.fairwork.gov.au/ArticleDocuments/723/Minimum-wages.pdf.aspx, viewed 16 December 2020; Australian Taxation Office, *Average weekly ordinary time earnings (AWOTE),* 2020, https://www.ato.gov.au/rates/key-superannuation-rates-and-thresholds/?page=40, viewed 16 December 2020.
30 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9319.4–6.
31 Transcript, Sydney Hearing 5, Thea Hordern, 21 September 2020 at T9492.10–15.
32 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9522.9–12.
33 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 114, RCD.9999.0522.0001 at 0008.
34 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9522.1. See also Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9140.45–9141.7; Transcript, Sydney Hearing 5 Michael Woods, 15 September 2020 at T9181.30–37; Transcript, Sydney Hearing 5, Nigel Murray, 18 September 2020 at T9427.8–15.
35 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9522.2–4.
36 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9429.9–13; T9424.10–15.
37 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9193 [17].
38 Submissions of the Commonwealth, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0014-0015 [45b].
39 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0008 [52].
40 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9320.30–9321.17.
41 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9216 [98].
42 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9216 [99].
43 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9216 [99].
44 Submissions of the Commonwealth, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0014–0015 [45b].
45 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9319.4–6.
46 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9320.31–40.
47 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9194 [18a], [18c], [20b].
48 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9193–9194 [18]; Submissions of the Commonwealth, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0014 [45(a)]; Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9428.30–37.
49 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0015 [45c]
50 Transcript, Sydney Hearing 5, Samuel Morris, 21 September 2020 at T9491.8–11.
51 BDO, *Report on the Profitability and Viability of the Australian Aged Care Industry*, A report prepared for the Royal Commission into Aged Care Quality and Safety, Research Paper 12, 2020, p 40 (Exhibit 21-1, Sydney Hearing 5, general tender bundle, Tab 10, RCD.9999.0388.0044).
52 StewartBrown, *Aged Care Financial Performance Survey Sector Report Nine months ended 31 March 2020,* 2020, p 7 [Table 2] (Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 61, RHC.9000.0002.0001); StewartBrown, *Aged Care Financial Performance Survey Sector Report June 2020*, 2020, p 19.
53 StewartBrown, *Aged Care Financial Performance Survey Sector Report Nine months ended 31 March 2020,* 2020, p 16 [Table 4] (Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 61, RHC.9000.0002.0001); StewartBrown, *Aged Care Financial Performance Survey Aged Care Sector Report For the year ended 30 June 2020*, 2020, p 33 [Table 9]; *Aged Care Award 2010*, cl 14; *Nurses Award 2010*, cl 14.
54 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, p 46 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017); Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9215 [94].
55 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9202 [45b].
56 StewartBrown, *StewartBrown Aged Care Financial Performance Survey Aged Care Sector Report for the year ended June 2020*, 2020, pp 45, 51.
57 Submission of Health Services Union, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0011.0165.
58 Submission of United Workers Union, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0010.0015 at fn 57, row 562.
59 Submission of United Workers Union, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0010.0015.
60 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, pp xii, 71 [Table 6.9] (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).
61 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0004 [26].
62 Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9132.22–24.
63 StewartBrown, *StewartBrown Aged Care Financial Performance Survey Aged Care Sector Report for the year ended June 2020*, p 34 [Table 10].

64 See, for example, Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9519.3–15; Exhibit 21-22, Sydney Hearing 5, Statement of Natasha Chadwick, WIT.1361.0001.0001 at 0020 [101]; Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0035 [55]–[59].
65 Transcript, Sydney Hearing 5, Nigel Murray, 18 September 2020 at T9431.18–26.
66 D Tune, *Legislated Review of Aged Care 2017*, 2017, pp 82–83 (Exhibit 1-35, Adelaide Hearing 1, RCD.9999.0011.0746).
67 D Tune, *Legislated Review of Aged Care 2017*, 2017, pp 9, 82–83 (Exhibit 1-35, Adelaide Hearing 1, RCD.9999.0011.0746).
68 StewartBrown, *StewartBrown Aged Care Financial Performance Survey Aged Care Sector Report for the year ended June 2020*, p 19; Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0021.
69 Transcript, Sydney Hearing 5, Nigel Murray, 18 September 2020 at T9431.18–26.
70 Submission of Health Services Union, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0011.0165.
71 Submission of Aged & Community Services Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0013.0102.
72 Submission of Aged & Community Services Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0013.0102.
73 Submission of Aged Care Crisis Inc, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0013.0184.
74 See, for example, Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9137.3–16; Transcript, Broome Hearing, Belinda Robinson, 18 June 2019 at T2141.29–36.
75 Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0052 [203].
76 Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0052 [207]–0053 [209].
77 Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0054 [212].
78 Submission of Glenn Bunney, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0016.0040.
79 See, for example, Transcript, Broome Hearing, Graham Aitken, 18 June 2019 at T2078.24–31; Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5778.1–34; Transcript, Adelaide Hearing 3, Katherine Ravenswood, 21 February 2020 at T7853.30–40.
80 Transcript, Sydney Hearing 5, Steven Kennedy, 18 September 2020 at T9390.44–47.
81 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9424.9–10.
82 Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9284.45–9285.2.
83 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9266.45–28.
84 Exhibit 21-3, Sydney Hearing 5, Statement of Michael Woods, RCD.9999.0465.0001 at 0017 [65].
85 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 77, WIT.1336.0001.0001 at 0022 [154]; tab 78, RCD.9999.0331.0001 at 0026 [72]; tab 79, RCD.9999.0330.0001 at 0010 [60]; Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0009 [58]; Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0007 [33]; Exhibit 21-20, Sydney Hearing 5, Statement of Ian Thorley, WIT.0776.0001.0001 at 0011 [72]; Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9573.41–9574.17; Transcript, Sydney Hearing 5, Cheyne Chalmers, 21 September 2020 at T9574.25–35; Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9598.25–31; Exhibit 21-21, Sydney Hearing 5, Statement of Jonathan Gavshon, WIT.1357.0001.0001 at 0015 [85g].
86 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9522.14–18.
87 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 82, RCD.9999.0359.0001 at 0016 [97].
88 Submissions of the Commonwealth of Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0014.0015 at 0019 [16].
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90 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9442.4–6.
91 Transcript, Final Hearing, Counsel Assisting, 23 October 2020, T9794.23–26
92 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9442. 6–8.
93 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9180.9–11; T9180.37–42.
94 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9234.14–15.
95 Exhibit 21-25, Sydney Hearing 5, Statement of Henry Cutler, RCD.9999.0380.0001 at 0011 [64].
96 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9573.41–9574.1.
97 Submission of Marie dela Rama, Response to Counsel Assisting's final submissions, 9 November 2020, RCD.0013.0007.0085.
98 Final Submissions of Counsel Assisting the Royal Commission, Final Hearing, 22 October 2020, RCD.9999.0541.0001 at 0377[1250].
99 Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0015.
100 See, for example, Transcript, Broome Hearing, Craig Barke, 17 June 2019 at T2018.23–32; Transcript, Mudgee Hearing, Dean Chesterman, 5 November 2019 at T6426.45–6427.2; Transcript, Mudgee Hearing, Margaret Denton, 6 November 2019 at T6537.12–18; Exhibit 12-15, Mudgee Hearing, Statement of Rachel Winterton, WIT.0589.0001.0001 at 0007 [26].
101 See, for example, Transcript, Melbourne Hearing 2, Nathan Klinge, 8 October 2019 at T5395.4–10; Transcript, Melbourne Hearing 2, Helen Radoslovich, 8 October 2019 at T5409.17–29; Transcript, Melbourne Hearing 2, Elizabeth Drozd, 10 October 2019 at T5642.35–41.
102 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9266.37–9267.6.

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105 Exhibit 21-11, Sydney Hearing 5, Statement of Kathleen Eagar, RCD.9999.0351.0001 at 0016 [97b].
106 Australian Nursing and Midwifery Federation, Public submission, AWF.600.02259.0001 at 0011 [56]; Submission of the Australian Nursing and Midwifery Federation, Response to Counsel Assisting's final submissions, RCD.0013.0013.0163 at 0169 [30].
107 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 21, RCD.9999.0401.0079 at 0098.
108 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9182.2–4.
109 Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0004 [19].
110 Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0004 [19].
111 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9522.28–9523.11.
112 Submission of Health Services Union, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0011.0165.
113 Submission of Health Services Union, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0011.0165.
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115 Victorian Government, Response to Counsel Assisting's final submissions, 13 November 2020, RCD.0013.0017.0012.
116 Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9286.28–30.
117 *Aged Care Act 1997* (Cth), s 52D-3.
118 *Aged Care Act 1997* (Cth), s 52C-4.
119 *Aged Care Act 1997* (Cth), s 95B-1.
120 Aged Care Pricing Commissioner, Public submission, AWF.600.01713.0001 at 0005.
121 D Tune, *Legislated Review of Aged Care 2017,* 2017, p 105 [6.74] (Exhibit 1-35, Adelaide Hearing 1, RCD.9999.0011.0746).
122 D Tune, *Legislated Review of Aged Care 2017,* 2017, p 83 [5.105] (Exhibit 1-35, Adelaide Hearing 1, RCD.9999.0011.0746).
123 D Tune, *Legislated Review of Aged Care 2017,* 2017, p 105 [6.80] (Exhibit 1-35, Adelaide Hearing 1, RCD.9999.0011.0746).
124 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 77, WIT.1336.0001.0001 at 0008 [62].
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126 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9330.28–9331.27.
127 *Aged Care Act 1997* (Cth), s 52G-2.
128 *Aged Care Act 1997* (Cth), s 52G-4.
129 Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9297.18–22.
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131 Submissions of Commonwealth of Australia, Response to Counsel Assisting's final submissions, 12 November 2020, RCD.0013.0014.0037.
132 Australian Department of Health, *Aged Care Financing Authority (ACFA)*, 2020, https://www.health.gov.au/committees-and-groups/aged-care-financing-authority-acfa, viewed 18 December 2020; Australian Department of Health and Ageing, *Living Longer. Living Better*. *Aged Care Reform Package – April 2012*, 2012, https://webarchive.nla.gov.au/awa/20130329024259/http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-acfa, viewed 18 December 2020.
133 *Committee Principles 2014* (Cth), s 6(1).
134 *Aged Care (Subsidy, Fees and Payments) Determination 2014* (Cth), s 51(4).
135 See the summary of these ratios produced by the Australian Department of Health: Australian Department of Health, *Responsibilities of residential aged care providers*, 2020, https://www.health.gov.au/initiatives-and-programs/residential-aged-care/responsibilities-of-residential-aged-care-providers#supported resident ratios, viewed 17 December 2020.
136 Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0006 [33].
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138 Exhibit 21-11, Sydney Hearing 5, Statement of Kathleen Eagar, RCD.9999.0351.0001 at 0005 [20].
139 Exhibit 21-25, Sydney Hearing 5, Statement of Henry Cutler, RCD.9999.0380.0001 at 0021 [110].
140 Exhibit 21-11, Sydney Hearing 5, Statement of Kathleen Eagar, RCD.9999.0351.0001 at 0005 [21]–[25]; 0006 [28].
141 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 69, RCD.9999.0347.0001 at 0005 [11].
142 See, for example, Exhibit 4-09, Broome Hearing, Statement of Ruth Crawford, WIT.0185.0001.0001 at 0013 [62].
143 Australian Department of Health, *Commonwealth Home Support Programme – Program Manual 2020-22, 2020,* pp 89–90, https://www.health.gov.au/sites/default/files/documents/2020/07/commonwealth-home-support-programme-chsp-manual.pdf, viewed on 18 December 2020.
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147 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9204 [57].
148 Exhibit 14-1, Canberra Hearing, general tender bundle, tab 67, RCD.9999.0279.0001 at 0005.

149 Exhibit 21-25, Sydney Hearing 5, Statement of Henry Cutler, RCD.9999.0380.0001 at 0023 [116].
150 Aged Care Financing Authority, *Report on respite for aged care recipients*, 2018, p 11 (Exhibit 7-1, Mildura Hearing, general tender bundle, tab 26, RCD.9999.0124.0102).
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18. Capital Financing for Residential Aged Care | Commissioner Pagone

By paragraphs (d) and (f) of our Terms of Reference we are required and authorised to inquire into:

> - what the Australian Government, aged care industry, Australian families and the wider community can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe…
> - how best to deliver aged care services in a sustainable way, including through innovative models of care, increased use of technology, and investment in the aged care workforce and capital infrastructure.[1]

Residential care will always remain a crucial part of the aged care system. Residential care is far more capital intensive than other forms of aged care. It requires ownership, or long-term rights of occupancy, of accessible land that is appropriately sited. The critical issues include that there is sufficient capital for the cost of infrastructure to provide high quality residential care. Allied to this will be the need to ensure that the system provides adequate returns on capital, but not excessive returns on capital, to encourage investment in high quality care. There are serious questions about whether the current design to promote capital financing strikes the appropriate balance between infrastructure investment for residential aged care and returns upon the investment needed. Amongst the questions raised in that context is whether the current arrangements insulates current providers from the rigours of the ordinary capital market and thus provides distorted returns.

Currently, residential aged care providers access capital to fund investment in residential aged care accommodation from four main sources:

- equity capital invested in residential aged care providers ($13.5 billion or 25.7% of total provider assets in 2018–19)
- debt capital as follows:
    - interest-free loans from residents receiving care through Refundable Accommodation Deposits ($30.2 billion, which represents liabilities corresponding to 57.4% of the value of total provider assets in 2018–19)
    - loans from banks ($2.1 billion, corresponding to 4.1% of total provider assets in 2018–19)
    - loans from related parties ($2.3 billion, corresponding to 4.4% of total provider assets in 2018–19)[2]
- capital from grants
- philanthropic donations.

The revenue that providers receive from providing accommodation must be appropriate to meet and service the costs of capital financing. These costs are not limited to the costs of establishing debt facilities and interest payable on debt financing: equity investors, too, will require a reasonable return on their investment.

Evaluating whether charging and funding arrangements for accommodation are appropriate to meet the cost of capital investment incurred by providers in accommodation is complicated by the fact that there are different arrangements for supported (and partially supported) residents, and for unsupported residents. Whether a resident is 'supported', 'partially supported' or 'unsupported' depends on a means test. The Australian Government pays all accommodation costs of a supported resident, some of the accommodation costs of a partially supported resident, and none of the accommodation costs of an unsupported residents. I expect that most aged care homes would have a mix of supported and unsupported residents, but that mix will vary. In my view, the amounts charged for each of these categories of resident should be appropriate in light of reasonable costs of capital investment of the accommodation they occupy.

The Accommodation Supplement sets the maximum amount of subsidy that the Australian Government will pay, and the price that may be charged for supported and partially supported residents. The Australian Government will pay all of the Accommodation Supplement for a supported resident, and part of it for a partially supported resident. The partially supported resident will contribute the balance, as determined by means testing. Elsewhere in this volume, we have explained our respective recommendations for the Pricing Authority to have responsibility for determining the Accommodation Supplement on the basis of its review of the costs of providing accommodation, a process that might involve consideration of models for the estimation of the Weighted Average Cost of Capital.[3] This should mean that the Accommodation Supplement will be well calibrated to provide an appropriate return on capital investment in accommodation assets.

Unsupported residents are subject to different arrangements, in which Refundable Accommodation Deposits play a prominent role. I am not proposing that the Pricing Authority should be given the responsibility for imposing price caps on the charges for accommodation of unsupported residents. Nor am I proposing a specific recommendation for change of the arrangements that apply to Refundable Accommodation Deposits. As mentioned in our separate chapters on funding the new aged care system, and as proposed in Recommendations 128.6 and 128.7, the only form of price regulation I recommend for accommodation charges for unsupported residents is, in essence, the continuation of the current arrangements. There should be a provisional price limit, defined as the 'Provisional Accommodation Charge Limit', that should be determined by the Pricing Authority from time to time, and it may be varied in specific cases on application to the Pricing Authority. Commissioner Briggs makes similar recommendations on this matter. Subject to this safeguard, it will essentially be left to each provider to propose accommodation charges to unsupported residents and for those residents to decide whether they wish to accept accommodation from that provider at that price, negotiate, or chose an alternative provider. In some locations, the ability to choose another provider will be constrained. In such places, the Pricing Authority may advise the implementation of measures, such as commissioning by direct grants.

18.1 Current arrangements

Equity

The Aged Care Financing Authority reported that as at 30 June 2019, the residential aged care sector had $13.5 billion in net assets (total assets minus total liabilities) or equity.[4] This equates to 25.7% of total assets. The levels of equity in residential aged care as a proportion of total assets varies significantly between providers, and by provider type. Equity was 34.7% of total assets for not-for-profit providers, but only 12.1% for for-profit providers.[5] This suggests that different parts of the sector tend to employ different capital structures, including different debt leveraging ratios, different levels of reliance on Refundable Accommodation Deposits and differences in distribution of profits.[6]

Loans and capital grants

As outlined earier in this chapter, loans from banks and other financial institutions are not currently a significant source of capital finance for residential aged care. Providers borrow slightly more from related parties within corporate group structures, and much more through interest-free loans from residents.

Approved providers and banks told us about the role that Refundable Accommodation Deposits play in supporting the development of new residential aged care facilities. They described a typical situation whereby approved providers use a combination of equity and bank debt to finance the initial construction of a residential aged care facility. However, the bank's expectation would be that the provider would repay the debt with incoming Refundable Accommodation Deposits as residents move in, and projected Refundable Accommodation Deposits are relevant to the approval of loans.[7]

The major banks also stated that, in general, approved providers operating multiple facilities, and predominantly in metropolitan areas, are lower risk and therefore more likely than other providers to satisfy lending criteria.[8] The Australian Government provides some capital grants to build or to upgrade residential aged care accommodation through the Rural, Regional and Other Special Needs Building Fund as part of the Aged Care Approvals Round. These grants are allocated in accordance with the *Aged Care Act 1997* (Cth) and the *Grant Principles 2014* (Cth).[9]

The 2018–19 Aged Care Approvals Round provided approximately $60 million in capital grants to 28 residential aged care facilities.[10] The average grant was $2.1 million. This figure represents about 1.1% of the $5.3 billion in building activity in 2018–19 reported by the Aged Care Financing Authority.[11] In Chapter 6: Aged Care Accommodation, we recommend the introduction of a new additional capital grants program for small household models of accommodation.

Refundable Accommodation Deposits

Refundable Accommodation Deposits, previously known as Accommodation Bonds, are lump sum deposits from residents to providers in return for accommodation. These lump sum deposits are refunded, less any deductions made under the Aged Care Act, on leaving residential aged care.[12] Refundable Accommodation Deposits act as an interest-free loan from people living in residential aged care to residential aged care providers, allowing providers to avoid other forms of financing and potentially significant interest costs.

Refundable Accommodation Deposits are a creature of Australian Government policy supported by legislation and a prudential regulatory framework. As far as I know, the prudential framework that has been set up around Refundable Accommodation Deposits is unique to residential aged care in Australia. We are not told of any other major sector of the Australian economy that has access to a potential source of interest-free loans from the consumers of their services under a government-imposed regulatory framework.

Refundable Accommodation Deposits are a significant source of funding for capital investment in residential care, corresponding in value to 57.4% of residential aged care providers' total assets.[13] At 30 June 2019, a total of $30.2 billion of Refundable Accommodation Deposits were held by providers. This equates to 94,870 Refundable Accommodation Deposits with an average value of $318,000. The average value of Refundable Accommodation Deposits has steadily increased over the last six years, with the total value of all accommodation deposits almost doubling since 2013–14.[14] This growth follows reforms included in the *Aged Care (Living Longer Living Better) Act 2013* (Cth), which commenced on 1 July 2014.[15]

The average values of both the published prices and agreed prices for new Refundable Accommodation Deposits have also increased over this period.[16] The average published and agreed price in metropolitan areas were significantly higher than in regional and remote areas.

The maximum amount of a Refundable Accommodation Deposit allowed to be charged is set by the responsible Minister. The current maximum amount is $550,000, which has not changed since July 2014.[17] Providers can apply to the Aged Care Pricing Commissioner for approval to charge a higher amount.[18] In 2018–19, the Aged Care Pricing Commissioner approved Refundable Accommodation Deposits in excess of $550,000 for 8117 rooms.[19]

Unsupported residents may choose to pay for all of their accommodation costs by providing a Refundable Accommodation Deposit, or part of those costs by a Refundable Accommodation Contribution, provided that the approved provider is satisfied that the resident will not be left with less than a prescribed minimum level of assessable assets, currently $50,500. [20] A partially supported resident may also choose to provide a Refundable Accommodation Contribution. If a person chooses to pay by Refundable Accommodation Deposit, payment is not required until six months after entry into residential aged care. Daily Accommodation Payments are charged until the Refundable Accommodation Deposit is paid.[21] A person may choose to pay a Refundable Accommodation Deposit at any time after entering into an accommodation agreement—for example, after a house sale is finalised.[22]

The use of the proceeds of Refundable Accommodation Deposits by providers is limited under the Aged Care Act. Permitted uses include for capital expenditure, investment in financial products, and making or repaying loans.[23]

Refundable Accommodation Deposits are guaranteed for residents by the Australian Government through the Accommodation Payment Guarantee Scheme.[24] This means that the Australian Government bears any financial risk from a provider becoming insolvent and being unable to refund the Refundable Accommodation Deposits of people living in its facilities. The Australian Government can place a levy on providers for the costs associated with the Accommodation Payment Guarantee Scheme. It has not done so.[25]

Daily Accommodation Payments

As noted above, as an alternative to a Refundable Accommodation Deposit, unsupported residents can choose to pay a Daily Accommodation Payment, or a combination of the two. In their current form, Daily Accommodation Payments were introduced as part of the Living Longer Living Better reforms. The Daily Accommodation Payment amount is derived from the agreed room price by using the Maximum Permissible Interest Rate based on the following legislatively prescribed formula.[26] This is:

$$DAP = RAD \times MPIR / 365$$

The Maximum Permissible Interest Rate for the period 1 January 2021 to 31 March 2021 September 2020 is 4.02%.[27] Changes in the Maximum Permissible Interest Rate are linked to the monthly average yield of 90-day Bank Accepted Bills published by the Reserve Bank of Australia.[28]

The Daily Accommodation Payment that an approved provider would receive is $35.02 per day based on the current Maximum Permissible Interest Rate, and the average value of a Residential Accommodation Deposit of $318,000. The Daily Accommodation Payment rises to $60.58 per day assuming the maximum value of a Residential Accommodation Deposit without seeking approval from the Aged Care Pricing Commissioner of $550,000.

18.2 Refundable Accommodation Deposits—pros and cons

Refundable Accommodation Deposits lower the cost of capital for residential aged care providers.[29] Refundable Accommodation Deposits appear to have supported the expansion of the residential aged care sector in recent years.[30]

Ms Julie-Anne Mizzi, Partner and Global Co-Head of Social Care at AMP Capital and a Board Member of Opal Aged Care, told us that Refundable Accommodation Deposits have been so successful in attracting capital that:

> accommodation is currently the only component on which aged care providers are able to earn a return, the aged care sector has effectively become a property industry rather than a care industry.[31]

Mr Paul Versteege, Combined Pensioners and Superannuants Association, told us that the introduction of Refundable Accommodation Deposits was a positive development. In his view, they allow older people to contribute to the cost of accommodation while preserving a significant asset that could be passed on.[32]

In contrast, Aged Care Crisis Inc. submitted that Refundable Accommodation Deposits are:

> unnecessarily complex, inequitable and cruel in the impact it has on the most vulnerable.[33]

Aged Care Crisis Inc. emphasised how decisions about accommodation payment arrangements are made by vulnerable people and their families in periods of great stress, and often with little time to consider appropriately all the options.[34] In combination with local shortages in availability of residential aged care, this vulnerability can lead to 'supra-competitive prices' being exacted through Refundable Accommodation Deposits.[35]

The Grattan Institute submitted that there is a power imbalance during payment negotiations between providers and incoming residents, and that providers have financial incentives for incoming residents to pay a Refundable Accommodation Deposit.[36] COTA Australia told us that providers use this power imbalance to pressure older people and their families into paying a Refundable Accommodation Deposit:

> Despite the fact that legally residents are required; to have free choice as to whether they pay by RAD or DAP or a combination, there are many providers that require a RAD or they will not accept the new resident. They may be informed that they have a choice but then then it will be made clear that a place in this facility is only possible if they pay a RAD. This pressure is inevitable when providers are over-dependent on RADs.[37]

This power imbalance may be exacerbated when older people and their families do not have sufficient knowledge about accommodation payment arrangements. Research undertaken for us by Ipsos concluded that the understanding of Refundable Accommodation Deposits among people accessing the aged care system is highly variable. Ipsos concluded that the level of funding required for a Refundable Accommodation Deposit was daunting for many who feared it would significantly reduce their available disposable income.[38]

Current challenges in attracting capital

In 2019, the Aged Care Financing Authority estimated that the combined total investment for new and rebuilt residential care places over the next decade will be about $55 billion.[39] The Association of Age Service Professionals have suggested to us that this estimate is excessive.[40] In contrast, Estia Health argued that, after factoring in the need to refinance or repay Refundable Accommodation Deposits and other debt, the sector will require access to up to $90 billion of capital in the next decade.[41]

Peak body Leading Age Services Australia told us that the feedback from its members was that it is becoming increasingly difficult to attract capital to invest in residential aged care. The factors they cited as impacting investor confidence in aged care were: a perception from investors that aged care is over-regulated and operating in an uncertain environment, declining profitability, and the highly fragmented nature of the industry. [42]

House prices, ability to pay, and occupancy levels

House prices, ability to pay, and occupancy levels were identified as key factors driving Refundable Accommodation Deposit values. Aged and Community Services Australia submitted that:

> The average prices of RADs paid in metropolitan areas is significantly higher than in regional and remote areas, reflecting differences in housing prices but it may also to some extent reflect RADs in regional and remote areas being based on what residents are able to pay rather than the value of the accommodation.[43]

Ms Mizzi explained that this was likely explained by residents choosing a residential aged care facility close to their former residence and family support networks, and the fact that most residents will pay a Refundable Accommodation Deposit by selling their former home. [44] She also explained the importance of occupancy for a provider's financial position:

> Based on current occupancy and care profit data, aged care providers need to operate at full or near-full occupancy in order to deliver an operating profit as noted by ACFA when they commented that 'a small decline in occupancy rates can have a significant impact on the financial results of providers.
>
> This is due to the high fixed costs for a home whereby small changes in the number of residents does not lead to any meaningful change in roster allocations of staffing. Over the last 3 years, there has been a steady decline in occupancy and correspondingly a steady decline in operating margin.[45]

Dr Linda Mellors from Regis Healthcare told us that financial advisors are taking advantage of providers' sensitivity to changes in occupancy levels by leveraging that to bargain for reductions in the Refundable Accommodation Deposit price.[46] For Mr Versteege this was a positive development, and he argued that providers should state the level of occupancy in a facility in order to assist incoming residents to question the Refundable Accommodation Deposit price.[47]

Daily Accommodation Payments are not equivalent

Professor Henry Cutler, Macquarie University Centre for the Health Economy, told us that Refundable Accommodation Deposits and Daily Accommodation Payments need to be economically equivalent for residents. If one is more expensive than the other, then this could distort older people's choices.[48]

As noted above, Refundable Accommodation Deposit values are converted to Daily Accommodation Payments using the Maximum Permissible Interest Rate, which is currently set at 4.02%.[49] In 2013, the Hon Mark Butler MP, then Minister for Mental Health and Ageing, requested advice from the Aged Care Financing Authority on whether the Maximum Permissible Interest Rate was appropriate for that purpose in the context of implementing the Living Longer, Living Better reforms. The Aged Care Financing Authority advised:

> a Weighted Average Cost of Capital (WACC) was inferior to the MPIR [Maximum Permissible Interest Rate] because:

- There is a wide divergence in WACC rates between providers, due to differences in operational efficiency (e.g. number and size of facilities), cost of debt, profit vs not-for-profit status, risk profile and relevance of WACC to actual investment decisions; and
- The use of differing rates between facilities in accommodation payment conversion may hamper pricing transparency. It is also likely to cause confusion for consumers and make it difficult to compare the relative value of each accommodation option. The MPIR has been used in aged care since 1997 and is specified in legislation as the 'conversion factor' to be applied when providers calculate an equivalent daily accommodation payment from an agreed bond amount. The MPIR is set three percentage points below the Australian Taxation Office's General Insurance Charge—a penalty rate applied by the ATO on outstanding debts—as it intends to keep parity with borrowing costs rather than exceed them.[50]

However, at the time that advice was given the Maximum Permissible Interest Rate was 6.95%.[51] At that level, the Daily Accommodation Payment for the current average Refundable Accommodation Deposit would be $60.55 per resident per day instead of the current $35.72, while for the maximum Refundable Accommodation Deposit value without needing to seek approval from the Aged Care Pricing Commissioner it would be $104.73 per resident per day instead of $61.78.[52]

We commissioned Frontier Economics to provide advice on the required rate of return for aged care service providers. In considering the use of the Maximum Permissible Interest Rate, they told us:

> this approach does not result in the RAD [Refundable Accommodation Deposit] and DAP [Daily Accommodation Payment] payments being economically equivalent. For the two payments to be economically equivalent, from the perspective of the provider, the MPIR [maximum permissible interest rate] would have to be set equal to the rate at which the provider would otherwise pay if the funds were borrowed on commercial terms.
>
> However, the rate of BAB [Bank Accepted Bill] plus 4% appears to be arbitrary, being based on the rate that is charged on the under-payment of taxation obligations. In our view, there is no reason to consider that the current specification of the MPIR bears any resemblance at all with the commercial borrowing rate that an aged care accommodation provider is likely to pay. In particular, the margin of 4% on top of the BAB rate is materially higher than the margin that would ordinarily be paid by an investment-grade borrower.[53]

We heard that the Maximum Permissible Interest Rate is no longer an appropriate basis for converting Refundable Accommodation Deposits to Daily Accommodation Payments from numerous residential aged care providers. Uniting NSW.ACT told us that in a low interest rate environment, a Refundable Accommodation Deposit does not produce the income equivalent of the Daily Accommodation Payment.[54] Mr Chris Mamarelis of the Whiddon Group told us that it is a 'broken model' that is incentivising a shift away from Refundable Accommodation Deposits.[55] Leading Age Services Australia submitted that 'equivalence would require the MPIR to be set at a rate representative of WACC [Weighted Average Cost of Capital]'.[56] Aged care providers Regis Healthcare and Estia Health both agreed that the Weighted Average Cost of Capital would be a more appropriate conversion rate between Refundable Accommodation Deposits and Daily Accommodation Payments.[57]

Reliance on Refundable Accommodation Deposits

Both approved providers and financial institutions gave evidence about the role of Refundable Accommodation Deposits in supporting the development of new residential aged care homes. The Australian and New Zealand Banking Group told us that Refundable Accommodation Deposits are 'fundamental' to aged care development lending.[58] Mr Chris Mamarelis, Chief Executive Officer of aged care provider the Whiddon Group, agreed. He told us that Refundable Accommodation Deposits are:

> extremely important. They're important in the context of a construction project which we have undertaken numerous of, in terms of raising capital to fund those projects, in raising capital for future projects as well. So they play a significant role in the aged care space, and in the profile of the aged care business.[59]

As noted above, currently bank lending is on the expectation of rapid repayment from the proceeds of Refundable Accommodation Deposits. Bank debt is typically repaid within three years of construction, effectively replaced by Refundable Accommodation Deposits in the capital structure.[60] This explains why bank loans only accounted for 4.1% of providers' total assets as at 30 June 2019. In contrast, Refundable Accommodation Deposits accounted for 57.4% of providers' total assets.[61]

A provider's ability to attract Refundable Accommodation Deposits is a key lending criterion applied by the banks.[62] This has implications for providers operating in areas that are unable to attract, or attract fewer, high value Refundable Accommodation Deposit paying residents, such as regional areas.

The National Australia Bank said:

> In general terms NAB considers providers operating in metropolitan areas to be lower risk than providers operating in regional, rural or remote areas, given metropolitan operators can generally attract higher RAD/DAP paying residents (in line with higher median house prices of metropolitan areas), have access to a larger resident catchment area, and can more readily attract and retain staff. Regional providers also have potentially diminishing future demand from their local population.[63]

As a result, the Refundable Accommodation Deposit model that providers rely on for funding new developments, and the way it interacts with banks' lending decisions, means that providers operating in regional areas are less able to access financing for developing new facilities.

Increasing use of Daily Accommodation Payments

The proportion of people choosing Daily Accommodation Payments or Daily Accommodation Contributions gradually increased from 33% in 2014-15 to 41% in 2018-19.[64] Of those making a payment or contribution toward their accommodation costs, there is a greater preference for Daily Accommodation Payments / Daily Accommodation Contributions in regional and remote areas compared with metropolitan areas.[65] Commenting on the increasing use of Daily Accommodation Payments, the Australian Treasury noted that:

> Providers will increasingly require new sources of capital and will have to adjust their business models in response to this change in preferences.[66]

This shift in the mix between Refundable Accommodation Deposits and Daily Accommodation Payments reflects older people exercising choice in how they contribute to their accommodation costs. However, this poses challenges for providers trying to make informed investment decisions. Leading Age Services Australia told us:

> Providers have limited control regarding a resident's accommodation choice and profile. Under current arrangements, providers are unsure if they are developing and operating a build to rent or build to sell model. This variability and uncertainty impacts the ability to make informed decisions for investments.[67]

Mr Sam Morris, Australia and New Zealand Banking Group, described the impact this shift would have on the sector:

> it is also important to the ongoing viability of the sector, given the large amount of RAD liability that does sit on an operator's balance sheet, and so there's two risks there: there's less liquidity available to a provider if that RAD/DAP mix would change, and, of course, you would see a reduction in bank appetite to fund new developments if those RADs weren't available as they had been in in the past.[68]

The Commonwealth Bank of Australia and National Australia Bank made similar points.[69]

Structural risks to providers' liquidity

Refundable Accommodation Deposits introduce structural risks for providers' liquidity, increasing the likelihood of insolvency events and threatening the continuity of care for residents. COTA Australia told us that:

> RADs are an unstable form of finance in that providers legally don't know whether a resident will pay by RAD or DAP so cannot guarantee that a RAD exit will be replaced by a RAD; and providers highly dependent on RADs are susceptible to a cluster of RAD losses in a short period (as COVID-19 in Victoria illustrates).[70]

These risks arise in situations where a provider is required to repay a Refundable Accommodation Deposit for a resident who leaves, but does not necessarily have an incoming Refundable Accommodation Deposit paying resident. Mr Ian Thorley, Chief Executive Officer of Estia Health, raised the possibility of this having sector-wide implications with us:

> A sector-wide, or nationwide event, such as a housing market fall, recession or a sentiment-driven or other change of accommodation payment preferences could result in a material reduction in the number and value of RADs being provided to the sector as more incoming residents opt to pay a DAP in preference to a RAD. If such a shift occurred across the whole sector to a degree of 10% then it could result in a capital shortfall of ~$3 billion.[71]

The potential for these risks to have system-wide implications has increased in the context of COVID-19's impact on the aged care sector, with older people being either unwilling or unable to enter residential aged care, further challenging occupancy. Mr Campbell Ansell, Managing Director of aged care consultancy Ansell Strategic, told us:

> We had been concerned that there was a migration away from residents electing to pay lump-sum deposits, RADS, in favour of periodic payments, DAPS. And we were concerned that this, over time, could place strain on the liquidity of the sector particularly given that a lot of the RADs were invested in bricks and mortar, the nursing homes themselves, and not a huge amount was necessarily held in cash. We then became more concerned that the onset of COVID might result in people finding it difficult to pay lump sums, difficult to sell their homes, or that they might be unwilling to divest or to liquidate their assets in the middle of a pandemic.
>
> And so our concern was that it would increase the movement away from lump-sum deposits in favour of periodic payments, and at the beginning of the process that was the main area that concerned us, that we might end up in a situation there might be a cash flow crisis while they were trying to deal with the infection.[72]

Based on trends observed in a sample of aged care providers, Ansell Strategic has estimated that COVID-19 will result in the residential aged care sector experiencing a net Refundable Accommodation Deposit outflow of approximately $2.6 billion by January 2021, representing 8% of all Refundable Accommodation Deposits.[73]

The Australian Government bears any financial risk from approved providers becoming insolvent and being unable to refund the Refundable Accommodation Deposits.[74] The Australian Government can pass on the cost of this guarantee to other residential aged care providers. Uniting NSW.ACT noted that providers have no way of mitigating against the management practices of the rest of the industry.[75] UnitingCare Australia has also questioned the Australian Government's commitment to the Accommodation Payment Guarantee Scheme.[76]

As a result, effective prudential oversight of Refundable Accommodation Deposits is important to maintain stability and confidence in the aged care industry.[77] However, a review conducted by EY Australia concluded that the data provided by providers to the Australian Department of Health is inadequate. There are deficiencies in disclosure and liquidity standards, and there are limited resources to conduct and adequately review and assess the compliance of providers with prudential standards.[78] We make recommendations about improving prudential regulation and financial oversight in our respective chapters on that topic.

Uniting NSW.ACT told us that ensuring the effective prudential management of Refundable Accommodation Deposits for providers at a steady state creates a substantial impost at current interest rates.[79] Dr Mellors expanded on this, linking the preferences for Refundable Accommodation Deposits or Daily Accommodation Payments to a provider's business strategy:

> To a large extent the preference of an Approved Provider will depend on their circumstances and business strategy. For example, an Approved Provider with little or no debt and no plans to building / extend facilities may prefer to receive DAP cashflow. The opposite would be true of an Approved Provider which plans to develop new facilities and use debt finance to support that strategy.[80]

Complacency and inefficiency

Regis Healthcare argued that Refundable Accommodation Deposits are an efficient source of capital for government and providers.[81] However, this view was disputed. For Professor Henry Ergas AO, former Professor of Infrastructure Economics at the University of Wollongong, there was no reason in principle to think that Refundable Accommodation Deposits are an efficient way to raise capital, as the opportunity cost to the older person of paying a Refundable Accommodation Deposit may well exceed the opportunity cost of the provider obtaining the funds from another source.[82] The Grattan Institute told us that this was likely to lead to undesirable overinvestment in residential aged care, particularly in light of the preference of older people to remain in their own home:

> The vast majority of older Australians want to receive care at home, rather than in a residential care facility. Yet the current financing model encourages a growing residential aged care sector. The interest-free financing for residential care providers encourages reinvestment of these funds into yet more residential care infrastructure.
>
> As home-based care increases, demand for residential care will fall. The upshot is more investment in residential aged care than the community needs. Some of this will be wasteful investment in underutilised facilities. The over-investment in residential care, driven by low-interest RADs, is thus an economically inefficient use of resources.[83]

18.3 Future reform

Refundable Accommodation Deposits have played an important role in funding residential aged care accommodation, facilitating significant investment in the sector. However, the sector has become reliant on them to the detriment both of approved providers and the older people those approved providers serve. My view, in light of the evidence outlined, is that:

- Refundable Accommodation Deposits and Daily Accommodation Payments are not economically equivalent, creating incentives for providers and older people to prefer one over the other, depending on changes in the Maximum Permissible Interest Rate
- the sustainability of the Refundable Accommodation Deposit model is questionable in light of the trend of people electing to pay Daily Accommodation Payments, making it harder for providers to attract replacement funds when required to repay Refundable Accommodation Deposits
- Refundable Accommodation Deposits are not particularly reliable as a capital financing mechanism for particular segments of the aged care sector, such as providers operating in regional, rural and remote areas
- heavy reliance on Refundable Accommodation Deposits introduces risks to the liquidity of providers and that an event like COVID-19 has the potential to exacerbate this, given the pressure it puts on providers' occupancy rates and the unpredictability it generates about property market outcomes
- Refundable Accommodation Deposits exacerbate the potential for inefficient investment.

As a result, I believe that in the longer term, Refundable Accommodation Deposits should be phased out. In the future aged care system, generally speaking, approved providers of residential care should be subject to the usual disciplines and rigours of the capital markets. However, there will always be a role for government in supporting specific investments in targeted forms of accommodation, in targeted areas, or for particular needs groups. The levers available for these purposes include capital grants and loadings on recurrent funding.

Some providers have indicated their resistance to such a move. For example, Leading Age Services Australia said that its members recommend addressing a range of short-term challenges before fundamentally changing how accommodation is funded.[84] Regis Healthcare told us it is 'strongly opposed' to the phasing out of Refundable Accommodation Deposits.[85]

In contrast, a number of stakeholders expressed their support for reducing the sector's reliance on Refundable Accommodation Deposits. For example, COTA Australia submitted that it believes they 'should play a much reduced role in future aged care financing'.[86]

Aged Care Crisis Inc. told us:

> RADs should be phased out. DAPs should be tied to the reasonable rental costs of the equivalent rooms and type of facilities in the area including maintenance. They should not cover major capital investments. If paying DAPs over a long period will cause hardship or a major disruption, then a HECS style funding loan would be sensible.[87]

The Association of Age Service Professionals suggested an alternative to the reliance on Refundable Accommodation Deposits:

> 1) A gradual reduction in RAD lump sums held by providers over a given period (around 8 years, allowing for a progressive plan to not damage the industry)
>
> 2) That DAP become a standard method of paying for accommodation,
>
> 3) That, based on banks requiring a cashflow servicing criteria, the current method calculating the MPIR [maximum permissible interest rate]…be amended to reflect a rate by which banks would approve loan applications (together with other risk criteria)
>
> 4) That a resident when paying a DAP for a specific room cost, have the value of that room accommodation as an [exempt] asset for the purpose of age pension assessment.[88]

The idea of Daily Accommodation Payments becoming the standard method of paying for accommodation was also supported by others, including the Grattan Institute and MyCDC, which offers a care management system to facilitate the provision of consumer directed care.[89]

In response to a call for submissions on capital financing, Estia Health suggested the establishment of a centrally managed pool of funds that would facilitate choice for both older people in residential aged care over how they paid for their accommodation, and for providers in how they are paid for that accommodation.[90] UnitingCare suggested that the Australian Affordable Housing Bond Aggregator would be a model for raising capital that could be applied to residential aged care.[91] Ansell Strategic submitted that an annuity product could be used to fund residents' contributions toward the cost of their accommodation, preserving the option for older people to pay a lump sum upfront where that was advantageous for pension means testing purposes.[92]

My preliminary view is that, on phasing out Refundable Accommodation Deposits, the simplest approach would be for unsupported residents to make rent-like payments similar to the current Daily Accommodation Payment. A key advantage of this approach is that more consistent arrangements for accommodation funding would then apply for both supported and unsupported residents. In both cases, providers would receive a regular income stream that could be used to inform investment decisions and secure finance from lenders.

I consider that it would be necessary for the Australian Government to implement a transitional mechanism supporting provider liquidity and viability while the sector transitions away from Refundable Accommodation Deposits.

Mr Mamarelis highlighted the difficulties that would be involved in phasing out Refundable Accommodation Deposits:

> I think one problem is that it's extremely difficult to undo where we're at at the moment, so rather than try to undo it we need mechanisms to reinforce it and support it and build more confidence into it, particularly when we're facing economic shock and things that we're facing today.[93]

Respondents to our call for submissions overwhelmingly said that such a transition would need to be carefully planned and managed, and that providers should be closely consulted on how this should occur and allow sufficient lead times to plan the transition.[94] COTA Australia submitted that:

> There needs to be a transition strategy to reduce the proportion of capital in the form of RADs. However, to stop any new RADs next year and grandparent the rest is likely to be too drastic. The key question is from where is substitute capital financing going to come?[95]

The Australia and New Zealand Banking Group told us that the general considerations for transitioning the accommodation funding arrangements would be:

- Development of the transition in consultation with the sector and its capital providers.
- Provision of significant lead times and transition periods to allow industry participants to plan appropriately.[96]

I agree. This transition would have a significant impact on the operations of providers, capital structures and financial viability. It is only appropriate that all affected stakeholders have an opportunity to input into the transition process. Aged and Community Services Australia told us that:

> Suggested elements of a transition plan include:
>
> - Undertaking a regulatory impact analysis of any proposed changes to capital financing arrangements, including addressing the fundamental question of why reform is required (i.e. what is the problem that needs to be solved)? Impact analysis must involve open consultation.
> - Any proposed changes to financing arrangements must require benefits to be quantified as far as possible and where appropriate, options compared.
> - Unintended consequences should be identified and addressed.
> - Any interim measures required to support the transition; and
> - Setting reasonable transition timeframes.
>
> Consideration should be given to whether interim measures are required to support providers until a new capital financing model is developed and in place.[97]

The Grattan Institute told us that without Refundable Accommodation Deposits, new forms of Government support for capital financing would be required. In the absence of Refundable Accommodation Deposits, it said:

> the financing problem may become too little capital rather than too much. Government should recognise this market failure with capital support through loan guarantees. The new capital financing model should recognise that residential aged care is part of the social infrastructure, and so government funding should be available to facilitate capital developments of both for-profit and not-for-profit providers.
>
> Government should create a financing facility to fund capital investment in residential aged care -including land and buildings - through concessional loans, where the facility's funds are raised through government bonds. Providers should be able to apply to the facility for capital grants, which would finance new facilities, facility upgrades, and repayment of RADs (to enable a smooth transition to the new model).[98]

The Grattan Institute went on to describe the transition mechanisms that would be required:

> RADs should be phased out as residents die or move to a different facility. The government financing pool should be made immediately available so that providers can begin making applications for financing where needed as RADs are phased out.
>
> At the same time, all new residents to residential care facilities should make rental payments.
>
> The financing pool must be large enough to retire existing RADs as residents leave residential aged care. This sets the minimum size of the fund at $30.2 billion (the current stock of RADs). This figure does not represent an increase in risk for the government, since RADs are already guaranteed by the Commonwealth. Nor does it represent an increased interest or long-term debt burden, because residents' rental payments will fully cover the government's costs.[99]

Importantly, the merits of phasing out Refundable Accommodation Deposits should not be judged in isolation of other reforms we have proposed. In particular, it would be important that the Australian Government allows a period for the implementation of higher staffing levels in residential aged care and the independent determination by the Pricing Authority of the prices of aged care services and of the Accommodation Supplement and Provisional Accommodation Charge Limit before considering the potential advantages and disadvantages of phasing out Refundable Accommodation Deposits. This would allow for any initial instability caused by the other reforms to be resolved before turning to the question of Refundable Accommodation Deposits.

Development of a suitable transitional mechanism would be integral to this reform. While there are various options for the transition and many details that would need to be finalised, I am inclined to support the Grattan Institute's proposal and urge the Australian Government to give it serious consideration when the time comes. A transitional mechanism along those lines would have three key components:

- First, it would be necessary to determine and publish the date from which the new accommodation funding arrangements would apply, with accommodation funding arrangements for existing residents as at that date to be preserved (that is, to continue in effect on their existing terms). Residents entering residential aged care from that date would be required to make rent-like payments when contributing to their accommodation costs, in line with Recommendation 128 on fees for residential aged care accommodation.
- Second, in the absence of new residents providing fresh Refundable Accommodation Deposits, providers will need an alternative source of finance to refund the Refundable Accommodation Deposits of existing residents as they leave. An Australian Government-backed temporary loan facility could be established for this purpose. This loan facility should be targeted, time-limited, and limited to maintaining liquidity for the purpose of repaying Refundable Accommodation Deposits until such time as the provider can establish a loan facility with a financial institution. Interest on any loans under this facility should be charged at commercial rates.
- Third, there would have to be a source or sources for providers to continue to access the money needed to construct new, and upgrade existing, residential aged care facilities. While there may be some scope for targeted capital grants, these will not be sufficient. Phasing out Refundable Accommodation Deposits is likely to disrupt the ability of at least some providers to proceed with capital expenditure, and there is a case for the Australian Government to provide loan guarantees during this transition period. This will give providers and financial institutions time to adjust to the absence of Refundable Accommodation Deposits. Presumably, any such loan guarantee would not be granted without close scrutiny leading to approval of a thorough business case. Like the temporary loan facility described above, Australian Government loan guarantees should not become a permanent feature of the capital financing for residential aged care facilities. Rather, this would be at most a temporary transitional measure to ensure continued development of residential aged care facilities while providers and financial institutions adjust to and develop confidence in the new capital financing arrangements.

Endnotes

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2 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, pp 88, 97 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).
3 See Recommendation 6, in which Commissioner Pagone recommends the establishment of the Aged Care Pricing Authority, and Recommendation 11, in which Commissioner Briggs recommends the conferral of expanded functions on a newly renamed Independent Hospital and Aged Care Pricing Authority. In this chapter, 'Pricing Authority' refers to whichever of these two alternatives is adopted by the Australian Government.
4 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, p 97 [Table 7.5] (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).
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16 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, p 93 [Chart 7.7] (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).
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18 *Aged Care Act 1997* (Cth), s 52G-4.
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19. Prudential Regulation and Financial Oversight | Commissioner Pagone

19.1 Introduction

A rigorous system of prudential regulation and financial oversight of service providers should be a critical component of the Australian Government's oversight of the aged care sector. Effective financial oversight provides protection for the taxpayer's investment in aged care services and a means of identifying potential risks to the quality and safety of care.

The concept of 'prudential regulation' is well known in Australia's financial system. It has been described by the Australian Prudential Regulation Authority as 'a legal framework focused on the financial safety and stability of institutions and the broader financial system', primarily designed to 'prevent problems emerging, rather than providing a means to take action after harm is caused'.[1]

In aged care, prudential regulation is concerned with ensuring the financial stability of providers. The financial stability of providers is crucial to continuity of the essential services they provide and their ability to provide those services safely and to a high quality. In addition, most residential care providers hold loans from residents in the form of Refundable Accommodation Deposits, which total about $30.2 billion across the sector.[2] The repayment of Refundable Accommodation Deposits is guaranteed by the Australian Government.

In August 2019, Commissioners Briggs and Tracey heard evidence of the severe impact on aged care residents and their families caused by the sudden cessation of services at a residential aged care facility located in the Earle Haven Retirement Village on the Gold Coast, due to a commercial dispute between the approved provider and a contracted management company. Since then, amongst all its other impacts on aged care, COVID-19 has posed significant financial challenges to the aged care system.

Prudential regulation and financial oversight in aged care should be consistent with best practice in other sectors where there is prudential oversight. It should be able to identify and respond appropriately to risks presented in the financial management and performance of particular approved providers and in the aged care sector as a whole. It should be responsive to changes in operating conditions in the aged care sector, to accounting standards and to innovations in financial and prudential oversight.

Effective prudential regulation and financial risk monitoring should complement effective monitoring of the quality and safety of aged care. It should involve an appropriate balance between the administrative burden and the need to mitigate financial risk, through the development and refinement over time of reasonable safeguards and transparency over providers' financial management.

The recommendations in this chapter outline the elements of a new prudential regulation and financial oversight framework, guiding principles for its refinement over time, certain statutory duties directly binding on providers, enhanced regulatory powers, and measures to improve regulatory capability. I first outline the existing arrangements and then address the case for reform of prudential regulation and financial oversight in aged care.

19.2 Existing prudential regulation and financial oversight

Current arrangements for prudential regulation and financial oversight are primarily focused on the risk attaching to management of Refundable Accommodation Deposits—and, as they were known until 1 July 2014, accommodation bonds—that some residents pay to providers on entry into residential care.[3] Refundable Accommodation Deposits must be returned to residents, or their estates, when they leave residential aged care, less any amounts deducted by agreement.[4] The existence of Refundable Accommodation Deposits is not the only reason for prudential regulation of aged care providers. The financial collapse of an aged care home is likely to impact adversely on the health, finances and wellbeing of older people who live in that home. One deficiency of the current prudential arrangements is in being more concerned with the financial risks of collapse than with the impact upon quality of care.

Home care providers also provide essential human services substantially funded by the Australian Government. This justifies a reasonable degree of monitoring of emerging financial risks, in the interests of the people in their care. Further, under current arrangements, home care providers hold unspent Home Care Package funds. However, the prudential requirements for home care providers are relatively weak.

Providers are subject to financial reporting obligations and, depending on the type of provider, must submit certain annual reports by 31 October each year. All approved providers must complete an Aged Care Financial Report.[5] For an approved provider of residential care that held a Refundable Accommodation Deposit, accommodation bond or entry contribution during the reporting year, the Aged Care Financial Report must include an Annual Prudential Compliance Statement.[6] That statement requires such providers to disclose certain information about accommodation payments.[7]

Non-government providers of one or more residential care services must also complete and submit to the Secretary a General Purpose Financial Report.[8] The General Purpose Financial Report (sometimes referred to as a General Purpose Financial Statement in the evidence) must be independently audited and provide 'a true and fair view of the financial position and performance of the approved provider'.[9] Home care providers are also required to submit an Aged Care Financial Report, but are only required to complete the Home Care Income and Expenses Statement section of that report.[10]

The key elements of the prudential regulation of providers of residential and flexible care are four 'Prudential Standards' imposed by delegated legislation under the *Aged Care Act 1997* (Cth).[11] These are:

- Liquidity Standard—directed to the protection of refundable deposit balances, accommodation bond balances and entry contribution balances of people receiving care
- Records Standard—directed to the sound financial management of providers
- Governance Standard—directed to arrangements by providers for the management of refundable deposit balances and accommodation bond balances
- Disclosure Standard—directed to the provision of information about the financial management of providers.[12]

The Liquidity Standard requires providers to establish and maintain a written liquidity management strategy that sets out the amount that they determine to be required to ensure they have sufficient liquidity to be able to repay Refundable Accommodation Deposits or accommodation bond balances or entry contribution balances that they expect will fall due in the following 12 months.[13]

The four Prudential Standards have various gaps and limitations. There is no capital adequacy requirement under the Prudential Standards. The Disclosure Standard does not require providers to disclose matters that may affect their financial viability. The Governance Standard does not include an obligation on providers to identify risks or to say how they will be mitigated. As to the Records Standard, under the Australian Accounting Standards the General Purpose Financial Report requirements differ between Tier 1 (private sector for-profit entities with public accountability) and Tier 2 entities (most privately held entities and all not-for-profits), with reduced disclosure requirements for the latter.[14] The vast majority of providers are not publicly accountable and report at the Tier 2 level.[15]

In the insurance context, prudential standards are independently set by the relevant prudential regulator rather than by the Australian Government.[16] The current Prudential Standards do not provide a sufficient regulatory framework to enable the regulator to identify adequately the prudential risk and to determine the financial viability of providers. Even more importantly, the Prudential Standards do not focus on ensuring the continuity of care of people receiving aged care services.

The Australian Department of Health also uses the information provided in the financial reports to undertake a 'first pass' risk assessment to identify those providers considered most at risk of non-compliance with the prudential requirements and most likely to be unable to refund Refundable Accommodation Deposits when they fall due. A risk rating, from 'low' to 'severe', is based on 'the assessment of a provider's operating performance, financial position, and metrics relating to prudential standards legislation'.[17] In February 2020, the assessment of 2018–19 financial year data determined that of approximately 871 non-government residential care providers:

(a) 75 were categorised as having a 'severe' risk rating

(b) 107 were categorised as having a 'high' risk rating

(c) 346 were categorised as having a 'moderate' or 'moderate / low' risk rating

(d) 324 were categorised as having a 'low' risk rating

(e) 19 were categorised as 'incomplete' due to insufficient data to make a risk assessment.[18]

Non-compliance with the Prudential Standards can be addressed by a range of actions, including: education; administrative compliance activities, such as increased monitoring; and regulatory compliance activities, such as inspections, investigations and sanctions. A provider that is a corporation commits an offence if it uses a Refundable Accommodation Deposit or accommodation bond for non-permitted purposes and in the two years prior to the use of the deposit, an insolvent event occurred and there was a least one outstanding accommodation payment balance.[19]

Similarly, an individual who is one of the key personnel of an approved provider corporation commits an offence where the corporation uses the Refundable Accommodation Deposit or accommodation bond for non-permitted purposes, and the individual knows, or is reckless or negligent as to the use of the deposit or bond, is in a position to influence the conduct of the provider and fails to take all reasonable steps to prevent the use of the deposit or bond.[20] Significantly, there is no ability or power on the part of the Aged Care Quality and Safety Commission to impose liquidity or capital adequacy requirements.

Recent reviews have supported the need for clear and enforceable liquidity and capital adequacy ratios, although different approaches have been recommended. I consider that liquidity and capital adequacy requirements, when properly imposed and based on the specific characteristics of aged care providers, will strengthen the prudential regulation framework and enable the Prudential Regulator, to identify prudential risks proactively.

19.3 Evidence base for reform of prudential arrangements

The evidence we received indicates to me that the current prudential arrangements in aged care can be improved. Mr Jaye Smith, First Assistant Secretary, Australian Department of Health, accepted that a purpose of prudential regulation is to prevent issues arising that would impede the quality of care delivered to older people.[21] Mr Smith summarised the position of the Department and the Australian Government on existing arrangements for the prudential regulation of the aged care system in the following terms:

> I would say that the Australian Government and then the Department [of Health] has absolutely accepted that the prudential framework is not currently fit for purpose, that it requires fundamental reform to make sure that it can meet contemporary needs in the system.[22]

Multiple reviews of the prudential regulatory function have been carried out for the Australian Government in recent years, including by EY Australia (*Review of Aged Care Legislation which provides for the regulation of Refundable Accommodation Payments in residential aged care*), Mr David Tune AO PSM (*Legislated Review of Aged Care 2017*), Deloitte Global (*Implementation Options Review: Managing Prudential Risk in Residential Aged Care*) and Ms Kate Carnell AO (*Inquiry into Events at Earle Haven*).[23] In 2017, EY Australia found that the Prudential Standards and the Liquidity Standard focus on an approved provider's ability to repay the Accommodation Payments which may fall due in the next 12 months and do not take account of the financial viability of the approved provider.[24] In 2019, the Earle Haven Inquiry made a number of recommendations relating to prudential regulation, each of which is supported by the Australian Government.[25] Recommendation 6 of the Earle Haven Inquiry called for the finalisation of prudential reforms 'as a matter of priority'.[26]

In the 2018–19 Budget, the Australian Government allocated funds to improve the management of prudential risk in residential aged care facilities. The Australian Government has undertaken a number of steps to enhance the existing prudential regulatory framework as proposed in the 2018–19 Budget, including:

- engaging StewartBrown to design amendments to the Aged Care Financial Report[27]
- commissioning Mr Gary Barnier, Aged Care Financing Authority, to undertake a project to review the Australian Department of Health's financial analysis processes and activities[28]
- conducting a Prudential Standards Review between 1 February 2019 and 15 March 2019, following the release of the Australian Department of Health's *Managing Prudential Risk in Residential Aged Care* discussion paper.[29]

Mr Chris Mamarelis, Chief Executive Officer of aged care provider the Whiddon Group, criticised the current prudential system as being overly reactive, particularly in terms of assessing the liquidity of providers. He described the risk of this reactive approach in the context of repayment of accommodation lump sums as 'a house of cards, a $30 billion house of cards that we are sitting on'.[30]

Mr Barnier's report to the Australian Department of Health, dated 25 February 2020, demonstrated the extent of prudential risk.[31] In that report, he indicated that nearly one-third of providers were either suffering or would soon suffer severe financial stress. There were approximately 229 providers in this category, representing 37,000 operating places and $5.3 billion in Refundable Accommodation Deposits. Mr Barnier defined 'severe financial stress' as providers that had an EBITDA (earnings before interest, taxes, depreciation, and amortization) of less than 4%.[32] Mr Barnier's analysis determined that 67 providers were experiencing immediate or imminent financial stress requiring close scrutiny and that 46 providers required immediate interventions. Identifying and working closely with high-risk providers well before they fail is the best way to minimise resident and community disruption.[33] He stated that the Australian Government was not currently set up to do this task.[34]

Despite the consistent call for stronger prudential regulation and financial reporting arrangements in aged care, there has been limited prudential reform to date. That said, submissions from the Australian Government supported strengthening prudential arrangements in aged care.[35] Witnesses for the Australian Department of Health and the Aged Care Quality and Safety Commission also supported greater tools for the Prudential Regulator to enforce prudential requirements.[36]

19.4 Improved prudential regulation

Recommendation 130: Responsibility for prudential regulation

1. **From 1 July 2023, the System Governor should be given by statute the role of the Prudential Regulator for aged care with responsibility for ensuring that, under all reasonable circumstances, providers of aged care have the ongoing financial capacity to deliver high quality care and meet their obligations to repay accommodation lump sums as and when the need arises.**
2. **The System Governor should also be given by statute the role of developing and implementing an effective financial reporting framework for the aged care sector that complements the purposes of the prudential standards.**

If my recommendation to establish the Australian Aged Care Commission is implemented, that body should be the Prudential Regulator. Alternatively, if Commissioner Brigg's recommendation for the establishment of a Department of Health and Aged Care to exercise system governance functions is implemented, that Department should be the Prudential Regulator. In either case, the System Governor will have the role of Prudential Regulator.

The prudential and financial reporting objectives of the Prudential Regulator should be to provide proactive, effective, risk-based and timely oversight of the financial sustainability of all providers. That oversight should be for the purpose of:

- identifying providers that are at risk of not having the financial capacity to repay their financial obligations and provide ongoing and high quality care to older people
- informing any remedial action by the prudential and quality regulators.

The new system of prudential regulation should apply to all providers of aged care services, including providers of home care.

In the case of providers who hold Refundable Accommodation Deposits, the purpose should be to ensure that these funds are:

- only used for permissible purposes
- able to be repaid as and when required.

It follows that the responsibilities of the Prudential Regulator should include establishing and enforcing:

- prudential standards and corresponding prudential guidelines that meet these objectives
- a financial reporting framework that involves the collection of financial information, primarily from providers, that is targeted at these objectives.

The Prudential Regulator should seek to identify prudential risks proactively and take action to prevent harm before it occurs. In doing so, it should undertake the following functions:

- effective monitoring and analysis of information received under providers' continuous disclosure obligations
- continuous monitoring of the ongoing financial sustainability and performance of providers
- sharing of information with other parts of the aged care institutional framework, including the quality and safety regulatory function and complaints-handling function
- the use of prudential and financial information to inform the evaluation of the financial risk profiles of providers
- selective interventions where required to manage financial risk in the system and safeguard the interests of people receiving aged care services
- agile use of enhanced information-gathering powers
- oversight of financial and commercial arrangements that have the potential to affect continuity of care.

If the Australian Aged Care Commission undertakes the prudential regulation and financial oversight function, as I recommend, the responsibilities for prudential oversight and financial reporting will be reposed in the Quality Commissioner as outlined in Recommendation 5.

Development of this framework will be critical during the period of reform and transition to the new aged care system described in this report.

Recommendation 131: Establishment of prudential standards

From 1 July 2023, the Prudential Regulator should be empowered under statute to make and enforce standards relating to prudential matters that must be complied with by approved providers, relating to:

a. the conduct of the affairs of providers in such a way as to:

i. ensure that they remain in a sound financial position, and

ii. ensure continuity of care in the aged care system, or

b. the conduct of the affairs of approved providers with integrity, prudence and professional skill.

The Prudential Regulator should have the power to set and enforce prudential standards for all providers. Those standards should encompass each of the elements of the current Prudential Standards—liquidity, governance, record keeping and disclosure—but go further.

The new prudential standards should address the deficiencies of the current Prudential Standards outlined above and ensure that the Prudential Regulator has sufficient information to assess the financial viability of providers and ensure continuity of care for people receiving aged care services. The Prudential Regulator should be able to impose further prudential standards as it sees fit, having regard to the purposes outlined above. This is likely to mean that different standards will apply in different contexts within the sector, depending upon the location, size, performance and regulatory history of particular providers.

19.5 Improved liquidity and capital adequacy requirements

Recommendation 132: Liquidity and capital adequacy requirements

From 1 July 2023, the Prudential Regulator should be empowered under statute to impose liquidity and capital adequacy requirements on approved providers, for the purpose of identifying and managing risks relating to whether:

a. providers have the financial viability to deliver ongoing high quality care

b. providers of residential care services that hold Refundable Accommodation Deposits are able to repay those deposits promptly as and when required.

19.5.1 Liquidity requirements

In its *Managing Prudential Risk in Residential Aged Care* discussion paper, the Australian Department of Health referred to key options recommended in recent reviews. This included that a provider must maintain a prescribed percentage of liquid assets—for example, 10% of the value of lump sum accommodation payments held.[37] This proposal adopts a recommendation made in the review undertaken by EY Australia that the Liquidity Standard should be redefined, with the following three options to achieve this:

- setting the liquidity threshold as a defined percentage of accommodation payment money held by a provider group
- phase in the defined threshold over a period of 5–10-years—for example, require 5% within five years and 10% within 10 years
- define the form of liquidity as real liquid or accessible funds being a combination of unpledged/unencumbered cash in the bank, a bank facility (such as an overdraft or line of credit), or money that can otherwise be accessed immediately.[38]

In its 2019 *Implementation Options Review*, Deloitte Global expressed similar views, and noted that there was 'room for improvement within the aged care legislation' in relation to liquidity management requirements.[39] It proposed three options:

- tiered liquidity threshold requirements based on a standard and advanced approach, where the standard approach required providers to maintain 35% minimum liquidity of Refundable Accommodation Deposit balances held and the advanced approach allowed providers to maintain an alternative or lower liquidity requirement where appropriate
- defined acceptable forms of liquidity
- phased roll-out of liquidity requirements.[40]

Deloitte Global recommended a liquidity level of 35% of Refundable Accommodation Deposits, but the StewartBrown Prudential Framework Review recommended a level set at 15% of total debt.[41] StewartBrown said that because many providers have a variety of operating segments, to consider only Refundable Accommodation Deposits in calculations of liquidity ratios may create a misleading picture of the provider's position. Consequently, StewartBrown recommended that liquidity be assessed against all debts at the provider level.[42] Mr Grant Corderoy, Senior Partner, StewartBrown, further recommended that the Annual Prudential Compliance Statement be amended to include questions relating to provider liquidity levels.[43]

To date, the focus on liquidity has been on the risk surrounding Refundable Accommodation Deposits held by residential care providers. However, liquidity requirements are also important for providers of home care services, particularly in circumstances where many older people prefer to remain at home for as long as possible. StewartBrown told us there are:

> no prudential requirements in respect of unspent funds relating to Home Care Packages or unspent funding relating to In-Home Support programs (CHSP). The exact amount outstanding under these programs is not currently known, but the balance unspent in relation to HCP is expected to exceed $700 million at 30 June 2019. These are funds that will need to be returned to Government or to the care recipient (or their estate) should they leave the home care system.[44]

The Earle Haven Inquiry report supported the introduction of specific liquidity requirements and also recommended that providers be required to assess their liquidity and ability to continue as a going concern on a quarterly basis.[45] Mr Nigel Murray of the Australian Department of Health told us that a specific liquidity requirement would assist the Department to assess provider risk, and that the regulator should have discretion to alter this in certain circumstances.[46]

Mr Bernard Gastin, Registrar of Housing Agencies, Victorian Housing Registrar, outlined a risk-based approach to liquidity. He said that the Victorian Housing Registrar determines liquidity and capital adequacy requirements for individual agencies based on several factors, including financial ratios, funding streams and associated financial risks.[47]

Ultimately, these are all matters that should be determined by the regulator. For this reason, I do not specify in this report what the particular liquidity ratio should be. However, the Prudential Regulator should be empowered to impose liquidity requirements on all providers subject to appropriate differences based on the type of aged care services provided, size and other variances.

It follows that, without limiting the manner in which the Prudential Regulator may impose liquidity requirements, that it may require providers to:

- obtain and submit annual certification by an independent auditor that the provider is able to meet its financial liabilities, including Refundable Accommodation Deposits, likely to become due and payable in the next 12-month period
- maintain a particular ratio of liquid assets to financial liabilities, including Refundable Accommodation Deposits, in excess of a specified ratio (liquidity threshold) and to notify the Prudential Regulator within a specified time if that liquidity threshold is infringed.

Consistent with a risk-responsive approach to regulation, the liquidity ratio may differ between providers. Therefore, the Prudential Regulator should be empowered to apply risk-adjusted liquidity requirements to providers, pursuant to guiding statutory principles. The Prudential Regulator should determine the liquidity thresholds and criteria on a basis that strikes a balance between the risk of providers defaulting on their obligations and the capital requirements of the providers' operations necessary for the provision of high quality aged care services. For example, the criteria may involve an assessment of:

- the provider's financial risk, balance sheet strength and financial viability
- the nature of the provider's services—that is, residential care only, home care only or residential care combined with other services
- the provider's business strategies and direction, including capital requirements
- the size of their financial liabilities, if any.

Where liquidity thresholds are proposed, there will be a need for a transition pathway that enables providers to take the necessary action to meet a higher liquidity threshold without affecting the continuity of aged care services.

19.5.2 Capital adequacy requirements

Capital adequacy refers to the amount of capital, or assets, that a provider has compared to its liabilities. Capital adequacy requirements may complement liquidity requirements as a means of identifying providers who may not have the financial capacity to deliver ongoing high quality care. Further, capital adequacy requirements should ensure that Refundable Accommodation Deposits are repaid without recourse to the Aged Care Accommodation Payment Guarantee Scheme and associated industry levies.

While capital adequacy is an important metric to calculate viability risk, it has been viewed as a secondary means of ensuring compliance and continuity. This is reflected in a divergence of views about the specific capital adequacy requirement, as opposed to the broader consensus for some form of liquidity requirement.[48]

The Australian Government has previously proposed a specific capital adequacy requirement involving maintenance of a prescribed percentage of net assets whereby, for example, assets must exceed liabilities by an amount exceeding 20% of total assets.[49]

The EY Australia review recommended the introduction of a 20% capital adequacy metric that is based on a definition of capital that includes tangible assets such as land and buildings, and intangible assets that are able to be valued.[50]

In its 2019 *Implementation Options Review*, Deloitte Global said that capital adequacy requirements are a way for the Australian Government to mitigate the risk of a provider defaulting and to ensure Refundable Accommodation Deposits are refunded on time.[51] It proposed three options:

- tiered requirements for capital adequacy based on a standard and advanced approach, where the standard approach required providers to maintain 20% capital adequacy and the advanced approach allowed providers to maintain lower capital adequacy where they could demonstrate an appropriate plan to manage their capital position
- allow some intangibles to count towards the capital adequacy requirements
- phased roll-out of capital adequacy requirements.[52]

Mr Peter Kohlhagen, General Manager of Advice and Approvals, Australian Prudential Regulation Authority, highlighted the need for capital adequacy requirements to reflect the risks of a particular organisation: as risks of potential future stressors differ between organisations, the capital required to deal with those stressors varies.[53]

In contrast, StewartBrown did not recommend a minimum capital adequacy requirement, but rather that capital adequacy be examined in the context of determining viability risk.[54]

I consider that the imposition of clear and enforceable capital adequacy requirements has the capacity to improve the prudential regulation framework in aged care. However, consistent with my conclusions surrounding the imposition of liquidity requirements, the question of capital adequacy should be a matter for the Prudential Regulator in its capacity as the Prudential Regulator. As with liquidity requirements, I do not specify in this report what the particular capital adequacy ratio should be. However, there should be a clear and enforceable capital adequacy ratio and the Prudential Regulator should be empowered to impose capital adequacy requirements on providers. The Prudential Regulator should have the same flexibility to apply different standards for various types of providers, sector segments and taking into account the regulatory performance of particular providers.

Although I do not specify the manner, I propose that the Prudential Regulator may:

- require providers to obtain and submit annual certification by an independent auditor that the provider has adequate capital to ensure the continuity of its aged care services
- require providers to maintain a particular ratio of net assets to liabilities in excess of a specified ratio (capital adequacy threshold), and to notify the Prudential Regulator within a specified time if that capital adequacy threshold is infringed.

Any proposal to introduce capital adequacy thresholds as part of the new prudential standards must allow some time for providers to prepare for higher capital adequacy thresholds.

19.6 Financial reporting

Recommendation 133: More stringent financial reporting requirements

1. **From 1 July 2023, the Prudential Regulator should be empowered under statute to require approved providers to submit financial reports.**
2. **The frequency and form of the reports should be prescribed by the Prudential Regulator.**

Access to the right financial and corporate information of providers, the timeliness of that information and the ability to analyse that information is critical to good prudential regulation and financial oversight. However, regarding the financial reporting requirements for providers, the Earle Haven Inquiry concluded that:

> the reports only provide a limited window into the financial and corporate affairs of approved providers. Providers are only required to report financial information at a single point in time each year and are not required to provide information about related parties that may be relevant to their stability or solvency.[55]

As set out above, financial reporting for providers consists of three reports.

The Australian Department of Health has acknowledged the inadequacy of the financial information it receives for the purposes of risk assessment. A troubling feature of the current arrangements lies in the timing of reporting. It is unacceptable for the Prudential Regulator to wait until the 'first pass' assessment process is completed before risk can appropriately be assessed. By this time, there is a danger that the risk in question may have occurred and that it is too late for the Prudential Regulator to intervene. Put simply, out-of-date data and an inability to request updated data can impede effective regulation.[56] One of the key findings in the EY Australia review was that:

> The data that the Department is given is inadequate for it to assess whether or not Approved Providers comply with the Prudential Standards.[57]

The EY Australia review linked this overall inadequacy to deficiencies in the information requested by the Australian Department of Health, and the quality, timeliness and frequency of information submitted.[58]

Mr Corderoy criticised the adequacy of the current system of reporting, especially the quality, consistency and timeliness of the information provided.[59] He recommended that all providers, including home care providers, be required to submit an annual General Purpose Financial Statement.[60]

Timeliness of reporting is important to the banks. Westpac Banking Corporation's system of oversight relies heavily on a risk-based provision of information, with lower-risk clients reporting quarterly or biannually, and higher-risk clients reporting more frequently, possibly monthly.[61] The Australia and New Zealand Banking Group told us that they require more frequent reporting for higher-risk clients and less frequent reporting for lower-risk clients.[62]

We also heard of reporting requirements with a range of indicators chosen to reflect the client's overall risk and to give an early warning of future difficulties.[63] This flexibility is reflective of the risk based approach to regulation I propose. The banks also rely on cash flow forecasts to determine the financial risk of providers. We heard that Westpac requests ongoing updated forecasts from providers where necessary, particularly if there will be a 'material change' in the provider's financial situation, and that the key issue is whether the provider's outflows outweigh its inflows.[64]

Some providers said that they agreed that the timing of information could be improved, and that there is scope for information to be provided more frequently and more regularly.[65]

Mr Kohlhagen described a risk-based system of supervision, which involves ongoing engagement with institutions and a targeting of supervision resources to larger and/or higher-risk entities.[66] He explained that the Australian Prudential Regulation Authority adopts 'pre-emptive, risk based supervision' and 'relies on an ongoing, open relationship with regulated institutions' rather than a checklist approach to regulation. The Australian Prudential Regulation Authority also directs its supervisory resources to areas of greatest risk of impact. In doing so, smaller or lower-risk entities may receive less frequent supervisory interaction than larger or higher-risk entities.[67] Similarly, Mr Gastin explained the regulatory engagement tool used to determine the number of engagement visits over the year ahead, based on financial and non-financial indicators.[68]

The Prudential Regulator should have access to the relevant and timely information it needs to exercise financial risk oversight functions in relation to the sector, by requiring expanded reporting obligations for providers to support effective financial oversight of the sector.

Without limiting the powers of the Prudential Regulator to determine the manner and form of the regulatory financial reporting regime, the Prudential Regulator may decide to:

- require providers, or certain classes of providers, to submit special purpose financial reports
- specify the required content of the financial reports
- determine the frequency of reporting based on historical prudential compliance and the likelihood of a provider being at risk of default
- specify a change in circumstances that may give rise to heightened prudential risk
- specify the frequency of reporting for all providers, or for particular classes of providers.

The required content of the financial reports should be specified by the Prudential Regulator to achieve the following purposes:

- improve transparency of providers' businesses and how they use accommodation payments
- improve understanding of the financial sustainability of providers and assist the regulator to identify and monitor providers potentially at risk of financial failure or non-permitted use of accommodation payment balances.

Guided by these purposes, the Prudential Regulator may, in determining the required content of the special purpose financial statements, be informed by such accounting standards as it deems fit.

In response to Counsel Assisting's final submissions in relation to more stringent financial reporting, the Health Services Union submitted that the timeframe for the recommendation should be brought forward 'for urgent and immediate implementation'.[69] Commissioner Briggs and I accept the importance of stronger financial reporting requirements, but note that the Prudential Regulator may require further time to make well-informed determinations as to the content of financial reports. The Prudential Regulator should consult with the aged care sector prior to making any determination about the content of aged care-specific financial reports.

Information-gathering powers

The Prudential Regulator needs enhanced information-gathering powers to undertake the proposed financial reporting functions. As set out above, the current powers of the Aged Care Quality and Safety Commission are inadequate. Part 8 of the *Aged Care Quality and Safety Commission Act* 2018 (Cth) permits, in a range of circumstances, authorised officers of the Aged Care Quality and Safety Commission to enter any premises, exercise a range of powers of search, and ask questions of persons at the premises.[70] Before exercising any of these powers, the relevant officer is required to inform the provider of their 'responsibility' under paragraph 63-1(1)(b) of the Aged Care Act to 'co-operate with a person who is performing functions' under the Act. Despite this, the occupier of the premises can simply refuse to consent to entry of the premises and any person to whom questions are directed can simply refuse to answer.

The Australian Department of Health appears to agree that the Prudential Regulator needs increased powers to seek information from providers and to investigate issues relating to the prudential and financial management.[71] Ms Janet Anderson PSM, Aged Care Quality and Safety Commissioner, told us that she supported increased capability, subject to the judicious use of the proposed powers. Mr Smith of the Australian Department of Health agreed.[72]

I make a specific recommendation in the event the Australian Aged Care Commission model is not adopted and I do so for the avoidance of doubt. The Prudential Regulator should have the additional powers in the following recommendation. Those powers would be conveyed in my previous recommendation, but would need to be located in the Prudential Regulator if the Prudential Regulator is an entity other than the Australian Aged Care Commission.

Recommendation 134: Strengthened monitoring powers for the Prudential Regulator

From 1 July 2023, the Prudential Regulator should have the following additional statutory functions and powers, to be exercised in connection with, or for the purposes of, its prudential regulation and financial oversight functions:

a. the power to conduct inquiries into issues connected with prudential regulation and financial oversight in aged care

b. the power to authorise in writing an officer to enter and remain on any premises of an approved provider at all reasonable times without warrant or consent

c. full and free access to documents, goods or other property of an approved provider, and powers to inspect, examine, make copies of or take extracts from any documents.

In the quality regulation and advocacy chapter of this report, we recommend that the Quality Regulator and the Prudential Regulator should have greater powers to undertake investigations and inquiries.

19.7 Continuous disclosure

Recommendation 135: Continuous disclosure requirements in relation to prudential reporting

1. From 1 July 2023, every approved provider should be required under statute to comply with continuous disclosure requirements to inform the Prudential Regulator of material information of which the provider becomes aware that:

    a. affects the provider's ability to pay its debts as and when they become due and payable, or

    b. affects the ability of the provider or any contractor providing services on its behalf to continue to provide aged care that is safe and of high quality to individuals to whom it is currently contracted or otherwise engaged to provide aged care.

2. The Prudential Regulator should also have the power under statute to designate events, facts or circumstances that may give rise to continuous disclosure obligations.

Prudential and financial risks occur in real time. This means that information relevant to these risks must be identified by the regulator in real time as well. Without such information, the regulator cannot effectively respond to risks as and when they occur.

Assessment of risk carried out purely on the basis of the various financial and prudential reports that are due for lodgement on 31 October each year is not likely to enable a timely response or intervention.

More regular reporting—for example, on a monthly or quarterly basis—would provide the regulator with relevant information that could identify risks more promptly and before they pose a risk to the continuity of care of people receiving aged care services. However, I recognise that a blanket approach in this manner could impose an unnecessary regulatory burden on providers.

I consider that the balance is to be found in establishing a continuous disclosure obligation triggered by significant events that provide a reliable indicator of impending risk. A continuous disclosure obligation exists for listed entities. Listed entities must disclose information 'that a reasonable person would expect…to have a material effect on the price or value of…securities of the entity'.[73] However, a very small proportion of providers are listed. Therefore, the majority of providers are not subject to any continuous disclosure obligations.

In response to Counsel Assisting's final submissions proposing a continuous disclosure obligation, the Governance Institute, Australian Institute of Company Directors and, in a joint submission, Leading Age Services Australia, Hall & Wilcox and HWL Ebsworth submitted that the proposal was not sufficiently articulated, was confusing, was potentially very broad and therefore was overly onerous.[74] I acknowledge that there is additional burden involved, and that there will be a period where some uncertainty will apply to the scope of the obligations in question. However, I consider that the risks to continuity of services, with the likely impact upon the health and wellbeing of vulnerable older people, justify the imposition of that burden. Much will depend on the Prudential Regulator taking a reasonable approach to providing guidance on the materiality of the information concerned, and effectively refining its guidance over time.

In its discussion paper on *Managing Prudential Risk in Residential Aged Care*, the Australian Department of Health proposed that providers be required to inform the Secretary of the Department of concerns relating to viability:

> Enhancing information and disclosure requirements to the Department where 'significant events' occur, such as major changes in corporate structure or ownership, significant related party transactions and where a provider is at imminent risk of no longer being able to continue operations.[75]

The Earle Haven Inquiry report recommended clarification of section 9-1 of the Aged Care Act. The proposed clarification included a requirement to advise the regulator of certain material changes affecting a providers' ability to continue as a going concern.[76] In my view, notification of such changes is unlikely to provide sufficient early warning and may be too late to enable an appropriate regulatory response.

A trigger based on insolvency, where the focus is on the ability of the provider to pay all of their debts as and when they become due and payable, is also likely to be too late for the purposes of identifying the sort of risk that the Prudential Regulator is focused upon.[77] Mr Ian Thorley of aged care provider Estia Health agreed that although solvency is an important factor, an appropriate trigger point should be earlier and more frequent reporting—and that this is the key to predict the likelihood of a provider being able to meet its financial obligations.[78] Dr Linda Mellors of aged care provider Regis Aged Care agreed with Mr Thorley. Dr Mellors said:

> I would like to make the point that much of the harm that's done to residents, families and workers happens probably over the last year before a provider does become insolvent as people are rapidly making changes to try to save their business. So it's not just the point of collapse. So I agree with you that there needs to be an earlier trigger.[79]

Another possible trigger that might be applied is a material deterioration in performance against budget. Mr Cam Ansell of aged care consultancy Ansell Strategic told us that most providers, in ordinary business circumstances, would have financial forecasts and budgets that would enable them to project their financial position and predict future financial difficulties.[80] However, Mr Ansell acknowledged that this would require visibility of a provider's capital flows from resident accommodation payments as well as operating deficits, and not all providers would be in a position to provide that much notice.[81] Mr Chris Williams of the Commonwealth Bank of Australia said that most providers borrowing funds from the Commonwealth Bank of Australia would have forward budgets and at least annual forecasts of expected future positions.[82] He noted that the level of financial sophistication would diminish for smaller providers, although he would expect them to have a 'degree of financial discipline' from a lending perspective.[83]

In its 2019 Implementation Options Review, Deloitte Global noted that there is no requirement for providers to self-report risks to viability or prudential obligations. Consequently, the report put forward an option for providers to report financial viability concerns.[84] The Deloitte Global option involved quarterly reporting that required providers to attest as to whether or not they have financial viability concerns, and to report significant risk events within 28 days of the event.[85] I do not favour such a response, given that quarterly reporting is likely to create a higher regulatory burden than is necessary in the circumstances and may not be suitable for all providers.

In its Prudential Framework Review, StewartBrown supported continuous disclosure on a risk-based exception basis, rather than required of all providers as proposed by Deloitte Global.[86] StewartBrown proposed a continuous disclosure requirement for any provider that 'is deemed to be high risk, has breached certain rules, can foresee a breach of rules or is requested to do so by the Department'.[87]

Witnesses from the Australian Department of Health and the Aged Care Quality and Safety Commission supported continuous disclosure, subject to a clear definition of what information is considered material.[88] In its response to Counsel Assisting's final submissions, the Australian Government said that the obligation should be 'adjusted to care settings, risks to care recipients and the scale of financial risk'. The definition of material should be balanced against the regulatory burden of reporting.[89]

Mr Corderoy recommended that providers should be required to report certain matters to the Australian Department of Health within 14 days, including moving below minimum liquidity levels or into a negative capital adequacy ratio position, as well as material adverse changes in financial position and breaches of permitted use rules.[90] This reflects the requirements of the Victorian Housing Registrar, in which registered agencies must notify the Registrar as soon as possible about reportable events. Reportable events include significant new funding, liquidity issues, breaches of loan covenants, changes in borrowings and new loans, and major investment strategy changes.[91]

The Prudential Regulator should be empowered to provide guidance as to the circumstances in which continuous disclosure obligations will be engaged, including the meaning of 'material information'. In doing so, the overriding considerations should be whether the information indicates a risk to the financial viability of the provider or the quality of care delivered to people receiving aged care services, including by any contractors.

The Prudential Regulator should bear in mind the regulatory burden that may be imposed by the continuous disclosure obligation and balance this against the financial risk or the risk to high quality care. It should adapt its guidance to changing circumstances in the aged care sector and have the power to designate events, facts or circumstances that may give rise to continuous disclosure obligations as necessary.

A failure to comply with the continuous disclosure obligation should carry an appropriate sanction and may be the subject of an application by the Prudential Regulator to a court of competent jurisdiction for a civil penalty.

A person involved in a contravention should be subject to accessorial liability. However, that person should not be liable if they prove that they took all steps (if any) that were reasonable in the circumstances to ensure that the provider complied with its continuous disclosure obligations, and that after doing so the person believed on reasonable grounds that the provider was complying.

19.8 Enforcement tools

Recommendation 136: Tools for enforcing the prudential standards and guidelines and financial reporting obligations of providers

1. From 1 July 2023, the Prudential Regulator should have the powers to take such action, and impose such obligations upon approved providers, as it considers necessary to deal with any breach of the new prudential standards or the financial reporting requirements, including a failure to comply with the continuous disclosure requirements.
2. The powers which the Prudential Regulator should be given should include:
    a. the power to give directions to a provider that mirror those that can be made by the Australian Prudential Regulation Authority pursuant to the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth)
    b. the power to impose administrative penalties in respect of any breach
    c. the power to apply to a court of competent jurisdiction for a civil penalty in respect of any relevant alleged contravention
    d. the ability to accept enforceable undertakings
    e. the ability to impose sanctions to limit the ability of the provider to expand its services, revoke accreditation for a service, or revoke approved provider status.

Good prudential regulation and financial oversight should be agile and responsive. The regulator should have a cascading range of powers enabling it to take proportionate corrective action promptly.[92] This should include consequences in terms of the prudential risk profile of the provider, with the result that the provider will be subject to increased regulatory scrutiny. Consistent with my recommendations for effective regulation, those powers should include the ability to issue infringement notices, accept enforceable undertakings, impose administrative penalties as well as sanctions, and apply to a court of competent jurisdiction for a civil penalty.

The EY Australia review proposed consequences for providers who do not comply with the proposed liquidity and capital adequacy requirements, such as restricting their ability to charge new accommodation payments or requiring them to provide additional security until they comply with those thresholds.[93]

19.9 Capability of the Prudential Regulator

Recommendation 137: Building the capability of the regulator

The Australian Government should ensure that the Prudential Regulator has prudential capability in relation to the aged care sector that includes the following:

a. an effective program to recruit and retain senior forensic accountants and specialists with prudential regulatory experience, and sufficient numbers of supporting employees who have either accounting qualifications or other financial skills

b. systems and processes to capture, collate, analyse and share regulatory intelligence from internal and external sources to build a risk profile of approved providers

c. a system and processes to monitor indicators of risk revealed by providers' financial reporting tailored to the aged care sector and to respond to them in a timely manner

d. an electronic forms and lodgement platform for the use of all large operators, with an optional alternative electronic filing system available for smaller operators

e. appropriate resourcing of the above system and processes, including design expertise, information and communications technology requirements, technical support, and recruitment and training of sufficient numbers of appropriately skilled staff.

The prudential regulation capacity of the Prudential Regulator must be adequately resourced to carry out its functions. Those resources should include well-trained staff with specialised skills and processes and systems to allow these staff to build a picture of prudential and financial risk within the sector.

The Australian Government, as mentioned above, allocated funds in the 2018–2019 Budget to improve the management of prudential risk in residential aged care facilities. The Budget measure was also intended to enhance the prudential and financial reporting capability of the Australian Department of Health and the Aged Care Quality and Safety Commission to assess the financial information of providers and 'assist in the early detection of prudential and viability concerns'.[94]

The EY Australia report recommended that the Australian Department of Health recalibrate its risk assessment methodology and model to reflect the proposed compliance requirements.[95] The review also recommended strengthening the tools, resources and capabilities of the prudential regulatory section of the Department of Health through:

- enhanced data collection and analysis in light of the proposed revisions to the Prudential Standards
- increased resources and more sophisticated tools to conduct compliance activities.[96]

The Earle Haven Inquiry recommended that steps be taken to ensure that aged care regulators have the capacity to understand risks to quality of care that might arise from a provider's financial or contractual arrangements, including by:

> increasing the capacity of aged care regulators to effectively scrutinise financial information; providing the Quality and Safety Commission with the capacity to include people with expertise in contracts and accounting in the team undertaking assessment contacts where there is an indication that there are risks associated with the approved provider's financial or contractual arrangements.[97]

Mr Corderoy criticised the level of specialist financial and analytical resources currently available within the Australian Department of Health to deal adequately with information from providers.[98] He was also critical of a lack of clarity within the Department about responsibilities for oversight and assessment, as well as an overlapping of responsibilities between the Department and the Aged Care Quality and Safety Commission.[99]

Ms Anderson told us that the Aged Care Quality and Safety Commission's prudential regulation staff are 'highly competent, but there aren't enough of them'.[100] She also said that she would understand if the Royal Commission made a recommendation for a thorough capability review of the Aged Care Quality and Safety Commission.[101] We recommend a capability review elsewhere in this report. Mr Smith of the Australian Department of Health supported greater capabilities within the Department, noting that the Department is already focused on increasing capacity and ensuring the right skill mix.[102]

Endnotes

1 Australian Prudential Regulation Authority, *What is prudential regulation?* https://www.apra.gov.au/what-prudential-regulation, viewed 23 December 2020.
2 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, p 89 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017 at 9031.
3 *Fees and Payments Principles 2014 (No. 2)* (Cth), s 41; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3550 [4].
4 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 67, RHC.9000.0012.0001 at 0011.
5 *Accountability Principles 2014* (Cth), s 35.
6 *Fees and Payments Principles 2014 (No. 2)* (Cth), ss 42, 51.
7 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3554 [12b].
8 *Accountability Principles 2014* (Cth), s 35A.
9 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 105, CTH.1000.0006.3520 at 3523; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3554 [12c].
10 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3553 [12]–3555 [13].
11 *Fees and Payments Principles 2014 (No. 2)* (Cth), pt 5. See also Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0005 [15].
12 *Fees and Payments Principles 2014 (No. 2)* (Cth), s 41.
13 *Fees and Payments Principles 2014 (No. 2)* (Cth), s 43.
14 Australian Accounting Standards Board, *AASB 1053: Application of Tiers of Australian Accounting Standards*, 2019, pp 4, 7.
15 Australian Department of Health, *Managing Prudential Risk in Residential Aged Care Discussion Paper*, 2019, p 41.
16 See, for example, *Private Health Insurance (Prudential Supervision) Act 2015* (Cth), s 92.
17 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3555 [15]–[15a]; 3583 [81].
18 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 122, CTH.1000.0006.0001.
19 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3557 [21]; *Aged Care Act 1997* (Cth), s 52N-2(1).
20 *Aged Care Act 1997* (Cth), s 52N-2(2).
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20. Financing the New Aged Care System | Commissioner Pagone

20.1 Introduction

The 'financing' of aged care refers to the raising of money for the purpose of funding the provision of aged care services. For many decades, aged care in Australia has been financed by a mix of public funding, sourced through the general taxation system; private contributions in the forms of means tested fees and co-payment for certain services; and public and private capital financing. I think that it is of profound importance that our thinking as a nation moves away from linking costs and expenditure by temporal expectations to seeing the long-term provision of high quality care as a promise for all Australians into the future.

Private contributions (through the Basic Daily Fee to cover the ordinary costs of living, and some minor contributions to care in each of the residential, home care and Commonwealth Home Support Programme settings) raise only a relatively small component of the funding needed to provide aged care services. In financial year 2018–19, these sources raised about $4.8 billion, compared with $19.9 billion in financing from the Consolidated Revenue Fund.[1] As we have discussed elsewhere in this report, the scheme of private contributions and means testing regimes that accompany them are complex, burdensome and inefficient.

Capital financing requirements of residential aged care providers are largely met through Refundable Accommodation Deposits and Daily Accommodation Payments, as well as by payments of or contributions to the Accommodation Supplement for many residents. Bank financing plays a relatively minor role.

By paragraph (f) of our Terms of Reference, we are required and authorised to inquire into 'how best to deliver aged care services in a sustainable way'.[2] The need to ensure a sustainable aged care system has informed our consideration of both future funding arrangements and future financing arrangements.

In Chapter 17: Funding the Aged Care System, I set out my recommendations for improving funding arrangements to ensure the economic sustainability of the aged care system as a whole, including recommendations for simplifying and improving the arrangements for private contributions. In Chapter 18: Capital Financing for Residential Aged Care, I set out my assessment of the current methods of raising capital for investment in accommodation assets, and proposals including a transition in the longer term away from the sector's reliance on Refundable Accommodation Deposits.

In this chapter, I consider the available options for sustainable public financing of the aged care system's recurrent operating costs into the future.

The operating costs of the aged care system in Australia are financed on a 'pay as you go' basis from the Consolidated Revenue Fund.[3] In Australia, all revenue or money raised or received by the Executive Government forms the Consolidated Revenue Fund. In the context of arrangements for financing ongoing services, pay as you go refers to arrangements whereby expenditure in any given period (for example, a year) is generally sourced from revenue raised in the same period, or a closely proximate period. The aged care system in Australia is, and has for many years been, financed primarily from Consolidated Revenue, which ultimately depends on general taxation revenues.[4] An important consideration of pay as you go tax financing for aged care is that (assuming annual government budgets are close to being balanced) the generation who are currently of working age are, in a narrow temporal sense, the source of the money paying for the costs of those receiving aged care services.[5]

Public financing of aged care has been tied to the annual budget cycle, and fiscal priorities of the day have been allowed to take precedence. There are stark examples of the adverse effects of this approach, such as the waiting list for Home Care Packages. Generally speaking, older people have contributed to the aged care system by paying income tax their entire lives. When they need aged care at home, they are assessed as needing care at a particular level. However, they have been made to wait, either without being given any aged care at all, or being given aged care below the level of their assessed needs. This is unacceptable.

20.2 A new aged care financing system

Fundamental to the vision Commissioner Briggs and I share of aged care in the future is a system of universal entitlement to high quality aged care based on assessed need. We envisage a system in which every person can have confidence that if they need aged care they will receive it. This is as much a promise made to 20-year-olds as it is to 70-year-olds: all of us have an entitlement to high quality aged care if we need it, and all of us must be able to plan for the future secure in that expectation. This means the funding and financing for future aged care needs must have a secure foundation. The Australian community must be confident that funds will be available to ensure any assessed need for high quality aged care will be met if and when called upon.

Under current policy settings, Australian Government expenditure on aged care is projected to increase from 0.97% of gross domestic product in 2018–19 to 1.34% in 2049–50.[6]

As explained elsewhere in the report, many of our recommended reforms have funding implications. Indicative modelling prepared for us by Deloitte Access Economics, based on assumptions set out in their report for a '4 star' scenario for the average level of staffing in residential aged care facilities, implies that the aged care sector may incur additional costs in 2050 of 0.5% of estimated gross domestic product.[7]

Since that modelling was done, we have revised our recommendations. Modelling undertaken for this chapter was undertaken by applying the growth factors in the Deloitte modelling for the Australian Government expenditure based on expected changes in

demand and supply to the new baseline of reform of our final recommendations. This modelling implies that Australian Government expenditure on aged care in 2050 is likely to be 2.75% of gross domestic product in total—or 1.41% of gross domestic product higher than it would be if the current policy settings were maintained.

This is a significant additional outlay. Research we commissioned suggests that there is a reasonable level of support to devote public funds to achieving high quality aged care.[8] Australia's current spending on aged care, expressed as a percentage of gross domestic product, is relatively low compared with many other Organisation for Economic Co-operation and Development countries.[9] The additional funding implied by our recommendations would still leave Australia well behind the levels of expenditure in the Netherlands, Japan, Denmark and Sweden.[10]

It should also be recalled, as discussed in Chapter 4: Systemic Problems in the Aged Care System in Volume 2, that at least half of the increase that we are recommending in expenditure is to undo the actions of successive governments over the last few decades to restrain expenditure on aged care by rationing access to care and by underfunding the sector. This must stop if older Australians are to receive the care that they deserve.

In my view, the aged care system needs a financing source that is as predictable, reliable, objective, and economically sound as possible, without compromising on the quality and safety of aged care or the equity of financing arrangements. It also needs to be accountable and transparent. Here is what I mean by these principles, in this context:

1. **Predictable.** The funding arrangements should ensure that people's expectations for high quality aged care are met as assessed and when they are needed. People should not be subject to unpredictable costs in the future.
2. **Reliable.** The arrangements should ensure that the funds necessary for timely and equitable access to high quality aged care, both now and as community expectations evolve, are available as assessed and when they are needed. The funding source for aged care should not be subject to the annual budget cycle and fiscal priorities of the government of the day.
3. **Objective.** The amount of funding necessary to secure sufficient funds to provide expected benefits to meet assessed needs should be arrived at using the best available evidence, knowledge and expertise. The calculations underlying these projected amounts should be actuarially-based, using appropriate statistical procedures.
4. **Economically sound.** The arrangements should ensure that there will be sufficient funds raised to meet expected expenditure.
5. **Accountable and transparent.** Financing arrangements should be publicly visible and accountable in order that the Australian community can see the connection between their contributions and the effective operation of the aged care system.
6. **Equitable.** Financing arrangements should maintain the general progressivity in the current taxation system.

In order to achieve the optimal balance of these principles in a newly designed approach to aged care financing, I envisage a greater role for contribution by each person toward the financing of the aged care system through that person's working life, and a greatly diminished or non-existent role for mandatory means tested co-payments by people when they are receiving aged care later in life. As I explain in more detail below, through the tax system people will have contributed to financing the aged care system in accordance with their income over their entire lives, and so should not be required to pay a means tested co-payment if and when they need aged care.

This does not mean that the more financially fortunate should pay the same share as the less financially fortunate. As they do now for aged care and government services in general, the more financially fortunate should continue to pay a greater share.

Further, to engender stability and confidence, I recommend consideration by the Productivity Commission of the adoption of insurance-based (actuarial) principles in the future financing of the system. I explain these principles in more detail, below.

Under my vision, the optimal approach is likely to be achieved by a different mechanism from the current approach: a hypothecated aged care levy. There are many options available as to how such a levy could be designed and imposed. One way in which this mechanism could work would be to require the payment of an additional percentage of each personal taxpayer's income tax. The additional percentage rate could be uniform (a flat levy, like the Medicare Levy) or there could be graduated rates for different taxable income brackets (a progressive levy).

In late 2019 and early 2020, it was my intention that staff and consultants assisting us would be able to formulate and test detailed proposed mechanisms for the future financing of aged care, including a hypothecated levy. In the event, 2020 confronted the work of this inquiry with a number of challenges and we lost valuable months by the restrictions imposed upon our work by the COVID-19 pandemic. The work planned for the second quarter of 2020 had to be deferred and it became practically impossible to research, model and test the various models that we needed to consider to place future aged care funding on a reliable, secure, predictable and sustainable footing. For these reasons, it has not been possible to make formal recommendations for the adoption of specific financing mechanism, but instead to recommend that the Australian Government should commission the Productivity Commission to investigate and report on the potential benefits and risks of adoption of an appropriately designed financing scheme based upon the imposition of a hypothecated levy.

Recommendation 138: Productivity Commission investigation into financing of the aged care system through an Aged Care Levy

Commissioner Pagone

By 1 July 2021, the Australian Government should refer to the Productivity Commission for inquiry and report under the *Productivity Commission Act 1998* (Cth) s 11 the potential benefits and risks of adoption of an appropriately designed financing scheme based upon the imposition of a hypothecated levy through the taxation system.

I am satisfied that there is a persuasive case for the adoption of a levy-based financing scheme, and every reason for an investigation of this topic by the Productivity Commission. However, there remain many complicated issues concerning the amount of the levy and how it should be administered. I set out below some details of the manner in which a new 'Aged Care Levy' could work and illustrative calculations of some different options for the design of the proposed levy. Annexure A to this chapter provides technical details of the modelling used to produce these calculations.

In setting out above my six guiding principles for a new financing arrangement for aged care, I propose a shift in the way the community perceives aged care, toward it being seen as something valuable in which we all have a stake, and where there is accountability for the way money is raised and spent on aged care. The public should see the aged care system as something that they contribute to all their lives in case they need it, just as people pay insurance premiums against certain risks that could have severe financial impact on them if they eventuate. Adoption of a hypothecated levy for all taxpayers should lead to greater interest in aged care outcomes amongst a wider pool of people.

Depending on future decisions of the Australian Government, a hypothecated Aged Care Levy might prove to be a step toward adoption of a social insurance scheme for aged care in the future of a kind prevalent in northern European countries and Japan. We have heard a lot about aged care financing systems in other countries. These offer exciting possibilities that meet many of the design principles set out above. Brief summaries of the systems in Germany, Japan and the Netherlands are set out in boxes, later in this chapter. In each case, the country has broad-based social health insurance, and each has, to different degrees and in different ways, adopted social long-term care (LTC) insurance arrangements that are consistent with existing health insurance arrangements. In many cases, there are important roles for private insurance companies, often required to provide basic services defined by the government but able to compete on extras. In each case, the balance between 'institutionalised' residential care and home care has been evolving, particularly in the Netherlands. The experience of the Netherlands is instructive for Australia as we too seek to rebalance the resources of the aged care system toward home care.

20.3 Financing options

In June 2020, we published *Consultation Paper 2 – Financing aged care.* This paper outlined three broad approaches to financing aged care:

- 'minimal change': continued reliance on taxation and co-contributions, with potential adaptations
- social insurance models
- private insurance and other voluntary arrangements.[11]

The paper identified that these three options were not mutually exclusive and that there is potential to combine financing options.[12] We received 31 submissions in response to Consultation Paper 2. The submissions reflected a wide cross-section of views on financing arrangements for aged care. Submissions were made by individuals and organisations spanning aged care providers, academics, peak and advocacy bodies, health care groups, accounting and financing organisations, and State and local government bodies.

We also examined the financing of the aged care system at a public hearing in September 2020. Evidence on arrangements to finance aged care was given by a number of prominent Australians, including former Prime Minister the Hon Paul Keating, and Australia's longest-serving Treasurer and Chair of the Board of Guardians of the Future Fund, the Hon Peter Costello AC. We also heard from academics, senior representatives of the Australian Treasury and others about current and potential future arrangements for financing aged care in Australia. Further, we heard about international financing mechanisms from Professor Naoki Ikegami of St Luke's International University, Tokyo, and Dr Pieter Bakx of Erasmus University, Rotterdam. Dr Bakx's evidence supplemented evidence about the Dutch long-term care system we received in an earlier hearing from Professor Jos Schols of Maastricht University.

20.3.1 Financing from the Consolidated Revenue Fund

Continued reliance on general taxation and annual appropriation from Consolidated Revenue is one option for the future financing of the aged care system. Overall, this option received the most support amongst submissions in response to Consultation Paper 2: specifically, a mixed funding approach comprised of taxpayer funding and pay as you go contributions.[13] There was significant support for increased user contributions as well as means tested co-payments.[14] Ansell Strategy submitted that a more balanced mix of taxpayer funding and co-contributions is 'the most important condition to facilitate the evolution of a high quality, sustainable aged care system', describing the imbalance between the Australian Government and consumer contributions as 'the single greatest limitation in our aged care system'.[15]

Financing through general taxation has certain advantages. General taxation is capable of generating additional funding and allows for a broad and flexible funding base. Funding through taxation may also be more stable because it relies on broader sources of revenue. It presents a potentially administratively simple and efficient financing arrangement.[16]

However, there are limitations to financing from the Consolidated Revenue Fund based on general taxation revenue. Taxation-based financing may be more variable because of its connection to the budget cycle.[17] National Seniors Australia suggests that an 'an unprecedented deficit and recommended improvements in staff training, quality and regulation' will necessitate support from other funding sources if general taxation continues as the status quo financing arrangement for aged care.[18]

Further, taxation financing approaches may be short-sighted in their outlook and fail to provide certainty about the availability of future funding.[19] They do not provide the opportunity to build financing reserves.[20] In that regard, we have been told that taxation as a financing option is not as strong on 'intergenerational equity' as other financing options because there is not the capacity to preserve funding for the future.[21] Intergenerational equity is the principle that each generation should bear the costs commensurate with the benefits that it receives or will receive, without disproportionate burdens being placed on particular generations.[22]

There are other dimensions of equity that should be considered in designing public financing arrangements, known as 'horizontal' equity and 'vertical' equity. Horizontal equity in taxation-based financing models means that people with equal resources should be taxed in an equivalent way and includes guaranteeing against 'capricious taxation' and taking into account only relevant considerations that are treated equally.[23] Vertical equity involves each person paying proportionately to the amount of resources that they have.[24]

We were told that the long-term care system in Sweden is an example of a system predominantly financed from general tax revenue, augmented by some private financing sources.

Sweden—a mixed general taxation-based funding model

In Sweden, long-term care sits within the overall health system, which is managed at a national, regional and local level, with local municipalities responsible for managing the care of older people and people with disability in their areas, including long-term care.[25]

There is some variability in how long-term care is funded and provided across each municipality—but nationally, long-term care is publicly subsidised with universal eligibility.[26] Older adults and people with disability make a co-payment for services commissioned by the municipalities.[27]

Within this system, family members can be approved as home care workers and receive cash payments for providing care. Cash benefits for family members play a minimal role and are decided locally. Not all municipalities provide cash benefits.[28]

Consumer contributions account for 5% of funding for long-term care. These fees are determined by a means test on median income but not assets, up to a set maximum for both residential care and home care. The majority of long-term care (90%) is funded through taxation, although individuals may choose to purchase additional support through private services.[29] Although Sweden ranks highly in providing care broadly to the older population, the range of services is limited.[30]

Sweden's long-term care system is an example of the financing of aged care through a universal, tax-based system that proves broad coverage to older people for basic support services.

20.3.2 Social insurance

A social insurance financing model is another potential model for the long-term financing of aged care. Social insurance has been adopted by some jurisdictions outside Australia to contribute to the financing of long-term care. It requires individuals to make compulsory contributions to a dedicated pool of funds. This fund is then used to finance a specific cost, such as the aged care costs of a defined group of individuals. Compulsory contributions allow for the sharing of long-term risks across the group.[31] Some examples of programs that use social insurance include pensions and unemployment programs.[32]

Social insurance models can be pay as you go or 'pre-funded' and may be managed by government or regulated insurers.[33] Under a pre-funded financing scheme, funds are deliberately raised and set aside to meet future costs.[34] This can be through personal savings, assets, superannuation, insurance or other form of compulsory saving. It may be difficult to estimate future aged care costs and to determine the level of contributions required. While some respondents to Consultation Paper 2 saw appeal in shifting to a system which pre-funds for aged care, such as a pre-funded social insurance scheme, it was widely accepted that this is not feasible considering the ageing population in Australia.[35]

In their submission to us, the ARC Centre of Excellence in Population Ageing Research at the University of New South Wales explained that a social insurance system of financing would require a number of matters to be stipulated, including:

- A contribution base
- A contribution rate
- A defined population who would be mandated to contribute
- A mechanism for managing reserves.[36]

A social insurance scheme could take a variety of forms. For example, as outlined in Consultation Paper 2, a social insurance scheme could be designed to cover everyone who is currently entitled to receive Australian Government-funded aged care. Contributions to the scheme could be paid by all people with the means to contribute and by the Australian Government on behalf of those who are not able to contribute regularly to the scheme. Contributions could be obtained in a number of ways. For example, they could be paid by employers (like the super guarantee charge) or workers through taxation (like the Medicare Levy).[37]

There may be a number of advantages to a social insurance model that are not present in arrangements based on general taxation. A social insurance arrangement may stabilise funding and reduce the political and financial pressures on government revenue with population ageing.[38] Premium payers may be more likely to hold the government to account if they interfere with funding arrangements because they have made an investment in the future system through their contributions.[39]

There are successful examples of social insurance schemes overseas for the financing of aged care (or 'long-term care'). One such example is the system in Germany.

Germany—a social insurance scheme

In Germany, both residential care and home care is financed through statutory long-term care insurance.

The scheme is paid for by contributions collected through income tax. The contribution rate is set as 3.05% of gross salary, shared equally between employers and employees. Those without children pay an additional 0.25% of their gross salary.[40]

Those assessed as eligible for access to aged care services can choose between cash payments for informal care, in-kind benefits for nursing and personal assistance services, or a combination of both.[41] For residential aged care, the benefits usually only cover half of the relevant costs, with people advised to buy supplementary private long-term care insurance. In 2013, the German Government began offering subsidies for the voluntary purchase of private long-term care insurance.[42]

A 2020 review of the academic literature concluded that Germany's system has achieved significant social reform, and reduced the financial burden on long-term care spending for individuals. Generally speaking, however, long-term sustainability of funding for long-term care insurance models remains a challenge.[43]

There are also successful examples of blended financing models incorporating aspects for social insurance financing together with taxation financing, or taxation and a modest amount of private co-contributions. The long-term care systems in the Netherlands and Japan are noteworthy examples of such models.

Netherlands—a mix of insurance and general taxation

The Dutch system for long-term care is administered under three different pieces of legislation regarding institutional care, home care, and social supports. The legislation for institutional care and home care establish mandatory social insurance schemes. Social supports are financed through general taxation.[44]

For home care, the 'social insurance' is administered by private entities acting as insurers, with competition between them on price and services. In home care, a means tested insurance premium and a 'nominal premium' is paid directly to insurers. Whilst the insurers set this latter premium, the premium must be the same for everyone they insure and they are required to accept everyone who wants to be insured. There is also a system of risk equalisation to ensure that the proper incentives are in place for the insurers to provide proper coverage and care for everyone they are insuring.[45]

Dr Pieter Bakx, Associate Professor, Erasmus School of Health Policy & Management Health Economics at the Erasmus University, Rotterdam, told us that that the scheme is pay as you go, and that the private insurers do not build up a fund from which they can generate returns and draw upon in the future.[46]

Residential care is administered by the relevant regional municipal authority with no private involvement and no competition. There is a means tested co-payment that those accessing institutional care must pay, and the maximum amount payable by someone is capped annually. There is also only a single insurer—a central social insurance fund operated by the Government.[47]

Coverage under the insurance scheme is very comprehensive. Out-of-pocket co-payments only made up 8.7% of total spending on long-term care services in 2015. Public expenditure on long- term care is very high, more than double the Organisation for Economic Co-operation and Development average. [48]

Japan—a mix of social insurance, taxation and private co-contributions

We heard from Professor Naoki Ikegami of the Division of Health Policy and Management, Graduate School of Public Health, St Luke's International University in Tokyo, Japan. He explained that Japan introduced its long-term care insurance due to perceived weakness in existing supports. He told us that with pre-existing services targeted at low-income older people, those on middle incomes had difficulty accessing services. Additionally, with health services offering free in-patient care to elders, this led to both poor financial results and inappropriate care, as older people received expensive medication-focused in-patient care in hospital.[49]

Under Japan's current system, the long-term care insurance is paid 50% from compulsory long-term care premiums, and 50% from taxes.[50] The premiums are levied on those aged 40 years and over. For those aged 40–64 years, premiums are deducted and allocated to a national fund, which provides funding to local municipalities who administer the insurance scheme in their respective areas.[51]

For those aged 65 years and above, the premium is deducted from the public pension and is means tested to income, with three rates for low, medium, and high income earners.[52]

Professor Ikegami explained that the insurance scheme is managed on a three-year basis by the national government, where premiums are revised in order to balance expenditures.[53] Differences in income from premiums and expenditure in a local municipality are equalised by the national government from the premiums gathered from those aged 40–64 years.[54] Similarly, the national government sets the cost of services in a fee schedule.[55] During this three-year period, the insurance premiums that may be charged by a local municipality are frozen.[56]

Professor Ikegami told us that funding by way of social insurance insulates the scheme, to an extent, from day-to-day fiscal pressures.[57]

However, the cost of the scheme has been a significant concern for sustainability, as expenditures on the scheme have tripled since its inception.[58] Professor Ikegami suggested that initial entitlements under the scheme were too generous and have proven hard to balance fiscally.[59] Since 2003, Japan has implemented measures to constrain increasing costs, including reduction of provider fees, reduction in benefits and introduction of bed and board charges in institutional care.[60]

Professor Michael Sherris is Professor of Actuarial Studies at the University of New South Wales and Chief Investigator at the ARC Centre of Excellence in Population Ageing Research. He told us that the benefit of a government insurance scheme over a private insurance scheme is the ability to limit adverse selection and to pool a large group of individuals. Professor Sherris considered a government insurance scheme could provide more flexibility in the financing of costs.[61]

At an individual level, a social insurance scheme may reduce anxiety in later life.[62] It may also alleviate the need for large precautionary savings.[63] Despite the potential advantages, there are aspects of a social insurance model which require careful consideration.

Adoption of a social insurance model may be seen by some as contrary to the principles of fairness and intergenerational equity, particularly those models which rely on pre-funding of aged care costs. Dr Kenneth Henry AC, Former Secretary, Australian Treasury, described a pre-funded arrangement as 'intergenerationally unfair' because it would require the generation that follow the baby boomer generation to pay for the aged care costs of their parents and grandparents and pre-fund their own aged care costs.[64] The Australian Treasury raised the same concern about a long- term pre-funded financing arrangement.[65] Other equity concerns may arise depending on how a social insurance

system is structured. For example, if payments to individuals from an insurance fund were determined by contributions made over the course of their working lives, higher income earners would receive higher benefits than those with more limited employment income.[66]

We also heard that it is not clear that compulsory social insurance would provide greater certainty about the availability of financing for future aged care needs.[67] The Australian Treasury cited the difficulty in predicting the future costs of care and contributions over time, even with actuarial estimates, as one factor that would limit the certainty of such a model.[68] Others raised doubts about the utility of a social insurance model, questioning the capacity of such an arrangement to deliver better outcomes than the current tax-based financing arrangements or otherwise deliver a material net benefit. [69]

Private insurance

Private insurance in aged care could take a variety of forms. Private insurance in aged care could involve the payment of premiums by individuals to an insurer and the claiming of costs by an individual once they have been assessed as meeting a threshold. Individuals could be reimbursed for aged care costs or they could receive a benefit of a fixed amount.[70]

Financing aged care from private insurance could also serve as an alternative to social insurance models. Under this model, contributions would be mandatory for those with capacity to pay and would be directed to a selected insurer.[71] This scheme is pre-funded, meaning that the premiums paid by each generation are used to cover that generation's claims.[72] This begs the question of what arrangements should apply for people who have not had sufficient financial capacity to pay contributions.

Some respondents to Consultation Paper 2 viewed private insurance of aged care costs as potential 'extra safety net' for older Australians, while others highlighted the risks involved in reliance on a private insurance model as it would only be viable if there is sufficient uptake.[73]

Private insurance products could be made available for purchase by individuals to insure their aged care costs and risks.[74] However, the development of a market for such products seems unlikely unless people are motivated to purchase such products by exposure to the future risk of having to pay large contributions if they need aged care. However, as I explain elsewhere in this chapter, and also in Chapter 17: Funding the Aged Care System, I do not consider that a system reliant on significant contributions of this kind would be consistent with the universal right to aged care in accordance with assessed need, and I doubt the efficiency of such an approach.

Levies

An Aged Care Levy could apply as part of either a taxation or social insurance model.

Tax levies may be non-hypothecated or hypothecated. A hypothecated levy is taxation that is 'earmarked' for a particular purpose. A key feature of a hypothecated levy is that the funds from the levy are designed to go to the particular purpose for which they have been earmarked.[75] An example of a non-hypothecated levy is the Medicare Levy.[76] However, the Australian Government is not legally obliged to spend these funds only on the identified purpose and may use the funds for purposes which are unrelated to the levy.[77]

One of the potential adaptations canvassed by Consultation Paper 2 was the introduction of an 'earmarked' or hypothecated levy imposed through the tax system, which could involve funds being paid into a dedicated account within the Consolidated Revenue Fund established for the specific purpose of aged care and being used only for that purpose.[78] The submissions reflected mixed views on the benefits of a hypothecated levy. I discuss those submissions later in this chapter.

20.4 A hypothecated Aged Care Levy

As I foreshadowed earlier in this chapter, I support the development of a detailed scheme for introduction of a hypothecated Aged Care Levy on taxable income. My recommendation that the Productivity Commission should investigate this matter, and my suggested guidance for that investigation, are informed by the principles stated earlier in the chapter, along with my view that high quality aged care in accordance with need is an entitlement for all members of the Australian community.

In this section of the chapter, I introduce and set out suggestions and guidance for the development of an Aged Care Levy, then test those concepts against each of my design principles. First, I discuss the efficiencies of levies compared with other approaches. Then I consider the idea of hypothecation as a mechanism to ensure that when government legitimately sets priorities for expenditures of taxpayer revenue, it does so over a longer time period than one year. I then consider the general form and parameters of the proposed Aged Care Levy, in terms of the appropriate tax base, the pay as you go approach to the timing of financing, and the general role of actuarial principles in designing the levy.

Some specific calculations of the proposed Aged Care Levy are then offered, to illustrate concretely what I am proposing. These calculations depend on choices about the parameters of the levy, such as:

- the scope of aged care expenditures covered
- the degree of 'progressivity' in the particular design for an Aged Care Levy, which governs the extent to which those earning more income pay a greater share, in a manner consistent with existing income tax arrangements
- the effects of specific policy options on 'tax incidence'; that is, the division and distribution of taxation burden between different cohorts of taxpayers defined by age and income.

The calculations establish a baseline based on the current levels of public financing of aged care, and then indicate the rates that could apply if the key reforms recommended in this report are adopted. Possible variants of the proposed Aged Care Levy are also considered, to address a range of issues. I recognise that revisions of the levy over time would be needed to ensure actuarial consistency as underlying expenditures naturally change due to demographics, changes in the costs or in response to our other many recommendations. This leads into a brief discussion of possible institutional arrangements for these financing mechanisms, to ensure the monitoring of the financing of quality aged care would be consistent with the principles I have identified.

20.4.1 Potential approach

On balance, I consider that an approach based on hypothecation of revenue from a levy imposed through the tax system has advantages over the other approaches to long-term financing of the aged care system, and that its advantages outweigh its disadvantages. The Aged Care Levy I envisage would finance an Aged Care Fund on a long-run pay as you go basis over, say, a thirty-year horizon, based on actuarial principles. The overarching elements of my proposed approach are as follows:

- Each individual should have a universal entitlement to receive high quality aged care based on assessed need.
- To support that entitlement, there should be unrationed provision of funding that is based on independent pricing of aged care services. That is, the Pricing Authority will determine the levels of funding required to meet the reasonable costs of high quality aged care services of all the kinds that are delivered across the system.
- It will be necessary to forecast (and keep under review), the likely aggregate funding requirements for the system for an extended period of, say, thirty years. This will be done on actuarial principles in light of data about demand for the relevant services and forecast prices for those services. I do not underestimate the extent of the data that will be needed for sound and reliable calculations to be made.
- It will be necessary to calculate the rate or rates of a levy that are needed to generate revenue that will meet those system funding requirements. This will be done on actuarial principles in light of economic forecasts and tax data.
- These actuarial calculations will be constantly under review, and the levy rates will be revised every three years.

Although the calculation of levy rates should be performed independently of the Australian Government's fiscal processes, particular levy rates should not (and on one view cannot) be imposed without the support of the Government and an Act of Parliament. The hypothecated levy applicable for each three-year period must in my view be imposed by a taxation Act, in accordance with constitutional requirements, and the Act should specify the rates of the levy rather than delegating those rates to be set by someone else.[79] The Australian Government would retain ultimate responsibility for bringing a tax Bill to Parliament for each revision of the levy, and would therefore retain ultimate control over the amount of the levy.

Consistent with a system based on universal entitlement, in Chapter 17: Funding the Aged Care System I note that both Commissioner Briggs and I have recommended that, for both home care and residential aged care, people should not be required to contribute means tested co-payments for the care services they receive. This leaves a role for means tested contributions towards the costs of residential care accommodation and basic living needs. However, in my view, if an Aged Care Levy is introduced, this will have an important bearing on the justification for any form of means tested contributions to remain in place. In my view, after a transitional period following the introduction of any such levy, people in residential care should not be required to contribute at all to the Accommodation Supplement irrespective of their means. I also propose that, in spite of the fact that in future residential care providers will be paid an independently determined amount for ordinary living costs that is likely to exceed the current price cap of 85% of the single basic age pension, residents should not be required to contribute any more than the current price cap to their ordinary costs of living. The Government should pay the difference for all residents, irrespective of their means. Viewed in light of the suggestions I make about introducing an Aged Care Levy, I suggest that my approach strikes an equitable balance between those who are more financially fortunate and those who are less financially fortunate. Under my proposals, the abolition of means tested care fees does not mean that the wealthy would necessarily contribute less. All it means is that they will contribute during their working lives in proportion to taxable income, through the hypothecated Aged Care Levy, and would not be required to contribute again. As they do now for aged care and government services in general, the more financially fortunate will continue to pay a greater share. Further, there would be scope for the Aged Care Levy to be implemented through different rates, increasing its progressivity. This is a far more appropriate and efficient approach than the current reliance on means testing, which is burdensome and somewhat arbitrary in its effects.

As I said in the introduction to this chapter, I see a hypothecated Aged Care Levy as the best way to engender stability and confidence in the future of aged care financing. I also consider it likely to change the way the community perceives aged care for the better, toward it being seen as something valuable in which we all have stake, and that it will lead to greater scrutiny and accountability in the way money is raised and spent on aged care into the future.

Assuming that the Productivity Commission and Australian Government see merit in the adoption of actuarial principles for the management of stable future financing of the aged care system, it would be necessary to establish an office to be held by skilled actuaries who would be responsible for management of the fund generated by the revenue from the Aged Care Levy—an Aged Care Fund Actuary. For a reasonable period before the Australian Government is required to introduce legislation imposing an Aged Care Levy, it may be necessary for the Aged Care Fund Actuary to collect and analyse data, including data generated by the Pricing Authority about the independent pricing of aged care services and data about demand for those services. For as long as may be required for the Aged Care Fund Actuary to collect data before making recommendations to the Australian Government about the appropriate rate or rates for an Aged Care Levy, the aged care system should be funded by appropriations from Consolidated Revenue.

20.4.2 Why a levy?

Nobody likes to pay extra taxes with nothing in return, but most Australians are content to pay insurance premiums today to ensure that they do not have to cover the risk of possible costs or losses in the coming year that come from lost life, disability, car crashes, home damage or travel interruptions. The logic for wanting to allow Australians to pay for the risk of possible costs of aged care is identical: risk-averse Australians are better off being able to pay upfront in a predictable manner than having to pay if the need for care arises. The key insight here is that younger Australians do get something tangible in return for their contributions to aged care: the knowledge that they will not have to pay if and when they need aged care. If we view aged care in Australia as an entitlement, then it is an entitlement that younger people receive by paying for it. This viewpoint deliberately shifts from viewing aged care as just something that older people get: the provision of aged care is, in this sense, no different from an insurance company paying a claim in the event of loss in life when someone is older, having paid premiums for the years prior.

Even if people pay for the expected costs of aged care up front, we can still have the contributions people make vary with their taxable income, to ensure that people who enjoy higher taxable incomes pay a larger share. If the primary goal of a means test is to ensure that Australians with greater means pay a greater share, then all that is being proposed via this levy is that there is a better way to do that. All of the calculations in this chapter and Annexure A build this feature in by reflecting the progressive income tax system Australia already has. In effect, those calculations merely involve shifting the means testing from the point where services are provided to an older person to the point when income is being earned, earlier in the person's working life.

In short, there are efficiency gains based on insurance principles that apply to insurance arrangements because the levies on income are predictable and known, and hence the funding aspects of the aged care entitlement is predictable and certain. In addition, the principles of equity are met because the levels of contributions vary according to income levels.

20.4.3 Hypothecation

Levies in Australia may be hypothecated or non-hypothecated. Funds raised by a hypothecated levy are paid into a dedicated account within the Consolidated Revenue Fund, established for the specific purposes for which the levy is imposed, and can only be used for those purposes. The funds cannot be used for any other purpose and any excess funds are rolled over from year to year.

Levies that are not hypothecated are also paid into Consolidated Revenue. Although the funds raised are notionally 'earmarked', the Australian Government is not legally obliged to spend those monies only on the purposes identified in the name of the levy.

The Medicare Levy is an important example of an earmarked, non-hypothecated levy. The Medicare Levy contributes to the costs of Australia's public health system and is collected in the same manner as income tax. The levy is a flat 2% of an individual's taxable income and is paid in addition to income tax. However, the funds raised by the Medicare Levy are far below the costs of the medical and pharmaceutical benefits provided through the Medicare system.

There are several arguments in favour of hypothecation. The first has to do with accountability and trust: since they are directed to a specific and identifiable fund, hypothecated levies provide taxpayers with some assurance about how their contributions will be used. The need for certainty and predictability is great in the provision of future benefits for older Australians. The second argument has to do with transparency: hypothecated levies can educate people about the cost of particular services. Taxpayers can then make better informed decisions about the balance between contribution burden and level of services provided. A final argument is public support: in some cases, hypothecation can generate public support for increased contributions where the service set to benefit from the levy is perceived to merit it.

Dr Henry commented that 'there are very few heads of government expenditure that, to my mind, satisfy the conditions for having a hypothecated levy. But aged care certainly does'.[80] Aged care expenditure will continue growing and should continue growing at a similar rate, if not faster, to overall personal income tax. It will need to be increased over time.

There are also several arguments against hypothecation. The most important is that hypothecated levies tie the hands of government: constraining the ways in which government can allocate limited revenue between competing priorities, reducing the opportunities for governments to deal with economic cycles. The Australian Treasury was not supportive of a levy or hypothecation. Its key concern was regarding 'flexibility', arguing that an aged care levy lacks flexibility both in terms of the taxpayer base and how funds are directed.[81] Treasury took the view that aged care should continue to be financed from general revenue and funded via appropriations from the Consolidated Revenue Fund. With his characteristic directness of language, the Hon Paul Keating told us that the notion of paying for aged care out of recurrent government income was 'standard Treasury nonsense' and that the deteriorating demographic profile of Australia would leave the burden of financing the system resting on fewer and fewer people.[82] Mr Keating told us that for many years he had favoured a levy to finance the system, which he called an 'age income longevity levy'. The revenue from the levy would be applied by the Commonwealth acting effectively in the role of an insurer of risks that people would need costly care in the older years. He had recently come to the view, however, that this proposal would be too 'politically difficult'.[83] The Hon Peter Costello AC also commented on hypothecated levies. He explained that governments generally perceive such levies to have two key disadvantages: the likelihood that they will generate either too little or too much revenue for the relevant purpose, and the tendency that they 'inhibit flexibility and overall budgetary policy', making it harder for government to find revenue for all those necessary expenditures that are not covered by a hypothecated source of financing.[84]

The Australian Treasury also identified an approach to committing public finances, specifically for aged care, without requiring hypothecation. Specifically, the Government's spending on the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme is accounted for in each Budget update as part of the Medicare Guarantee Fund. The Treasury suggests that these funds are drawn down from consolidated revenue, providing 'flexibility for government budgeting but enhancing public accountability'.[85]

The advantages of an aged care levy, hypothecated or otherwise, were articulated by a number submissions made in response to the Financing Aged Care consultation paper.[86] Many were specifically supportive of a hypothecated levy approach.[87] Some, however, qualified their support in terms of a short-term levy.[88]

On balance, I believe that hypothecation is consistent with the principles I have set out for designing a system of financing for quality aged care.

20.4.4 Form and parameters of an Aged Care Levy

As already noted, we have obtained indicative modelling that demonstrates how a hypothecated Aged Care Levy could be constructed and how it could be made to work. In providing the outcomes of this modelling, I am not suggesting that the levy should necessarily be constructed in this way, but the modelling is useful because it shows that a hypothecated aged care levy is workable.

Revenue base for application of levy

There are various potential bases for a new, hypothecated Aged Care Levy. One possible approach, which is the one that has been modelled for us, is to impose the Aged Care Levy on personal income taxpayers. If this approach is adopted, the principle of equity that I want to apply means that I can use the general taxation progressivity in income taxes as the basis for contributions that Australians make for the Aged Care Levy. This does not necessarily mean that the only option available is to impose the Aged Care Levy solely on personal income taxpayers. In fact, there would be advantages in imposing it more broadly, as (based on tax data from 2017–18) personal income tax makes up about 52% of all taxes in Australia.[89] However, for the purposes of the illustrative modelling we have obtained, this is the primary approach adopted.

We also obtained alternative modelling of an approach by which 52% of the financing requirements of the aged care system is obtained from a levy, and 48% from general revenue in the Consolidated Revenue Fund.

Pay as you go or pre-funded?

Pure pay as you go refers to arrangements where finances are raised in each period to cover the costs of providing care in that period for today's older people. Pre-funding refers to schemes in which finances collected in a period for a certain group are set aside to meet the future aged care costs of that group.

The transition time needed for pre-funding is likely to be great, such that the benefits of pre-funding would not accrue for some time. Many submissions in response to Consultation Paper 2 argued that the time for pre-funding to ease the burdens of future funding had passed, because the generation of baby boomers have now left their prime income-earning years behind them.

Long-run pay as you go is the most appropriate arrangement in the context of the principles I stated in the introduction to this chapter. In this context, I mean setting a contribution rate that is expected to raise finances now and into the future to be sufficient to meet current and future aged care costs, for the group currently receiving aged care and for future recipients. I describe later the way in which these arrangements can be set up, and the calculations that go with them. A key feature is the actuarial determination of costs for the coming years, so that we can generate funds that are sufficient to meet expected costs based upon insurance principles actuarially.

In general, it is common in insurance settings that a levy or premium is set at a level that is sufficient to fund expected claims over a given time horizon. It is common that this horizon be quite long, usually in terms of decades. However, it is expected that there would be regular review of these calculations, and revisions to reflect updated data on expected costs. I explicitly illustrate this review step later, in the context of some calculations with specific aged care levy proposals.

Here I am proposing a 30-year horizon, with potential resetting of the contribution rates every three years. Further, I envisage that the Aged Care Fund would be subject to pay as you go financing, not pre-funding. That seems to me to be the most appropriate arrangement in the context of the principles I stated in the introduction to this chapter.

This approach will involve setting a contribution rate (that is, a levy) that is as stable as possible over the long term (that is, over 30 years), and that is calculated to raise sufficient revenue to meet the funding of aged care services year-on-year and across the 30-year period, together with a buffer to account for potential volatility.

The role of actuarial principles in long-run pay as you go

Several key actuarial principles underpin the requirement that a long-run pay as you go levy will need to be set at a level that can be expected to be sufficient to pay for all relevant ('in-scope') aged care costs over the long term. This kind of calculation is routine work for insurance companies.

The Fund Actuary should prepare, at regular intervals, a central estimate of the expected future revenue and expenditure that are in scope. I illustrate below these calculations as relevant aged care expenditures expand incrementally. This calculation should rely on the best available historical information and relevant projections as inputs, and assumptions regarding the future should be based on the actuary's understanding of likely future experience.

There are two sides to this calculation:

- On the **cost** side, projecting long-term aged care costs across a population involves a detailed consideration of demand for and cost of aged care services, as well as supply side factors, each of which has many different demographic and socioeconomic inputs.
- On the **revenue** side, dynamic projections of taxable income for each tax band over time are required, which also involve detailed considerations of demographic and socioeconomic drivers.

It is self-evident that long-term projections evolve over time. For example, predictions of aged care costs for the year 2050 will change as one gets closer to that time. This is because actual emerging aged care service usage and costs can be monitored, and these outcomes can then be compared to what had previously been predicted. As a result, subsequent projections can be refined and updated. This will enable the Fund Actuary to regularly advise on the likely sufficiency and appropriateness of the prevailing levy rates and, if necessary, suggest potential revisions. This is completely standard in the actuarial calculations underlying the pricing of insurance products and annuities.

With any long-term projection there is considerable inherent uncertainty, captured by the actuary statistically. Given this uncertainty, in addition to setting a central estimate the range of potential outcomes should be evaluated in order to determine the likelihood that the revenue raised by a specific levy will be sufficient to cover future outgoings. Thus the actuary comes up with estimates of what range of levies, today and into the future, will be needed to cover expected claims with some specified level of confidence (for example, at a statistical 'confidence interval' of 75% or 90%).

Taken together, these analyses enable the selection of a levy with an understanding of the consequent risks of shortfalls in the hypothecated aged care fund, such that future increases in the levy would be required. Again, the point is illustrated later with some specific policy calculations. I also discuss the institutional arrangement that would support these calculations being undertaken in an actuarially sound manner and, critically, being revised in a systematic and regular manner as needed. An important part of this revision process would be transparent review by the public and the Australian Government.

Calculating the proposed Aged Care Levy

I summarise below some illustrative calculations demonstrating how the current government funding requirements of the aged care system could be financed from a levy. I then summarise illustrative calculations demonstrating how a future aged care system could be financed from a levy. A key, and foundational, feature in these calculations is the actuarial determination of costs for the coming years, and the setting of levies to generate funds that are sufficient to meet expected costs, based upon insurance principles.

These calculations set out ways in which the current financing arrangements in aged care can be replaced with predictable, known tax levies during the life of Australians.

Baseline scenario—current aged care services

As a baseline scenario, I consider the case where no changes are made to aged care policy other than the source of its public financing. In this scenario, there would be no increase in expenditure on aged care other than that already provided for under current policy. The arrangements for private contributions, including means tested contributions, remain the same under this scenario.

The modelling indicates that if public financing of aged care was converted to a flat rate levy on taxable income, in broadly the same form as the Medicare Levy, then the required Aged Care Levy would be 2.61%.

The approach to this calculation was as follows. The modelling starts by evaluating the public costs of various components of aged care, as well as identifying the private costs. By 'private costs' I mean the costs that are currently met by individual contributions from people receiving aged care. An example of a private cost is the means tested fees that contribute towards Residential Care costs. Table 1 explains what these costs refer to by the scope of service provided. For Residential Care, I separate out care costs, living costs and accommodation costs. There is an option to include imputed interest from Residential Accommodation Deposits as a proxy for the accommodation costs they represent.

Table 1: Scope of aged care service costs

Care type and scope of services	Public costs	Private costs
Home Support	Government contributions	Consumer contributions
Home Care low	Government contributions	Consumer contributions
Home Care high	Government contributions	Consumer contributions
Residential care (care-only costs)	• Basic care subsidies (Permanent and Respite) • Hardship Supplement • Viability Supplement • Preserved Supplements (Transitional, Charge Exempt, Basic Daily Fee) • Other Supplements (Veterans' and Homeless) • Other reductions	• Means tested care fees • Resident other care fees
Residential care (living costs)	Not applicable	• Resident Basic Daily Fee • Extra Service Fees • Additional Service Fees
Residential care (Accommodation)	• Accommodation Supplement • Hardship Accommodation Supplement • Transitional Accommodation Supplement • Concessional Accommodation Supplement • Accommodation Charge Top-up • Pensioner Supplement	Accommodation payments from residents in the form of Daily Accommodation Payments were included as private accommodation costs. There is an option to include an equivalent Refundable Accommodation Deposit payment through converting the respective Refundable Accommodation Payment into an annual income using an imputed interest rate.

We have obtained projections of how these components of aged care costs might grow until 2050, so that all of the calculations take into account the anticipated demographic changes coming in the next few decades. The cost projection is made by calculating the relevant unit costs and selecting inflation assumptions so that the cost projections broadly align with outputs from the economic model we obtained from Deloitte Access Economics (Deloitte Model).[90] The figures are only indicative, and will need to be revised based on finalised inputs and costings implemented by the Australian Government. Calculated in this way, however, the estimated total public cost levy is 2.61%.

An alternative to a flat levy would be to design a progressive series of rates, rather than a flat rate Aged Care Levy. The progressive Aged Care Levy would consist of a series of different rates, with higher rates applying to amounts of a person's taxable income falling within higher taxable income bands.

I illustrate below the manner in which the proposed levy rates would be progressive in this sense by showing how the 2.61% total public cost levy might translate into increasing tax levies by taxable income band. The additional marginal tax levies, rounded to one decimal place, are shown below. These are additional marginal levy rates (that is, they apply to each dollar in the tax band earned over the band's lower threshold), and the fixed tax component for income earned below that threshold is subject to the rates for the lower bands:

- 0.0% for those in the lowest income tax bracket up to $18,200
- then increasing to 2.1% for the tax bracket up to $37,000
- then to 3.7% for the tax bracket up to $87,000
- then to 4.2% for the tax bracket up to $180,000
- finally, 5.1% for those in the income tax bracket greater than $180,000.

These rates preserve the proportional relationships between tax bands that already exist in the present income tax system. The details of the derivation of these rates are explained in Annexure A, in the text above Table 3.

Because no additional funds are expended under this scenario than under current policy, the Government could, in a revenue-neutral way, reduce marginal tax rates in the various tax bands. In other words, if the savings in appropriations from the Consolidated Revenue Fund attributable to the Aged Care Levy were allocated in their entirety to a reduction in personal income tax rates, there would be scope for the aged care levy to have *no net effect* on marginal rates, depending on the design of the levy.

The remainder of the analysis here assumes that this happens—so as to illustrate the net effect of the introduction of the Aged Care Levy and the recommendations in this report.

The key difference from the current arrangements would be that the funding for aged care would be directly identified and hypothecated to that purpose. On the approach modelled, there would also be a slight increase in the amount of money allocated to aged care in the early years of the arrangement, as explained in more detail under the heading 'Cash Accumulations', later in this chapter.

Reform scenarios for the proposed Aged Care Levy

The next iteration of the modelling calculates the levy rates that would be required to provide financing of the funding of the aged care system if all our key recommendations are accepted, including that care and accommodation not be means tested and that contributions to ordinary living costs not exceed the current price cap. In that scenario, the Aged Care Levy in the form of a flat levy on taxable personal income would need to be set at 5.4%.

This would represent an increase in taxation. If the Aged Care Levy was to be designed progressively rather than as a flat rate, then on the same approach as above, the rates would be:

- 0.0% for those in the lowest income tax bracket up to $18,200
- then increasing to 4.4% for the tax bracket up to $37,000
- then to 7.6% for the tax bracket up to $87,000
- then to 8.7% for the tax bracket up to $180,000
- finally, 10.5% for those in the income tax bracket greater than $180,000.

I call these rates the 'Gross Levy' rates. Assuming that baseline rates for the current costs of the aged care system had been reduced as discussed above, the impact of these Gross Levy rates on effective tax rates would be the differences between the Gross Levy rates in the reform scenario and the levy rates in the baseline scenario. I call these differentials the 'Net Levy' rates:

- 0.0% for those in the lowest income tax bracket up to $18,200
- then increasing to 2.3% for the tax bracket up to $37,000
- then to 3.9% for the tax bracket up to $87,000
- then to 4.5% for the tax bracket up to $180,000
- finally, 5.5% for those in the income tax bracket greater than $180,000.

The Net Levy rates set out above are those that would be required to finance the additional costs of our recommended reforms from a levy imposed on personal income taxpayers alone. Alternatively, if (in line with the current distribution of financing burden between personal income taxpayers and other elements of the tax base) the levy were to generate only 52% of the additional costs of our recommended reforms, the rates ('Alternative Net Levy') rates would be:

- 0.0% for those in the lowest income tax band, up to $18,200
- then increasing to 1.2% for tax band 2, from $18,001 up to $37,000
- then to 2.1% for tax band 3, from $37,001 up to $87,000
- then to 2.3% for tax band 4, from $87,001 up to $180,000
- finally 2.8% for those in income tax band 5, greater than $180,000.

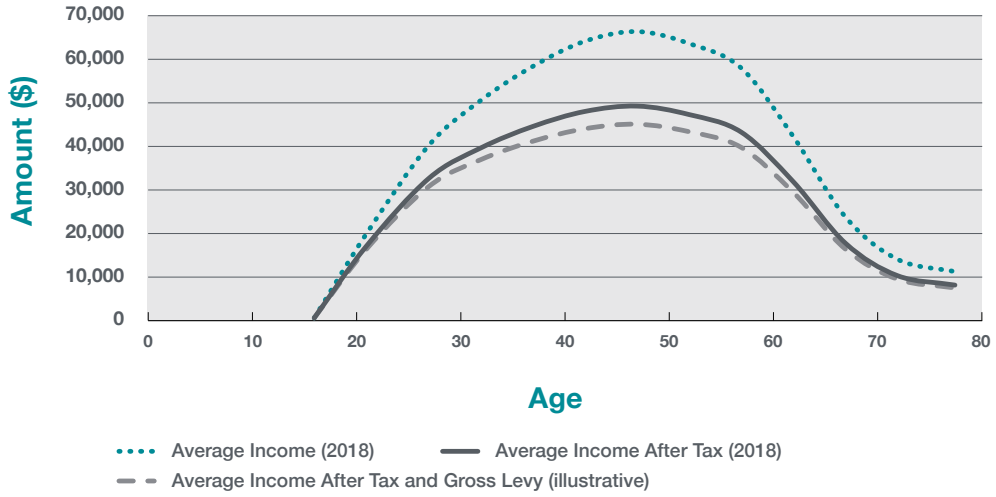
Figure 1 displays:

- Average Taxable Income by age based on 2017–18 tax data
- Average After-Tax Income modelled under the baseline scenario, that is, a progressive Aged Care Levy which finances all the current public financing of the aged care system, but without any other aged care reforms, on the assumption that marginal income tax rates in each tax band are reduced by the amount of the marginal Aged Care Levy rate in each tax band
- Average After-Tax Income modelled under the baseline plus a scenario involving acceptance of key recommended reforms to the new aged care system, including removal of means testing for contributions to care and accommodation. This modelling shows the impact of the Net Levy on average after tax income, added to the taxation effects of the baseline scenario.

Figure 1: Implied average after-tax income for progressive Aged Care Levy financing of baseline plus all reforms

The impact of replacing care costs, living costs and accommodation costs (including Refundable Accommodation Deposits) for residential care, home care, and home support with a progressive levy.

A. Average After-Tax Income by Age:



B. Average After-Tax Income by Taxable Income:

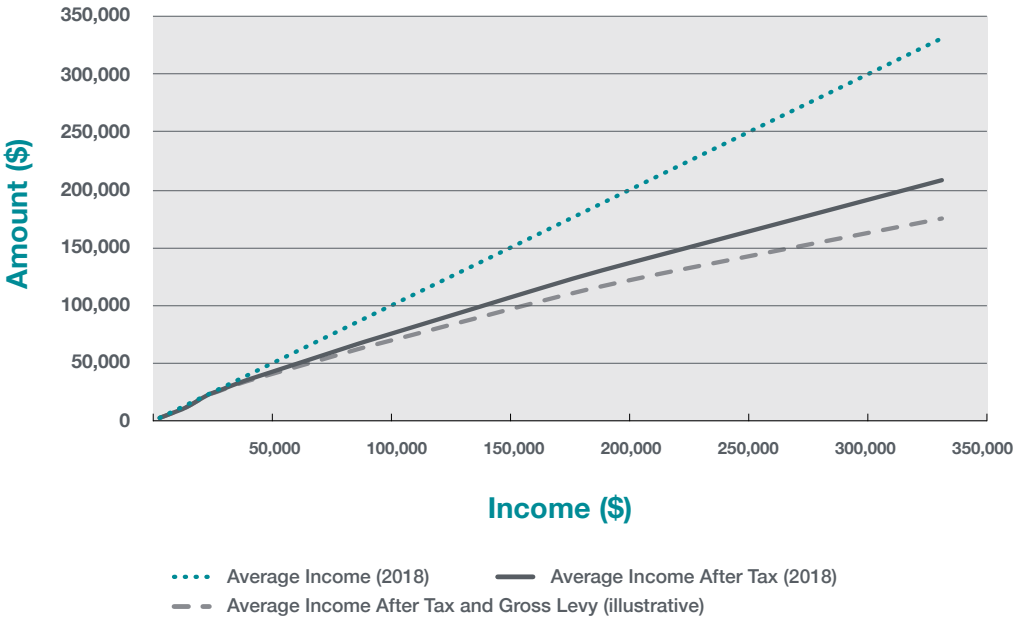
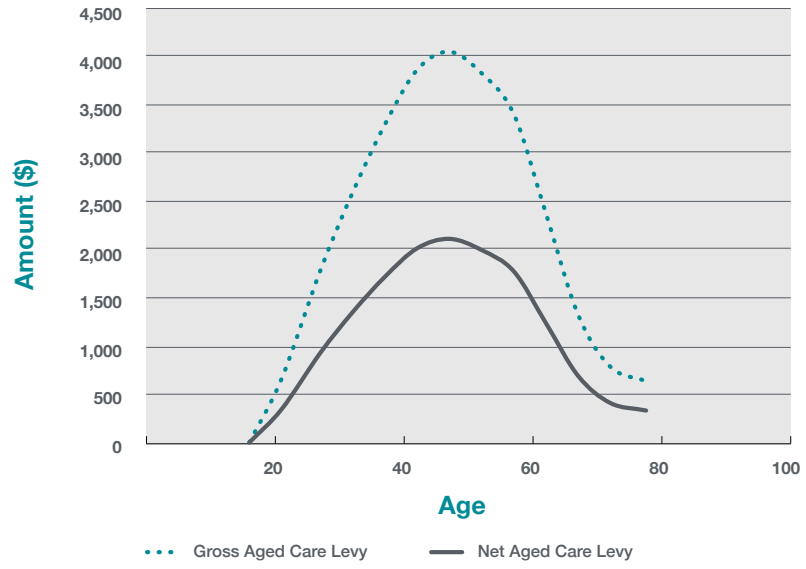


Figure 2 displays the price tag of aged care in a stark manner. Panel B clearly shows the progressive nature of who pays this price tag, in the black and red lines respectively, consistent with one of the core principles stated earlier. Panel A clearly shows that the burden falls primarily on those aged 25 to 65 years, with a peak around those aged 50 years. This incidence by age is solely due to the positive correlation of taxable income with age.

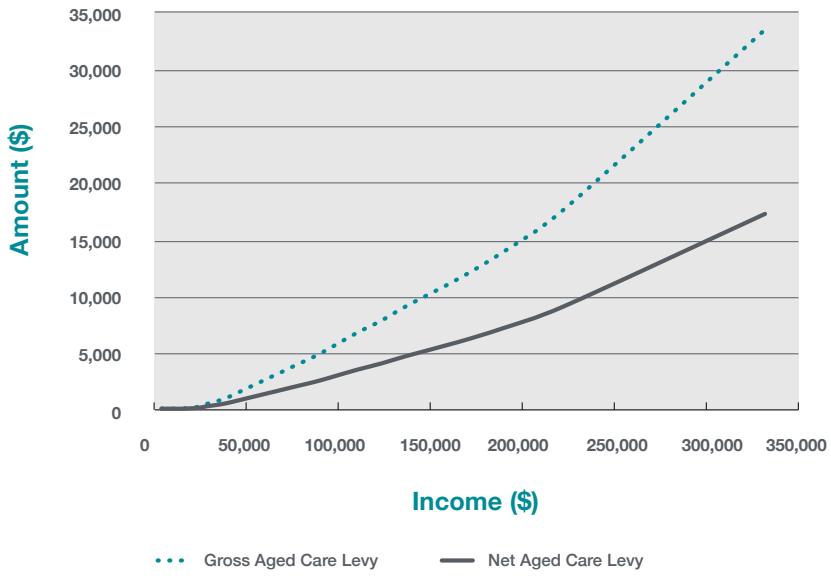
Figure 2: Implied net tax levy for Aged Care Levy financing of baseline plus all reforms

The Gross Levy shows the impact of a personal income tax increase to cover all public aged care costs including all reforms. The Net Levy shows the impact of a personal income marginal tax increase and corresponding fixed amount for taxable income beneath required in addition to the current amount of personal income tax contributing to the scope of costs via general revenue.

A. Aged Care Levies by Age:



B. Aged Care Levies by Taxable Income:



Commissioner Briggs and I are largely in agreement on the key reforms which underlie this modelling, which are as follows:

- increases in staffing for residential care to '4 star' average levels by 1 July 2024
- removal of the waiting list for Home Care Packages, and increases in the levels of funding permitted to be assessed for home care, up to the level of the care component the individual would receive in residential care, by 1 July 2024
- abolition of means tested contributions to the costs of care in all settings by 1 July 2024
- equity for people with disability receiving aged care.

However, we differ in our approach to means tested contributions toward the costs of accommodation and, to the extent I identified earlier in this chapter, on the question whether a resident's contribution to their ordinary living costs in residential care should remain capped at 85% of the single basic age pension, irrespective of means. I consider the cost of accommodation should be regarded as part of care, and that after a transitional period the Australian Government should pay the Accommodation Supplement for all aged care residents. Commissioner Briggs considers that the current principle of applying means testing as a condition of eligibility for the Accommodation Supplement should continue, subject to improvement of the means test itself. We have therefore obtained an iteration of the modelling which provides the Net Levy implied by all the key recommendations save for abolition of means testing for accommodation. The modelled outcomes in that scenario are similar to the modelled outcomes for all reforms. The modelling has disregarded the minor difference between us on ordinary costs of living for the purposes of the modelling. The respective Aged Care Levy rates are:

- 0.0% for those in the lowest income tax bracket up to $18,200
- then increasing to 2.1% for the tax bracket up to $37,000
- then to 3.6% for the tax bracket up to $87,000
- then to 4.1% for the tax bracket up to $180,000
- finally, 5.0% for those in the income tax bracket greater than $180,000.

Differential Aged Care Levy for 40-year-olds and over

As I have mentioned, it was submitted to us that the introduction of an Aged Care Levy would raise issues of 'intergenerational inequity'. Further, we are aware that younger people face particular costs—for example, establishing a family, paying off their Higher Education Contribution Scheme debt and trying to buy a home. An iteration of the modelling examined an alternative approach whereby the Aged Care Levy imposed differentially on the taxable incomes of people who are aged 40 years or older to generate the revenue required to pay for the reforms we recommend from this age cohort.

In this scenario, the modelling estimates that the net Aged Care Levy in flat form would be 4.5% for people aged 40 years and over (with zero net levy for people aged under 40 years). The modelling continues to assume that the Australian Government and Parliament would reduce marginal income tax rates commensurately with the 2.6% flat rate. Using the same approach to designing a series of progressive rates, the marginal net levy rates for each tax band for people aged 40 years and over would be:

- 0.0% for those in the lowest income tax bracket up to $18,200
- then increasing to 3.5% for the tax bracket up to $37,000
- then to 5.9% for the tax bracket up to $87,000
- then to 6.8% for the tax bracket up to $180,000
- finally, 8.2% for those in the income tax bracket greater than $180,000.

Cash accumulations

It is inevitable that there will be differences, from year to year, between the revenue generated by the aged care levy and the required outlays consistent with the delivery of the entitlement to a quality aged care system. These differences are natural, and familiar in all private or social insurance settings. These differences also imply cash accumulations in some years and cash drawdowns in other years, and raise the question of an appropriate level of reserves. Again, these are familiar calculations in any insurance context. In fact, the actuarial determination of reserves and the actuarial determination of premiums are considered 'dual' to each other: they are just two sides of the same calculation.

Further, the need for a reserve buffer arises for several reasons. The first, as usual with insurance arrangements, is the need to attend to fluctuations in revenues and expenditures referred to above. The second reason is the need to ensure that the fund does not incur a negative balance, which would be a breach of the underlying legislation containing the appropriation authority and the *Public Governance, Performance and Accountability Act 2013* (Cth). Any negative balance would correctly attract the attention of the Australian Department of Finance, the Minister for Finance and the Auditor-General.

Once the notion of some reserve is accepted, the question arises as to what to do with it. One suggestion is that the Future Fund Management Agency could manage the reserves. Whatever mechanism for administering the reserves is chosen, it is important that the Government recognises its requirement to meet long-term costs and therefore does not consider them as available funding to meet other (non-aged care related) purposes—even if, from an accounting perspective, they might technically be recorded as net assets on the Government's balance sheet.

Although it might seem tempting and attractive, I do not recommend that the reserves be recycled back into the aged care system in some substantive manner (for example, interest earnings being added back, infrastructure support, or used for research and development). The reason is that the actuarial need for reserves, and their prudential management, should be wholly separate from the determination of specific funding priorities for quality aged care.

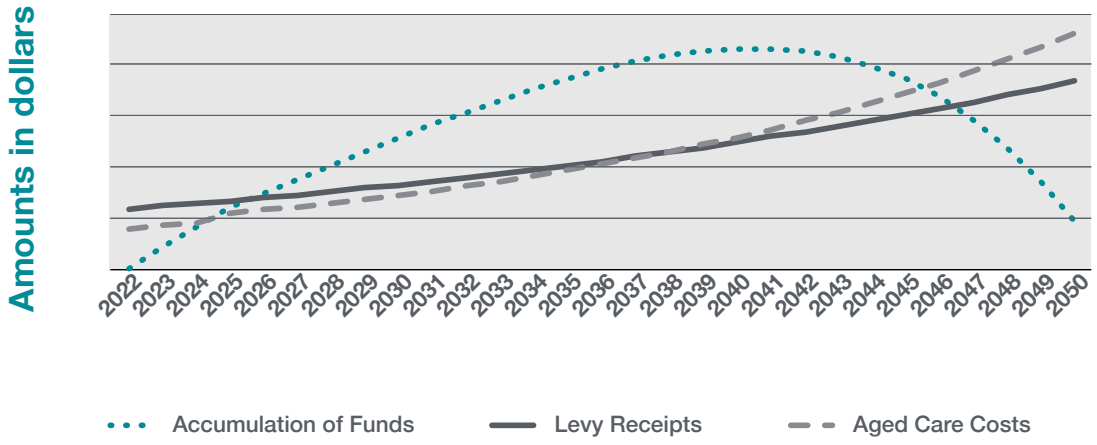
For various reasons, I propose that needless cash accumulations or drawdowns be avoided by having regular approval cycles for the aged care levy. For now, put aside who is approving what: I return to this important issue when discussing institutional arrangements. There are several reasons for wanting regular review cycles:

- There will be natural changes in the expenditures needed to provide aged care, as the population ages, salaries change, care technologies change, and so on. These changes are reasonably predictable for the short-run of the next five to 10 years, but understandably become harder to predict reliably for longer horizons.
- I expect that there will be significant changes to the aged care system consistent with our many recommendations. We have provided costing estimates for these changes, but those too are subject to uncertainty. In part, uncertainty comes from whether our recommendations are adopted as a whole or just in part.
- The Aged Care Levy will be calculated to meet some financing balance target over a longer horizon, and without regular revisions over shorter horizons that would lead to needless adjustment when that initial, longer horizon ended. To be specific, it is common to set a financial target of zero aggregate cash accumulations over a lengthy period, say from FY22–FY50. If the levy set in this manner was unchanged, and revenues and expenditures exactly matched those 29-year projections, there would be no reserves to handle day-to-day, month-to-month, or quarter-to-quarter fluctuations, nor would the reserves be set appropriately to allow the levy to be sustainable beyond the end of 29 years.
- It is appropriate that government, on behalf of taxpayers and all Australians, have a review of the commitment to a quality aged care levy, and these revisions would be a natural place to undertake that review. Again, I say 'review' here to postpone discussion of who gets to approve what.
- If reserves accumulate, as discussed further below, there are understandable political reasons for them not to become too large, lest they attract demands from other government programs that might be the 'priority of the day' or annual budgetary cycle. Again, I accept that government should have priorities for taxpayer revenue, but reject that quality aged care can be safely left to be prioritised on an annual basis.

A long-run pay as you go levy (or levies) would need to be set at a level that can be expected to be sufficient to pay for all relevant aged care costs over the long term. Because of differences in cashflow timings—in particular, that aged care costs are expected to grow more quickly than taxable income—the introduction of such a levy would result in accumulations of money at different times. In the modelling, the levy (or levies) are set such that, at the end of the projection period (FY55), all relevant aged care costs would have been met by the collection of levies to that point. An investment return (4.29%) has been assumed on any temporary accumulated money in a hypothecated levy fund. The return was based on similar rates assumed in the Deloitte Model. Administration expenses relating to the collection and distribution of the levies have been assumed to be in proportion to investment returns and have been assumed to have an effect of increasing the levy required (all else equal).

An example of this is shown in Figure 3 for the financing of all our recommended reforms through a progressive Aged Care Levy. The balance of accumulated funds (green line) changes due to differences between levy receipts (blue line) and aged care costs (red line) being met by those levies, as well as net interest. The model assumes that levy receipts are collected each year and flow through immediately to accumulated funds. In reality, there may be differences in timings.

Figure 3. Aged Care Levy component



All of these issues can be avoided by having regular reviews of the aged care levy.

One key reason for requiring a regular review of the levy is that, after a few years, it is inevitable that the future outlook upon which the levy was originally set will no longer be applicable. As well as a changed outlook due to unforeseen circumstances impacting the social, demographic and economic future landscape, the levy can be updated to apply for a new 29-year period beginning from the date of the review.

Table 2 illustrates the impact of resetting the flat levy percentages at alternative time periods in the full reform scenario. It demonstrates that, with the current outlook of an ageing population, using the current projections in the full reform scenario, the flat levy percentage required is higher the further into the future the levy is set. For example, if one were to set and commence the levy in five years' time, in financial year 2026–27, the required levy (described in the form of a flat levy) would be 6.0%. And if a flat levy were to commence in financial year 2051–52, it would be 7.3%.

Table 2: Flat levies at alternative time periods under full reform scenario

FY22-FY50 Flat Levy	Alternative A: Reset Flat Levy for FY27-FY55, i.e. after 5 years	Alternative B: Reset Flat Levy for FY51-FY55 , i.e. after 29 years
5.4%	6.0%	7.3%

Table 2 also indicates that more frequent resetting of the levy enables smaller incremental changes to the levy over time. For example, to cover costs up to FY55, under current expectations, a revised levy set at FY27 would require a 0.6% increase from the current proposed levy of 5.4%, whereas a revised levy set at FY51 would need to be 1.9% larger. This demonstrates the smoothing benefit of more frequent revisions to the levy even before accounting for the fact that resetting of the levy may be desirable over time as future experience will not perfectly match current projections.

20.4.5 Institutional arrangements

As outlined above, I suggest that a hypothecated aged care levy should be developed, to raise funds to cover aged care costs funded by the Australian Government. Therefore, an entity must set the levy, revise it on a regular basis, and monitor long-term financial viability of the system. Witnesses emphasised the importance of structuring this entity carefully.[91]

The independent entity fulfilling this role should be the Pricing Authority, whether that be the Aged Care Pricing Authority (if Recommendation 6 is implemented by the Australian Government) or the Independent Hospital and Aged Care Pricing Authority (if Recommendation 11 is implemented). Within the Pricing Authority, it will no doubt be important to have certain roles clearly identified and functions allocated, including the role and functions of the Aged Care Fund Actuary. This role will undertake calculations of projected levies. This will, in turn, require projections of likely future trends in aged care costs, evaluations of historical levies and realised aged care costs.

One important issue to be resolved is whether the determination of proposed levies by the Pricing Authority is binding or is just advisory. As I noted above, I consider it appropriate for the Australian Government and the Parliament to carry changes to levy rates into effect by statutory amendment. It follows that the role of the Pricing Authority with respect to the Aged Care Levy should be advisory only.

The role of the Pricing Authority would be to report new determinations of aged care levies every three years, along with detailed reports to the Government explaining the logic and calculations underlying that determination. The Pricing Authority would also have the option of reporting within three years of the last report, in the event that significant changes occur that warrant earlier review of the levy. Hence, the underlying calculations would be reviewed continuously, which is common in private and social insurance schemes. The regular report every three years should also be subject to external evaluation, including the use of a Reviewing Actuary. The Reviewing Actuary should probably be the Australian Government Actuary. This external review would also be presented to the Government. This would align with the approach adopted in the National Disability Insurance Scheme.[92]

High-level updates of these continuous reviews of the levy would be appropriate to include in annual reports of the Pricing Authority, which would be required under the *Public Governance, Performance and Accountability Act 2013* (Cth).

20.5 Conclusion

My suggestions for financing aged care support in Australia by means of a hypothecated aged care levy on income derive from the principles I stated at the beginning of this chapter, along with our proposal to establish a universal entitlement to aged care in accordance with need. I considered options for phased implementation of a levy, but have concluded that it is appropriate that the Productivity Commission investigate the development of a scheme by which the system should transition to financing arrangements based upon an Aged Care Levy in a single step, once the mechanisms are in place for reliable determination of the levy rates.

These financing arrangements would be based, and seen by the community to be based, on a portion of the income that Australians earn throughout their working lives. This would inject predictability into both the contributions that people are expected to make during their working lives and the plans they can make for their retirement, as there would be no unpredictable costs such as means tested care fees in the future as needs suddenly arise. The arrangement will reliably deliver the revenue needed to meet expected claims, without being subject to annual budgetary cycles and priorities. This would engender stability and confidence in the sustainability of the system. It is appropriate for government to set priorities, but quality aged care is not a priority that can be traded off on an annual basis. The calculations underlying the levy, and its adjustments every three years, would be objectively determined using standard actuarial principles.

The levy would result in all Australians contributing to the cost of their entitlement in an economically sound manner, in a similar manner to the way they pay premiums for insurance before needing to make a claim. In paying these levies during their working life, Australians would be conscious of their contribution to the entitlement of all to high quality aged care in accordance with need, tending to encourage government accountability to taxpayers for providing that entitlement, and making the cost of that entitlement transparent to the nation. Finally, the aged care levy would be collected on an equitable basis, reflecting the general progressivity of the current income tax system, whereby those with larger incomes pay a larger share of the expected costs.

20.6 Annexure A—Model methodology

The Financing Model was developed to support consideration of a variety of financing mechanisms and, in particular, illustrate indicative variants of levies that might be sufficient for financing certain components of the aged care system. This was for the purpose of exploring an approach to financing rather than necessarily recommending the specific values for the levies themselves, which would require more detailed modelling for implementation.

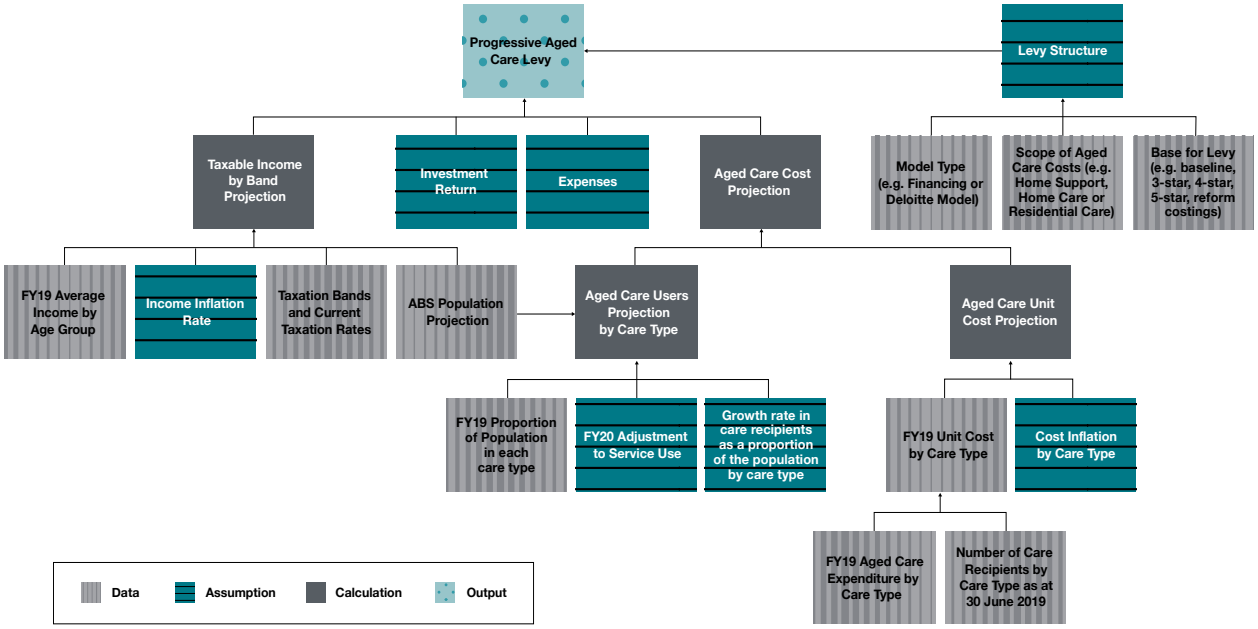
The general approach for the Financing Model was that its outputs should be able to align broadly with the outputs of the Deloitte Model and our Costings Unit to ensure consistency. However, it was built with a completely different (and less granular) structure compared to the Deloitte Model to enable the testing of alternative financing approaches applied to a variety of cost projections.

This section outlines the model methodology, data sources and assumptions used to develop the estimates within the chapter.

A.1 Financing Model methodology

Figure 4 illustrates a high-level overview of the Financing Model. The model was structured to project aged care costs from FY19 to FY55. It projected aged care costs by service type and taxable income by age. It was structured in this way to enable flexibility in modelling levy variants. However, the model's outputs are intended to be aggregated across relatively wide age and income bands and to provide indicative levies only.

Figure 4: Financing Model map



A.2 Data sources and inputs

The model is based on publicly available data and has reliances on the 2016 Australian Bureau of Statistics Population Projection, and the Deloitte Model prepared for us. The data sources used to inform the Financing Model are described in Table 3.

Table 3: Modelling data sources and inputs

Data Type	Source
FY20 Number of care recipients by care type	GEN aged care data • **Commonwealth Home Support Programme:** https://www.gen-agedcaredata.gov.au/Resources/Access-data/2020/October/Aged-care-data-snapshot%E2%80%942020 • **Home care:** https://gen-agedcaredata.gov.au/www_aihwgen/media/Home_care_report/Home-Care-Data-Report-4th-qtr-2019-20-AIHW-version.pdf • **Residential care:** https://www.gen-agedcaredata.gov.au/Resources/Access-data/2020/October/Aged-care-data-snapshot%E2%80%942020
FY19 Number of care recipients by care type	GEN aged care data • **Number of care recipients by care type:** https://www.gen-agedcaredata.gov.au/Resources/Access-data/2019/September/Aged-care-data-snapshot%E2%80%942019 • Distribution of care recipients by age: • **Commonwealth Home Support Programme:** https://gen-agedcaredata.gov.au/www_aihwgen/media/Factsheet-PDFs-and-thumbnail/CHSP-Fact-Sheet-2017-18.pdf?ext=.pdf • **Home care:** https://www.gen-agedcaredata.gov.au/Resources/Access-data/2020/March/GEN-data-People-using-aged-care • **Residential care:** https://www.gen-agedcaredata.gov.au/Resources/Access-data/2020/March/GEN-data-People-using-aged-care
FY19 Aged care expenditure by care type	This data was used to reconcile the aged care expenditure data provided by the Royal Commission: • https://www.health.gov.au/sites/default/files/documents/2020/07/eighth-report-on-the-funding-and-financing-of-the-aged-care-industry-july-2020-eighth-report-on-the-funding-and-financing-of-the-aged-care-industry-may-2020_0.pdf
Average income by age group	Australian Taxation Office: • https://data.gov.au/dataset/ds-dga-23b8c299-a85b-4fc0-a07d-5ed14e23a103/distribution/dist-dga-f214eb40-31e5-4af0-a395-bc77b5d50d58/details?q=%22taxation%20statistics%22
Taxation bands and current taxation rates	Australian Taxation Office: • https://www.ato.gov.au/rates/individual-income-tax-rates/
Australian Bureau of Statistics Population Projection	Australian Bureau of Statistics • Projected population (2016–2066): https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3222.02017%20(base)%20-%202066?OpenDocument
Reform costings	Costings from 2021 to 2025 relating to the recommendations in the Counsel Assisting's final submission as published on 29 October 2020 were provided by our Costings Unit.

A.3 Model assumptions

This section outlines the model assumptions used to inform the Financing Model and its applications. As the model's outputs are intended to be aggregated across relatively wide age and income bands and to give indicative levies only, the assumptions have been selected consistently with this objective.

A.3.1 Population projection

The 2016 Australian Bureau of Statistics population projection was used in the Financing Model to project the number of individuals by age up to 2055. As this was the most current population projection available through the Australian Bureau of Statistics, it was assumed to be representative of future expectations about the population. Office of the Royal Commission staff verified that 2019 and 2020 actual population statistics did not indicate that the population projections from 2016 were unreasonable.

A.3.2 Projection of care population

The proportion of the population using each care type in FY19 was initially calculated as the number of Full Year Equivalent (FYE) care recipients divided by the number of people in the population. The scope of care types includes:

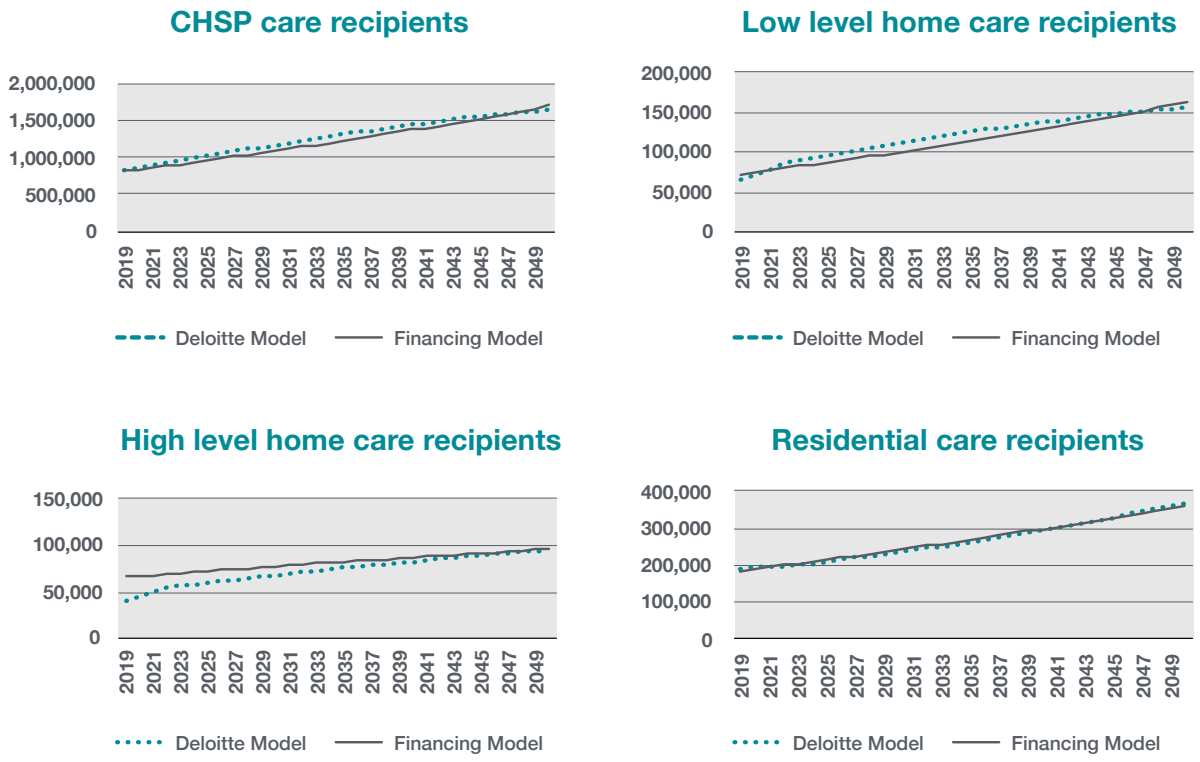
- **Home Support:** Commonwealth Home Support Programme and Home and Community Care (HACC) in Western Australia
- **Low-level Home Care:** Home Care Level 1 and Home Care Level 2
- **High-level Home Care:** Home Care Level 3 and Home Care Level 4
- **Residential:** permanent and respite residential.

1. Care recipients as a proportion of the population is expected to grow over time to reflect the ageing population. The process for calculating the number of care recipients for each care type involves:
2. Calculating the care recipients as a proportion of the FY19 population. Royal Commission staff used GEN aged care data to infer an approximate distribution of the total FY19 recipients by age;
3. As there is publicly available information for Home Care and residential FYE care recipients in FY20, an adjustment can be conducted to improve the precision of the model and better align the outputs to actual experience. This is particularly important for Home Care services as there has been a significant increase in the volume of packages released since FY19. Adjusting the FY19 experience was preferred over shifting the analysis to commence at FY20 as aged care costs were derived from FY19 information and this approach would maintain consistency. This adjustment changes the FY19 care recipients as a proportion of the population, such that the actual and expected number of care recipients in FY20 align. This step implicitly assumes the same proportional impact for every age.

4. Care recipients for each care type were projected by multiplying the proportion of the population using care in FY19 by the relevant growth rates and the population for the year. The annual change in the proportion of the population using aged care services was selected to minimise long-term differences (in aggregate) with the Deloitte projection at the overall care type level. In hindsight, the Deloitte Model underestimated the actual FY20 Home Care high usage, which may be due to the additional ad-hoc release of packages. However, Office of the Royal Commission staff did not expect this underestimation to persist in the long-run and so the choice of 0% growth as a proportion of the population enables the projections to converge.

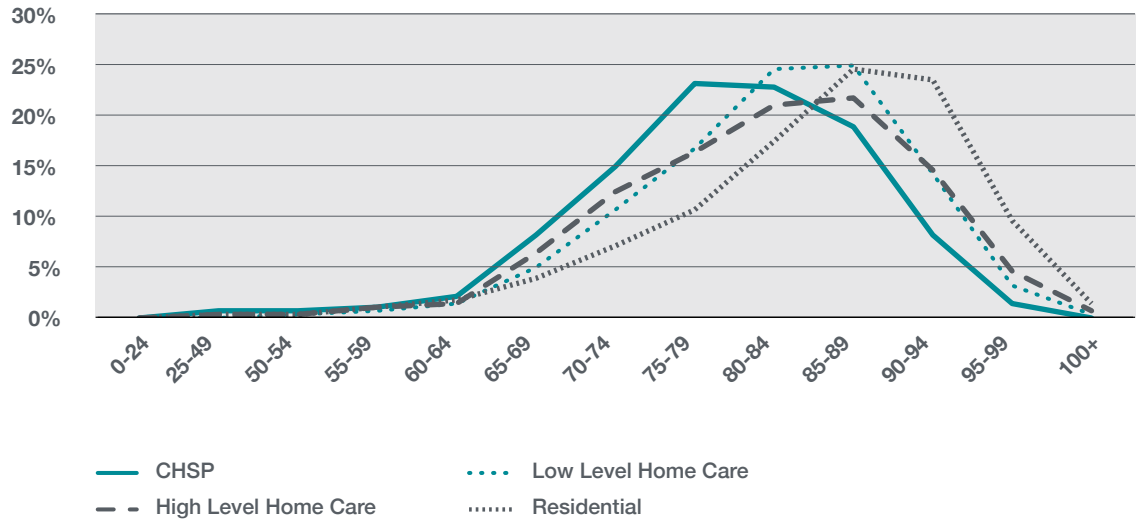
The projection of care recipients from both the baseline Deloitte Model and the Financing Model with no enhancements is illustrated in Figure 5. While the two models generally align, there are notable differences between the numbers of individuals receiving high-level Home Care services. The Financing Model projects a higher starting number of recipients, which is reflective of the release of additional high care packages. It is expected that these packages will be maintained and will not be retracted in the future. As such, a flat growth rate is selected so that the long-term projections of high-level Home Care Packages align between the Financing Model and Deloitte Model.

Figure 5. Comparison of number of care recipients between the Financing and Deloitte Models



The projected total number of care recipients was apportioned by age based on the distribution of the population within each age group. Figure 6 illustrates the distribution of FY19 care recipients by age group and care type.[93] As expected, older cohorts tend to use more intensive services such as residential care compared to younger cohorts. The proportion of care recipients by age group remained constant throughout the projection period as this reflects the most recent publicly available data.

Figure 6: Distribution of care recipients by age group



A.3.3 Projection of unit costs

The scope of costs included in the Financing Model has been segmented by the type of care and whether the financing source was considered public or private. Here, I reproduce Table 1 from earlier in the chapter to outline the items included within each of these scopes.

Table 1. Scope of aged care service costs

Care type and scope of services	Public costs	Private costs
Home Support	Government contributions	Consumer contributions
Home Care low	Government contributions	Consumer contributions
Home Care high	Government contributions	Consumer contributions
Residential care (care-only costs)	• Basic care subsidies (Permanent and Respite) • Hardship Supplement • Viability Supplement • Preserved Supplements (Transitional, Charge Exempt, Basic Daily Fee) • Other Supplements (Veterans' and Homeless) • Other reductions	• Means tested care fees • Resident other care fees
Residential care (living costs)	Not applicable	• Resident Basic Daily Fee • Extra Service Fees • Additional Service Fees
Residential care (Accommodation)	• Accommodation Supplement • Hardship Accommodation Supplement • Transitional Accommodation Supplement • Concessional Accommodation Supplement • Accommodation Charge Top-up • Pensioner Supplement	Accommodation payments from residents in the form of Daily Accommodation Payments were included as private accommodation costs. There is an option to include an equivalent Refundable Accommodation Deposit payment through converting the respective Refundable Accommodation Payment into an annual income using an imputed interest rate.

The FY19 unit costs were determined by dividing the FY19 aged care expenditure by the FY19 care recipients for each care type. The care recipients for Home Support were based on clients using services during 2018-19, while care recipients for Home Care and Residential Care were based on clients as at 30 June 2019. This represents a proxy of the FYE care recipients for each care type based on publicly available data. Again, for simplicity, these unit costs are assumed to apply uniformly across each age.

The FY19 unit costs were inflated by an annual growth rate for each care type. Consistent with the care recipient projection, these unit cost inflation rates were calculated by minimising the difference in expenditure between the Financing Model with no enhancements and the Deloitte Model under the baseline scenario. The short-run (FY19–FY35) and long-run inflation (FY35+) rates are generally assumed to be equal. However, for Residential Care (Accommodation), the long-run inflation rates are set to equal the inflation rates for Residential Care (Care Only). This is due to expectations that the accommodation and care inflation are expected to be driven by similar factors in the future.

The model includes annualised income from Refundable Accommodation Deposits. The average Refundable Accommodation Deposit income was calculated as the total number of Refundable Accommodation Deposits held by residential aged care providers divided by the number of residents multiplied by an interest rate. This interest rate is currently assumed to be 3% as the maximum permissible interest rate (MPIR) would likely overestimate the return that can be earnt on these deposits in the current environment. The selected interest rate reflects a small margin above the Consumer Price Index and in the absence of specific information is relatively immaterial. The growth in the Refundable Accommodation Deposit income is based on the private accommodation rate that is in the Daily Accommodation Payment.

A.3.4 Aged care reform

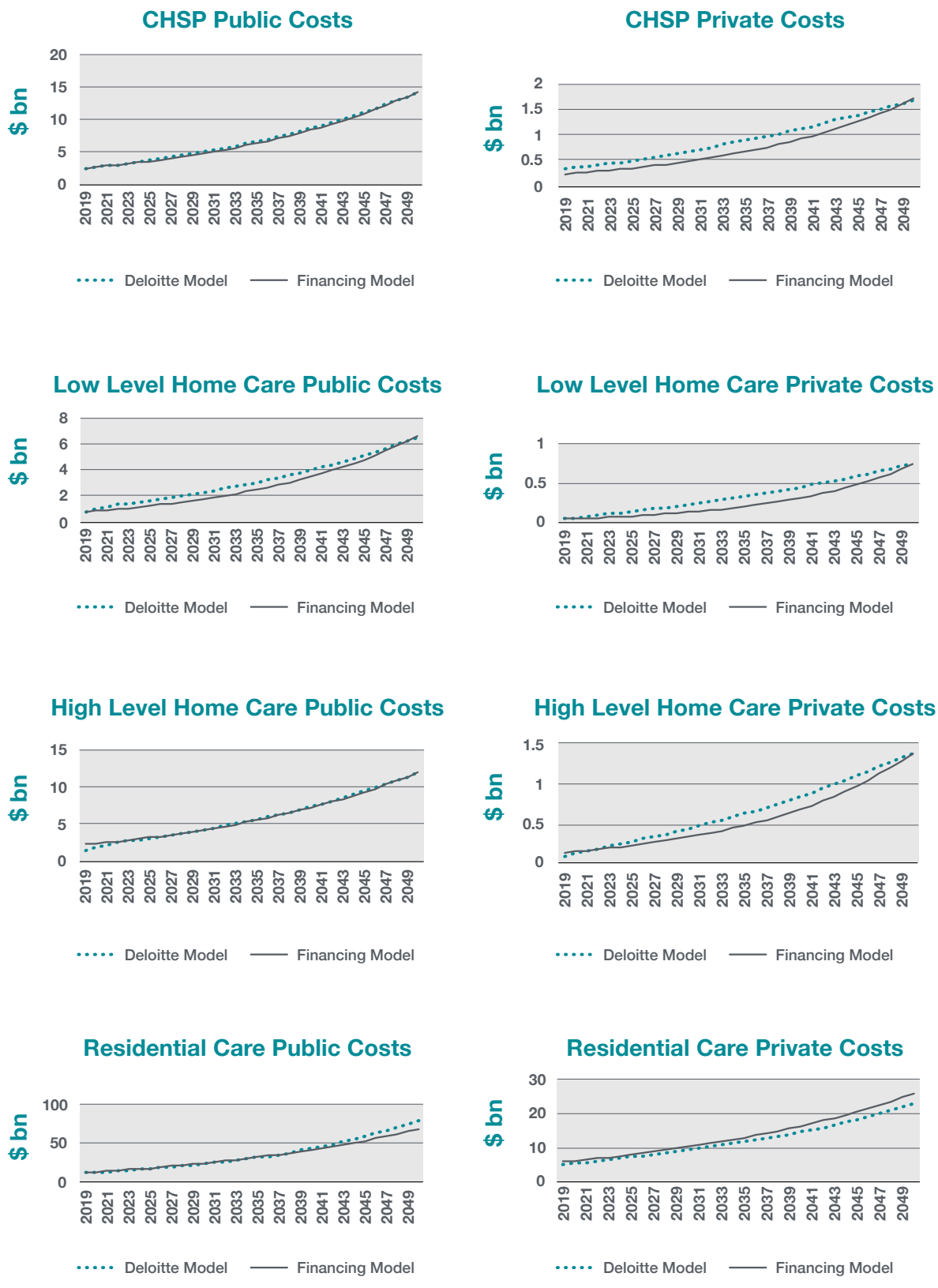
Funding for enhancements to the aged care system were also incorporated into the model. This results in a percentage increase to the FY19 unit costs of care which is expected to be maintained into the future.

Several options for reform were modelled, including those directly from the Deloitte model (3 star, 4 star and 5 star) and those for the recommendations in Counsel Assisting's final submissions. The Counsel Assisting's final submissions costings were only provided for the period 2021 to 2025. As such, the Financing Model projects longer-term Counsel Assisting's final submissions reform costs for the years following 2025 by applying annual growth rates that align to the growth in costs under the Deloitte model 4 star scenario.

A.3.5 Projection of aged care costs

Aged care costs for each care type were projected through multiplying the number of care recipients by the unit costs. This results in a projection of care costs by care type, age and financial year from FY19 to FY55. A comparison of aged care costs between the Financing and Deloitte Model is illustrated in Figure 7. The public costs in the Financing Model aligns closely with the Deloitte Model, except for residential care after FY35 due to the deliberate long-term adjustment to residential accommodation inflation. The shape of private costs differs between the Financing and Deloitte Model. Whilst the Deloitte Model has an approximately linear trend, the choice to have an exponential trend is consistent with other assumptions and modelling choices for the Financing Model.

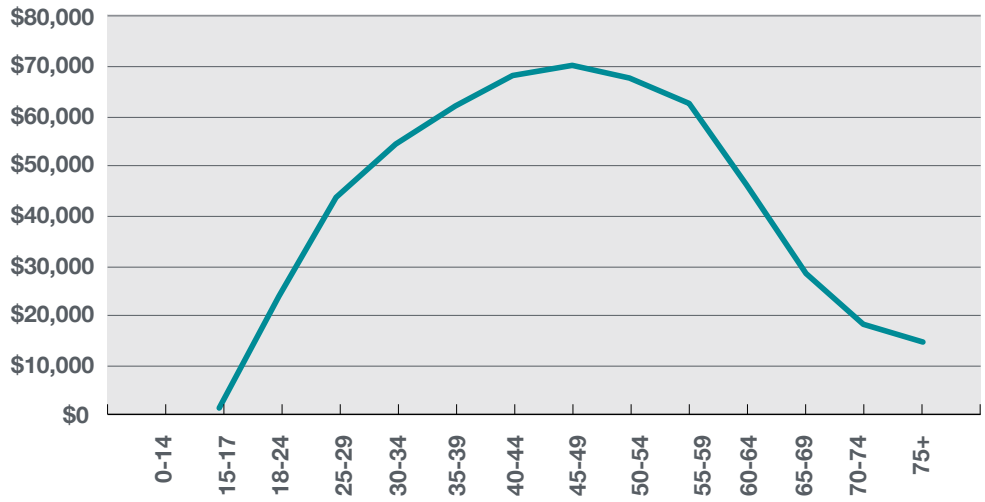
Figure 7: Comparison of number of aged care costs ($bn) between the Financing and Deloitte Models



A.3.6 Projection of base taxable income

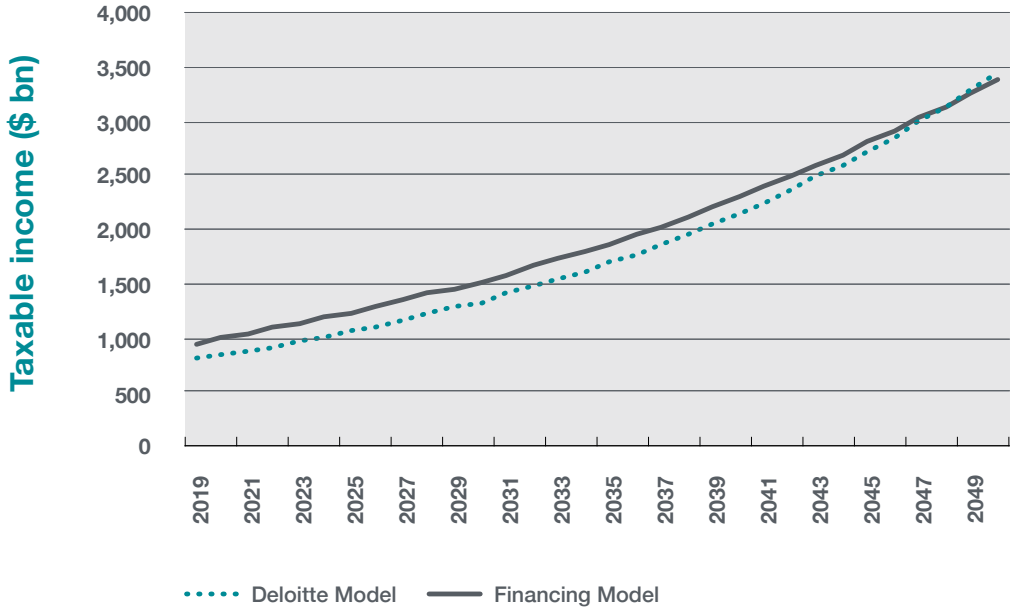
The Australian Taxation Office provides publicly available data regarding taxpayers' ages and taxable income. This data was combined with historical population data from the Australian Bureau of Statistics to derive the average taxable income per person by age group, as illustrated in Figure 8.

Figure 8: Distribution of average income by age group



Average income was inflated by a static growth rate throughout the projection period. This implicitly assumes that inflation is equal across age groups and income. The distribution of taxation bands by age was based on FY18 Australian Taxation Office data and has been assumed to remain constant through the projection period. As results were aggregated to large cohorts (for example, population-wide or across wide age bands), this assumption was considered to be reasonable. The inflation rate was calculated to minimise the sum of squared differences in taxable income between the Financing and Deloitte Models. This resulted in an income inflation of 3%, which was comparable with the 2.7% average income growth over the past five years, with results displayed in Figure 9.

Figure 9: Comparison of taxable income ($bn) between the Financing and Deloitte Models



The taxable income projection was distributed by taxation bands and age groups using a method intended to reflect the proportional relationships between average effective tax rates for taxpayers within each of the five tax bands, derived from 2017–18 Australian Taxation Office taxation data.[94] The method involved calculating the average effective tax rate for all personal income taxpayers, calculating the average effective tax rates for taxpayers in each of the five bands, and then representing the average effective tax rates in each of the five bands as a ratio of the overall effective tax rate for all personal income taxpayers. Those ratios were then applied in the design of the progressive Aged Care Levy rates for each of the five tax bands.

This method of presenting the proportional relationships between the tax bands assumes that the proportion of taxable income generated in each band will remain constant within tax bands and age groups over time. By presenting the proportional relationships between tax bands in this manner, the modelling mimics the progressivity of the taxation system in designing the series of progressive Aged Care Levy rates.

The additional levy rate value for each taxation band bears the same proportional relationship to the flat levy (of 2.61%) as the average effective tax rate in each band bears to the overall average effective tax rate of all income taxpayers. This suggests that the effective levy rate for individuals earning between $37,001 and $87,000 would be 49.6% of the effective levy rate applied to individuals earning $180,000 or more. These average effective rates were then converted to marginal tax rates for each band (see Table 4).

Table 4: Marginal and effective tax rates

	Total taxable income	Total number of people	Max income threshold	Average income	Marginal Levy Rate	Levy per person in band	Effective Levy rate	Levy raised
Tax Band 1	$21,288,237,169	13,369,929	$18,200	$1,592	0.0%	$0	0.00%	$0
Tax Band 2	$88,644,215,612	3,099,196	$37,000	$28,602	2.1%	$218	0.76%	$677,015,817
Tax Band 3	$349,976,033,191	5,738,636	$87,000	$60,986	3.7%	$1,282	2.10%	$7,358,534,037
Tax Band 4	$279,135,362,875	2,296,046	$180,000	$121,572	4.2%	$3,697	3.04%	$8,488,097,218
Tax Band 5	$174,041,704,376	478,881		$363,434	5.1%	$15,506	4.27%	$7,425,500,598
Total	$913,085,553,223	24,982,688						$23,949,147,669
					Levy raised as a % of Total Taxable Income			2.6%

A.4 Scenarios that were modelled

Variants of a progressive aged care levy were investigated to understand its impacts and considerations for implementation in different scenarios.

Table 5: Aged Care Levy scenarios, variants and sensitivity analysis

Aged Care Levy variant	Description
Baseline–Current aged care policy	• **Scenario 1A:** A flat rate levy on personal income sufficient to raise revenue equal to what Australian Government expenditure on aged care would be under current policy settings • **Scenario 1B:** A progressive levy on taxable income sufficient to raise revenue equal to what Australian Government expenditure on aged care would be under current policy settings • **Scenario 1C:** An alternative consideration is if individuals only have a higher additional marginal tax rate after a certain age (40 years in this example) to cover the costs of aged care. As such, the levy would only apply to individuals aged over 40 years and those aged under 40 years would effectively have a 0% levy.
Royal Commission recommendations	• **Scenario 2A:** A flat rate levy on personal income sufficient to raise revenue equal to what Australian Government expenditure on aged care would be following the adoption of the recommendations made by the Royal Commission (including the assumption that care is not means tested but that Australian Government assistance for accommodation costs in residential aged care is means tested) • **Scenario 2B:** A progressive levy on taxable income sufficient to raise revenue equal to what Australian Government expenditure on aged care would be following the adoption of the recommendations made by the Royal Commission (including the assumption that care is not means tested but that Australian Government assistance for accommodation costs in residential aged care is means tested) • **Scenario 2C:** An alternative consideration is if individuals only have a higher additional marginal tax rate after a certain age (40 years in this example) to cover the costs of aged care. As such, the levy would only apply to individuals aged over 40 years and those under aged 40 years would effectively have a 0% levy.
Royal Commission Variant	• **Scenario 3A:** A flat rate levy sufficient to raise revenue equal to what Australian Government expenditure on aged care would be following the adoption of the recommendations made by the Royal Commission (including the assumption that care and Australian Government assistance for accommodation costs in residential aged care are not means tested). • **Scenario 3B:** A progressive levy on taxable income sufficient to raise revenue equal to what Australian Government expenditure on aged care would be following the adoption of the recommendations made by the Royal Commission (including the assumption that care and Australian Government assistance for accommodation costs in residential aged care are not means tested). • **Scenario 3C:** An alternative consideration is if individuals only have a higher additional marginal tax rate after a certain age (40 years in this example) to cover the costs of aged care. As such, the levy would only apply to individuals aged over 40 years and those under 40 years would effectively have a 0% levy.
Sensitivity Analysis	• The following sensitivities were tested over a short-term (five-year) stress but unchanged assumptions thereafter. They have been designed in this way to reflect that the levy may be adjusted based on emerging experience after five years. As a result, if the stressed outcomes do emerge over the first five years and, at that point, are then expected to continue, additional incremental changes to the long-term levy can be made then: o Using Budget COVID-19 tax revenue impacts for the next four years o Increasing the number of people needing aged care by 10% for the next five years o Increasing Unit Costs by 10% for the next five years o Ensuring that the accumulation of funds at the end of the five-year period are sufficient to meet three months of expected costs

Baseline sensitivities

The sensitivities in the following table show the long-term levy required to cover the costs of a short-term (five-year) stress to the baseline—that is, higher than expected costs or lower than expected taxable income for five years, but unchanged assumptions thereafter. They have been designed in this way to reflect that the levy may be adjusted based on emerging experience after five years. As a result, if the stressed outcomes do emerge over the first five years and, at that point, are then expected to continue, additional incremental changes to the long-term levy can then be made.

Table 6: Impact of aged care levy by sensitivities

Funding mechanism	Coverage	Financing Model Levy
5a. Flat % levy on personal income	All public aged care costs	2.61%
5b. Using budget COVID-19 tax revenue impacts for the next four years	All public aged care costs	2.64%
5c. Increasing the number of people needing aged care by 10% for the next five years	All public aged care costs	2.62%
5d. Increasing Unit Costs by 10% for the next five years	All public aged care costs	2.62%
5e. Combined impact of 5b, 5c and 5d	All public aged care costs	2.66%

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94 Australian Government, *Individuals – Table 3,* 2020, https://data.gov.au/dataset/ds-dga-23b8c299-a85b-4fc0-a07d-5ed14e23a103/distribution/dist-dga-f214eb40-31e5-4af0-a395-bc77b5d50d58/details?q=%22taxation%20statistics%22, viewed 23 December 2020.

Overview | Funding and Financing the New Aged Care System | Commissioner Briggs

In the preceding chapters in this volume, Commissioner Pagone and I have set out our vision for a new aged care system centred on a universal entitlement to high quality aged care based on assessed need. While we disagree about how the aged care system might best be governed, we are broadly in agreement on how aged care programs should be designed and how the quality and safety of services should be assured and regulated.

We envisage an aged care system where quality and safety standards are set independently and care services are delivered by a larger and better paid workforce employed by better governed providers. The system will acknowledge and support the important contribution of informal carers and volunteers, and it will meet the specific needs of Aboriginal and Torres Strait Islander people. The system will be supported by focused research, and it will make better use of data and information technology to deliver better care. Younger people with disability will receive more appropriate care elsewhere, and older people with disabilities will receive equivalent care within the system to their younger counterparts in the National Disability Insurance Scheme. There will be reforms to the health care system to ensure that older people receiving aged care also receive health care commensurate with their needs.

The next five chapters deal with the funding and financing of the aged care system. This includes how the level of funding for aged care services is determined, how the contributions from individuals to the cost of the services they use are determined, how residential aged care providers access capital, how the Australian Government oversights the financial position of providers, and how the Australian Government raises the money it requires to provide its contribution to the system. The design of these elements is crucial to ensuring that the aged care system can deliver the safe and high quality care that older people deserve and expect.

Many of these funding and financing issues are interrelated. While Commissioner Pagone and I agree on a number of these issues, we have different views on some matters. In this section, I outline my overall approach to the funding and financing arrangements of the aged care system, set out in detail in the next five chapters. These chapters are:

- Funding the Aged Care System (Chapter 21)
- Personal Contributions and Means Testing (Chapter 22)
- Capital Financing for Residential Aged Care (Chapter 23)
- Financial Oversight and Prudential Regulation (Chapter 24)
- Financing the New Aged Care System (Chapter 25).

An entitlement-based system will only operate effectively to deliver high quality care if the funding available to deliver care to people with an entitlement is adequate. This necessitates allocating responsibility for determining the level of funding providers should receive, based on actual cost data, to an independent body. This body should be an augmented Independent Hospital Pricing Authority—to be renamed the Independent Hospital and Aged Care Pricing Authority. Given the significant fiscal impact these determinations may have, I consider that they should be subject to Parliamentary scrutiny and approval. The model to distribute funding is also important. While there are arguments for relying on activity based funding, I consider that a mix of block and activity based funding will help to ensure service availability, particularly for low-cost services or providers in outer regional and remote areas.

In considering the balance between individual and Australian Government contributions to the cost of the aged care system, it is important to distinguish between the different components of an aged care service. Care provided in the community or in somebody's home may include health care and personal care (for example, nursing, physiotherapy, and assistance with showering and dressing) as well as assistance in the activities of daily living (for example, cooking, cleaning, laundry, and shopping). People living in an aged care residence will receive these services together with accommodation.

Older people should not be required to make a contribution to the costs of their health care and personal care. For the last 35 years, Australians have received medical and hospital care through Medicare without compulsory co-payments. I see no reason why older people should be required to make compulsory contributions towards the cost of the health care and personal care they receive through the aged care system. Such payments amount to a tax on frailty.

Health and care costs are different from other living costs. As a general principle, I consider that older people should be required, subject to a means test, to contribute to the costs of the ordinary activities of daily living and the costs of accommodation. These are costs faced by all Australians living in the community, and people receiving these services through the aged care system should not receive them for free. The retirement income policy framework—which includes substantial taxation concessions—is designed to provide older people with an adequate income to meet these costs. The taxpayers who have funded the taxation concessions should not also be required to fund these costs through the aged care system. These costs should continue to be funded from the retirement income stream that is supported by the taxation concessions.

However, there should be an exception to the principle for people living in the community and receiving support from aged care providers for the ordinary activities of daily living, who should not be required to contribute to the cost of that support. The services will only be made available after the person has been assessed as requiring them, and they will in many cases delay the recipient's entry into far more expensive residential aged care.

While I consider people living in residential aged care should be required to contribute to the costs of their accommodation, this contribution should not be through interest-free loans to aged care providers. The current system of Refundable Accommodation Deposits has resulted in distorted investment decisions within the sector, and distracted some providers from their core business of providing care services. The activities of some providers in seeking these payments is a further source of stress on vulnerable people entering aged care.

Refundable Accommodation Deposits should be phased out and replaced by an Australian Government loan facility which can be used to encourage investment in better accommodation models. Subject to a reformed means test, aged care residents should be required to make recurrent accommodation payments to providers to allow them to meet their loan obligations. Pensioner residents will be protected from making such payments and other low-income residents will make reduced rental payments.

In Chapter 6: Aged Care Accommodation, I also recommend that the Australian Government increase significantly its capital grants contributions to $1 billion a year and indexed from 2023–24 (Recommendation 46). The expanded capital grants program is designed to support the rapid spread of small-scale congregate living which facilitates the small household model of residential aged care accommodation, including for people who do not live in major city. This will deliver better quality aged care in a much more home-like environment.

Given the very significant amounts of money made available to aged care service providers by taxpayers and people receiving aged care, there is a strong public interest in a more effective system of financial oversight and prudential regulation of the aged care sector. The current oversight arrangements focus primarily on managing the risk to the Australian Government that arises from an approved provider's inability to repay the Refundable Accommodation Deposits that it holds. The inadequacies of these arrangements have been documented in numerous expert reviews. They need to be strengthened.

The financial strength of aged care service providers is intrinsic to their ability to provide high quality and safe care and continuity of services. We heard distressing evidence of lapses in care that arise when service providers experience financial difficulties. Taxpayers also have a legitimate interest in greater transparency than is currently available over how aged care service providers employ the funds provided to them from public sources.

I have therefore proposed a significant strengthening of the arrangements for financial oversight and prudential regulation of aged care service providers so that the Australian Government has the means to identify providers that may be at financial risk. This will permit timely action to ensure the continued wellbeing of people receiving care. The recommendations that I am making on increased reporting and disclosure requirements should also provide taxpayers and people receiving care with more confidence that the very substantial public and private funds that the Australian Government mandates for payment to aged care service providers are properly directed to the care and welfare of older people.

I have reflected very carefully on arrangements for the long-term financing of aged care. Under the financing arrangements that have applied since the Australian Government was first involved in aged care, each generation has paid the aged care costs of earlier generations through the general taxation system. Most witnesses supported a continuation of this arrangement.

Some witnesses suggested to us that this approach is unsustainable, and should be replaced with a system under which current generations of working age set money aside now to meet aged care needs when they emerge. I do not agree. I consider this is both inequitable and unnecessary.

It is inequitable because it would require the current generation to pay for both its own aged care and for the generation now entering aged care. This could only be avoided by requiring much larger contributions from the people now entering aged care—which would also be inequitable, as these people will not have planned their affairs to meet these costs.

It is also unnecessary as long as there is sustained long-term growth in the economy. Between 1978–79 and 2018–19, Australian Government expenditure on aged care as a share of the economy increased almost threefold without causing affordability problems or lowering the standard of living enjoyed by the Australian community.

I do not support proposals to introduce a hypothecated levy on incomes to fund Australian Government aged care expenditure. While I acknowledge that this could improve transparency and provide additional certainty around the long-term funding for aged care, I consider that the security of funding for aged care is best assured by a legislated entitlement to services and an independent determination of the cost of those services, rather than a dedicated source of financing.

I consider that there is a role, however, for a non-hypothecated aged care improvement levy—similar to the Medicare levy on income taxpayers—to raise additional revenue to finance the cost of the recommendations we have made to improve the quality and safety of aged care.

For the last 25 or more years, Australian Governments have taken funding out of aged care through various budget savings measures, which has contributed to the current poor state of care. The Government is obligated to increase its funding significantly to cover the cost of the health and disability recommendations that we have made; to provide any necessary supplementary aged care funding beyond that met by the aged care improvement levy; and to fund demographic growth, indexation and further aged care program enhancements over time.

21. Funding the Aged Care System | Commissioner Briggs

21.1 Introduction

Public funding is critical to the aged care system, although private sources of funding are also significant. The Australian Government spent $19.9 billion on aged care in 2018–19.[1] Private contributions were $5.6 billion.[2] Despite these large expenditures, as we explain in Volume 2 of this report, the current system delivers services that are all too often substandard, and sometimes unsafe. Many people do not receive the care that they need because of the current rationing arrangements.

In many instances, the current system fails to deliver services simply because there is not enough funding to meet the assessed need. The waiting lists for access to home care are the direct result of inadequate funding. In some cases, the funding arrangements create perverse incentives that do not support high quality care. At the moment, funding for approved providers is reduced if an aged care resident regains lost functionality and achieves greater independence. This does not encourage an approved provider to invest in reablement of the older people in their care.

The design of co-contribution regimes can also have an impact on access to care. The requirement to pay a basic fee of $82 per week from a weekly pension of $472 to receive a Level 1 Home Care Package which delivers four hours of services may discourage people from taking up these packages. This is undesirable for the individual and for the taxpayer, as the delays in accessing care may mean that the person is likely to require more intensive care earlier than if they had been able to live more independently at home for longer.

There is an important point of tension in the task we are required to perform. By paragraphs (a) and (d) of our Terms of Reference, we are required and authorised to inquire into actions that should be taken in response to systemic causes of substandard care, and what the Australian Government and others can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe. We recommend numerous reforms, almost all of them have funding implications. For example, we make recommendations for the removal of planning limits in favour of providing publicly funded care based on assessed need (Recommendation 41), more generous funding of care at home (Recommendations 118 and 119), and higher levels of staffing of residential care facilities (Recommendation 86). At the same time, we are acutely conscious that by paragraph (f) of our Terms of Reference, we are also required and authorised to inquire into 'how best to deliver aged care services in a *sustainable* way'.[3]

I have given careful consideration to ways in which funding arrangements should be improved to ensure the economic sustainability of the aged care system as a whole. This includes the need to ensure value and accountability for public expenditure, while also ensuring that there is a sufficient number of approved providers to supply the increasing aged care needs of our community.[4] In a separate chapter on financing future aged care, I have also given consideration to options for sustainable public financing of the system into the future.

21.2 Principles

In 2019 the Aged Care Financing Authority identified what it considered to be the characteristics of 'a viable and sustainable aged care system'. These included:

> confidence and trust in policy settings; stable, predictable, efficient, equitable and effective arrangements for allocating Government funding; appropriate overall funding; funding arrangements that are flexible and adaptable to changing demographics and demands; equitable contribution to costs by consumers; effective prudential oversight; and sound management and governance arrangements.[5]

Subject to the need to consider the principle of contributions from people receiving services in the light of the universal entitlement to aged care that we recommend, we agree that the design of the funding arrangements for a reformed aged care system should have these attributes. We also consider that funding arrangements should be transparent—the basis for funding allocations should be clear—and should support accountability for the use of funding, whether from the Government or from service users. The following analysis by the Aged Care Financing Authority in 2019 resonates with the evidence we have heard:

> The overriding challenge facing the Government is maintaining confidence and trust in the quality of aged care services and the funding and financing arrangements for the industry. Towards achieving trust, the regulatory and funding arrangements have to be stable, understood, and transparent. Trust is essential because while the Government is the main source of funding for aged care, the services are primarily delivered by the non-government sector: for-profit and not-for-profit providers. These providers will not invest in the industry, nor will they be able to attract the required staff, unless they understand the basis of regulation, the Government's approach to the funding of the industry, and they have confidence in the adequacy and stability of Government policies. From the consumer perspective, there needs to be trust in the quality of care people will receive from the aged care system for this will influence the preparedness of consumers and their families to seek the support that they need. [6]

21.3 Financial pressures on providers

The diverse and complex nature of the aged care sector makes overall assessment of the financial state of the sector challenging. While many approved providers are privately owned organisations run as a commercial business ('for-profits'), many others are organisations owned by community, charity or religious groups ('not-for-profits', even though they may or may not be run like a commercial business). There are also some government providers.

Table 1: Number of providers by ownership and program, 2018–19[7]*

	For-profit	Not-for-profit	Government	Total
Residential	288	488	97	873
Home Care Packages (at 30 June 2019)	335	479	114	928
Commonwealth Home Support Programme	102	1006	350	1458

Source: Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, 2020.

* Providers can operate in more than one program

The reported financial returns of aged care providers are widely dispersed. Some providers from each of these groups have reported profits in recent years while others have reported losses.[8]

In evidence, individual experts, banks, approved providers, chartered accounting firm StewartBrown and the Australian Department of Health told us that the financial performance of approved providers has been deteriorating over a period of several years, and that the continued viability of a significant number of residential care providers is doubtful under current funding levels and arrangements.[9]

Based on a sample of 187 approved provider organisations, the accounting firm StewartBrown has estimated that a significant number of approved providers are currently not covering their expenses. The StewartBrown data may not be representative of the sector as a whole. It is based on returns that cover 22% of the residential care segment and 44% of residential aged care homes, as well as 33% of Home Care Packages.[10] It includes a greater proportion of not-for-profit aged care providers than for-profit providers.[11] However, allowing for the fact that the StewartBrown data is not comprehensive, the data for 2019–20 indicates that the 'bottom 75%' of aged care homes participating in the survey (835 residential care facilities) are making an average operating loss of $20.31 per resident per day.[12]

Concerns about provider viability and the adequacy of funding levels are not new. In his 2002 *Review of Pricing Arrangements in Residential Aged Care*, which undertook the first comprehensive analysis of sector viability, Professor Warren Hogan, economist, found that 29% of residential aged care services were making an operational loss, measured as Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA).[13]

To gain a comprehensive assessment of the financial health of the sector, we obtained our own analyses of profitability and viability of the sector, based principally on data reported by approved providers to the Australian Department of Health up to the end of financial year 2018–19.[14] These comprised a report analysing those financial data from accountancy firm BDO, and a report on industry returns from Frontier Economics.[15]

BDO found that total income for the aged care industry in 2017–18 was $25.0 billion, total expenses were $23.9 billion, and profit was $1.1 billion, representing a profit margin of 4.4%.[16] The aggregate EBITDA for for-profit providers was 12.2% of income, 4.2% of assets, and 38.1 % of equity in FY2018. For not-for-profits, EBITDA was 9.0% of income, 3.1% of assets, and 7.7% of equity. [17] On this basis, at least, the sector as a whole made a profit in 2017–18, though BDO reported that there was considerable variation across individual providers.[18]

BDO focused primarily on 2017–18 and preceding years because data for 2018–19 was incomplete. In any event, BDO considered that because of limitations in the way financial data was reported by the aged care sector, it could not reach firm conclusions about 'true' returns:

> It is possible to calculate a reported profit margin, return on assets and return on equity from the data provided. However, our view is that consideration should also be given to any gains or losses made by related parties to the extent that they can be attributed to capital obtained from the sector (for example, how RADs are used to make gains). It is possible that such gains or losses are quite significant given the total value of RADs in aged care ($28.4Bn in FY2018).
>
> In our view, shareholders of individual Approved Providers would consider such benefits when evaluating their investment in the sector. The data that would be required to develop this more holistic, true return, is not available within the ACFR. Approved Providers do not have an obligation to report it.[19]

Notwithstanding this limitation, as one of the authors of the report explained, some of the top 25% of financial performers reported that they had made a good return in recent financial years.[20] A table presented in the report indicated that the top quartile of for-profit residential care providers made a return (calculated as EBITDA) of 7.61% in financial year 2017–18.[21]

Frontier Economics reported that industry returns over several years to 2016–17 appeared sufficient to attract investment:

> Average returns in Residential Aged Care were reasonably constant in FY2015, FY2016 and FY2017. Because these returns are averaged over for-profits, not-for-profits and government entities it is not clear that returns covered the cost of capital for all entities. However, the substantial investment in the sector in FY2015 to FY2017 suggests that returns for many providers did cover their cost of capital in these years. Average returns to the sector have decreased in each of the last two financial years.[22]

I acknowledge that despite the overall profitability of the sector, many approved providers are struggling to provide high quality care and make a reasonable return with the revenue provided by the Australian Government. This presents an immediate threat to the quality and safety of services that can be provided for older people. The funding of aged care requires significant reform to ensure adequate funding levels to support the sector to deliver high quality care into the future. Measures are also needed in the short term to ensure the viability of the sector and support continuity of suitable aged care.

21.4 Proposed reforms

We recommend a revolution in the way that funding levels are determined for aged care. The key reform should be the introduction of independent pricing of aged care services, based on analysis of the costs of providing high quality and safe aged care. Independent pricing would provide a foundation underpinning a new form of casemix funding for residential care, appropriate staffing levels and skills mixes in residential care, and appropriate calibration of funding for aged care services in other settings. We recommend the introduction of new accountability measures, to ensure that funding is directed towards the high quality and safe aged care to which older people are entitled. Until independent pricing is operational, there should be immediate changes in the annual indexation method for aged care services and targeted increases to certain funding streams for the provision of residential aged care. The additional funding should come with additional responsibilities for approved providers and care managers.

21.5 Independent Pricing Authority

As we outline in Chapter 2: Governance of the New Aged Care System, the introduction of independent pricing of aged care services is central to our recommendations for reform to funding arrangements.

The general concept of introducing some form of independent review of costs is uncontroversial, and is supported by the Secretaries of the Australian Treasury and Department of Health, as well as eminent economists.[23] Professor Flavio Menezes, Chair of the Queensland Competition Authority and former Head of the School of Economics at the University of Queensland, said the current arrangements involve a conflict of interest for the Australian Government as it is simultaneously trying to ensure the provision of high quality care while constraining costs.[24]

A wide range of aged care providers and their peak representative organisations have told us that independently assessed funding levels are important for ensuring they are adequately funded to deliver high quality care. This includes Leading Age Services Australia, the Aged Care Guild, Aged & Community Services Australia, Catholic Health Australia, Regis Aged Care, Estia Health, the Whiddon Group, Ryman Healthcare, ECH and Group Homes Australia.[25] Mr Nicholas Mersiades of Catholic Health Australia told us:

> While recognising that there's a large number of reforms which would be a dead heat for coming second, I would prioritise the creation of a reform—independent pricing authority to administer a new funding system as a means to increasing the number of staff, planning them better and up-skilling them more and which will be required if we're going to be able to meet community expectations about quality of care.[26]

Mr Paul Versteege, of the Combined Pensioners & Superannuants Association, also described the importance of this type of change:

> The need for independence in the setting of a national price for aged care services, both residential aged care and home-based aged care, cannot be overstated. Price setting of aged care services needs to be free of undue influence by Government, who will be paying the aged care subsidies based on this price, and by aged care providers, who will be receiving these subsidies.[27]

We consider that the introduction of independent pricing into the system is critical to restore or instil confidence and trust between the sector and the Australian Government, and thus to instil confidence in the sustainability of the system in the wider community. While we both consider that the Pricing Authority should be established on the basis of governance arrangements that ensure it is independent from both the sector and the Government, we differ on the detail of how this should be achieved.

As set out in the chapter on system governance, I recommend the expansion of the functions of the Independent Hospital Pricing Authority, and renaming it as the Independent Hospital and Aged Care Pricing Authority, while Commissioner Pagone recommends the establishment of a new pricing authority specifically for aged care.

Recommendation 115: Functions and objects of the Pricing Authority

1. **Before the commencement of independent pricing of aged care services by the Pricing Authority, preliminary work on estimating the costs of providing high quality aged care should be undertaken by or at the direction of the implementation unit or taskforce referred to elsewhere in these recommendations.**

Commissioner Pagone

2. **Upon its establishment, by 1 July 2023, under the new Act, the Pricing Authority should take over that work and all resources developed by the implementation unit.**

3. **The functions of the Pricing Authority should include:**

   a. **providing expert advice to the System Governor on optimal forms for funding arrangements for particular types of aged care services and in particular market circumstances**

   b. **reviewing data and conducting studies relating to the costs of providing aged care services**

   c. **determining prices for particular aged care services based on estimates of the amounts (whether constituted by government subsidies or user payments or both) appropriate to the provision of high quality and safe aged care services**

d. evaluating, or assisting the System Governor to evaluate, the extent of competition in particular areas and markets

e. advising on appropriate forms of economic regulation, and, where necessary, implementation of such regulation.

4. In undertaking its functions, the Pricing Authority should be guided by the following objects:

a. ensuring the availability and continuity of high quality and safe aged care services for people in need of them

b. ensuring the efficient and effective use of public funding and private user contributions in the provision of high quality and safe aged care services, taking into account the principles of competitive neutrality

c. promoting efficient investment in the means of supply of high quality and safe aged care services in the long-term interests of people in need of them

d. promoting the development and retention of a highly motivated and appropriately skilled and numerous workforce necessary for the provision of high quality and safe aged care services in the long-term interests of people in need of them.

A binding or advisory pricing function

We heard competing views from witnesses about whether the pricing function should be binding or advisory. A submission from the Australian Government said that it:

> supports the proposed Aged Care Pricing Authority (ACPA), however considers it should provide independent and transparent advice to Government regarding prices and funding arrangements rather than determining prices. This would ensure Government remains accountable for pricing and funding decisions. [28]

Dr Brendan Murphy, Secretary of the Australian Department of Health, expressed concerns that unless the government of the day was free to accept or reject the advice of the independent Pricing Authority it would be 'locked into delivering a price'.[29] He said 'price needs to be transparently determined and recommended to Government, but whether Government should have the fiscal right to determine how that's manifested is a matter for debate'.[30] Professor Michael Woods, member of the Aged Care Financing Authority and presiding Commissioner for the Productivity Commission's report *Caring for Older Australians*, expressed a similar reservation. [31]

On the other hand, Professor John Piggott AO, Director of the Australian Research Council Centre of Excellence in Population Ageing Research at the University of New South Wales, supported a binding price-setting role for the independent body.'[32] Professor Henry Cutler, from the Macquarie University Centre for the Health Economy, said that 'there are good reasons why price should be set by an independent authority', including removing 'volatility to provider revenue' caused by policy change and ensuring transparent price setting.[33]

We also heard from approved providers on this subject. For example, Mr Chris Mamarelis of the Whiddon Group spoke of the need for independent pricing from the perspective of an approved provider:

> I believe we need independent price setting. I think the examples of the past when we are caring for older Australians, and in Whiddon's case, we have thousands of people we care for annually, we can't operate in an environment where the Government just decides, for example, to put a funding pause on our revenues when we are planning around people's lives, we are planning around the people who care for those individuals and our funding is just withdrawn from us and literally at a minute's notice.[34]

I consider that the most appropriate balance between independence in price setting and budgetary control by the government of the day is to be struck by conferring a determinative pricing power on the Pricing Authority, but by making the schedule setting out those determinations an instrument that is disallowable in Parliament. This would ensure that, in a case where the Australian Government wishes to depart from the prices determined by the Pricing Authority, it would have to obtain a motion from either House of Parliament to disallow the schedule, in an open and accountable manner. If the schedule determined by the Pricing Authority was disallowed, the Minister should be empowered to make a new determination, which would also be subject to disallowance.

Recommendation 139: Parliamentary scrutiny of determinations by the Pricing Authority

Commissioner Briggs

1. **The determination of prices by the Pricing Authority under Recommendation 115.3(c) should be in the form of a legislative instrument subject to Parliamentary disallowance.**
2. **If the determination by the Pricing Authority is disallowed, legislation should provide for the Minister to make a new determination in the form of a legislative instrument subject to Parliamentary disallowance.**

Costing and pricing considerations

There are a number of considerations that should guide the Pricing Authority in exercising its functions of costing and pricing aged care services.

It should clearly have regard to the safety and quality standards that approved providers will be required to meet. In Chapter 3, we recommend that the Australian Commission for Safety and Quality in Health Care should take on the responsibility of defining those standards, and throughout Volume 3 we have outlined what those standards should incorporate. The Pricing Authority will need to take account of the impact on costs of quality improvements, guided by advice from the System Governor on the nature of these changes. Unless this happens, determinations based on the existing costs of delivering poor quality care will perpetuate this standard of care.

More generally, the Pricing Authority should have regard to the System Governor's overall system priorities and objectives in making its determination. These might include, for example, encouraging a better geographic distribution of aged care services, increasing the cultural sensitivity of aged care services, prioritising services for special needs groups such as the prematurely aged, or encouraging the development of smaller, congregate living facilities. Addressing these issues might lead the Pricing Authority to use price loadings or mixed funding methods, or to recommend commissioning of services to address gaps in service delivery, particularly in regional, rural and remote Australia.

The Pricing Authority will also need to factor in the impact on costs of the recommendations we make in Chapter 12 to improve the quality and further increase the size of the aged care workforce. These include measures to improve rates of pay, introduce mandatory qualification and registration requirements for personal care workers, and require residential care providers to meet a minimum staff time standard. The Pricing Authority will need to adjust prices as these measures are introduced so that approved providers will be properly resourced to implement them.

The Pricing Authority needs to take account of the full range of the direct and indirect costs of providing aged care services. For example, Mr Grant Corderoy, Senior Partner of StewartBrown Chartered Accountants, told us that there is no allowance for administration costs within the current funding arrangements for residential aged care, and that these costs are increasing due to increasing compliance requirements.[35] In his view, the failure to provide for these indirect costs of providing care is weighing down the financial performance of residential care providers. We were also told of the cost differentials involved in providing services in different regions and to groups with diverse needs.[36] Determinations by the Pricing Authority should take into account these cost factors.

It is also important that the different types of aged care services—care, activities of daily living, and accommodation—should be costed separately. Dr Ken Henry AC, a former Secretary of the Australian Treasury, told us about the importance of unbundling different types of aged care services in the costing process. It avoids the potential for cross-subsidisation to create perverse incentives.[37] It enables governments to apply different funding, means testing and co-contribution arrangements to different types of aged care services.[38] It also promotes allocative efficiency, in that a particular type of service is not undersupplied or oversupplied.[39]

We heard a range of views on whether and to what extent determinations by the Pricing Authority should allow for a profit or a return on investment. Professor Kathy Eagar, Director at the Australian Health Services Research Institute, University of Wollongong, told us that she supports a 'no profit on care' requirement, which would require approved providers to remit any funding provided for care that was unspent.[40] Under this arrangement, approved providers would be able to make a profit from accommodation, hotel and other auxiliary services. The Australian Nursing and Midwifery Federation submitted that approved providers should be required to report on the application of funds provided for direct care, and that an acquittal and return mechanism should be adopted.[41]

I am sympathetic to Professor Eagar's views, and believe that our recommendations for a minimum staff time quality and safety standard (Recommendation 86) and acquittal of staffing hours (Recommendation 122) will largely address this issue in residential care. While it is important for providers to receive a return on their capital investment—and the Pricing Authority should take this into account—I consider it needs to be cautious in including profit margins in other elements of pricing.

Finally, the Pricing Authority will need to develop an appropriate indexation methodology to reflect the lag between the costing data provided and the period for which prices are set. Later in this chapter, I recommend a short-term improvement in the indexation arrangements for aged care, pending the establishment of the Pricing Authority.

Economic regulation

Under current arrangements, the primary form of economic regulation is price caps or other restrictions on how much approved providers can charge older people for particular types of aged care services. Older people with a Home Care Package or living in residential care are required to pay a Basic Daily Fee, also known as the standard resident contribution. For those on a Home Care Package, the amount of the Basic Daily Fee is set at 17.5% of the single basic age pension.[42] For older people living in residential care, the Basic Daily Fee is set at 85% of the single basic age pension.[43]

In addition to those legislatively established price caps, the *Aged Care Act 1997* (Cth) also establishes a role for the Aged Care Pricing Commissioner in regulating the fees that residential aged care providers can charge. The Commissioner's functions include reviewing—and approving, if appropriate—Extra Service Fees for a higher than average standard of accommodation, food and services. The Commissioner is also responsible for considering applications to charge Refundable Accommodation Deposits above the maximum amount determined by the Minister, which is currently $550,000.[44] In his submission to us, the Aged Care Pricing Commissioner, Mr John Dicer, said that:

> The ACPC's role was established to ensure that accommodation prices represent value for prospective aged care residents and that higher prices reflect the standard of accommodation rather than a resident's capacity to pay.[45]

Professor Menezes described the current limit of $550,000 on the value of Refundable Accommodation Deposits above which approval must be sought from the Aged Care Pricing Commissioner as a 'coarse instrument', but did not recommend abandoning it.[46] The consensus between Professor Menezes and Professor Cutler was that this form of economic regulation is reasonably appropriate to protect the interests of unsupported residents from approved providers' market power, and that heavier forms of regulation such as fixed price caps would not be justified.[47]

In the *Legislated Review of Aged Care 2017*, Mr David Tune AO PSM concluded that the Aged Care Pricing Commissioner's role will remain a necessary regulatory mechanism in the medium term.[48]

Residential aged care providers have generally supported increased flexibility in the accommodation prices they charge to older people. For example, Mr Sean Rooney, Chief Executive Officer of Leading Age Services Australia, told us that:

> In residential care, accommodation charges for non-supported residents are really the only place where there is a reasonable degree of flexibility over fees being charged. While the need to make applications to the Pricing Commissioner for charges above the cap is cumbersome—and LASA supports the Tune Review recommendation that the cap be indexed—it supports a reasonable degree of price flexibility to respond to local factors, and changes in the economy.[49]

COTA Australia argued for stronger consumer protections for older people accessing aged care services. In a submission in response to Counsel Assisting's funding, financing and prudential regulation propositions, it told us that:

> There must be regulation of private pricing. All costing information must be published. Consumers have provided us with numerous examples of providers charging 'additional service' or 'extra service' fees the basis for which is not revealed to them or is opaque and confusing. [50]

I consider that the Pricing Authority should carry on the work of the current Aged Care Pricing Commissioner in relation to accommodation charges. It should also be responsible for providing advice to the Australian Government on whether and what mode of economic regulation or other intervention is appropriate in the absence of service availability or a workably competitive market for particular services. These interventions may include, but will not be limited to, price caps.

21.6 Requirements to provide information

Recommendation 116: Requirement to participate in Pricing Authority activities

1. **By 1 July 2022, the *Accountability Principles 2014* (Cth) should be amended to require participation by approved providers in cost data reviews.**
2. **By 1 July 2023, the new Act should require that as a condition of approval or continued approval, aged care providers are required to participate in any activities the Pricing Authority requires to undertake its functions, including transmitting cost data in a format required by the Authority for the purposes of costing studies. The Authority should take costs associated with these activities into account when determining funding levels.**

To support the pricing function, it will be necessary for the Pricing Authority to obtain cost data from the sector. It will require wide-ranging powers to obtain financial information from approved providers and their participation in costs studies and standard form cost surveys.

Costing studies will be critical to the Pricing Authority's functions. Mr James Downie, the Chief Executive of the Independent Hospital Pricing Authority explained:

> Annual costing studies ensure that the ABF [activity based funding] system is self-correcting. For example, if there is a wide spread practice of increasing the coding complexity of patients, then over time the price weight will reduce, and as such the incentive to over code complexity is ameliorated.[51]

The Australian Department of Health agreed that upon implementation of an activity based funding model such as the Australian National Aged Care Classification, costing studies would need to 'be undertaken to ensure that the cost weights attached to each class remain relevant'.[52] The exact scope of the required activities should be left to the determination of the Pricing Authority.

21.7 Specific funding arrangements for particular services

As Professor Eagar told us, funding system design is not a set of free choices and not an end in itself. It cannot be separated from program design and should be seen as the best means to achieve the aged care system that Australia should have into the future.[53]

In broad terms, the components of funding system design for aged care can be described as:

- **Assessment:** the process and tools by which people's needs are assessed for their eligibility for services, and the type and amount of those services. This also includes a process for reassessing people's needs when they change.
- **Needs categorisation:** the model that categorises people's needs and allocates resources to support those needs.
- **Funding methods:** the basis on which funds are paid to approved providers for service provision.

These components are interrelated, often complex, and must operate together to achieve a set of diverse objectives, for the person, providers and the broader aged care system.

As Professor Cutler told us:

> There is no perfect funding model for residential aged care. All funding models have their advantages and disadvantages. Selecting a funding model will require trade-off between complexity and the ability to incentivise good quality care. For example, historical block funding is relatively easy to administer, but it does not incentivise better care quality or efficiency improvements. It will also lead to inequitable access to care if funding fails to reflect population need.[54]

In making recommendations about funding arrangements for aged care services, I have had regard to the need to put people first, and to strive as far as possible for arrangements that are simple, practical, equitable, efficient, consistent, and responsive or 'agile'. I have also had regard to the need to create explicit relationships between people's needs, costs, prices and outcomes.[55]

We have heard a wide range of evidence on the preferred way in which aged care services should be funded. For example, Dr David Panter, Chief Executive Officer of aged care provider ECH Incorporated, argued that approved providers should be funded on the basis of the outcomes they achieve. He told us:

> An ideal system would be user-focused and goal-orientated so that it is measured by the outcomes achieved rather than inputs. So for example, if an older person's desire is to stay living independently at home for as long as possible, which it is for by far the majority, then the system should be structured to incentivise providers to achieve this goal. In this context length of tenure in a HCP [Home Care Package], supported by 'quality of life' indicators, is a critical measure of success (outcome). However, home care provider performance does not get measured on these factors, instead they are measured on inputs, e.g. hours of service provided.[56]

I believe it would take many years for the outcomes monitoring recommendations we have made in Chapter 3: Quality and Safety to mature to the point where they could be relied on for funding purposes. As a result, I do not believe that an outcomes-based funding model is appropriate at this time. The Pricing Authority should, however, consider moving to such a system in the medium term, albeit that some input controls on staffing, for example, may need to be retained.

We have also heard about the advantages of block funding for providers, which is currently used for the Commonwealth Home Support Programme.[57] Providers are paid quarterly in advance and have to report on the level of activity they perform. Providers are required to return unspent funds, except in exceptional circumstances, and they do not receive any additional funds if the budgeted activity level is exceeded.[58]

Block funding provides more confidence for providers about the expected funding stream. This encourages establishment and retention in areas of thin markets—that is, those that are not workably competitive—and allows the flexibility to provide greater levels of service to people, and in places where they are needed.[59] This level of flexibility is particularly important when people need to access services at short notice or in response to a crisis.

A block funding approach is used under the National Health Reform Agreement for smaller public hospitals in regional areas. Mr Downie told us:

> So, for those smaller hospitals, they're block-funded. So they receive a fixed amount of funding each year. So the National Efficient Cost is used for that and the current model consists of two parts. There's a fixed amount, it covers the fixed cost of opening—or keeping that hospital open, and there's a variable amount based on the National Efficient Price that recognises that the more activity a hospital does, the more costs it incurs but importantly, that's a fixed amount for the year based on historical activity trends.[60]

However, there are also drawbacks to block funding. Generally speaking, funding through grant rounds tends to confer an advantage on existing contract holders, creating barriers to new entrants and potentially reducing competitive pressures on incumbents to innovate.[61] There are also issues with transparency and choice, as there is limited publicly available information on how grants are reconciled and potentially less choice for people receiving care.[62] As a matter of logic, it seems to me that providing block funding irrespective of activity and performance could generate a perverse incentive to reduce service delivery.

I believe that there are many benefits in a system of activity based funding. We note that when activity based funding was introduced on a national basis for public hospitals in 2011 under the National Health Reform Agreement, governments stated that the Agreement would:

> (a) improve patient access to services and public hospital efficiency through the use of activity based funding (ABF) based on a national efficient price
>
> ...
>
> (c) improve the transparency of public hospital funding through a National Health Funding Pool and nationally consistent approach to ABF[63]

However, activity based funding can add complexity to an already overly complicated system of funding and provide less flexibility for providers to respond to the changing needs or circumstances of the older people in their care.

Professor Cutler argued that there are benefits in combining approaches to funding model design. He told us:

> Funding models can also be combined to mitigate disadvantages or introduce further advantages associated with using only one funding model. While this increases the administrative burden, benefits associated with better targeted funding and subsequent improved outcomes can outweigh these costs.[64]

I agree. My view is that the primary approach for funding approved providers for the aged care services they deliver should be based on the volume of activity each provider performs. Activity based funding should be supplemented with block funding where required to ensure area coverage, continuity of service, and service viability objectives. This approach combines the access, efficiency, transparency, and competition advantages of activity based funding, with the greater confidence provided by block funding.

Below, I set out recommendations for the funding arrangements that would apply to each of the five service categories we recommend in our new program design: social supports (Recommendation 33); respite supports (Recommendation 32); assistive technologies and home modifications (Recommendation 34); care at home (Recommendations 35 and 36); and residential care (Recommendations 37 and 38).

Elsewhere in this volume, we make recommendations for alternative funding arrangements to those outlined here on the basis that the specific circumstances justify a different approach. For example, in regional, rural and remote areas and other thin markets, it may be appropriate to commission aged care providers to ensure there is adequate service coverage (Recommendation 54). Similarly, the nature of delivering aged care services to Aboriginal and Torres Strait Islander people requires a high degree of funding security and flexibility (Recommendations 52 and 53). The rationale for these different approaches is outlined in the relevant chapters.

21.8 Social supports, respite supports, assistive technologies and home modifications

Recommendation 117: Grant funding for support services to be funded through a combination of block and activity based funding

1. **The Pricing Authority should advise the System Governor on the combination and form of block and activity based grants that should be adopted for social supports, respite, and assistive technology and home modifications, having regard to the characteristics of these services and market conditions where they are delivered.**
2. **Growth funding of 3.5% should continue to be provided for these service categories until a demand-driven planning regime is in place.**
3. **The Australian Government should grant fund these services from 1 July 2022.**

Commissioner Briggs

Grant funding of social supports, respite supports, and assistive technologies and home modifications on an activity basis, with a block-funded component as required, is intended to achieve a number of objectives.

The first objective is to ensure area coverage across Australia. Grant funding on this basis should ensure that everyone who needs to access these types of supports can do so, irrespective of how widely dispersed the population might be or how scarce the number of organisations willing to supply services might be. Meeting that objective will require a robust planning regime, active system management, and approved providers having a degree of certainty over their funding. In my view, grants based on a combination of block and activity based funding are the appropriate mechanism to achieve this objective.

While area coverage is an important consideration, ensuring there is sufficient capacity and service availability to meet demand are also significant objectives. Older people and their carers often need to make urgent use of respite support to ensure the long-term continuity of care without an older person being forced to enter residential care. Respite providers should be grant funded and sufficiently numerous to ensure that there is capacity to meet the needs of older people in the areas they live. To achieve that outcome, a combination of block and activity based grants should also be used for respite supports. However, in this case it may be appropriate for a higher proportion of the funding to be paid through the block funded component to ensure respite providers' viability and access for older people in the event that usage patterns fluctuate. This approach will also encourage residential care providers to allocate permanent beds for respite care.

In Chapter 4: Program Design, we highlight the need to foster and grow the provision of assistive technologies and home modifications, and the need for the System Governor to develop a needs-based planning framework for assistive technologies and home modifications. Providers should be grant funded, at least until the provision of assistive technologies and home modifications for older people matures. Providers should, where possible, be funded through a combination of block and activity based payments.

As part of its advisory function on funding arrangements for aged care services, the Pricing Authority should advise on the appropriate combination of block and activity based payments in the grants for social supports, respite, and assistive technologies and home modifications. The block funding component will cover the fixed costs of operating the service plus a minimum number of services that must be delivered. This will give both providers and individuals requiring care some certainty that a minimum level of services will be provided.

The justification for block funding is likely to vary between program categories, as well as the geographic location in which the service is being provided. The Pricing Authority should take account of these factors and the balance between security, flexibility, accountability and incentives in providing advice to the System Governor on the mix of block and activity based funding. I believe that the Pricing Authority will be best placed to determine how activity based funding is allocated by setting out the prices for individual services and any additional weightings that should be applied.

Historically, under the Home and Community Care program, these supports grew at 6% per annum. The growth rate was cut to 2.8% in 2015–16, 1.5% in 2016–17, and 2.4% in 2017–18. In 2018–19, the growth rate was increased to 3.5%, which aligned with the annual growth in the population aged over 65 years. This growth is in addition to annual indexation for home support funding.[65]

There should be continued growth in funding for social supports, respite supports and assistive technologies and home modifications, in addition to indexation, until the demand-driven model is established. Planning and allocation for the growth funding should take into account the need to provide equitable access across regions, States and Territories to the supports categories. Additional growth funding may be needed in the transition to a demand-driven program to ensure that there is an adequate supply of supports.

21.9 Care at home service category

Recommendation 118: New funding model for care at home

1. By 1 July 2024, the Australian Government should pay subsidies for service provision within the care at home category through a new funding model that takes the form of an individualised budget or casemix classification. The new funding model should provide an entitlement to care based on assessed need across the following domains:
    a. care management
    b. living supports—cleaning, laundry, preparation of meals, shopping for groceries, gardening and home maintenance
    c. personal, clinical, enabling and therapeutic care, including nursing care, allied health care and restorative care interventions
    d. palliative and end-of-life care.
2. The funding model should be developed as part of the development of the new care at home category (see Recommendation 35). Ongoing evidence-based reviews should be conducted thereafter to refine the model iteratively, and ensure that it provides accurate classification and funding to meet assessed needs.

The Australian Department of Health told us that it is currently developing a model for assessment, classification and funding within a unified home care program, combining the existing Home Care Packages Program and the Commonwealth Home Support Programme.[66]

The System Governor should be in a position to begin payment of subsidies for service provision within the care at home category by 1 July 2024. The details of the service arrangements should be developed and iteratively refined in consultation with older people and the aged care sector. The starting point for this consultation, development and refinement process is set out in Chapter 4: Program Design. The Department's work on these issues should continue. However, in the recommendation above, I outline the key features I consider are required.

The first step is a process by which the needs of older people would be assessed and classified. Each classification would be linked to an entitlement to care that would be expressed in terms of the hours of support that would be provided within specified domains—care management; living supports; personal, clinical enabling and therapeutic care; and palliative and end-of-life care—and a budget (or budgets) associated with those services.

Consistent with Recommendation 123, on payment on an accruals basis for care at home, approved providers would submit invoices for payment by the System Governor against the budget for each older person receiving care at home. The older person should be able to exceed temporarily their budget to fund services in response to a period of increased need, such as while recovering from a fall. Where the older person exceeded their budget for over three months this would act as an automatic trigger for reassessment.

I expect that under this arrangement, grant funding would only be used to commission care at home providers to service thin markets. This is discussed further in Chapter 8: Aged Care in Rural, Regional and Remote Australia.

21.10 Upper limit on funding for care at home

Recommendation 119: Maximum funding amounts for care at home

1. **With effect from 1 July 2024, the Australian Government should provide funding for a person receiving care at home in accordance with their assessed needs, subject to the following limitation.**
2. **The funding available for a person receiving care at home should be no more than the funding amount that would be made available to provide care for them if they were assessed for care at a residential aged care service.**

Older people overwhelmingly prefer to remain in their home.[67] To allow this to occur, significantly more funding will need to be available to older people to allow them to access more care in the home for longer. The limit on the funding a person should receive for care at home should be equivalent to the care component of the funding that the Australian Government would provide for them in a residential care setting.

In the current system, the maximum level of funding under a Level 4 Home Care Package for people with high-care needs is approximately $52,250 a year.[68] A survey of home care providers conducted by StewartBrown for the Australian Department of Health found that in 2018–19, this provided on average eight hours and 45 minutes of service per week. This included three hours of personal care and less than 20 minutes of clinical care (nursing and allied health).[69] This level of care will not be enough to support someone with high care needs at home.

We have recommended a universal entitlement to aged care—an entitlement to receive high quality and safe care to meet ageing-related needs. This is not an absolute right to have that care delivered in a particular setting. Care provided to a person in a congregate setting may be more cost-effective in certain circumstances than care provided to that person in their own home. In cases where the person can no longer safely continue to receive subsidised care at home, the approved provider may have to decide whether it is willing to continue to provide services to the person at home, in light of its duty to ensure

the person receives high quality care. The *User Rights Principles 2014* (Cth) currently contemplate this scenario and allows an approved provider to discontinue home care under certain conditions.[70] This should continue to be the case.

The most appropriate limit to be placed on the funding a person should be entitled to receive for care at home is the care component of the funding that the Australian Government would provide for them in a residential care setting. If the older person is prepared and able to supplement that funding with their own resources, and if an approved provider of home care is prepared to assume responsibility for care of the person in those circumstances, this may mean the person will be able to remain longer at home, and may be able to remain at home until the end of their life.

Mr Paul Sutton, the Victorian Operations Manager of Ryman Healthcare (Australia), submitted that Ryman was concerned that a person receiving care in residential aged care has direct access to care on demand 24 hours a day, and will receive more minutes of care a day than a person living at home. Home care, he submitted, cannot provide the same level of care on demand as provided in residential care.[71] While I acknowledge this point, I strongly prefer the position that a universal entitlement to aged care requires people to be able to receive the care they require in the setting they prefer to receive it to the extent possible. No Australian should be prevented from receiving care at home because of an arbitrary lower limit on what can be funded in the home. We know that the vast majority of Australians would prefer to receive care at home.

The *Legislated Review of Aged Care* 2017 included a recommendation for the introduction of an additional level of Home Care Package to the four existing levels.[72] We do not recommend the introduction of a new level of Home Care Package given the prospect of more comprehensive re-ordering of the service arrangements for care in the home and community in the near future—by mid-2024, as we have recommended in Chapter 4: Program Design.

Under a casemix funding model for residential aged care, there is an issue concerning how the maximum funding amount for home care is to be calculated. For example, if the Australian National Aged Care Classification model is the casemix model for residential aged care, an issue arises because the estimated comparison base tariff varies with features of the facility.[73] The calculation of the maximum amount of home care funding involves a counterfactual scenario—a determination of the care funding that would be payable if the individual was receiving residential care. There being no actual facility, a notional amount based either on a national average or regional average for the base tariff would be required, and this would be added to the individualised care payment. The adjustment tariff would not apply. I consider that this should be determined by the Pricing Authority.

21.11 Residential care

Revenue for approved providers of residential care is currently configured into three main streams:

- care
- ordinary costs of living
- accommodation costs.[74]

Both Commissioner Pagone and I consider that this approach should continue under the future system.

We both recommend a new model for funding of care in residential aged care settings which will take into account the 'activity' of the approved provider at a given time (that is, how many residents it is caring for), and the 'casemix' of that activity (that is, the variation in needs of the residents).

There is a clear case, supported by the Australian Department of Health, to transition away from the Aged Care Funding Instrument.[75] Such a transition needs to be implemented at the earliest reasonable opportunity.

The new activity and casemix model should be based on the assessment of needs and classification of individuals to one of a number of funding categories, each of which reflects the costs of caring for a person classified to that level of need. An example of the new model is the Australian National Aged Care Classification, which is currently in trials. It, or preferably some variant on the model to incorporate our recommendations, may be an appropriate casemix model for adoption by the Pricing Authority.

Recommendation 120: Casemix-adjusted activity based funding in residential aged care

By 1 July 2022, the Australian Government should fund approved providers for delivering residential aged care through a casemix classification system, such as the Australian National Aged Care Classification model. The classification system should take into account the above recommendations for high quality aged care. Ongoing evidence-based reviews should be conducted thereafter to refine the model iteratively, for the purpose of ensuring that the model provides accurate classification and funding to meet assessed needs.

This model of funding found broad support when tested with witnesses across the sector and from several union groups. [76]

A team from the University of Wollongong led by Professor Kathy Eagar has been working on the replacement of the Aged Care Funding Instrument by an appropriate casemix model since 2017. In their Resource Utilisation and Classification Study, they developed a proposal for a new casemix-adjusted activity based funding model for residential aged care, the Australian National Aged Care Classification. Under this model, approved providers would receive:

- a base tariff payable daily to meet the costs of care delivered equally to all residents (such as clinical supervision and training, facility clinical management and shared care activities such as night supervision and resident observation during social activities and meal times), with the level of the base tariff varying by remoteness, and facility size and type
- an individualised care payment based on each resident's casemix classification to meet the costs associated with the care of residents with different needs
- an adjustment tariff payable during the first 28 days of care to meet the costs of settling residents into new arrangements.[77]

The payment model is structured in this way to recognise the fact that about half of care costs within a facility are driven not by the individual care needs of the residents but by care delivered equally to all residents.[78]

There are additional costs incurred when a resident first transitions into residential aged care relating to:

- time spent getting to know the resident and their family
- individualised care planning
- behaviour management
- health care assessments
- facilitating health care arising from assessments (including pain management, dental care, palliative care and other issues that need attention)
- developing an advanced care directive in partnership with the resident and their family.[79]

Under this model, each payment is expressed as a National Weighted Activity Unit, which describes the relative value of each payment to the national average.[80] My view is that this payment structure should be adopted for residential aged care facilities and updated as required in line with changes to the Australian National Aged Care Classification itself. Before it is implemented, the Pricing Authority will need to set a price and update relative value units for the base care tariff, individualised care payment, and adjustment tariff. These will need to reflect changes in costs that have occurred since the Resource Utilisation and Classification Study was completed, including those brought about from our recommendations such as the introduction of a minimum staff time quality and safety standard (Recommendation 86) and improvements to aged care workers' pay (Recommendation 84).

The Resource Utilisation and Classification Study also recommended:

> That, in residential care facilities in remote areas (MMM [Modified Monash Model] 6 or MMM 7), the base tariff be based on approved beds (capacity) with all other base tariffs being based on occupancy.[81]

This recommendation effectively provides a guaranteed or block funded component for eligible residential aged care facilities. The size of the block funded component would increase based on the size of the facility. In line with the approach to funding I have outlined above, I believe it should be open to the Pricing Authority to adopt this approach in other circumstances where required to meet service continuity and viability objectives. This could include residential aged care facilities in regional and remote areas, or where it is required to ensure the viability of specialist facilities.

The Australian National Aged Care Classification model incorporates costs associated with a range of existing supplements, including for specialist homeless services, facilities in regional, rural and remote areas, and facilities catering for Aboriginal and Torres Strait Islander people. It does not account for the cost of the enteral feeding, oxygen, and veterans' supplements.[82]

If the Australian National Aged Care Classification model is implemented in residential aged care, it will be important that these supplements be continued until they can be considered, and their costs ascertained, by the Pricing Authority.

A number of responses to Counsel Assisting's Final Submissions raised some issues with a casemix-adjusted funding model for residential care based on the Australian National Aged Care Classification. The United Workers Union was concerned that the system was based on staff time and costs, not on the true time and costs involved in providing quality care.[83] That is why we suggest that the Pricing Authority will need to update the classification and cost structure before it is implemented, to reflect, among other things, the impact of our other recommendations.

The Victorian Government noted the potential for gaps with the Australian National Aged Care Classification because part of the service system was excluded from the first study examining resident needs, and not all resident needs were considered. It also observed that the Australian National Aged Care Classification was informed by a cost weights study rather than a cost of care study, and it did not include all care needs or the small proportion of people with very complex needs that are common in Victorian public sector residential aged care services.[84] I agree, and consider that the initial version of any casemix classification system will need further development and refinement over time, but I do not consider that this is a reason for not proceeding with its introduction.

The Victorian Government also suggested that further consideration could be given to how the Australian National Aged Care Classification might prejudice access for people within smaller rural and regional communities.[85] Similarly, the National Advisory Group for Aboriginal and Torres Strait Islander Aged Care raised the point that the Australian National Aged Care Classification funding model is as yet almost entirely untested in remote and very remote settings and has not been piloted in any remote services.[86] While I note these

concerns, I consider that rigorous analysis of cost differentials across regions by the Pricing Authority and pricing on the basis of these studies will improve the viability of aged care services in remote and very remote settings compared with the arbitrary Viability Supplement paid under current arrangements. We have also recommended that the Pricing Authority be empowered to introduce funding models which operate differently in thin markets, to ensure that there is no prejudice to older people in rural, regional or remote locations.

21.12 Ordinary costs of living

Under current arrangements, the amount an approved provider of residential care is permitted to charge a resident for basic living expenses such as food, laundry cleaning and utilities is the Basic Daily Fee, currently set at 85% of the basic single age pension or $52 per day. The Basic Daily Fee operates as a price cap for the bundle of goods and services set out in Part 1 of Schedule 1 to the *Quality of Care Principles 2014* (Cth). Payments of the Basic Daily Fee by residents made up $3.4 billion of a total of $4.8 billion paid by people receiving residential care in 2018–19.[87]

StewartBrown has identified that for the year ended 30 June 2020, the costs of providing everyday living services exceeded revenue by $9.11 per bed per day on average for those providers participating in its survey.[88] Aged care providers have told us that the inadequacy of the revenue stream they receive from the Basic Daily Fee limits the quality of care they can provide.[89] The Australian Government accepts that revenue from the Basic Daily Fee is insufficient.[90]

The Pricing Authority should determine a 'Services Fee Amount' as the cost of everyday living needs on the basis of comprehensive and statistically valid cost studies and having regard to any advice from the System Governor on quality objectives and policy priorities. It should determine different amounts for different regions if studies suggest this is appropriate. I am confident that the Services Fee Amount will exceed 85% of the basic single age pension.

I consider that the Services Fee Amount determined by the Pricing Authority should continue to operate as a price cap, consistent with the evidence of Professors Menezes and Cutler.[91] Given the stapling (bundling) of the goods and services that meet basic living needs to the care that people receive in residential care, it is particularly important that the prices for these ordinary living goods and services are regulated. This is especially true in residential aged care, where there can be a degree of provider capture after a resident has moved into an aged care home due to the difficulties in moving.

To ensure that pensioners and other low-income groups can afford an increased Services Fee Amount, I propose in my chapter on personal contributions and means testing (Chapter 22) that the Australian Government should pay a means tested 'Ordinary Cost of Living Top-up Subsidy', representing the gap between the Services Fee Amount and 85% of the basic single age pension. This subsidy would vary for each resident to reflect the outcome of the means test, with approved providers receiving the full subsidy for supported residents, a part subsidy for partially supported residents, and no subsidy for

non-supported residents. Unlike Commissioner Pagone, I consider that this means testing arrangement should continue indefinitely. Later in this chapter, I also propose a short-term increase in the Basic Daily Fee to be paid for by the Australian Government pending the determination of the Services Fee Amount by the Pricing Authority and the introduction of the Ordinary Cost of Living Top-up Subsidy.

21.13 Recurrent accommodation costs

To provide residential aged care, an approved provider must be able to provide accommodation to its residents in premises accredited as a residential aged care service.

Under current arrangements, the Australian Government pays an accommodation supplement, in whole or in part, for residents who are assessed under a means test as unable to afford to make a full accommodation payment to their aged care provider. Residents eligible for the full supplement are referred to as supported residents, and those partly eligible are referred to as partially supported residents. The rate of the supplement varies according to the proportion of the residents in a service who are supported or partly supported, and is also adjusted if the building housing the service is new or has been recently refurbished.

Unsupported residents, who are assessed by the means test as ineligible for the accommodation Supplement, are required to pay a Refundable Accommodation Deposit (or an equivalent Daily Accommodation Payment). Refundable Accommodation Deposits are considered separately in Chapters 18 and 23, on capital financing for residential aged care.

Some approved providers raised concerns about the adequacy of the level at which the accommodation supplement is set. Uniting NSW.ACT told us that:

> The Accommodation Supplement (particularly the significantly refurbished supplement) is constrained by government regulation. Apart from the requirement of the level of expenditure to uplift from the base level of accommodation supplement, the full supplement is only paid when the supported resident ratio in a home is greater than 40%. The higher supplement amount paid would cover a build cost $345,000 over 30 years (with no allowance for refurbishment or cost of land). The less than 40% supported resident ratio accommodation supplement would cover a build cost of $260,000—no refurbishment or land.[92]

We commissioned Frontier Economics to report on the required revenues to support investment in residential aged care, including the potential use of a building block model incorporating a weighted average cost of capital.[93] There was support for the level of accommodation funding to reflect the weighted average cost of capital from peak bodies Aged and Community Services Australia and Leading Age Services Australia.[94] Mr Mamarelis of the Whiddon Group supported the principles underpinning the weighted average cost of capital, but had some reservations about how it would be applied in practice.[95] Some providers disputed Frontier Economics' estimate of the applicable weighted average cost of capital. [96]

In advice prepared for us, Professor Menezes pointed to challenges associated with the possible use of rate of return regulation to set prices for residential aged care.[97] Amongst other difficulties, he indicated that it was unclear how a regulator would determine the allowed rate of return for a government or a not-for-profit facility.[98] He suggested that benchmarking approaches may be more straightforward to implement, requiring less judgement and involving the least cost.[99]

I consider that the Pricing Authority should determine the level (or levels) of the accommodation supplement as the cost of renting accommodation from a landlord on commercial terms, and regularly review and update the accommodation supplement when required. The methodology to be employed should be a matter for the Pricing Authority to determine.

21.14 Assessment principles – incentives for an enabling approach

Recommendation 121: Incentives for an enablement approach to residential care

From 1 July 2022, the following incentives should be incorporated into the rules, principles and guidelines for assessment and funding eligibility:

a. **an approved provider should be paid retrospectively from the date when a reassessment was requested where it is determined on reassessment that a person is entitled to a higher level of funding, and the provider can demonstrate that it has been providing the higher level of care**

b. **a resident should not be required to be reassessed for funding eligibility if their condition improves under the care of a provider.**

The aged care system should help people to maintain independence. The funding mechanism that subsidises the provision of residential aged care should be aligned with this goal. Witnesses told us that the administration of the current funding arrangement, the Aged Care Funding Instrument, lacks incentives towards reablement and instead generates incentives that reinforce dependency.[100] Under the current regime, if a provider is successful in assisting a person to regain some of their independence or to improve their health condition, their funding is reduced after that person is reassessed.[101] As an incentive to restore health and wellbeing, the assessment process should be reformed such that approved providers retain the previous level of funding if a resident becomes less dependent or becomes healthier. Professor John McCallum, of National Seniors Australia, told us that this approach would be a 'great positive'. [102]

Approved providers should be regularly testing whether the services they are delivering are meeting the older person's needs, supporting their independence and helping them to achieve their goals. If that process shows that services could be improved, approved providers should revise their care plans. In some cases, the older person may require additional care to manage an episode or for a short period of time. For example, where an older person may benefit from a short-term reablement intervention, the base tariff under the Australian National Aged Care Classification should be set at such a level as to fund short-term additional care across a residential service. If approved providers do increase care, and if the reassessment process finds that a higher level of funding is required, providers should be eligible for back payment to the date that the additional care was provided.

At the same time, there should be an explicit incentive for approved providers to invest in restorative care and reablement.[103] I expect that this will encourage more approved providers to focus on improving the quality of life of older people receiving aged care. However, we heard from Allied Health Professions Australia that this may not be sufficient:

> The proposal for a new aged care funding instrument has specifically identified the need to remove such disincentives for improving the health and wellbeing of aged care residents, allowing aged care homes to retain any difference between the level of funding the resident is assessed for and the actual cost of providing care to a resident that has benefited from reablement and restorative care.
>
> Unfortunately, it is not clear that removing the disincentive in the funding model will be sufficient to improve quality and may need to be enhanced through additional funding aimed at investing in improving the health and wellbeing of the resident. The costs of reablement and restorative services as well as preventive care may not be covered by the potential difference in funding and care costs and may mean aged care providers do not choose to spend limited funds in this way.[104]

I accept this point and do not propose to rely solely on this incentive to promote reablement. In Chapter 4: Program Design, we make recommendations that would lead to the increased provision of allied health to promote restorative care. We also make further recommendations below to improve the availability of information on how care funds are spent.

21.15 Accountability

We make a number of recommendations to enhance accountability for the appropriate expenditure of government funding. These measures are complementary to financial reporting and prudential regulatory requirements, which we address in separate chapters on prudential regulation and financial oversight.

21.15.1 Reporting of staffing expenditures

Recommendation 122: Reporting of staffing hours

1. From 1 July 2022, the *Accountability Principles 2014 (*Cth) should be amended to require all approved providers of residential aged care to report, on a quarterly basis, setting out total direct care staffing hours provided each day at each facility they conduct, specifying the different employment categories (including personal care workers, enrolled nurses engaged in direct care provision, registered nurses engaged in direct care provision, and allied health care professionals engaged in direct care provision).
2. The System Governor should assess the reports against the minimum staffing requirements, and initiate appropriate action in cases of non-compliance.

The current aged care system is not well designed to ensure that the care being provided meets people's needs. Residential care providers receive approximately $12.4 billion in overall care-related revenue annually, made up of $11.7 billion in Australian Government care subsidies and $700 million in contributions from residents.[105] However, there is no specific requirement on residential aged care providers to spend any portion of the money they receive on care. Transparency around the deployment of staffing hours in residential care facilities will do a great deal to ensure that approved providers are accountable for the funding they receive.

Transparency and accountability should be embedded in the new aged care system. Witnesses who gave evidence about this issue, including experts, providers, the Australian Department of Health, and consumer advocates, supported increased transparency and accountability in the spending of public money for care.[106] Professor Michael Woods was of the view that:

> An approach worthy of further analysis is to require a clear level of specification of care service levels, including both clinical and care staffing standards, as well as ring-fencing of the funding for care services to ensure that the public and consumer funds are not sources of excess profits. Such ring-fencing should include very high levels of transparency and public accountability for expenditure on those care services.[107]

I have carefully considered the issue of a formal ring-fencing requirement around aged care businesses. This would provide more transparency and accountability around the use of the substantial quantities of taxpayer and Government-mandated funding provided to care for older people. However, such a requirement would be burdensome and reduce the flexibilities available to providers that would likely add to the cost of setting up and operating aged care services. [108] On balance, I do not recommend a formal ring-fencing requirement. In my view, a requirement to report on staffing levels strikes an appropriate balance between administrative costs and accountability.

Ideally, providers should be held accountable for the quality of the services they deliver on the basis of outcomes, rather than inputs or outputs.[109] However, given the underdeveloped state of performance indictors and quality measurement in the aged care sector, I am convinced that it is appropriate to require the reporting of staff hours as an important accountability measure.

The Health Services Union and the United Workers Union both raised concerns about the possibility of providers transferring non-direct care duties such as cleaning, laundry, and catering to the direct care workforce. [110] The Health Services Union suggested that providers should be required to report on all staffing categories, including catering and food services, cleaners, laundry staff, and contract and agency workers and external consultants.

The reporting arrangements need to be carefully set up to avoid this possibility of work transfer and I consider that the form in which reporting requirements are imposed should be carefully designed to ensure that only direct care hours are measured. This may include a requirement for reconciliation with total staff numbers.

In Chapter 12: The Aged Care Workforce, we recommend the introduction of a quality and safety standard mandating minimum staffing levels and skills mixes for residential aged care. Reports by providers should be reviewed against these standards.

21.15.2 Management of payments for home care

Recommendation 123: Payment on accruals basis for care at home

The Australian Government should pay home care providers for services delivered or liabilities incurred from Home Care Packages on accrual.

Recommendation 124: Standardised statements on services delivered and costs in home care

1. **The Australian Government should develop and implement a standardised statement format for home care providers to record services delivered and costs incurred on behalf of Home Care Package holders.**
2. **From 1 July 2022, providers should be required to issue completed statements in the standardised format to people receiving their care on a monthly basis.**

3.	**From 1 July 2022, providers should be required to provide reports on a quarterly basis in a standard format setting out total direct care staffing hours provided each day at each home they service, specifying the different employment categories (including personal care workers, enrolled nurses engaged in direct care provision, registered nurses engaged in direct care provision, and allied health care professionals engaged in direct care provision).**	**Commissioner Briggs**

To increase efficiency, transparency and accountability in the system, home care providers should be paid after they have incurred a financial liability for the delivery of services.

At present, home care providers are paid subsidies for each month in advance, regardless of the services actually provided.[111] This means the Australian Government is wholly reliant on approved providers for accurate reporting and reconciliation of funds. This arrangement has several undesirable effects, including the accumulation of 'unspent funds' and a lack of clarity regarding what services are delivered.

Under the current home care payment arrangements, any amount that is not spent providing care and services in any given month is held by the provider as available funds to be used by the person receiving the package in the future. These funds are commonly referred to as 'unspent funds'. According to StewartBrown, unspent funds in home care average $8250 per person, totalling in excess of $1.1 billion of public funds, and are shown in approved providers' accounts as a liability.[112]

Approved providers of home care hold and use unspent funds in a variety of ways. Some treat unspent funds as part of their working capital, reducing the need to access other sources, some quarantine unspent funds in a separate account and use them only to pay for care and services, and some have the money held by a third party, effectively in trust.[113] The Australian Government does not give guidance to providers on whether interest may be earned and does not require interest to be paid to the Government if it has been earned.[114] Due to the high level of unspent funds, there is a reluctance by some providers to levy, and among older people to be charged a client contribution in home care, as it would effectively only add to the quantum of unspent funds.

In the 2019–2020 Budget, the Australian Government announced its intention to change payment arrangements in home care from payment in advance to payment upon delivery of service. One of the intentions of this change is to avoid Australian Government funding being held as unspent funds by providers. The *Aged Care Legislation Amendment (Improved Home Care Payment Administration No. 1) Bill 2020* has passed the House of Representatives and received a second reading in the Senate on 9 November 2020. Together with the *Aged Care Legislation Amendment (Improved Home Care Payment Administration No. 2) Bill 2020*, introduced in the House of Representatives on 21 October 2020, these Bills change the payment of home care subsidies to approved providers from being paid in advance to being 'paid in arrears'.[115] They also amend the arrangements relating to the payment of the home care subsidy to approved providers by providing that the Australian Government will retain, on behalf of people receiving home care, any subsidy

that may be in excess of the care and services provided, to be drawn down as care and services are provided in future.[116]

The Bills remain before the Australian Parliament. Work should continue to implement the arrangements as soon as possible, having regard to the need for an orderly transition.[117]

We heard that the statements provided to people receiving care by Home Care Package providers can be confusing and unhelpful.[118] There are many advantages in requiring approved providers to follow a standard format to show the services provided and the associated costs. A well designed presentation would assist people to understand the information and support them to review it and question issues with the provider, if required. A standard format used by all approved providers would also assist care finders and other advocates to understand the care that has been provided in the course of reviewing the suitability of the care people are receiving, or in advocating with providers on behalf of people receiving care.

I am concerned that the Australian Government does not know much about the goods and services that are provided to people through Home Care Packages. Home care providers are not required to report to the Australian Government on the kinds of goods and services they provide using Home Care Package subsidies, which amount to about $2.5 billion a year (based on 2018–19 data).[119]

To fill in this gap in knowledge, the Australian Department of Health commissioned StewartBrown to undertake a survey of approved home care providers, which provided useable data for 416 providers covering just over half of aged care packages as at 30 June 2019.[120] The results are concerning in many ways, not least in that they show an older person receiving a Level 4 package received on average one hour per week of care management, but only 10 minutes of nursing care and eight minutes of allied health professional care.[121]

However, in the absence of regular reporting on the mix of goods and services that are provided as care at home, the Department is not able to assess whether the program is delivering the right kinds of services to achieve its objectives or initiate remedial action to rectify any shortfalls. I recommend a regular reporting regime for home care providers at Recommendation 124.

21.16 Immediate funding measures

The introduction of the new funding measures recommended above will take some time to implement. However, it is important to provide some immediate relief to support the aged care sector in providing safe and high quality care, and I set out below some recommendations in this area.

Indexation of funding to aged care providers

I recommend the following short-term measures to address the inadequacy of indexation of aged care funding levels in the next few years, until the independent pricing of aged care services that we recommend can begin. Once this is in operation, it should generate annual revisions of funding levels that take into account estimated inflation in cost inputs, dispensing with the need for the application of an indexation formula. Until then, however, there is a need for immediate action, as I explain below.

Recommendation 110: Amendments to residential aged care indexation arrangements

1. Commencing with effect on 1 July 2021, the Australian Government should amend the indexation arrangements for residential aged care so that all care subsidies, and the viability supplement, are increased on 1 July each year by the weighted average of:
    a. 60% of the yearly percentage increase to the minimum wage for an Aged Care employee – Level 3 under the *Aged Care Award 2010* (clause 14.1) that is determined by the Fair Work Commission immediately prior to 1 July as part of the annual review of award minimum wages
    b. 30% of the yearly percentage increase to the minimum wage for a Registered nurse Level 2 – pay point 1 under the *Nurses Award 2010* (clause 14.3) that is determined by the Fair Work Commission immediately prior to 1 July as part of the annual review of award minimum wages
    c. 10% of the yearly percentage (to the 31 March immediately preceding the indexation date) increase to the Australian Bureau of Statistics Consumer Price Index.
2. Whenever the Fair Work Commission makes a change to a minimum wage in either the *Aged Care Award 2010* or the *Nurses Award 2010* other than as part of the annual review of award minimum wages, subsidies should be indexed from the operative date of those increases by the weighted average of:
    a. 60% of the percentage increase to the minimum wage for an Aged Care employee – Level 3 under the *Aged Care Award 2010* (clause 14.1) that is determined by the Fair Work Commission
    b. 30% of the percentage increase to the minimum wage for a Registered nurse Level 2 – pay point 1 under the *Nurses Award 2010* (clause 14.3) that is determined by the Fair Work Commission.
3. The increases based on these arrangements should apply to the financial year commencing 1 July 2021 and continue until such time as the Pricing Authority has commenced independent determination of prices for residential care.

Recommendation 111: Amendments to aged care in the home and Commonwealth Home Support Programme indexation arrangements

1. Commencing with effect on 1 July 2021, the Australian Government should amend the indexation arrangements for home care and the Commonwealth Home Support Programme so that subsidy rates are increased on 1 July each year by the weighted average of:
    a. 55% of the yearly percentage increase to the minimum wage for a Home Care employee – Level 3 pay point 1 under the *Social, Community, Home Care and Disability Services Industry Award 2010* (clause 17.3) that is determined by the Fair Work Commission immediately prior to 1 July as part of the annual review of award minimum wages
    b. 15% of the yearly percentage increase to the minimum wage for a Registered Nurse Level 2 – pay point 1 under the *Nurses Award 2010* (clause 14.3) that is determined by the Fair Work Commission immediately prior to 1 July as part of the annual review of award minimum wages
    c. 30% of the yearly percentage (to the 31 March immediately preceding the indexation date) increase to the Australian Bureau of Statistics Consumer Price Index.
2. Whenever the Fair Work Commission makes a change to a minimum wage in either the *Social, Community, Home Care and Disability Services Industry Award 2010* or the *Nurses Award 2010* other than as part of the annual review of award minimum wages, subsidies should be indexed from the operative date of those increases by the weighted average of:
    a. 55% of the percentage increase to the minimum wage for a Home Care employee – Level 3 pay point 1 under the *Social, Community, Home Care and Disability Services Industry Award 2010* (clause 17.3) that is determined by the Fair Work Commission
    b. 15% of the percentage increase to the minimum wage for a Registered Nurse Level 2 – pay point 1 under the *Nurses Award 2010* (clause 14.3) that is determined by the Fair Work Commission.
3. The increases based on these arrangements should apply to the financial year commencing 1 July 2021 and continue until such time as the Pricing Authority has commenced independent determination of prices for aged care in the home.

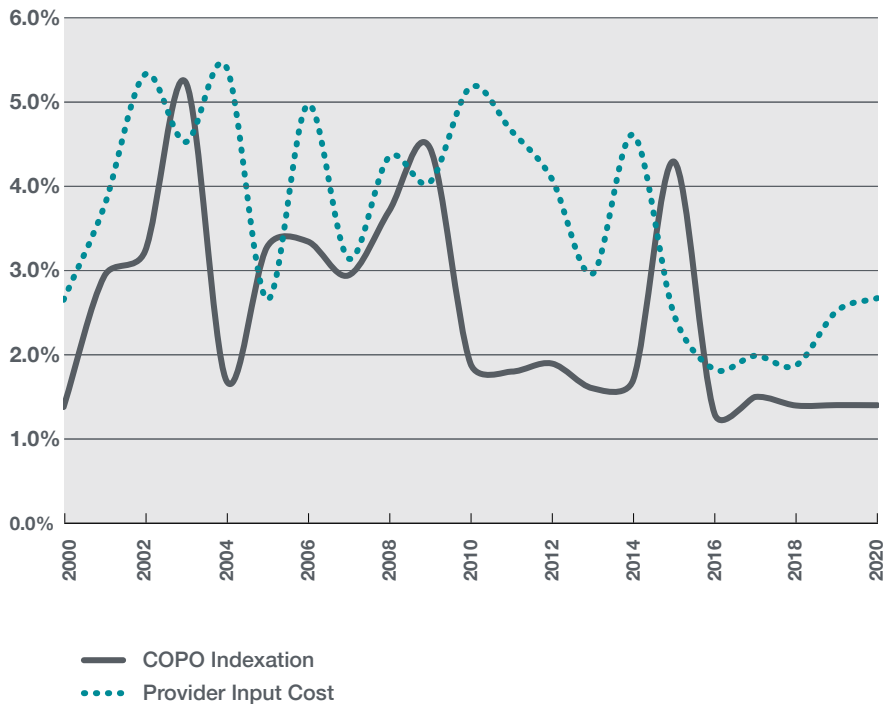
The Australian Government's approach to indexation of funding levels for aged care services has been inadequate to keep up with real cost increases over many years. Since 2012, the indexation of funding levels has contributed to volatility in decision-making about the funding made available for residential care.

The annual indexation that has been applied to aged care funding levels since 1996–97 is based on a composite index that comprises a wage cost component and a non-wage cost component.[122] Under this index, the increase in the wage cost component is based on the dollar increase in the national minimum wage expressed as a percentage of the latest available estimate of average weekly ordinary time earnings published by the Australian Bureau of Statistics as at November of each year. The value of the non-wage cost component is based on changes in the Consumer Price Index between the March quarters each year.[123]

The calculation of the wage cost component systematically undercompensates funding recipients for wage increases. For example, if the minimum wage (currently $753.80 a week) were increased by 2% or $15, this dollar increase would be divided by current average weekly ordinary time earnings of $1713.90 to calculate an increase in the wage cost component of the index of 0.9 percentage points.[124] Such an increase would not generate enough of an increase in revenue to compensate an aged care provider paying its workforce a 2% increase.

Figure 1 illustrates how subsidy levels have been consistently indexed each year at a lower rate than provider input costs (measured as the weighted (25/75) average increase in the Consumer Price Index and Average Weekly Ordinary Time Earnings).

Figure 1: Comparison of the rates of growth of subsidy levels and provider input costs



Source: Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 114, RCD.9999.0522.0001 at 0009, Figure 8.

A number of witnesses, including current and former members of the Aged Care Financing Authority and representatives of major lending institutions, identified inadequate indexation compared with wage rises as a driver of the declining financial performance of the sector.[125] Mr Nicholas Mersiades, Director of Aged Care at Catholic Health Australia and a member of the Aged Care Financing Authority, said that funding is 'predicated on an indexation formula which is based on a labour productivity expectation which is not sustainable' and 'involves a significant discount on the minimum wage adjustments'.[126]

The inadequate performance of the indexation formula has been exacerbated by decisions by the Australian Government to 'pause', 'freeze' or 'discount' indexation of funding levels under the Aged Care Funding Instrument in 2012 and again from 2016 to 2018. The Australian Department of Health said that in 2012, the Australian Government 'paused indexation for twelve months' and made changes to the Aged Care Funding Instrument 'to address concerns of over claiming and to bring growth more in line with estimated sustainable funding levels'.[127] The Department again perceived higher than expected claiming growth in 2014–15 and 2015–16.[128] In response to these perceived issues, the Australian Government again paused indexation of Aged Care Funding Instrument funding for a year (2017–18), as well as applying a 50% reduction in indexation of the Complex Health Care domain under the Aged Care Funding Instrument for the preceding and succeeding financial years.[129]

The suggestion that providers were 'making higher than appropriate claims' is a contentious one. The Australian Department of Health has identified higher than forecast expenditure under the Aged Care Funding Instrument at various times since 2011 and has claimed that this has been driven by higher than appropriate claiming.[130] But it is also possible that average resident acuity has been gradually increasing, leading to what Mr Mersiades described as 'frailty drift'.[131] Some combination of these factors is possible.

Both Commissioner Pagone and I recommend changes to the indexation arrangements for residential aged care and home care services to apply from 2021–22 to prevent any further erosion of the value of Government funding compared with the costs of service delivery until such time as funding levels are set based on independent pricing.

We have developed two indexation formulas, one for residential care funding and the other for Home Care Package levels and Commonwealth Home Support Programme funding. Both are imprecise, but we consider them to be appropriate as interim measures.

For residential care and Home Care Packages, they are based on the distribution of direct care costs between labour and other costs reported in recent StewartBrown Aged Care Financial Performance Survey Sector reports. These reports suggest that in residential care, direct care labour costs make up over 90% of direct care costs.[132] For the purposes of this recommendation, we estimate that labour costs make up about 90% of direct care costs. Based on care time data included in the StewartBrown reports, multiplied by the relevant award rates, direct care labour costs comprise about two-thirds by value in wages for personal care workers and one-third in wages for nurses and others.[133] We thus propose an index made up of 60% increases in the award wages of personal care workers, 30% increases in the award wages for nurses, and 10% increases in the Consumer Price Index.

Applying a similar approach to home care funding, we recommend an index made up of 55% increases in the award wages of personal care workers, 15% increases in the award wages for nurses, and 30% increases in the Consumer Price Index.[134]

While I am unaware of any evidence on the breakdown of costs for the Commonwealth Home Support Programme, I note that it is currently indexed under Wage Cost Index 3: 60% wage costs and 40% non-wage costs. I recommend that the home care funding index we set out above should also apply to the Commonwealth Home Support Programme.

The Health Services Union and United Workers Union both submitted that they do not support the connection between award rates and funding.[135] Whether or not such a linkage is appropriate in determining increases in funding in the medium term will be a matter for the Pricing Authority. I am satisfied that decisions of the Fair Work Commission as to movements in award wages are an appropriate basis for an interim indexation measure but agree that they do not represent a sound basis for determining the actual costs of high quality care.

Other interim funding measures

In addition to indexation, there are three further areas where I propose urgent interim action to ensure the financial viability of approved providers of residential care. The first of these recommendations is an urgent measure to increase the revenues available to meet residents' ordinary living needs; the second is continuation of an increased amount of Viability Supplement payable under certain conditions to approved providers in regional and remote locations (this should also apply to home care); and the third is a measure reimbursing the costs of certain additional staff training.

Recommendation 112: Immediate changes to the Basic Daily Fee

1. **The Australian Government should, no later than 1 July 2021, offer to provide funding to each approved provider of residential aged care adding to the base amount for the Basic Daily Fee by $10 per resident per day, for all residents. The additional funding should be provided only on a written undertaking that:**
    a. **the provider will conduct an annual review of the adequacy of the goods and services it has provided to meet the basic living needs of residents, and in particular their nutritional requirements, throughout the preceding 12 months, and prepare a written report of the review**
    b. **the review report will set out:**
        i. **details of the provider's expenditure to meet the basic needs of residents, especially their nutritional needs, and will include spending on raw food, pre-processed food, bought-in food, kitchen staff (costs and hours), and the average number of residents**
        ii. **changes in expenditure compared with the preceding financial year**

iii. the number of residents who have experienced unplanned weight loss or incidents of dehydration

c. by 31 December each year, commencing in 2021, the governing body of the provider will attest that the annual review has occurred, and will give the review report and a copy of the attestation, to the System Governor

d. the System Governor should make the annual review report publicly available

Commissioner Briggs

e. in the event of failure to comply with the above requirements, the provider will be liable to repay the additional funding to the Australian Government, and agrees that this debt may be set-off against any future funding as a means of repayment.

2. The Australian Government will commence payment of the additional funding to a provider within one month of the provider giving its written undertaking.

3. The results of any review may be taken into account in any reviews of the compliance of the provider with the Aged Care Quality Standards.

4. This measure should continue until such time as the Pricing Authority has commenced its independent determination of prices for aged care.

As I observed earlier in this chapter, the basic daily fee—currently about $52 per day—is intended to cover everyday living expenses such as food, laundry, cleaning, and utilities.[136] The goods and services that depend on this revenue stream are essential to meet everyday living needs. A failure to provide these services at an acceptable level has a clear impact on the overall quality and safety of the care provided to older people living in aged care residences.

It is clear from the evidence before us that the revenue from the basic daily fee is inadequate to provide these services at an adequate standard.[137]

Under current arrangements, according to StewartBrown, residential care providers who participate in its survey are underspending their Aged Care Funding Instrument revenue on care at an average of $15.22 per resident per day, after inclusion of administration overhead costs, probably in order to meet shortfalls in other areas and perhaps to earn a profit margin.[138] In short, money which would be used to provide high quality care, including additional staffing or better training and qualifications, is being directed to meet everyday living expenses because the maximum allowable charge to permit recovery of those costs is too low.

In Recommendation 115 above, I recommend that the Pricing Authority, once established, should ascertain the costs of delivering the ordinary living needs of residents. I also recommend a method for meeting these costs from a combination of resident payment and government subsidy. Until these longer-term arrangements are in place, it is necessary that the Australian Government provide additional interim funding.

In constructing a plan for additional interim funding for ordinary daily living needs, we have sought to balance urgency, simplicity, ease of administration, and accountability. Balancing these considerations, we recommend an immediate conditional increase in the Basic Daily Fee of $10 per resident per day, to be funded by the Australian Government.

I am conscious that our recommendation for an extra $10 per resident per day is a very imprecise estimate of what is needed but consider it to be justified as an interim measure. I am concerned to ensure that approved providers are encouraged to use the additional revenue that would flow from this measure appropriately in light of their circumstances, informed by a detailed review of the adequacy of the goods and services they provide to meet older people's basic living needs, particularly nutrition.

I am also conscious that some providers will already be spending appropriately on nutrition and other ordinary living needs and absorbing the costs of doing so, perhaps contributing to losses. The conditions for the payment therefore do not include a prescriptive requirement to spend the additional revenue in a particular manner.

However, it is necessary, in my view, that approved providers who wish to receive this additional revenue be made accountable by reporting on the levels of expenditure they have had in the recent past on ordinary living needs of residents, and the changes in expenditure that result from the receipt of this additional revenue. The reports provided by approved providers under this recommendation could be taken into consideration by the Quality Regulator during audits.

I also consider it is important that the reports are made public. The additional funding made available to the sector under this recommendation amounts to about three-quarters of a billion dollars per year. I am conscious that extra government funds to approved providers for wage increases have not flowed to workers.[139] I therefore consider that the taxpayers who will fund this expenditure should have access to information that shows their money has been spent on providing better food and supports to older people. In the absence of a comprehensive acquittal process for taxpayer funds spent on care, it is especially important that the public have access to this information. People considering entering aged care, and people assisting them in the process, should be able to obtain information on the relative performance of different approved providers in meeting the basic living needs of the older people they are caring for. If the reports are public, residents, their families, and staff will be able to review the reports against their experience and direct observations of what is provided, and raise discrepancies with the System Governor.

Aged & Community Services Australia submitted that the annual review should be incorporated in financial reporting instead of being a separate requirement.[140] We both disagree. Improved accountability for the spending of care subsidies is a separate issue to general financial reporting requirements and should be treated as a quality of care issue. In the absence of a formal acquittals system, we consider that this specific additional funding requires further transparency in order to ensure that it is directed towards the desired improvements in quality and safety.

Recommendation 113: Amendments to the Viability Supplement

1. **With immediate effect, the Australian Government should continue the 30% increase in the Viability Supplement that commenced in March 2020, as paid in respect of each residential aged care service and person receiving home care, until the Pricing Authority has determined new arrangements to cover the increased costs of service delivery in regional, rural and remote areas and has commenced independent determination of prices.**
2. **The increased indexation arrangements proposed in Recommendations 110 and 111 should apply in addition to the measure in this recommendation.**

The costs of goods and services are higher in regional, rural and remote Australia. We have heard uncontested evidence that this worsens the financial performance of approved providers in these areas, and that these providers are experiencing deteriorating financial performance and risks to viability in higher proportions than their major city counterparts.[141] Our recommendations on regional, rural and remote aged care can be found in Chapter 8.

Under current arrangements, the Australian Government pays a Viability Supplement to residential and home care providers in these areas.[142] For residential aged care services, the Viability Supplement is based on the remoteness and size of the service and on the acuity of the resident population.[143] For home care, it is based on the place of residence of the person receiving care, and is available to people living in remote areas and smaller, more isolated regional areas.[144]

The Australian Government announced a 30% increase to this supplement on 17 December 2018, and an additional temporary 30% on 31 March 2020. It is evident that a significant proportion of outer regional and remote facilities are facing significant financial stress.[145]

We recommend the increases to the Viability Supplement be maintained until the Pricing Authority is established and undertakes its independent cost analysis and pricing processes, including the cost of delivering aged care in regional, rural and remote areas.

Recommendation 114: Immediate funding for education and training to improve the quality of care

1. The Australian Government should establish a scheme, commencing on 1 July 2021, to improve the quality of the current aged care workforce. The scheme should operate until independent pricing of aged care services by the Pricing Authority commences. The scheme should reimburse providers of home support, home care and residential aged care for the cost of education and training of the direct care workforce employed (either on a part-time or full-time basis, or on a casual basis for employees who have been employed for at least three months) at the time of its commencement or during the period of its operation. Eligible education and training should include:
    a. Certificate III in Individual Support (residential care and home care streams) and Certificate IV in Ageing Support
    b. continuing education and training courses (including components of training courses, such as 'skill sets' and 'micro-credentials') relevant to direct care skills, including, but not limited to, dementia care, palliative care, oral health, mental health, pressure injuries and wound management.
2. Reimbursement should also include the costs of additional staffing hours required to enable an existing employee to attend the training or education. The scheme should be limited to one qualification or course per worker.

We heard evidence across our inquiry that made it very clear that the training of staff was a key issue for the delivery of quality care in aged care.[146] Not only that, but as explained above in relation to our Recommendation 112, it seems that funds which could be used to provide high quality care, including on better training and qualifications for staff, are being directed to meet living costs because the price cap that is imposed to permit recovery of those costs is too low.

It is therefore essential that the Australian Government provide funding for the training of the direct care workforce in aged care, until independent pricing for aged care begins. As a simple accountability measure, that funding should be provided on a reimbursement basis.

Endnotes

1 Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry, 2020*, pp 12–13 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).

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22. Personal Contributions and Means Testing | Commissioner Briggs

22.1 Overview

Under current arrangements, older people who use aged care services pay for about one-quarter of the total cost of those services.[1] Subject to means testing, people contribute to the costs of their care in residential aged care, and can be asked to do so in the Home Care Packages Program and by Commonwealth Home Support Programme providers. People using residential care also contribute to the cost of their accommodation and associated living expenses. Older people make these contributions through a complex mix of co-contributions and means tested fees.

Commissioner Pagone and I heard a lot about the existing co-contribution and means testing arrangements in the aged care system during our inquiry. Witnesses described these arrangements as inequitable and confusing.[2] Some considered that they contributed to perverse incentives around the types of aged care services people accessed.[3] The Productivity Commission's 2011 *Caring for Older Australians Inquiry* report stated that the system of co-contributions was 'often arbitrary in nature, lacking any obvious rationale and relationship to a person's capacity to pay'.[4] A number of changes have been made since that report.[5] However, problems persist and the arrangements are in need of fundamental reform.

During Adelaide Workshop 1, we heard that means testing needs to be 'simplified and equitable', 'fair and sustainable' and 'robust and consistently applied'.[6] We both agree. Our recommended reforms in this area go further. As we set out in Chapter 1: Foundations of the New Aged Care System, fundamental to our vision of aged care in the future is a system of universal entitlement to high quality aged care based on assessed need. Although there are some differences between Commissioner Pagone and me on matters of implementation of this principle, we agree that this should guide the approach to contributions and means testing.

22.2 Foundations

The entitlement to aged care has particular implications for the system of contributions and means testing for aged care. In the new aged care system, there should be no requirement to pay a co-contribution toward care—as distinct from the ordinary costs of living or accommodation costs—in any community setting or residential aged care, including respite.

Consistent with the provision of health care to public patients in public hospitals, personal care services and clinical care services should be available free of service charges. In our view, because all Australians should have an entitlement to aged care, the costs of care should be distributed equitably across the community. It should not be imposed disproportionately on the people who need and receive aged care services.

This reform represents a significant departure from current arrangements.

In making this recommendation, we acknowledge that the current co-contribution arrangements for care contribute to the financing of the system. In 2018–19 people receiving residential aged care made contributions of $586 million to their care. This amounts to 4.9% of total care revenue.[7] In addition, people receiving Home Care Packages paid Basic Daily Fees worth $66 million (2.6% of total funding for providers).[8] Our recommendation will place an additional burden on financing the aged care system from public sources. We have each addressed aged care financing more broadly, including raising the additional money to cover the costs of this and other recommendations, in our respective chapters on financing the new aged care system.

Similarly, we do not consider that contributions or fees should be charged for social support (including transport), home modifications and assistive technologies, and domestic assistance (including cleaning and gardening) where these services are being supplied as elements of aged care provided to a person who has been assessed as needing that care.

We also consider that people should not be required to pay for the respite care they receive, nor for associated accommodation costs. Respite is intended to sustain the long-term capability of people to remain in their own home and to receive care there. Where people and their carers have been assessed as needing respite, it is important to make access to respite care easy and affordable. This is because of the important role respite can play in sustaining the care relationship and delaying or preventing entry to permanent residential aged care. People receiving respite care are highly likely to have accommodation-related costs to bear for their own homes which they will still incur while they are receiving respite care. They should not be required to meet two sets of accommodation costs at the same time.

In relation to residential aged care, I consider that individuals should continue to be primarily responsible for meeting the ordinary costs of living—such as food, cleaning, laundry and utilities—and accommodation. This is consistent with current arrangements, and I believe it is in line with community expectations that these costs are a personal expense normally met by individuals in the community. Entry into residential aged care should not relieve older people of meeting the living and accommodation costs that all other Australians are required to meet.

The Pricing Authority should be responsible for determining the amounts that approved providers of residential aged care may charge for the ordinary costs of living and for accommodation. If a means test determines that residents are unable to meet these costs themselves, the Australian Government should contribute to them. The current aged care means test should be reformed to address the extraordinarily high effective marginal tax rates that apply to many individuals receiving residential aged care who are part-pensioners.

22.3 Current fees and means testing arrangements

Just as aged care arrangements are complex, so too are the fees and means testing arrangements applied to the different types of care available and to the older people who use them. As the following section shows, the current complex system of fees and charges has developed piecemeal without fundamental review over the last two decades. It is hard for older people and their families to understand the system and make adequate financial plans to meet its demands. This complexity has led to fears and uncertainty around aged care costs and inefficient 'precautionary savings' to manage the risk of funding unknown future aged care costs.[9]

22.3.1 Commonwealth Home Support Programme

There are no formal means testing arrangements for the Commonwealth Home Support Programme, although there are non-mandatory co-payments. There is significant flexibility around the fees that people are charged for services under this program. This is a result of the guidance and principles set out in the *Client Contribution Framework* and the *National Guide to the CHSP Client Contribution Framework.*[10] The basic principles of the framework are that:

- people in similar circumstances receiving similar services should pay similar fees
- people who can afford to contribute to the cost of their care should do so
- access to care should not be determined by the ability to contribute.

Access to services is based on need and the availability of funding for the service provider. In practice, individuals who have similar support needs may be charged different fees by different providers for the same service.[11]

In 2018–19, individual contributions through this program totalled around $252 million, which represented 9.9% of total program expenditure.[12] The average co-contribution paid was about $300 per year.[13] This amount is lower than the co-contributions seen in other aged care programs, possibly reflecting the entry-level nature of the program and the low monetary value of many of the services provided. However, co-contributions make up a higher percentage of total program expenditure than in other programs.

22.3.2 Home care

Current arrangements in the Home Care Packages Program require people to contribute to the cost of their care. They can be asked to pay both:

- a non-compulsory Basic Daily Fee up to 17.5% of the single basic age pension
- a contribution towards the cost of their care through an income tested fee.

The package amount paid by the Australian Government to providers on behalf of an older person is reduced by the amount of the income tested fee regardless of whether or not the fee is collected by the provider.[14] The income tested fee arrangements are subject to annual and lifetime caps and do not apply to older people who were receiving a Home Care Package on or before 30 June 2014. These fees are determined by providers, up to the maximums specified by the Australian Government.[15]

There is strong evidence to suggest that many providers do not charge the full Basic Daily Fee allowable, and some evidence that some providers do not always charge the income tested fee.[16] Such differential fee arrangements can create inequities between older people and between providers.

In 2018–19, people receiving Home Care Packages paid Basic Daily Fees worth $66 million (2.6% of total funding for providers). That equates to an average of about $665 per year per person.[17] The maximum allowable fee at 30 June 2019 was $3847.10 a year.[18]

In addition, individuals paid $42 million (1.7% of total funding for providers) in income tested fees in 2018–19. That equates to an average of about $425 per year per person.[19]

22.3.3 Residential aged care

People in permanent residential aged care can be asked to pay four types of fees:

- a Basic Daily Fee up to 85% of the single basic age pension (a total of $3.4 billion in 2018–19)
- a contribution towards the cost, or the full cost, of their accommodation on a means tested basis
- a contribution towards the cost of their care through a means tested fee. The subsidy amount paid by the Australian Government on behalf of an older person is reduced by the amount of the fee regardless of whether the fee is collected by the provider or not
- the full cost of any additional or extra services they receive.[20]

Most people pay the Basic Daily Fee. The average basic daily fee paid in 2018–19 was about $18,366 a year, which is close to the maximum permitted amount for the fee.[21]

People receiving residential aged care also bear the majority of their accommodation costs. In 2018–19, this consisted of over $800 million in accommodation payments, excluding lump sum deposits.[22] Imputing the interest notionally earned on lump sum deposits as accommodation fees increases the amount spent on accommodation by older people in permanent residential aged care to $2.3 billion.[23] By comparison, Australian Government expenditure on Accommodation Supplements was $1.2 billion.[24]

People receiving care made a much smaller contribution to care costs through the means tested care fee. This comprised almost $600 million in 2018–19, which was only 4.9% of all care costs.[25] Other care fees and payments for additional and extra services made up $320 million in revenue in 2018–19.[26]

22.4 Proposed changes

22.4.1 Services where no contributions or means testing required

Consistent with our proposed universal entitlement to aged care, we recommend that people should not be required to pay a contribution towards the care services they receive in the community, their home or in residential aged care, including for respite. In our view, this principle should extend to social supports, assistive technologies and home modifications, and care at home for people who are assessed to need these services because of ageing-related infirmity. There is a community expectation of universal access at minimal cost to a high standard of health care for people who require it. People who need care because of disability or age-related frailty should receive it on the same basis.

Recommendation 125: Abolition of contributions for certain services

1. **Individuals who are assessed as needing social supports, assistive technologies and home modifications, or care at home should not be required to contribute to the costs of that support.**
2. **Individuals who are assessed as needing residential care should not be required to contribute to the costs of the care component of that support.**

I acknowledge that there are differing views about whether people should be required to contribute to the cost of care services they receive. The prevailing approach in the aged care system is that people should contribute, according to their means. That approach received support from witnesses who appeared before us. For example, Professor Woods stated that fees for care at home needed to be means tested, and that this should be consistent with the means testing for residential aged care.[27] Mr Callaghan suggested that the current contribution that comes from consumers for home care services is too small in comparison to the Australian Government's contribution.[28] The Australian Treasury also supported the continuation of a system of private contributions towards the costs of care, while noting the need for reform of the means testing arrangements.[29]

On the other hand, Mr Craig Gear of the Older Persons Advocacy Network opposed co-payments. He noted that there are no co-payments for this type of support under the National Disability Insurance Scheme and submitted that it is inequitable to suggest that co-payments should be required of people with disability aged over 65 years.[30]

Relationships Australia also supported universal access to social supports, assistive technologies and home modifications.[31]

On balance, both Commissioner Pagone and I have decided to recommend that contributions for these services be dispensed with as a matter of principle. We also consider that the risks and burdens of retaining some form of modest contribution outweigh any advantage. Attempting to impose a system of means tested fees is likely to involve administrative burden and cost that is disproportionate to the value of the services, and might discourage people from making use of these services.

All services provided in a person's home should be regarded as care, including those, such as home modifications, cleaning, gardening and transport, that might be regarded as part of the ordinary daily activities of living. While there may be a risk of people accessing more services than they require, this risk will be mitigated because services are only subsidised based on assessed need. There is also a likely fiscal benefit to the Australian Government from these early investments.[32]

22.4.2 Respite care

Recommendation 126: Fees for respite care

1. **Individuals receiving respite care under the new Act should only be required to contribute to the costs of the services that they receive associated with ordinary costs of living (as defined in Recommendation 127, below) up to a maximum of 85% of the single basic age pension, and any additional services they choose to receive. They should not be required to contribute to the costs of the accommodation and care services that they receive.**
2. **The level of the maximum amount that respite providers may recover for the ordinary costs of living should be determined by the Pricing Authority.**
3. **The new Act should also contain provisions that ensure that individuals who are unable to pay the co-payments toward the ordinary costs of living are not denied access to the high quality respite care that they have been assessed as needing.**
4. **The Australian Government should pay each approved provider of respite to a person an amount representing the difference between the contribution the person makes to their ordinary costs of living in accordance with paragraph 126.1 and the amount that the respite provider may recover (which may not exceed the amount calculated by the Pricing Authority in accordance with paragraph 126.2).**

Respite care is defined within the *Aged Care Act 1997* (Cth*)* as an alternative care arrangement with the primary purpose of giving a carer or care recipient a short break from their usual care agreement.[33] In our view, respite care should also serve as an opportunity to sustain the long-term capability of people to remain in their own home and receive care there. This rationale has underpinned our recommendations relating to respite care.

At present, people are able to access respite care through a range of aged care programs, including the Commonwealth Home Support Programme, Home Care Packages Program and residential aged care.[34]

People who access respite care through the Commonwealth Home Support Programme may be charged a contribution towards their care, but this is not mandatory and there is no fixed value. In comparison, fees for respite care through a Home Care Package have a capped maximum value. These fees include the home care Basic Daily Fee set at between 15.7% and 17.5% of the age pension and an income tested fee, although as I outlined above these fees are not compulsory.[35] People who access respite care in a residential setting can be charged a Basic Daily Fee that is set at 85% of the single basic age pension.[36] Unlike people who receive permanent residential aged care, respite residents do not need to pay any means tested care fees or accommodation payments. A 2018 review carried out by the Aged Care Financing Authority suggested that fees for residential respite care can be a barrier to access, with a disparity in fees for different types of respite care across the different programs.[37]

Respite should sustain the long-term capability of people to remain in their own home and to receive care there. The Australian Government benefits from the delivery of respite services, through a reduction in the long-term cost of care. If, and to the extent that, the deferral or prevention of entry into residential care can be achieved, this will represent a saving to the Australian Government on the costs of permanent residential aged care, including Accommodation Supplement payments, and so the costs of respite can be justified as a probable good 'investment' by the Australian Government. It is important, therefore, not to provide a disincentive to the uptake of these services through co-payments or means tests. Both Commissioner Pagone and I recommend that there be no such co-payments or means tests for the care component of respite.

Accommodation costs, although normally a personal responsibility, should continue to be met by the Australian Government as the older person will need to meet the accommodation costs of their usual place of living while they are receiving respite. This is in line with the arrangements that currently operate in residential respite care. Residential respite care should be priced by the Pricing Authority taking into account reasonable returns on capital investment.

I consider that the amount that individuals pay for ordinary costs of living associated with respite care should continue to be set at 85% of the single basic age pension in line with the current arrangements. This will avoid the need to carry out a means test on all individuals receiving respite care. As with other fees, hardship arrangements should be available for people who cannot afford the co-payment.

22.4.3 Residential aged care

Ordinary costs of living

Recommendation 127: Fees for residential aged care—ordinary costs of living

1. Individuals receiving residential aged care under the new Act should be required, subject to the other parts of this recommendation, to contribute to the costs of the goods and services that they receive to meet their ordinary living needs, comprising all the goods and services currently specified in Part 1 of Schedule 1 of the *Quality of Care Principles 2014* (Cth) (the ordinary costs of living).
2. The Pricing Authority should determine the maximum amount payable for residents' ordinary costs of living based on an analysis of the efficient costs of delivering high quality goods and services to meet their ordinary living needs (the Services Fee Amount).
3. The maximum level of the fee that an individual resident can be asked to pay toward the ordinary costs of living (Basic Daily Fee) should be determined in accordance with provisions in the new Act and should equal the sum of:
    a. a base fee equal to 85% of the maximum amount of the basic age pension, and
    b. a means tested amount determined in accordance with Recommendation 129 or 141,

    and must not exceed the Services Fee Amount most recently determined by the Pricing Authority in accordance with Recommendation 127.2 above.
4. The new Act should contain provisions that ensure that individuals who are unable to pay the Basic Daily Fee are not denied access to high quality residential aged care.
5. The new Act should also provide that where:
    a. an approved provider provides residential care to an individual and charges an amount for that individual's ordinary costs of living, and
    b. the amount charged does not exceed the Services Fee Amount most recently determined by the Pricing Authority in accordance with Recommendation 127.2, and
    c. the Basic Daily Fee payable by the individual is below the amount charged by the approved provider for the individual's ordinary costs of living,

    then
    d. the Australian Government will pay the approved provider the difference (Ordinary Cost of Living Top-up Subsidy) between:
        i. the Basic Daily Fee for the individual, and
        ii. the amount charged by the approved provider for the individual's ordinary costs of living.

While we both consider that people who receive aged care should not be responsible for their care costs, they should be required to contribute to their ordinary costs of living, including food, cleaning, laundry, utilities, and any additional services. In the general community, the ordinary costs of living are funded in their entirety by individuals who live in their own home, with any Australian Government assistance provided through the age pension.

As I said above, there should be an exception to this general principle when older people after assessment are provided through the aged care system with domestic assistance to enable them to continue to live independently at home. Even though the costs of this assistance may be regarded as part of the ordinary costs of living, a full subsidy of these costs is justified as a good investment to delay or prevent entry into more costly residential aged care.

However, I consider that people who receive residential aged care should be required to pay a minimum fee set at 85% of the single basic age pension as a contribution to their ordinary costs of living. Information provided by StewartBrown and set out in my funding chapter suggests that a contribution of this amount is insufficient to cover ordinary living costs. Commissioner Pagone and I both recommend that the Pricing Authority should regularly determine the maximum level (which I will refer to as the Services Fee Amount) which a residential aged care provider may charge to provide the goods and services for the essentials of ordinary living necessary to provide safe and high quality care.

It is highly likely that the Services Fee Amount will be greater than 85% of the single aged pension. The reformed means test I recommend below should determine the part of the difference between 85% of the single basic age pension and the Service Fee Amount to be paid by the individual receiving care and the part to be paid by the Australian Government as the Ordinary Cost of Living Top-up Subsidy. Full age pensioners will continue to pay 85% of their pension. Other residents will pay 85% of the single aged pension plus an amount determined by the means test, up to a maximum of the Services Fee Amount.

This arrangement will ensure an adequate funding stream for high quality goods and services to meet essential living needs, and will allow for greater levels of contributions from people receiving care, according to their means. It does not preclude providers from offering additional or premium daily living goods and services (above an already high minimum) through additional service charges, if the resident chooses to purchase such additional services.

Accommodation

Like the ordinary costs of living, accommodation has been regarded by many as primarily the responsibility of the person receiving care, provided they have the means to pay for it.[38] These costs are generally seen as a personal expense normally met by individuals in the community. Currently, an Accommodation Supplement is paid by the Australian Government to approved providers for ‘supported’ residents found eligible under asset and income means testing arrangements.[39]

'Unsupported' residents—those ineligible for an Accommodation Supplement because of the operation of the aged care means test—are required to make either a Refundable Accommodation Deposit or a Daily Accommodation Payment (or a combination of both). I discuss the future of Refundable Accommodation Deposits in my chapter on capital financing for residential aged care and recommend that they be phased out, beginning on 1 July 2025.

Recommendation 140: Fees for residential aged care accommodation **Commissioner Briggs**

1. Individuals receiving residential aged care under the new Act should be required, subject to the other parts of this recommendation, to contribute to the costs of their accommodation.
2. The Pricing Authority should from time to time determine the Accommodation Supplement as the maximum amount or amounts payable for the accommodation of a resident eligible to receive the supplement under the means test (an eligible resident), based on an analysis of the efficient costs of delivering high quality accommodation and a reasonable rate of return on capital investment. The Pricing Authority may determine one uniform amount to apply in all cases, or a number of different amounts based on factors such as the date of construction or refurbishment of the facility, the size or other features of the room, and the region or degree of remoteness of the location of the facility.
3. The new Act should provide that the maximum amount an approved provider may receive for the accommodation of an eligible resident should be the Accommodation Supplement determined by the Pricing Authority in Recommendation 140.2 above, payment of which will comprise:
    a. a means tested amount paid for accommodation determined in accordance with Recommendation 141, payable directly by the individual resident, and
    b. funding of the difference between the means tested fee for accommodation and the maximum level determined by the Pricing Authority in Recommendation 140.2 above, payable by the Australian Government (Accommodation Top-up Supplement).

4. The Pricing Authority should:
    a. from time to time determine the Provisional Accommodation Charge Limit (as a lump sum or an equivalent daily amount) applicable to a facility based on factors such as the date of construction or refurbishment of the facility, the size or other features of the room, and the region or degree of remoteness of the location of the facility. The daily amount of the Provisional Accommodation Charge Limit should be based on an analysis of the efficient costs of delivering high quality accommodation and a reasonable rate of return on capital investment
    b. on the application of an approved provider, and after consideration of factors including the cost of investment and any particular constraints on supply of residential aged care services in the relevant area, determine that the Provisional Accommodation Charge Limit for one or more rooms of a facility should be varied to a different amount.
5. Until Refundable Accommodation Deposits are phased out under Recommendation 142, approved providers may charge residents who are not eligible for the Accommodation Supplement a Refundable Accommodation Deposit (or an equivalent Daily Accommodation Payment) up to the Provisional Accommodation Charge Limit.
6. After Refundable Accommodation Deposits are phased out under Recommendation 142, approved providers may charge residents who are not eligible for the Accommodation Supplement a Daily Accommodation Payment up to the level of the Provisional Accommodation Charge Limit.
7. The new Act should contain provisions that ensure that individuals who are unable to pay for accommodation are supported by the Australian Government and not denied access to high quality residential aged care.

The means testing arrangements applicable to qualification for full or partial Accommodation Supplement should be reformed to ensure they do not have a disproportionately harsh impact on people who do not meet the requirements for full support by the Australian Government, but who have limited means. I discuss this further below.

I consider that older people with higher incomes should be required to make a fair and reasonable contribution to their accommodation costs in residential aged care, according to their means. The existing arrangements, which constrain providers from charging above a provisional ceiling, subject to application for the ceiling to be lifted in particular cases, should be retained to prevent financial exploitation of older people.

22.4.4 Changes to the operation of the means test

There are some means testing principles that can be applied to aged care, in whole or in part, namely:

- equity—older people should pay according to their means and circumstances
- disincentives to save are minimised
- simplicity—means testing arrangements should be simple and easy to understand
- means testing arrangements should ensure that services and payments are directed to those who need them the most and do not unduly penalise or exclude people who should be entitled to support.

However, the current aged care means testing arrangements are complex, difficult to understand, and generate very high effective marginal taxation rates at relatively low levels of private income.[40] They cause financial hardship.[41] An important reason for these problems is that the current test overlaps with the age pension means test.[42] It also takes into account both the assets held by an individual and the income generated by those assets in reducing eligibility for Australian Government subsidy. This 'double counting' effect is not present in the pension means test and should be removed from the aged care means test.

The means test currently applies to two payments applicable to residential aged care—the accommodation payments and the care subsidy.[43] Both income and assets are assessed in the residential aged care means test.[44] The amount payable by the Australian Government as a subsidy in respect of an individual is reduced by the sum of the result of the two tests.

The current arrangements include daily, annual and lifetime means testing caps which shield people with substantial means from the effects of the income and asset tests. These caps ensure that the means tested fees that a person pays cannot be greater than the sum of the maximum value of the Accommodation Supplement and the amount of care subsidy that would be paid by the Australian Government on their behalf. The maximum means tested care fee a person could be charged in a single day is $256.44.[45] The maximum yearly cap is $28,087 and the lifetime cap was $67,410.[46] These caps are fixed, irrespective of a person's wealth.

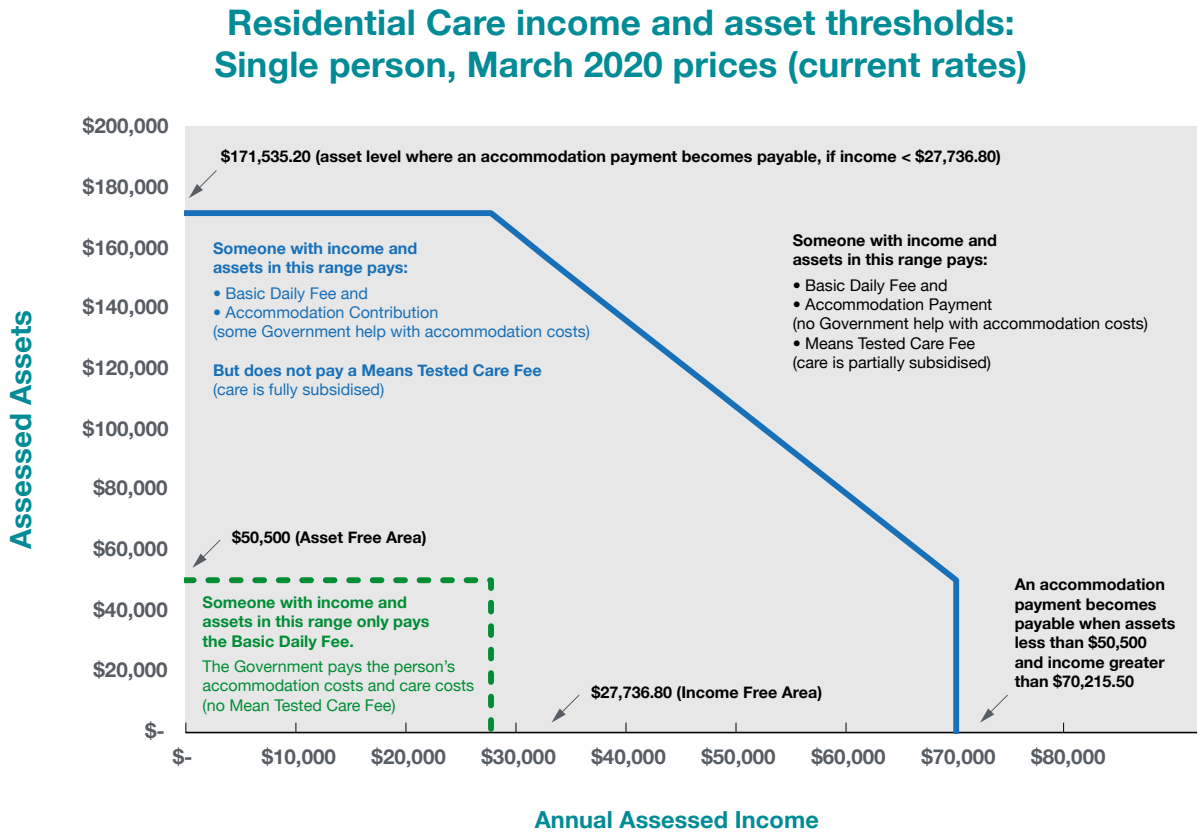
The income test reduces the amount of subsidy payable by 25% for every dollar in excess of the maximum income for a full pensioner. The assets test reduces the amount of subsidy payable by:

- 17.5% of assets between the asset-free threshold ($50,500) and the first asset threshold ($171,535)
- plus 1.0% of assets between the first asset threshold and the second asset threshold ($413,606)
- plus 2.0% of assets above the second assets threshold.[47]

The means test first reduces the level of the Accommodation Supplement payable by the Australian Government when a person exceeds the existing thresholds. Thereafter, it reduces the level of care subsidy payable by the Australian Government.

Figure 1 shows that means testing results in essentially three tiers of payment.

Figure 1: Operation of the aged care income and assets tests[48]



Source: Figure E.2, Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, 2020.

People within the green box are fully supported residents. These residents have income below $27,736.80 a year and assessable assets below $50,500. They do not need to contribute to their accommodation costs or their care costs.

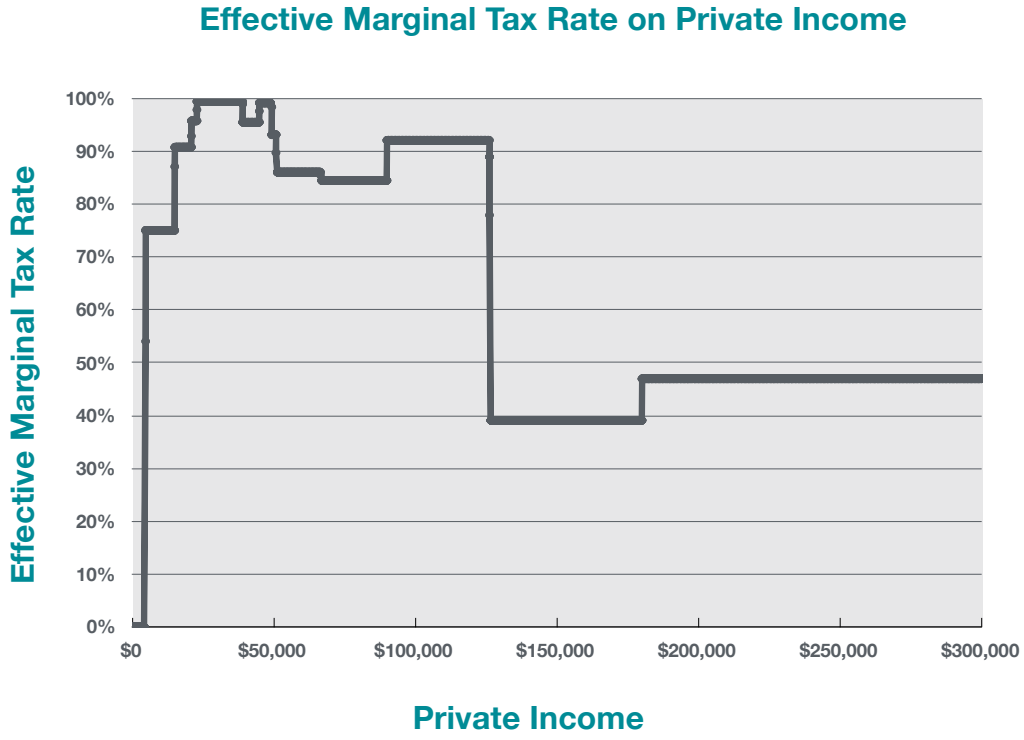
Partially supported residents are those within the blue area of Figure 1 and are required to pay for some of their accommodation costs, but are not required to contribute to their care costs through a means tested care fee.

Unsupported residents fall outside the blue line and have income above $70,215 per year or assets above $171,535. Unsupported residents have to pay for the full cost of their accommodation and contribute to their care costs. About half of all residents are unsupported residents.[49]

The information provided to us suggests that partially supported and unsupported residents who just fall into this category are the worst affected by the asset and income tests. Professor McCallum, Chief Executive Officer of National Seniors Australia, referred to this as a 'means test trap'.[50] As an example, a pensioner who is a partially supported resident would need to pay both a Basic Daily Fee and a means tested contribution towards their accommodation. These fees are likely to consume the value of their age pension and could potentially leave them with negative income.[51] I personally heard stories to this effect in community forums in Rockhampton and Canberra.

Figure 2 illustrates how the residential aged care income test operates and how it affects the marginal tax rate. The effective marginal tax rate is significantly higher for people who are on a private income of below $130,000 a year, and is greatest for people who have a private income of between $20,000 and $50,000. This shows that people who have some of the lowest private incomes are facing the highest effective marginal tax rates. What this means in practice is that the people with some of the lowest incomes have very little or no income left over once they pay residential care fees.

Figure 2: Effective marginal tax rates under the current residential aged care income test



Source: Exhibit 21-2, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0016.

A fairer approach would be to begin to means test for aged care purposes after the age pension means test had reduced the amount of the age pension a person received to zero. This would mean the aged care means test would not overlap with the means test for the

age pension. On this approach, in essence, the Australian Government assistance available to the individual would be treated as the sum of:

- the age pension
- the Ordinary Cost of Living Top-up Subsidy
- the Accommodation Top-up Supplement

The pension means test should be applied to this total and progressively reduce the three amounts to zero. As a result, all full and part pensioners would receive the maximum amounts of the Ordinary Cost of Living Top-up Subsidy and the Accommodation Top-up Supplement. Self-funded retirees with assets or income above the pension cut offs would receive progressively less assistance from these two payments.

Recommendation 141: Changes to the means test

Commissioner Briggs

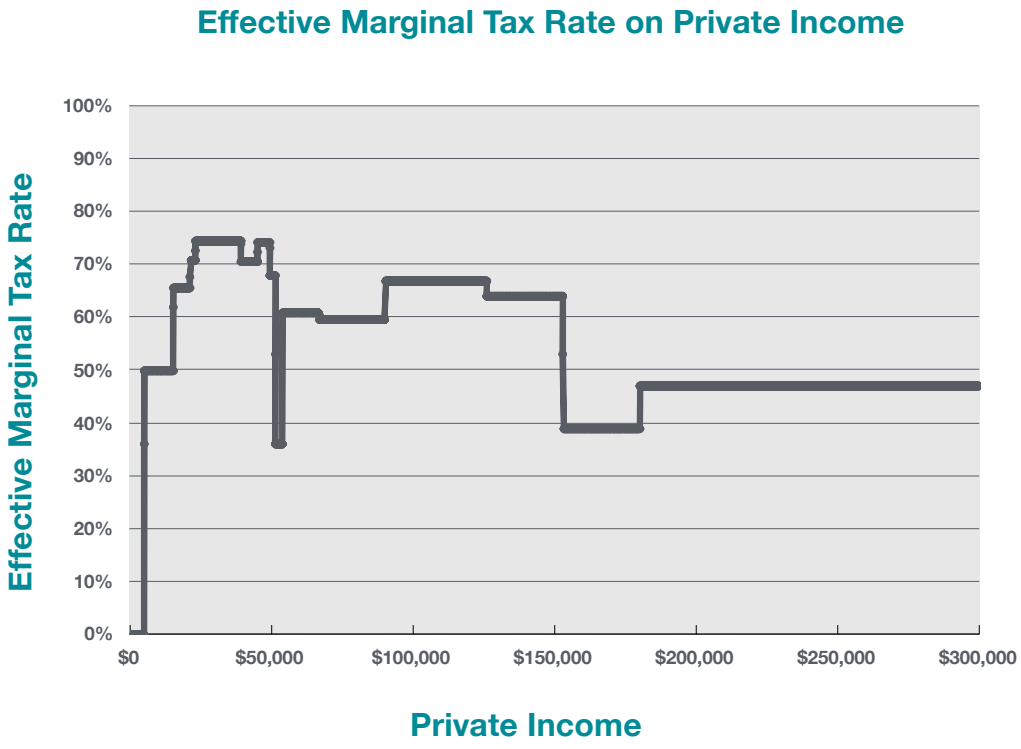
1. **The means test will determine a means tested amount for each individual receiving residential aged care under the new Act who is not in receipt of an income support payment or a service pension or an income support supplement or a veteran payment (as defined in the *Social Security Act 1991* (Cth) and the *Veterans' Entitlements Act 1991* (Cth)).**
2. **An individual's means tested amount will be the greater of an amount worked out under the income test or the asset test.**
3. **An individual's means tested amount under the income test is 25% or 50% of the amount by which their assessable income exceeds the maximum income point at which a part pension is payable.**
4. **An individual's means tested amount under the assets test is 3.9% or 7.8% of the amount by which their assessable assets exceed the maximum level of assets at which a part pension is payable.**
5. **The means tested amount is applied first to reduce the Ordinary Cost of Living Top-up Subsidy (as determined under Recommendation 127).**
6. **If the means tested amount is greater than the maximum rate of the Ordinary Cost of Living Top-up Subsidy it is then applied to reduce the Accommodation Top-up Supplement (as determined under Recommendation 140).**
7. **If the means tested amount is greater than sum of the Ordinary Cost of Living Top-up Subsidy and the Accommodation Top-up Supplement then the individual's accommodation fees are subject to Recommendations 140.5 and 140.6 above.**
8. **The lifetime caps on the amount of means tested contributions payable by an individual should be removed.**

Under the current age pension, means test taper rates apply that reduce eligibility for the age pension as assets and income increase. The current taper rates are 7.8% for the assets test and 50% for the income test.[52]

If the means test is to apply progressively as I recommend, there would be merit in applying the same taper rates under the aged care means test as those applying under the age pension means test. However, our analysis shows that the application of these rates would still leave very high effective marginal tax rates in place for some residents in some income bands. While many residents are likely to be receiving concessionally taxed retirement income, some will not.

Another option would be to halve the taper rate to 3.9% for assets and 25% for income. This would smooth the tapered withdrawal effect and provide greater residual income to cover other expenses for part-pensioners and self-funded retirees. It would also avoid the marginal tax rates of self-funded retirees being higher than for pensioners, and remove savings disincentives. The impact on effective marginal tax rates under this version of an income test are set out in Figure 3.

Figure 3: Effective marginal tax rates under a revised residental aged care income test with a 25% taper



Source: Exhibit 21-2, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0016.

While I think the taper rates of 3.9% and 25% are more appropriate as they provide a fairer income distribution regime, I appreciate that means testing arrangements have much wider implications than for aged care alone. Accordingly, I suggest that the Australian Government should consider the balance between simplicity, equity and incentives principles in the aged care means test, and decide on the most appropriate taper rates for aged care in the context of its consideration of the report of the Retirement Income Review released in November 2020.

Under the age pension means test, a person's principal residence is an exempt asset if either they or their partner is living in it.[53] If a person enters residential aged care, and their partner is not living in the home, then for pension purposes the principal residence is not counted in the assets test for two years, but after that time the value of the principal home is counted in the assets test and the person is treated as a non-homeowner for pension purposes.[54] Commissioner Pagone and I propose that the same treatment should apply for aged care.

Aligning these arrangements for aged care with those that apply in the pension context involves an approach that is generally more 'generous' to people receiving aged care, but also involves a limitation on the extent to which the principal residence is currently exempt from the aged care assets test. Under the current aged care assets test, the principal residence is exempt, provided a 'protected person' resides there, and the definition of 'protected person' is broader than the exemption that applies for the age pension.[55]

I also propose that the lifetime caps on the amount of means tested contributions by an individual should be removed. While there may have been a case for limiting personal contributions to care, under the regime I have recommended in this chapter people will no longer have to pay any contribution towards the costs of their care. A person with substantial means living in a residential aged care facility for a number of years should be expected to pay for their ordinary costs of living on an ongoing basis, and I see no reason for limiting their contribution and requiring the Australian Government to meet these costs after a number of years.

As well as being generally more equitable than the current arrangements, my recommendation will remove the particular distortion in the current aged care means test under which both assets and the income derived from those assets contribute toward the reduction of eligibility for assistance.

Endnotes

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14 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, p 47 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).
15 The maximum Basic Daily Fees and income tested care fees are outlined in the Schedule of Fees and Charges for Residential and Home Care published by the Australian Department of Health. The income tested fee arrangements do not apply to older people who were receiving a Home Care Package on or before 30 June 2014. The income test is subject to annual and lifetime caps. See, for example, Australian Department of Health, *Schedule of Fees and Charges for Residential and Home Care: From 1 July 2020*, 2020 (Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 37, RCD.9999.0498.0001).
16 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, p 47 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).
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23. Capital Financing for Residential Aged Care | Commissioner Briggs

Aged care providers require access to significant start-up and ongoing refurbishment capital financing.

Under current arrangements, residential aged care providers access capital to fund investment in residential aged care accommodation from two main sources: equity capital of $13.5 billion or 25.7% of total provider assets as at 30 June 2019; and interest-free loans from residents in the form of Refundable Accommodation Deposits totalling $30.2 billion, representing liabilities corresponding to 57.4% of the value of total provider assets as at 30 June 2019. Other sources of capital include loans from banks and related parties ($2.1 billion and $2.3 billion respectively as at 30 June 2019), capital grants ($70 million in 2018–19) and donations and fund raising ($24 million).[1]

The revenue that approved providers receive must be able to service the costs of capital, in addition to other costs. Their capital costs are not limited to the costs of establishing debt facilities and interest payable on debt financing: equity investors, too, require a reasonable return on their investment.

In our chapters on funding, Commissioner Pagone and I recommend that the Pricing Authority should have responsibility for determining the costs of providing accommodation for aged care residents, a process that might involve consideration of models for the estimation of the cost of capital. This should mean that the accommodation supplement paid to providers will be well calibrated to provide an appropriate return on capital investment in accommodation assets. It should ultimately reflect the costs of renting accommodation from a landlord on commercial terms.

Once this regime is in place, the Australian Government should phase out Refundable Accommodation Deposits. The evidence we have received about the problems with the Refundable Accommodation Deposit regime is set out below. I consider that the provision of billions of dollars of interest-free loans to residential aged care providers by aged care residents is not appropriate as a long-term means of financing aged care providers. The Australian Government should establish an aged care accommodation capital facility as an alternative source of capital funding to assist providers in the transition away from Refundable Accommodation Deposits after the other related reforms we recommend are in place. The facility should remain once the transition has been completed as it will provide a mechanism for the System Governor to influence the nature of refurbished and new residential facilities.

Recommendation 142: Phasing out of Refundable Accommodation Deposits

Commissioner Briggs

The Australian Government should:

a. from 1 July 2025, begin to phase out Refundable Accommodation Deposits for new residents

b. assist providers with the transition away from Refundable Accommodation Deposits as a source of capital by establishing an aged care accommodation capital facility, with the terms and conditions of assistance designed to create incentives for providers to develop small household models of accommodation.

23.1 Refundable Accommodation Deposits

Refundable Accommodation Deposits—previously known as Accommodation Bonds—are lump sum deposits from residents to providers in return for accommodation. These lump sum deposits are refunded when people leave residential aged care or die. Refundable Accommodation Deposits act as an interest-free loan from people living in residential aged care to providers, allowing residential aged care providers to avoid raising other, more expensive, forms of capital.

As far as I am aware, the aged care sector is the only major sector in the Australian economy that has access to interest-free loans from the users of its services under a government-imposed regulatory framework.

Refundable Accommodation Deposits are the largest source of capital in residential care. As at 30 June 2019, providers held 94,870 Refundable Accommodation Deposits with an average value of $318,000. The average value of Refundable Accommodation Deposits has steadily increased over the last six years, and the total value of all accommodation deposits has almost doubled since 2013–14.[2] The average value of both the published and agreed price for Refundable Accommodation Deposits has similarly increased over this period.[3] The average Refundable Accommodation Deposit entry 'price' is now $350,000. As a consequence of the differential cost of housing, the average published and agreed price in metropolitan areas was significantly higher than in regional and remote areas, and can be as much as $700,000 to $800,000. These are significant financial imposts on vulnerable older people at a time of extreme stress as they enter residential care.

The maximum amount a provider can charge as a Refundable Accommodation Deposit is set by the Australian Minister for Health. The current maximum amount is $550,000, which has not changed since July 2014.[4] However, providers can apply to the Aged Care Pricing Commissioner for approval to charge a higher amount.[5] In 2018–19, the Aged Care Pricing Commissioner approved Refundable Accommodation Deposits in excess of $550,000 for 8117 rooms.[6]

If a person does not wish to pay a Refundable Accommodation Deposit, or is unable to do so immediately upon entering residential care, they must make a Daily Accommodation Payment. If a person chooses to pay by Refundable Accommodation Deposit, payment is not required until six months after entry into residential aged care. Daily Accommodation Payments are charged until the Refundable Accommodation Deposit is paid.[7] A person may choose to pay a Refundable Accommodation Deposit at any time after having entered into an accommodation agreement—for example, after a house sale is finalised.[8]

The use of the proceeds of Refundable Accommodation Deposits by providers is limited under the *Aged Care Act 1997* (Cth). Permitted uses include for capital expenditure, investment in certain financial products, and making or repaying loans.[9] Refundable Accommodation Deposits are guaranteed for residents by the Australian Government through the Accommodation Payment Guarantee Scheme.[10] This means that the Australian Government bears any financial risk from a provider becoming insolvent and being unable to refund the Refundable Accommodation Deposits of people living in its facilities. Between 2006 and 2017, the Australian Government paid $43 million under the Scheme.[11] Although the Australian Government can place a levy on providers for the costs associated with the Accommodation Payment Guarantee Scheme, it has not done so.[12]

Approved providers and banks told us about the role Refundable Accommodation Deposits play in supporting the development of new residential aged care facilities. They described a typical situation in which approved providers use a combination of equity and bank debt to finance the initial construction of a residential aged care facility. The bank's expectation would be that the provider would repay the debt with incoming Refundable Accommodation Deposits as residents moved in and that, as a consequence, projected Refundable Accommodation Deposits are an important criterion in the approval of loans.[13] Wide use of this model may explain why, at 30 June 2019, the residential aged care sector had only $2.1 billion in liabilities to banks.[14]

The fact that an approved provider's ability to attract Refundable Accommodation Deposits is a key lending criterion applied by the banks has implications for providers operating in areas that are unable to attract, or that attract fewer, high value Refundable Accommodation Deposit paying residents, such as regional areas.[15]

The National Australia Bank said:

> In general terms NAB considers providers operating in metropolitan areas to be lower risk than providers operating in regional, rural or remote areas, given metropolitan operators can generally attract higher RAD / DAP [Refundable Accommodation Deposits / Daily Accommodation Payment] paying residents (in line with higher median house prices of metropolitan areas), have access to a larger resident catchment area, and can more readily attract and retain staff. Regional providers also have potentially diminishing future demand from their local population.[16]

Similarly, Aged and Community Services Australia submitted that:

> The average prices of RADs [Refundable Accommodation Deposits] paid in metropolitan areas is significantly higher than in regional and remote areas, reflecting differences in housing prices but it may also to some extent reflect RADs in regional and remote areas being based on what residents are able to pay rather than the value of the accommodation.[17]

As a result, the Refundable Accommodation Deposit model that providers are reliant on for funding new developments, and the way it interacts with banks' lending decisions, means that providers operating in regional areas are less able than those in the major cities to access financing for developing new facilities.

Ms Julie-Anne Mizzi, Partner and Global Co-Head of Social Care at AMP Capital and a Board Member of Opal Aged Care, explained the importance of occupancy for a provider's financial position:

> Based on current occupancy and care profit data, aged care providers need to operate at full or near-full occupancy in order to deliver an operating profit as noted by ACFA [Aged Care Financing Authority] when they commented that 'a small decline in occupancy rates can have a significant impact on the financial results of providers'.
>
> This is due to the high fixed costs for a home whereby small changes in the number of residents does not lead to any meaningful change in roster allocations of staffing. Over the last 3 years, there has been a steady decline in occupancy and correspondingly a steady decline in operating margin.[18]

Dr Linda Mellors, from Regis Healthcare, told us that financial advisors are taking advantage of providers' sensitivity to changes in occupancy levels by leveraging that to bargain for reductions in the Refundable Accommodation Deposit price.[19] For Mr Paul Versteege of the Combined Pensioners and Superannuants Association, this is a positive development. He argued that providers should state the level of occupancy in a facility in order to assist incoming residents to question the Refundable Accommodation Deposit price.[20]

23.2 Daily Accommodation Payments

As I noted above, unsupported residents who do not wish to pay a Refundable Accommodation Deposit can choose to pay a Daily Accommodation Payment. They can also choose to pay a combination of a partial Refundable Accommodation Deposit and a Daily Accommodation Payment In their current form, Daily Accommodation Payments, or Daily Accommodation Contributions for people who choose a combination, were introduced as part of the Living Longer, Living Better reforms in 2014. The Daily Accommodation Payment (DAP) amount is derived from the agreed room Refundable Accommodation Deposit (RAD) price using the maximum permissible interest rate (MPIR) based on the following legislatively proscribed formula.[21] This is:

$$DAP = RAD \times MPIR / 365$$

The maximum permissible interest rate is linked to the monthly average yield of 90-day Bank Accepted Bills published by the Reserve Bank of Australia, and was 4.02% for the period 1 January 2021 to 31 March 2021.[22]

The Daily Accommodation Payment that an approved provider would receive is $35.02 per day based on the current maximum permissible interest rate, and the average value of a Residential Accommodation Deposit of $318,000. The Daily Accommodation Payment rises to $60.58 per day assuming the maximum value of a Residential Accommodation Deposit of $550,000, unless a higher amount is approved by the Aged Care Pricing Commissioner.

23.3 Balance between lump sums and daily payments

While the policy intent is that Refundable Accommodation Deposits and Daily Accommodation Deposits should be equivalent, it is apparent to me that payers and recipients have different perspectives on equivalence. From a payer's or resident's perspective, the Daily Accommodation Payment should reflect the opportunity cost of not having access to the capital tied up in a Refundable Accommodation Deposit. Professor Henry Cutler of Macquarie University's Centre for the Health Economy told us that Refundable Accommodation Deposits and Daily Accommodation Payments need to be economically equivalent for residents. If one is more expensive than the other, then this could distort older people's choices.[23]

From the recipient's or provider's perspective, the Daily Accommodation Payment should reflect the cost of access to borrowed capital to replace the interest-free loan constituted by the Refundable Accommodation Deposit. A number of providers and provider organisations told us that the maximum permissible interest rate is no longer an appropriate basis for converting Refundable Accommodation Deposits to Daily Accommodation Payments. Leading Age Services Australia, the national association for aged care services, submitted that 'equivalence would require the MPIR [maximum permissible interest rate] to be set at a rate representative of WACC [weighted average cost of capital]'.[24] Both Regis Healthcare and Estia Health agreed that the weighted average cost of capital would be a more appropriate conversion rate between Refundable Accommodation Deposits and Daily Accommodation Payments.[25] However, to the extent that the weighted average cost of capital includes an equity component, and equity is more expensive than debt, this approach would go beyond compensating providers for the interest costs of securing replacement capital. It would make Daily Accommodation Payments considerably more expensive than Refundable Accommodation Deposits for residents.

Uniting NSW.ACT told us that in a low interest rate environment, a Refundable Accommodation Deposit does not produce the income equivalent of the Daily Accommodation Payment.[26] On this basis, older people should prefer to make Refundable Accommodation Deposits. However, the proportion of people choosing Daily Accommodation Payments or Daily Accommodation Contributions increased gradually from 33% in 2014–15 to 41% in 2018–19.[27] This suggests that factors other than the interest rate used in calculating Daily Accommodation Payments are influencing their decisions.

This shift in the mix between Refundable Accommodation Deposits and Daily Accommodation Payments reflects older people exercising choice in how they contribute to their accommodation costs. However, this poses challenges for providers trying to make informed investment decisions. Leading Age Services Australia told us:

> Providers have limited control regarding a resident's accommodation choice and profile. Under current arrangements, providers are unsure if they are developing and operating a build to rent or build to sell model. This variability and uncertainty impacts the ability to make informed decisions for investments.[28]

Mr Sam Morris from the Australia and New Zealand Banking Group described the impact this shift would have on the sector:

> it is also important to the ongoing viability of the sector, given the large amount of RAD [Refundable Accommodation Deposits] liability that does sit on an operator's balance sheet, and so there's two risks there: there's less liquidity available to a provider if that RAD/DAP [Daily Accommodation Payment] mix would change, and, of course, you would see a reduction in bank appetite to fund new developments if those RADs weren't available as they had been in the past.[29]

The Commonwealth Bank of Australia and National Australia Bank made similar points.[30] The Australian Treasury noted that as the use of Daily Accommodation Payments increases, 'providers will increasingly require new sources of capital and will have to adjust their business models in response to this change in preferences'.[31]

23.4 The appropriateness of Refundable Accommodation Deposits as a source of capital

It is clear to me that Refundable Accommodation Deposits lower the cost of capital for residential aged care providers, and they appear to have supported the expansion and refurbishment of the residential aged care sector in recent years.[32] However, they also represent a welfare transfer from people receiving aged care and distort the financing of aged care in ways that are not fully transparent to the people who pay the deposits or to taxpayers.

Ms Mizzi told us that Refundable Accommodation Deposits have been so successful in attracting capital that:

> As accommodation is currently the only component on which aged care providers are able to earn a return, the aged care sector has effectively become a property industry rather than a care industry.[33]

Regis Healthcare argued that Refundable Accommodation Deposits are an efficient source of capital for government and providers.[34] However, this view was disputed. Professor Henry Ergas, former Professor of Infrastructure Economics at the University of Wollongong, suggested there was no reason in principle to think that Refundable Accommodation Deposits are an efficient way of raising capital, as the opportunity cost to the older person of paying a Refundable Accommodation Deposit may well exceed the opportunity cost of the provider obtaining the funds from another source.[35]

The Grattan Institute told us that easy access to capital through Refundable Accommodation Deposits was likely to lead to undesirable over-investment in residential aged care, particularly given the preference of older people to remain in their own home:

> The vast majority of older Australians want to receive care at home, rather than in a residential care facility. Yet the current financing model encourages a growing residential aged care sector. The interest-free financing for residential care providers encourages reinvestment of these funds into yet more residential care infrastructure.
>
> As home-based care increases, demand for residential care will fall. The upshot is more investment in residential aged care than the community needs. Some of this will be wasteful investment in underutilised facilities. The over-investment in residential care, driven by low-interest RADs [Refundable Accommodation Deposit], is thus an economically inefficient use of resources.[36]

Mr Versteege told us that the introduction of Refundable Accommodation Deposits was a positive development. In his view, they allow older people to contribute to the cost of accommodation while preserving a significant asset that could be passed on.[37]

In contrast, community-based advocacy group Aged Care Crisis Inc. submitted that the system of Refundable Accommodation Deposits is 'unnecessarily complex, inequitable and cruel in the impact it has on the most vulnerable'.[38] The group emphasised that decisions about accommodation payment arrangements are made by vulnerable people and their families in periods of great stress, and often with little time to appropriately consider all the options. In combination with local shortages in availability of residential aged care, this vulnerability can lead to 'supra-competitive prices' being exacted through Refundable Accommodation Deposits.[39]

The Grattan Institute submitted that there is a power imbalance during payment negotiations between providers and incoming residents, and that providers have financial incentives for incoming residents to pay a Refundable Accommodation Deposit.[40] COTA Australia told us that providers use this power imbalance to pressure older people and their families into paying a Refundable Accommodation Deposit.[41]

This power imbalance may be exacerbated by deficits in the knowledge older people and their families have about accommodation payment arrangements. Research undertaken for us by Ipsos concluded that there is a highly variable understanding about Refundable Accommodation Deposits among people accessing the aged care system. Ipsos concluded that the level of funding required for a Refundable Accommodation Deposit is daunting for many who fear it will significantly reduce their available disposable income.[42] I agree.

At Sydney Hearing 5, I heard that reliance on Refundable Accommodation Deposits introduces a risk for providers' liquidity in situations where a provider is required to repay a Refundable Accommodation Deposit for a resident who leaves, but does not receive a Refundable Accommodation Deposit from the incoming resident. Mr Ian Thorley, Chief Executive Officer of Estia Health, suggested that:

> A sector-wide, or nationwide event, such as a housing market fall, recession or a sentiment-driven or other change of accommodation payment preferences could result in a material reduction in the number and value of RADs [Refundable Accommodation Deposit] being provided to the sector as more incoming residents opt to pay a DAP [Daily Accommodation Payment] in preference to a RAD. If such a shift occurred across the whole sector to a degree of 10% then it could result in a capital shortfall of ~$3 billion.[43]

COVID-19's impact on the aged care sector has highlighted these risks, as older people have been either unwilling or unable to enter residential aged care. Mr Campbell Ansell, Managing Director of Ansell Strategic, an aged care consultancy service, told us that while he had been concerned at the long-term trend away from Refundable Accommodation Deposits to Daily Accommodation Payments, he:

> then became more concerned that the onset of COVID might result in people finding it difficult to pay lump sums, difficult to sell their homes, or that they might be unwilling to divest or to liquidate their assets in the middle of a pandemic.[44]

Based on trends observed in a sample of aged care providers, Ansell Strategic has estimated that COVID-19 will result in the residential aged care sector experiencing a net Refundable Accommodation Deposit outflow of approximately $2.6 billion by January 2021, representing 8% of all Refundable Accommodation Deposits.[45]

Effective prudential oversight of Refundable Accommodation Deposits is important to maintaining stability and confidence in the aged care industry.[46] I make recommendations about improving prudential regulation and financial oversight in Chapter 24.

23.5 Future reform

We received submissions for and against the retention of Refundable Accommodation Deposits as a means of financing the aged care sector.

Some service providers and peak bodies opposed removal of Refundable Accommodation Deposits. For example, Leading Age Services Australia said that its members recommend addressing a range of short-term challenges before fundamentally changing how accommodation is funded.[47] Regis Healthcare told us it is 'strongly opposed' to the phasing out of Refundable Accommodation Deposits.[48]

Other providers and interest groups expressed their support for reducing the sector's reliance on Refundable Accommodation Deposits. For example, COTA Australia submitted that it 'believes RADs [Refundable Accommodation Deposits] should play a much reduced role in future aged care financing'.[49] A number of organisations argued

that Daily Accommodation Payments should become the standard way of paying for accommodation. Aged Care Crisis Inc. told us that:

> RADs [Refundable Accommodation Deposits] should be phased out. DAPs [Daily Accommodation Payments] should be tied to the reasonable rental costs of the equivalent rooms and type of facilities in the area including maintenance. They should not cover major capital investments. If paying DAPs over a long period will cause hardship or a major disruption, then a HECS [Higher Education Contribution Scheme] style funding loan would be sensible.[50]

I agree that Refundable Accommodation Deposits should be discontinued. However, because the immediate withdrawal of this source of funding would have significant implications for the stability and business structures of many providers, I favour a gradual withdrawal of Refundable Accommodation Deposits over a defined period of time.

I also agree with the numerous submissions we received arguing that the Australian Government would need to implement a mechanism supporting provider liquidity and viability for the sector as Refundable Accommodation Deposits are phased out.[51] It is unreasonable to expect the sector to run down Refundable Accommodation Deposits that make up almost 60% of its assets base over a period of two or three years as existing residents who have paid Refundable Accommodation Deposits leave care, without an alternative source of capital. As COTA Australia submitted:

> There needs to be a transition strategy to reduce the proportion of capital in the form of RADs [Refundable Accommodation Deposits]. However, to stop any new RADs next year and grandparent the rest is likely to be too drastic. The key question is from where is substitute capital financing going to come?[52]

It will be important for the Australian Government, in developing a transition mechanism, to consult widely with the sector and its capital providers, and to allow significant lead times for the sector to adjust its funding structure.[53]

As Refundable Accommodation Deposits are phased out, unsupported residents should be required to make rent-like payments similar to the current Daily Accommodation Payment. A key advantage of this approach is that more consistent arrangements for accommodation funding would then apply for both supported and unsupported residents. In both cases, providers would receive a regular income stream that could be used to inform investment decisions and secure finance from lenders.

In response to our call for submissions on capital financing, we received a number of submissions suggesting alternative means of providing access to capital. Estia Health suggested the establishment of a centrally managed pool that would facilitate choice for both older people in residential aged care over how they paid for their accommodation, and for providers in how they are paid for that accommodation.[54] UnitingCare Australia suggested that the Australian Affordable Housing Bond Aggregator would be a model for capital raising that could be applied to residential aged care.[55] Ansell Strategic submitted that an annuity product could be used to fund residents' contributions toward the cost of their accommodation, preserving the option for older people to pay a lump sum upfront where that was advantageous for pension means testing purposes.[56]

The Grattan Institute agreed that without Refundable Accommodation Deposits, new forms of Australian Government support for capital financing would be required. It suggested that without Refundable Accommodation Deposits, 'the financing problem may become too little capital rather than too much'.[57] The Institute proposed that:

> Government should create a financing facility to fund capital investment in residential aged care—including land and buildings—through concessional loans, where the facility's funds are raised through government bonds. Providers should be able to apply to the facility for capital grants, which would finance new facilities, facility upgrades, and repayment of RADs [Refundable Accommodation Deposits] (to enable a smooth transition to the new model).[58]

The Grattan Institute went on to describe the transition mechanisms that would be required:

> RADs [Refundable Accommodation Deposits] should be phased out as residents die or move to a different facility. The government financing pool should be made immediately available so that providers can begin making applications for financing where needed as RADs are phased out.
>
> At the same time, all new residents to residential care facilities should make rental payments.
>
> The financing pool must be large enough to retire existing RADs as residents leave residential aged care. This sets the minimum size of the fund at $30.2 billion (the current stock of RADs). This figure does not represent an increase in risk for the government, since RADs are already guaranteed by the Commonwealth. Nor does it represent an increased interest or long-term debt burden, because residents' rental payments will fully cover the government's costs.[59]

I consider that the merits of phasing out Refundable Accommodation Deposits should not be judged in isolation from the other reforms we have proposed. In particular, it would be important that the Australian Government allow a period for the implementation of higher staffing levels in residential aged care and the independent determination by the Pricing Authority of the prices of aged care services and of the accommodation supplement and provisional accommodation charge limit before proceeding to a consideration of the potential advantages and disadvantages of phasing out Refundable Accommodation Deposits. Similarly, a substantial alternative capital grants program would need to be in place, as proposed in Recommendation 46. Both changes would allow for any initial instability caused by the other reforms to be resolved before turning to the question of Refundable Accommodation Deposits.

Development of a suitable transitional mechanism would be integral to this reform. While there are various options for the transition and many details that would need to be finalised, I am inclined to support the Grattan Institute's proposal. I propose that the Australian Government should establish an aged care accommodation capital facility to provide an alternative source of capital when Refundable Accommodation Deposits are phased out. The Government should consider using conditions on access to its capital assistance to support providers that are unsuccessful in applying for capital grants, but wish to develop or refurbish facilities to provide lower-density congregate living or smaller-scale facilities.

Endnotes

1 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, pp 71–72 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).
2 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, pp 89 [Table 7.1], 90 [Chart 7.1] (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).
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7 *Aged Care Act 1997* (Cth), s 52F-3(1)(g).
8 *Aged Care Act 1997* (Cth), s 52J-2(1).
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16 Exhibit 21-17, Sydney Hearing 5, Statement of National Australia Bank, RCD.9999.0386.0001 at 0005.
17 Aged & Community Services Australia, Public submission, AWF.680.00056.0001 at 0007.
18 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 84, WIT.0764.0001.0001 at 0025 [87]–[88].
19 Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0016.
20 Transcript, Sydney Hearing 5, Paul Versteege, 14 September 2020 at T9125.30–35.
21 *Fees and Payments Principles 2014 (No. 2)* (Cth), s 20.
22 Australian Department of Health, *Base interest rate (BIR) and maximum permissible interest rate (MPIR) for residential aged care*, 2020; *Fees and Payments Principles 2014 (No. 2)* (Cth), s 6; *Taxation Administration Act 1953* (Cth), s 8AAD.
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24 Leading Age Services Australia, Public submission, AWF.680.00061.0001 at 0007.
25 Regis Healthcare, Public submission, AWF.680.00052.0001 at 0011; Estia Health, Public submission, AWF.680.00048.0001 at 0009 [49].
26 Uniting NSW.ACT, Public submission, AWF.680.00049.0001 at 0010.
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51 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9587.5–8; Exhibit 21-15, Sydney Hearing 5, Statement of Australia and New Zealand Banking Group Limited, RCD.9999.0393.0001 at 0012; Aged and Community Services Australia, Public submission, AWF.680.00056.0001 at 0017.
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24. Financial Oversight and Prudential Regulation | Commissioner Briggs

24.1 Introduction

A rigorous system of financial oversight of service providers should be a critical component of the Australian Government's oversight of the aged care sector. Effective financial oversight provides protection for the taxpayer's investment in aged care services and a means of identifying potential risks to the quality and safety of care.

Under current arrangements, the financial oversight of aged care providers is focused on managing the risk to the Australian Government associated with the Aged Care Accommodation Payment Guarantee Scheme. Most residential care providers hold loans from residents in the form of Refundable Accommodation Deposits, which at 30 June 2019 totalled $30.2 billion across the sector.[1] Refundable Accommodation Deposits must be repaid to residents, or their estates, when they leave residential aged care, less any amounts deducted by agreement.[2] The repayment of Refundable Accommodation Deposits is guaranteed by the Australian Government under the Aged Care Accommodation Payment Guarantee Scheme.[3]

While the Australian Government has an interest in managing its prudential risk, it also has broader financial oversight responsibilities with respect to aged care providers. This is because the financial health of providers is crucial to the continuity of the essential aged care services they provide, and their ability to provide those services safely and to a high quality. This is equally true for residential care and home care. At present, the Australian Government has limited authority to undertake action in instances where there are concerns about a provider's financial viability.[4]

In August 2019, Commissioner Tracey and I heard evidence of the severe impact on aged care residents and their families caused by the sudden cessation of services at a residential aged care facility located in the Earle Haven Retirement Village on the Gold Coast, due to a commercial dispute between the approved provider and a contracted management company.[5]

Prudential regulation and financial oversight in aged care should be consistent with best practice in other sectors. It should be able to identify and respond appropriately to risks presented in the financial management and performance of particular approved providers and in the aged care sector as a whole. It should be responsive to changes in operating conditions in the aged care sector, to accounting standards and to innovations in financial and prudential oversight.

The recommendations in this chapter outline the elements of a new financial oversight and prudential aged care regulation framework, guiding principles for its refinement over time, certain statutory duties directly binding on providers, enhanced regulatory powers, and measures to improve regulatory capability.

24.2 Existing arrangements

The current arrangements are primarily concerned with prudential regulation of an approved provider's ability to repay Refundable Accommodation Deposits.

Under the existing arrangements, service providers are required to submit annual reports by 31 October each year, with the nature of the reports depending on the type of provider. All providers must complete an Aged Care Financial Report, which includes an Annual Prudential Compliance Statement. The Statement requires providers that held a Refundable Accommodation Deposit, accommodation bond or entry contribution during the reporting year to disclose certain information about accommodation payments.[6]

Non-government providers of one or more residential care service must also complete and submit to the Secretary of the Australian Department of Health a General Purpose Financial Report. The General Purpose Financial Report must be independently audited and provide 'a true and fair view of the financial position and performance of the approved provider'.[7]

Home care providers are also required to submit an Aged Care Financial Report but only need to complete the Home Care Income and Expenses Statement section of that report.[8] They are not required to complete a General Purpose Financial Report.

The Australian Government uses the information provided through these reports to assess providers' compliance against the Prudential Standards. The key elements of the prudential regulation of providers of residential and flexible care are four 'Prudential Standards' imposed by delegated legislation under the *Aged Care Act 1997* (Cth).[9] These are:

- Liquidity Standard—directed to the protection of refundable deposit balances, accommodation bond balances and entry contribution balances of people receiving care
- Records Standard—directed to the sound financial management of providers
- Governance Standard—directed to arrangements by providers for the management of refundable deposit balances and accommodation bond balances
- Disclosure Standard—directed to the provision of information about the financial management of providers.[10]

The four Prudential Standards have various gaps and limitations. There is no capital adequacy requirement under the Prudential Standards. The Disclosure Standard does not require providers to disclose matters that may affect their financial viability. The Governance Standard does not include an obligation on providers to identify risks or to say how they will be mitigated. The Records Standard provides for different reporting requirements between Tier 1 (private sector for-profit entities with public accountability) and Tier 2 entities (most privately-held entities and not-for-profits).[11] Under Australian Accounting Standards, Tier 2 entities operate under significantly reduced disclosure requirements. The vast majority of aged care providers are Tier 2-level entities.[12]

The Australian Department of Health also uses the information provided in the financial reports to undertake a 'first pass' risk assessment to identify those providers considered most at risk of non-compliance with the prudential requirements and most likely to be unable to refund Refundable Accommodation Deposits when they fall due. A risk rating from 'low' to 'severe' is given based on 'the assessment of a provider's operating performance, financial position, and metrics relating to prudential standards legislation'.[13] However, the Department has acknowledged that these arrangements do not provide sufficient or adequate data to allow robust financial risk assessments to be undertaken.[14]

The current regulatory framework does not provide a sufficient basis for the regulator to adequately identify prudential risk to the Australian Government or to properly assess risks to the quality or continuity of care that might arise from changes in the financial position of a provider.

24.3 The need for reform of the existing arrangements

The current financial and prudential oversight arrangements in aged care need to be strengthened.

Numerous reviews of the prudential regulatory function have been carried out in recent years, including by EY Australia, Mr David Tune AO PSM, Deloitte Global and Ms Kate Carnell AO.[15] While the detailed findings and recommendations of these reviews differ, there is agreement on the need for prudential reform. In particular, there is a need to address:

- more comprehensive financial reporting, including information on transactions with related entities
- more regular and timely reporting
- liquidity and capital adequacy standards in aged care, and
- improved capacity within the regulator to use the information effectively.[16]

A 2019 Australian Department of Health discussion paper, *Managing Prudential Risk in Residential Aged Care*, observed that the current model provides insufficient and inadequate data to allow a robust risk assessment of service providers to be undertaken.[17] The Department suggested that its ability to mitigate insolvency risk could be enhanced by requiring providers to:

- make available financial information as and when there are concerns about viability;
- make available the financial information of related entities as and when there are concerns about viability and or suspected non-compliance with the Prudential Standards, and
- pro-actively bring relevant matters to the attention of the Department.[18]

Later in 2019, the Earle Haven Inquiry made a number of further recommendations to strengthen the prudential regulation and financial oversight of aged care service providers.[19] Recommendation 6 of the Earle Haven Inquiry called for a finalisation of prudential reforms 'as a matter of priority'.[20]

In the 2018–19 Budget, the Australian Government allocated funds to improve the management of prudential risk in residential aged care facilities.[21] The Australian Government has used these funds to conduct further reviews of the existing prudential regulatory framework, including:

- engaging StewartBrown to design amendments to the Aged Care Financial Report
- commissioning Mr Gary Barnier, Aged Care Financing Authority, to undertake a project to review the Australian Department of Health's financial analysis processes and activities
- conducting a Prudential Standards Review between 1 February 2019 and 15 March 2019 following the release of the Australian Department of Health's *Managing Prudential Risk in Residential Aged Care* discussion paper.[22]

Mr Jaye Smith, First Assistant Secretary of the Australian Department of Health, accepted that a purpose of prudential regulation is to prevent issues arising that would adversely impact on the quality of care delivered to older people.[23] Mr Smith summarised the position of the Department and the Australian Government on existing arrangements for the prudential regulation of the aged care system in the following terms:

> I would say that the Australian Government and then the Department [of Health] has absolutely accepted that the prudential framework is not currently fit for purpose, that it requires fundamental reform to make sure that it can meet contemporary needs in the system.[24]

Mr Chris Mamarelis, the Chief Executive Officer of aged care provider the Whiddon Group, criticised the current prudential system as being overly reactive, particularly in terms of assessing the liquidity of providers. He described the risk of this reactive approach in the context of repayment of accommodation lump sums as 'a house of cards, a $30 billion house of cards that we are sitting on'.[25]

Mr Barnier's report to the Australian Department of Health suggested that identifying, and working closely with, high-risk providers well before they fail is the best way to minimise resident and community disruption.[26] He stated that the Australian Government was not currently set up to do this task.[27]

Mr Grant Corderoy, a Senior Partner at StewartBrown Chartered Accountants, criticised the level of specialist financial and analytical resources currently available within the Australian Department of Health to deal adequately with information from providers.[28] He was also critical of a lack of clarity within the Department about responsibilities for oversight and assessment, as well as an overlapping of responsibilities between the Department and the Aged Care Quality and Safety Commission.[29]

Despite the fact that numerous expert reviews have identified the need for stronger prudential regulation and financial reporting arrangements in aged care, there has been limited prudential reform to date. That said, submissions from the Australian Government supported strengthening prudential arrangements in aged care.[30] Witnesses from the Australian Department of Health and the Aged Care Quality and Safety Commission also supported access to a broader suite of tools for the prudential regulator to enforce prudential requirements.[31]

24.4 Improved prudential regulation

Recommendation 130: Responsibility for prudential regulation

1. **From 1 July 2023, the System Governor should be given by statute the role of the Prudential Regulator for aged care with responsibility for ensuring that, under all reasonable circumstances, providers of aged care have the ongoing financial capacity to deliver high quality care and meet their obligations to repay accommodation lump sums as and when the need arises.**
2. **The System Governor should also be given by statute the role of developing and implementing an effective financial reporting framework for the aged care sector that complements the purposes of the prudential standards.**

If my recommendation for a Department of Health and Aged Care is implemented, that Department should be the Prudential Regulator. Alternatively, if Commissioner Pagone's recommendation to establish the Australian Aged Care Commission is implemented, that Commission should be the Prudential Regulator. In either case, the System Governor will have the role of Prudential Regulator.

The prudential and financial reporting arrangement should aim to ensure proactive, effective, risk-based and timely oversight of the financial sustainability of all providers, not just those that hold Refundable Accommodation Deposits. That oversight should be for the purpose of identifying providers that are at risk of not having the financial capacity to repay their financial obligations or provide ongoing and high quality care to older people, and to inform remedial action by the prudential and quality regulators. The new system of prudential regulation should apply to all providers of aged care services, including providers of home care.

In the case of providers who hold Refundable Accommodation Deposits, the purpose should be to ensure that these funds are used only for permissible purposes, and are able to be repaid as and when required.

It follows that the responsibilities of the Prudential Regulator should include establishing and enforcing:

- prudential standards and corresponding prudential guidelines that meet these objectives, and
- a financial reporting framework that involves the collection of financial information, primarily from providers, that is targeted at these objectives.

The Prudential Regulator should seek to identify financial and prudential risks proactively and take action to prevent harm before it occurs. In doing so, the Prudential Regulator should undertake the following functions:

- effective monitoring and analysis of information received under providers' continuous disclosure obligations
- continuous monitoring of the ongoing financial sustainability and performance of providers
- sharing of information with other parts of the aged care institutional framework, including the quality and safety regulatory function and complaints-handling function
- the use of prudential and financial information to inform the evaluation of the financial risk profiles of providers
- selective interventions where required to manage financial risk in the system and safeguard the interests of people receiving aged care services
- agile use of enhanced information-gathering powers
- oversight of financial and commercial arrangements that have the potential to affect continuity of care.

Development of this framework will be critical during the period of reform and transition to the new aged care system described in this report.

Recommendation 131: Establishment of prudential standards

From 1 July 2023, the Prudential Regulator should be empowered under statute to make and enforce standards relating to prudential matters that must be complied with by approved providers, relating to:

- **a. the conduct of the affairs of providers in such a way as to:**
  - **i. ensure that they remain in a sound financial position, and**
  - **ii. ensure continuity of care in the aged care system, or**
- **b. the conduct of the affairs of approved providers with integrity, prudence and professional skill.**

The Prudential Regulator should have the power to set and enforce prudential standards for all providers. Those standards should encompass each of the elements of the current Prudential Standards—liquidity, governance, record keeping and disclosure—but go further.

The new prudential standards should address the deficiencies of the current Prudential Standards outlined above and ensure that the Prudential Regulator has sufficient information to assess the financial viability of providers and ensure continuity of care for people receiving aged care services. The Prudential Regulator should also have the freedom to impose further prudential standards as it sees fit, having regard to the purposes outlined above. This is likely to mean that different standards will apply in different contexts within the sector, depending upon the location, size, performance and regulatory history of particular providers.

24.5 Financial reporting

Recommendation 133: More stringent financial reporting requirements

1. **From 1 July 2023, the Prudential Regulator should be empowered under statute to require approved providers to submit financial reports.**
2. **The frequency and form of the reports should be prescribed by the Prudential Regulator.**

Access to the right financial and corporate information of providers, the timeliness of that information and the ability to analyse that information is critical to good prudential regulation and financial oversight. The current reporting arrangements do not meet these requirements.

The current prudential scheme was introduced in 2006.[32] Even though it was an improvement over the arrangements that operated before that time, the Australian Department of Health has noted that the scheme as introduced did not sufficiently contemplate:

- the current complexity of providers corporate structures;
- that there would be significant movements of Refundable Accommodation Deposits (within corporate groups or financial institutions for investment or loan purposes); or
- that enhanced provider and Refundable Accommodation Deposit disclosures may be required.[33]

In reflecting on the financial reporting requirements for providers, the Earle Haven Inquiry concluded that:

> the reports only provide a limited window into the financial and corporate affairs of approved providers. Providers are only required to report financial information at a single point in time each year and are not required to provide information about related parties that may be relevant to their stability or solvency.[34]

One of the key findings in a *Review of Aged Care legislation which provides for the regulation and protection of Refundable Accommodation Payments in Residential Aged Care*, undertaken by EY Australia in 2017, was that:

> The data that the Department is given is inadequate for it to assess whether or not Approved Providers comply with the Prudential Standards.[35]

The EY Australia review linked this inadequacy to deficits in the information requested by the Australian Department of Health, and the quality, timeliness and frequency of information submitted.[36]

Mr Corderoy criticised the adequacy of the current system of reporting, especially the quality, consistency and timeliness of information provided.[37] He recommended that all providers, including home care providers, be required to submit an annual General Purpose Financial Statement.[38] The Australian Department of Health has acknowledged problems with the timeliness of reporting and its limited powers to require additional information to assess financial risks.[39] Some providers said that they agreed the timing of information could be improved, and that there is scope for information to be provided more frequently and more regularly.[40]

The Prudential Regulator should have access to the relevant and timely information it needs to exercise financial risk oversight functions in relation to the sector, by requiring expanded reporting obligations for providers to support effective financial oversight of the sector.

Without limiting the powers of the Prudential Regulator to determine the manner and form of the regulatory financial reporting regime, it should have the power to:

- require providers, or certain classes of providers, to submit financial reports
- specify the required content of the financial reports
- determine the frequency of reporting based on historical financial performance and prudential compliance, and the likelihood of a provider being at risk of default
- specify a change in circumstances that may give rise to heightened prudential risk
- specify the frequency of reporting for all providers, or for particular classes of providers.

The required content of the financial reports should be specified by the Prudential Regulator to achieve the following purposes:

- improve transparency of providers' businesses and how they use accommodation payments
- improve understanding of the financial sustainability of providers and assist the regulator to identify and monitor providers potentially at risk of financial failure or non-permitted use of accommodation payment balances.

Guided by these purposes, the Prudential Regulator may, in determining the required content of the special purpose financial reports, be informed by such accounting standards as it deems fit.

In response to Counsel Assisting's submission in relation to more stringent financial reporting, the Health Services Union submitted that the timeframe for the recommendation should be brought forward 'for urgent and immediate implementation'.[41] I agree that stronger financial reporting requirements are important and urgent. While I recognise that the Prudential Regulator may require some further time to make well-informed determinations as to the nature of the financial reporting that it requires, I recommend elsewhere in this chapter (Recommendation 143) that if the Government Leadership model is adopted, the reforms to financial oversight and prudential regulation arrangements that I have proposed in this chapter should be implemented by the earlier date of 1 July 2022.

The Prudential Regulator should consult with the aged care sector, the Australian Accounting Standards Board and other key financial reporting stakeholders, including the professional accounting bodies, in this process.

As noted in a joint submission by the Chartered Accountants Australia and New Zealand and CPA Australia, wider consultation will assist with ensuring:

> - development of appropriately worded reporting requirements that support the achievement of the prudential objectives
> - that these requirements can be readily complied with, are capable of easy enforcement and produce consistent and comparable reporting outcomes, and
> - that they do not impose unnecessary, duplicative or complex levels of reporting red tape that unnecessarily draw scarce and valuable sector resources away from the sector's key quality aged care objectives.[42]

24.6 Information-gathering powers

Recommendation 134: Strengthened monitoring powers for the Prudential Regulator

From 1 July 2023, the Prudential Regulator should have the following additional statutory functions and powers, to be exercised in connection with, or for the purposes of, its prudential regulation and financial oversight functions:

a. **the power to conduct inquiries into issues connected with prudential regulation and financial oversight in aged care**

b. **the power to authorise in writing an officer to enter and remain on any premises of an approved provider at all reasonable times without warrant or consent**

c. **full and free access to documents, goods or other property of an approved provider, and powers to inspect, examine, make copies of or take extracts from any documents.**

Effective financial oversight and prudential regulation requires stronger information-gathering powers than are currently available to either the Australian Department of Health or the Aged Care Quality and Safety Commission.

Part 8 of the *Aged Care Quality and Safety Commission Act* 2018 (Cth) permits, in a range of circumstances, authorised officers of the Aged Care Quality and Safety Commission to enter any premises, exercise a range of powers of search, and ask questions of persons at the premises.[43] Before exercising any of these powers, the relevant officer is required to inform the provider of their 'responsibility' under paragraph 63-1(1)(b) of the Aged Care Act to 'co-operate with a person who is performing functions' under the Act. Despite this, the occupier of the premises can simply refuse consent to entry of the premises and any person to whom questions are directed can simply refuse to answer. Moreover, the Aged Care Quality and Safety Commission currently does not have power to conduct inquiries, which is an essential function for a prudential regulator.

In Chapter 14 of this volume, on quality regulation and advocacy, we recommend that the Quality Regulator should have access to a strengthened power to undertake investigations and inquiries. In the Government Leadership model that I propose, the Department should have access to similar powers.

The Australian Department of Health appears to agree that the prudential regulator needs increased powers to seek information from providers and investigate issues relating to prudential and financial management. Ms Janet Anderson, Aged Care Quality and Safety Commissioner, told us that she supported increased capability, subject to the judicious use of the proposed powers.[44] Mr Smith of the Australian Department of Health agreed.[45]

24.7 Continuous disclosure

Recommendation 135: Continuous disclosure requirements in relation to prudential reporting

1. From 1 July 2023, every approved provider should be required under statute to comply with continuous disclosure requirements to inform the Prudential Regulator of material information of which the provider becomes aware that:
    a. affects the provider's ability to pay its debts as and when they become due and payable, or
    b. affects the ability of the provider or any contractor providing services on its behalf to continue to provide aged care that is safe and of high quality to individuals to whom it is currently contracted or otherwise engaged to provide aged care.
2. The Prudential Regulator should also have the power under statute to designate events, facts or circumstances that may give rise to continuous disclosure obligations.

Prudential and financial risks occur in real time. This means that information relevant to these risks must be identified by the regulator in real time as well. Without such information, the regulator cannot effectively respond to risks as and when they occur.

Assessment of risk carried out purely on the basis of the various financial and prudential reports that are due for lodgement on 31 October each year is not likely to enable a timely response or intervention. By the time that the 'first pass' process has been completed, the possible harm of the continuity or quality of care that timely financial oversight might have prevented may already have occurred. The Earle Haven Case Study provided a very unfortunate example of the consequences of delays in recognising early signs of financial distress in an aged care service provider. More timely reporting would provide the regulator with relevant information that could identify risks more promptly and before they pose a risk to the continuity of care to people receiving aged care services.

A continuous disclosure obligation exists for listed entities. Listed entities must disclose information 'that a reasonable person would expect…to have a material effect on the price or value of…securities of the entity'.[46] However, only a very small proportion of providers are listed, so the majority of providers are not subject to any continuous disclosure obligations.

In response to a submission from Counsel Assisting's final submissions proposing a continuous disclosure obligation, the Governance Institute of Australia, Australian Institute of Company Directors and, in a joint submission, Leading Age Services Australia, Hall & Wilcox and HWL Ebsworth submitted that the proposal was not sufficiently articulated,

was confusing, was potentially very broad and therefore was overly onerous.[47] I acknowledge that some additional burden will be involved, and that there will be a period where some uncertainty will apply to the scope of the obligations in question.

However, I consider that the risks to continuity of essential services to vulnerable older people justify the imposition of a continuous disclosure obligation. In my view, a balance can be found that provides a sufficiently rigorous continuous disclosure obligation that alerts the Prudential Regulator to impending risks while avoiding undue burdens on service providers.

Much will depend on the Prudential Regulator taking a reasonable approach to providing guidance on the materiality of the information concerned, and effectively refining its guidance over time.

In its discussion paper *Managing Prudential Risk in Residential Aged Care*, the Australian Department of Health canvassed a proposal that providers be required to inform the Secretary of the Department of concerns relating to viability:

> Enhancing information and disclosure requirements to the Department where 'significant events' occur, such as major changes in corporate structure or ownership, significant related party transactions and where a provider is at imminent risk of no longer being able to continue operations.[48]

The Earle Haven Inquiry report recommended clarification of section 9-1 of the Aged Care Act. The proposed clarification included a requirement to advise the regulator of certain material changes affecting a provider's ability to continue as a going concern.[49] In my view, notification of such changes is not likely to provide sufficient early warning and may be too late to enable an appropriate regulatory response.

A trigger based on insolvency, where the focus is on the ability of the provider to pay all of their debts as and when they become due and payable, is also likely to be too late for the purposes of identifying the sort of risk that the prudential regulator is focused upon.[50] Mr Ian Thorley of aged care provider Estia Health said that more frequent reporting was the key to predict the likelihood of a provider being able to meet its financial obligations.[51] Dr Linda Mellors of aged care provider Regis Aged Care agreed with Mr Thorley. Dr Mellors said:

> I would like to make the point that much of the harm that's done to residents, families and workers happens probably over the last year before a provider does become insolvent as people are rapidly making changes to try to save their business. So it's not just the point of collapse. So I agree with you that there needs to be an earlier trigger.[52]

Another possible trigger that might be applied is a material deterioration in performance against budget. Mr Campbell Ansell of aged care consultancy Ansell Strategic told us that most providers, in ordinary business circumstances, would have financial forecasts and budgets that would enable them to project their financial position and predict future financial difficulties.[53] However, Mr Ansell acknowledged that this would require visibility of a provider's capital flows from resident accommodation payments as well as operating deficits, and not all providers would be in a position to provide that much notice.[54]

Mr Chris Williams of the Commonwealth Bank of Australia said that most providers borrowing funds from the Commonwealth Bank of Australia would have forward budgets and at least annual forecasts of expected future positions.[55] He noted that the level of financial sophistication would be less for smaller providers, although he would expect them to have a 'degree of financial discipline' from a lending perspective.[56]

In its 2019 review entitled *Implementation Options Review: Managing prudential risk in residential aged care*, Deloitte Global noted that there is no requirement for providers to self-report risks to viability or prudential obligations. Consequently, the report put forward an option for providers to report financial viability concerns.[57] The Deloitte Global option involved quarterly reporting that required providers to attest as to whether or not they have financial viability concerns, and to report significant risk events within 28 days of the event.[58] I do not favour such a response, given that quarterly reporting is likely to create a higher regulatory burden than is necessary in the circumstances and may not be suitable for all providers.

In its Prudential Framework Review, StewartBrown supported continuous disclosure on a risk-based exception basis, rather than required of all providers as proposed by Deloitte Global.[59] StewartBrown proposed a continuous disclosure requirement for any provider that 'is deemed to be high risk, has breached certain rules, can foresee a breach of rules or is requested to do so by the Department'.[60]

Witnesses from the Australian Department of Health and the Aged Care Quality and Safety Commission supported continuous disclosure, subject to a clear definition of what information is considered material.[61] In its response to Counsel Assisting's final submissions, the Australian Government said that the obligation should be 'adjusted to care settings, risks to care recipients and the scale of financial risk'. The definition of material should be balanced against the regulatory burden of reporting.[62]

Mr Corderoy recommended that providers should be required to report certain matters to the Australian Department of Health within 14 days, including moving below minimum liquidity levels or into a negative capital adequacy ratio position, as well as material adverse changes in financial position and breaches of permitted use rules.[63]

The Victorian Housing Registrar requires registered agencies to notify the Registrar as soon as possible about reportable events. Reportable events include significant new funding, liquidity issues, breaches of loan covenants, changes in borrowings and new loans, and major investment strategy changes.[64]

The Prudential Regulator should be empowered to provide guidance as to the circumstances in which continuous disclosure obligations will be engaged, including the meaning of 'material information'. In doing so, the overriding considerations should be whether the information indicates a risk to the financial viability of the provider or the quality of care delivered to people receiving aged care services, including by any contractors.

The Prudential Regulator should remain cognisant of the regulatory burden that may be imposed by the continuous disclosure obligation and balance this against the financial risk or the risk to high quality care. It should adapt to changing circumstances in the aged care sector and have the power to designate events, facts or circumstances that may give rise to continuous disclosure obligations as necessary.

A failure to comply with the continuous disclosure obligation should be a contravention. It may be the subject of an application by the Prudential Regulator to a court of competent jurisdiction for a civil penalty.

A person involved in a contravention should be subject to accessorial liability. However, that person should not be liable if they prove that they took all steps (if any) that were reasonable in the circumstances to ensure that the provider complied with its continuous disclosure obligations, and that after doing so the person believed on reasonable grounds that the provider was complying.

24.8 Improved liquidity and capital adequacy requirements

Recommendation 132: Liquidity and capital adequacy requirements

From 1 July 2023, the Prudential Regulator should be empowered under statute to impose liquidity and capital adequacy requirements on approved providers, for the purpose of identifying and managing risks relating to whether:

a. **providers have the financial viability to deliver ongoing high quality care**

b. **providers of residential care services that hold Refundable Accommodation Deposits are able to repay those deposits promptly as and when required.**

24.8.1 Liquidity requirements

Liquidity refers to the readily accessible funds that a provider has in proportion to its debts.

The objective of the current Liquidity Standard is to ensure that providers have sufficient funds to refund the Refundable Accommodation Deposits they would expect to fall due within the following 12 months.[65] To support that objective, providers are expected to develop a liquidity management strategy, but the Liquidity Standard stops short of setting a specific liquidity target.

As noted by the Australian Department of Health in its discussion paper *Managing Prudential Risk in Residential Aged Care*, the adequacy of these arrangements has been considered in a number of expert reports commissioned by the Australian Government. These reports have offered recommendations to strengthen the prudential standards, including a specific liquidity requirement that a provider maintain a prescribed percentage of liquid assets.[66]

In its 2017 *Review of Aged Care legislation*, EY Australia recommended that the Liquidity Standard should be better redefined, with the following three measures to achieve this:

- setting the liquidity threshold as a defined percentage of accommodation payment money held by a provider group
- phase in the defined threshold over a period of 5–10 years —for example, require 5% within five years and 10% within 10 years
- define the form of liquidity as real liquid or accessible funds being a combination of unpledged/unencumbered cash in the bank, a bank facility (such as an overdraft or line of credit), or money that can otherwise be accessed immediately.[67]

In its 2019 *Implementation Options Review*, Deloitte Global expressed similar views, and noted that there was 'room for improvement within the aged care legislation' in relation to liquidity management requirements.[68] It included three possible actions:

- tiered liquidity threshold requirements based on a standard and advanced approach, where the standard approach required providers to maintain 35% minimum liquidity of Refundable Accommodation Deposit balances held and the advanced approach allowed providers to maintain an alternative or lower liquidity requirement where appropriate
- defined acceptable forms of liquidity
- phased roll-out of liquidity requirements.[69]

While Deloitte Global recommended a liquidity level of 35% of Refundable Accommodation Deposits, the StewartBrown Prudential Framework Review recommended a level set at 15% of total debt.[70] StewartBrown said that because many providers have a variety of operating segments, to consider only Refundable Accommodation Deposits in calculations of liquidity ratios may create a misleading picture of the provider's position. Consequently, StewartBrown recommended that liquidity be assessed against all debts at the provider level.[71] Mr Corderoy, Senior Partner, StewartBrown, further recommended that the Annual Prudential Compliance Statement be amended to include questions relating to provider liquidity levels.[72]

These recommendations focused on the risk surrounding Refundable Accommodation Deposits held by residential care providers. However, liquidity requirements are also important for providers of home care services, particularly in circumstances where many older people prefer to remain at home for as long as possible. StewartBrown told us there are:

> no prudential requirements in respect of unspent funds relating to Home Care Packages (HCP) or unspent funding relating to In-Home Support programs (CHSP). The exact amount outstanding under these programs is not currently known, but the balance unspent in relation to HCP is expected to exceed $700 million at 30 June 2019. These are funds that will need to be returned to Government or to the care recipient (or their estate) should they leave the home care system.[73]

The proposed reforms to change the way that home care providers are paid should reduce the scope for the accumulation of significant unspent home care funds in the future.[74]

The Earle Haven Inquiry report supported the introduction of specific liquidity requirements and also recommended that providers be required to assess their liquidity and ability to continue as a going concern on a quarterly basis.[75] Mr Nigel Murray of the Australian Department of Health told us that a specific liquidity requirement would assist the Department to assess provider risk, and that the regulator should have discretion to alter this in certain circumstances.[76]

Mr Bernard Gastin, Registrar of Housing Agencies, Victorian Housing Registrar, outlined a risk-based approach to liquidity. He said that the Victorian Housing Registrar determines liquidity and capital adequacy requirements for individual agencies based on several factors, including financial ratios, funding streams and associated financial risks.[77]

Ultimately, these are matters that should be determined by the regulator. For this reason, I do not specify in this report what the particular liquidity ratio should be. However, the Prudential Regulator should be empowered to impose liquidity requirements on all providers subject to appropriate differences based on the type of aged care services provided, size and other variances.

Without limiting the precise liquidity requirements that the Prudential Regulator may impose, I would envisage that the requirements should include obligations on the provider to:

- obtain and submit certification by an independent auditor that the provider is able to meet its financial liabilities, including Refundable Accommodation Deposits, likely to become due and payable in the next 12-month period
- maintain a particular ratio of liquid assets to financial liabilities, including Refundable Accommodation Deposits, in excess of a specified ratio (liquidity threshold), and
- notify the Prudential Regulator within a specified time if that liquidity threshold is infringed.

Given the importance of timely reporting against these requirements, the Prudential Regulator may consider it appropriate to specify the frequency of this reporting as part of any Special Purpose Financial Reporting or on an as needs basis.

Where liquidity thresholds are proposed, there will be a need for a transition pathway that enables providers to take the necessary action to meet a higher liquidity threshold without affecting the continuity of aged care services.

24.8.2 Capital adequacy requirements

Capital adequacy refers to the amount of capital, or assets, that a provider has compared with its liabilities. Capital adequacy requirements may complement liquidity requirements as a means of identifying providers who may not have the financial capacity to deliver ongoing high quality care, or may be unable to repay the Refundable Accommodation Deposits without recourse to the Aged Care Accommodation Payment Guarantee Scheme.

The EY Australia *Review of Aged Care legislation* recommended the introduction of a 20% capital adequacy ratio that is based on a definition of capital that includes tangible assets such as land and buildings, and intangible assets that are able to be valued.[78]

In its 2019 *Implementation Options Review*, Deloitte Global said that capital adequacy requirements are a way for the Australian Government to mitigate the risk of a provider defaulting and to ensure Refundable Accommodation Deposits are refunded on time.[79] It proposed three options:

- tiered requirements for capital adequacy based on a standard and advanced approach, where the standard approach required providers to maintain 20% capital adequacy and the advanced approach allowed providers to maintain lower capital adequacy where they could demonstrate an appropriate plan to manage their capital position
- allow some intangibles to count towards the capital adequacy requirements
- phased roll-out of capital adequacy requirements.[80]

In its Discussion Paper *Managing Prudential Risk in Residential Aged Care*, the Australian Department of Health subsequently canvassed a specific capital adequacy requirement involving maintenance of a prescribed percentage of net assets whereby, for example, assets must exceed liabilities by an amount exceeding 20% of total assets.[81]

Mr Peter Kohlhagen, General Manager of Advice and Approvals, Australian Prudential Regulation Authority, highlighted the need for capital adequacy requirements to reflect the risks of a particular organisation: as risks of potential future stressors differ between organisations, the capital required to deal with those stressors varies.[82]

In contrast, StewartBrown did not recommend a minimum capital adequacy requirement, but rather that capital adequacy be examined in the context of determining viability risk.[83]

The imposition of clear and enforceable capital adequacy requirements has the capacity to improve the prudential regulation framework in aged care. However, consistent with my conclusions surrounding the imposition of liquidity requirements, the question of capital adequacy should be a matter for the Prudential Regulator. As with liquidity requirements, I do not specify in this report what the particular capital adequacy ratio should be. However, there should be a clear and enforceable capital adequacy ratio and the Prudential Regulator should be empowered to impose capital adequacy requirements on providers. The Prudential Regulator should have the same flexibility to apply different standards for various types of providers, sector segments and taking into account the regulatory performance of particular providers.

Without specifying the precise capital adequacy requirements that the Prudential Regulator may impose, I would envisage that these would include requirements on the provider to:

- obtain and submit annual certification by an independent auditor that the provider has adequate capital to ensure the continuity of its aged care services
- maintain a particular ratio of net assets to liabilities in excess of a specified ratio (capital adequacy threshold), and
- notify the Prudential Regulator within a specified time if that capital adequacy threshold is infringed.

Any proposal to introduce capital adequacy thresholds as part of the new prudential standards must allow some time for providers to prepare for higher capital adequacy thresholds.

Consistent with a risk-responsive approach to regulation, the liquidity and capital adequacy ratios may differ between providers. The Prudential Regulator should therefore be empowered to apply risk adjusted liquidity and capital adequacy requirements to providers, pursuant to guiding statutory principles. The Prudential Regulator should determine the liquidity and capital adequacy thresholds and criteria on a reasonable and proportionate basis that strikes a balance between the risk of providers defaulting on their obligations and the cost of maintaining these requirements. For example, the criteria may involve an assessment of:

- the provider's financial risk, balance sheet strength and financial viability
- the nature of the provider's services—that is, residential care only, home care only, residential care combined with home care, or residential and/or home care combined with other non-aged care related services
- the provider's business strategies and direction, including capital requirements, and
- the size of their financial liabilities, if any.

24.9 Enforcement tools

Recommendation 136: Tools for enforcing the prudential standards and guidelines and financial reporting obligations of providers

1. From 1 July 2023, the Prudential Regulator should have the powers to take such action, and impose such obligations upon approved providers, as it considers necessary to deal with any breach of the new prudential standards or the financial reporting requirements, including a failure to comply with the continuous disclosure requirements.
2. The powers which the Prudential Regulator should be given should include:
    a. the power to give directions to a provider that mirror those that can be made by the Australian Prudential Regulation Authority pursuant to the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth)
    b. the power to impose administrative penalties in respect of any breach
    c. the power to apply to a court of competent jurisdiction for a civil penalty in respect of any relevant alleged contravention
    d. the ability to accept enforceable undertakings
    e. the ability to impose sanctions to limit the ability of the provider to expand its services, revoke accreditation for a service, or revoke approved provider status.

Good prudential regulation and financial oversight should be agile and responsive. The regulator should have a cascading range of powers enabling it to take proportionate corrective action promptly.[84] This should include consequences in terms of the prudential risk profile of the provider, with the result that the provider will be subject to increased regulatory scrutiny.

The EY Australia review proposed consequences for providers that do not comply with the proposed liquidity and capital adequacy requirements, such as restricting their ability to charge new accommodation payments or requiring them to provide additional security until they comply with those thresholds.[85]

Consistent with my recommendations for effective regulation, the enforcement powers available to the prudential regulator should include the ability to issue infringement notices, accept enforceable undertakings, impose administrative penalties, apply to a court for civil penalties and to impose other proportionate sanctions.

24.10 Capability of the prudential regulator

Recommendation 137: Building the capability of the regulator

The Australian Government should ensure that the Prudential Regulator has prudential capability in relation to the aged care sector that includes the following:

a. **an effective program to recruit and retain senior forensic accountants and specialists with prudential regulatory experience, and sufficient numbers of supporting employees who have either accounting qualifications or other financial skills**

b. **systems and processes to capture, collate, analyse and share regulatory intelligence from internal and external sources to build a risk profile of approved providers**

c. **a system and processes to monitor indicators of risk revealed by providers' financial reporting tailored to the aged care sector and to respond to them in a timely manner**

d. **an electronic forms and lodgement platform for the use of all large operators, with an optional alternative electronic filing system available for smaller operators**

e. **appropriate resourcing of the above system and processes, including design expertise, information and communications technology requirements, technical support, and recruitment and training of sufficient numbers of appropriately skilled staff.**

The Prudential Regulator must be adequately resourced and equipped to carry out its prudential functions. Those resources should include well-trained staff with specialised skills, and processes and systems to allow these staff to build a picture of prudential and financial risk within the sector.

I am not satisfied that the Australian Government possesses the capabilities or capacity to adequately perform the level of prudential regulation and financial oversight required for the aged care sector.

The need for improved capacity within the regulator was highlighted by the Earle Haven Case Study. The approved provider had a record of submitting troubling or incomplete financial returns, including in relation to its 2014–15 General Purpose Financial Report.[86] In 2018, People Care failed to file some of its financial reports. The Australian Department of Health followed this up from late 2018 through to June 2019. However, on 13 June 2019 an officer in the Department decided to take no further action on this non-compliance.[87] In July 2019, the relationship between People Care and HelpStreet, which managed the facilities at the Earle Haven retirement village, broke down and aged care services ceased

abruptly, with significant impact on the residents and their families. This case study highlights the importance of paying attention to prudential 'red flags'. For this to happen, there needs to be systems to manage the relevant information and officers who are well trained to recognise and act on the sometimes complex information provided in financial returns.

Mr Kohlhagen described a risk-based system of supervision, which involves ongoing engagement with institutions and a targeting of supervision resources to larger and/or higher-risk entities.[88] He explained that the Australian Prudential Regulation Authority adopts 'pre-emptive, risk based supervision' and 'relies on an ongoing, open relationship with regulated institutions' rather than a checklist approach to regulation. The Australian Prudential Regulation Authority also directs its supervisory resources to areas of greatest risk of impact. In doing so, smaller or lower-risk entities may receive less frequent supervisory interaction than larger or higher-risk entities.[89] Similarly, Mr Gastin of the Victorian Housing Registrar explained the regulatory engagement tool used to determine the number of engagement visits over the year ahead, based on financial and non-financial indicators.[90]

The development of these capabilities will take a significant investment and a sustained management focus over a considerable period of time.

The Australian Government, however, has before it a range of expert advice on the capabilities that need to be developed. The EY Australia report recommended that the Australian Department of Health recalibrate its risk assessment methodology and model to reflect the proposed compliance requirements.[91] The review also recommended strengthening the tools, resources and capabilities of the prudential regulatory section of the Australian Department of Health through enhanced data collection and analysis given the proposed revisions to the Prudential Standards, and increased resources and more sophisticated tools to conduct compliance activities.[92]

The report of the Earle Haven Inquiry recommended that steps be taken to ensure that aged care regulators have the capacity to understand risks to quality of care that might arise from a provider's financial or contractual arrangements, including by:

> increasing the capacity of aged care regulators to effectively scrutinise financial information; providing the Quality and Safety Commission with the capacity to include people with expertise in contracts and accounting in the team undertaking assessment contacts where there is an indication that there are risks associated with the approved provider's financial or contractual arrangements.[93]

In the 2018–19 Budget, the Australian Government provided $8.6 million over four years to improve the management of prudential risk in residential aged care facilities and enhance the capacity of the Australian Department of Health and the Aged Care Quality and Safety Commission to assess the financial information of providers and 'assist in the early detection of prudential and viability concerns'. [94]

While additional funding is welcome, the additional funds allocated in 2018–19 appear to have been spent on more reviews rather than on tangible improvements to the prudential and financial oversight arrangements.[95]

Ms Anderson told us that the Aged Care Quality and Safety Commission's prudential regulation staff are 'highly competent, but there aren't enough of them'.[96] Mr Smith of the Australian Department of Health supported greater capabilities within the Department, and indicated that the Department is already focused on increasing capacity and ensuring the right skill mix.[97]

Elsewhere, I have recommended the need for investment in the right people and capability within the Australian Government to lead the reform of the aged care system. As much as anywhere, this investment is required in relation to the prudential regulatory body and its functions.

24.11 Implementation of new arrangements

Recommendation 143: Implementation of new arrangements for financial oversight and prudential regulation — **Commissioner Briggs**

If the Government Leadership model is adopted, implement the reforms to financial oversight and prudential regulation arrangements set out in Recommendations 130, 131, 132, 133, 134, 135, 136, and 137 from 1 July 2022.

If the Government Leadership model of system governance that I propose is adopted, it would be possible to introduce the new financial oversight and prudential arrangements earlier than indicated in the joint recommendations set out in this chapter. In Chapter 2: Governance of the New Aged Care System, I have recommended that the Aged Care Safety and Quality Authority should commence operations from 1 July 2022. If the Australian Aged Care Commission model were to be adopted, it would not be established until 1 July 2023.

If the Government Leadership model is adopted, it would be preferable to establish the new financial and prudential regulatory functions with the new powers and responsibilities recommended in this chapter within the Australian Department of Health and Aged Care at the earlier date of 1 July 2022.

This would allow for an earlier application of the more rigorous regime for financial oversight of service providers that we have proposed and would facilitate the development of appropriate cooperation and information-sharing arrangements between the Quality Regulator and the Prudential Regulator as they develop their systems and processes.

Endnotes

1 Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, p 89 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017).
2 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 67, RHC.9000.0012.0001 at 0011.
3 See, for example, Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3357 [21].
4 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3569 [62]–3570 [63]; Australian Department of Health, EY, *Review of Aged Care legislation which provides for the regulation and protection of Refundable Accommodation Payments in Residential Aged* Care, 2017, p 11 (Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 51, CTH.9100.0001.0266); Australian Government, *Inquiry into Events at Earle Haven*, 2019, pp 5–6 (Exhibit 13-1, Hobart Hearing, general tender bundle, tab 4, RCD.9999.0266.0003).
5 See Volume 4, Chapter 8.2.1. Earle Haven Case Study.
6 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3553 [12b].
7 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 105, CTH.1000.0006.3520 at 3523; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3554 [12c].
8 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3554–3555 [13].
9 *Fees and Payments Principles 2014 (No. 2)* (Cth).
10 *Fees and Payments Principles 2014 (No. 2)* (Cth), s 41.
11 Australian Accounting Standards Board, *AASB 1053: Application of Tiers of Australian Accounting Standards*, 2019, pp 4, 7.
12 Australian Department of Health, *Managing Prudential Risk in Residential Aged Care Discussion Paper*, 2019, p 41.
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25. Financing the New Aged Care System | Commissioner Briggs

25.1 Introduction

It is important that the Australian public has confidence that high quality and safe services for older people will be available when they need them. The aged care system requires a clear and transparent source of public funding that is adequate to deliver high quality aged care for everyone.

To date, the financing of aged care has relied on Australian Government subsidies funded by general taxation and other revenue supported by contributions from older people receiving care. Most of the funds have come from the Australian Government. This form of financing aged care costs has proven to be a remarkably flexible and resilient means of financing the growth in aged care expenditures over the past 60 years and could be expected to continue to work effectively into the future.

Aged care services are one of the few Australian Government services universally available to everyone, irrespective of their means. Funding through the general revenue system reflects the nature of aged care as an entitlement supported by the community as a whole. General revenue funding very effectively spreads the risk of incurring aged care costs late in life across the population as a whole. This is far more efficient than if each individual were separately required to arrange insurance to cover these costs, or if the risks of incurring catastrophic costs late in life were spread across a smaller part of the population.

The problem with the current arrangements is not the source of the financing arrangements or the way in which funds destined for aged care are collected, but the clarity and transparency of the arrangements for allocating those funds.

Under current arrangements, the allocation of funding for aged care has been subject to decisions in the annual budget process and one-off additional top-ups agreed from time to time outside the Budget. This has provided considerable flexibility for governments in responding to emerging needs within the aged care sector. However, it has also meant that funding for aged care has been determined through a series of trade-offs and compromises between aged care and other fiscal priorities. The absence of a robust system to measure the cost and price of aged care provision has also meant that it has been difficult to assess the adequacy of aged care provision. Over time, it is clear that the availability of funding has not kept pace with the need for aged care.

We have recommended that aged care should be established as a universal entitlement based on independent and clinically informed assessments of need (Recommendation 25) and the price of the provision of that care (Recommendation 115). With appropriate legislation to ensure that funds flow in accordance with these assessments, the universal entitlement should ensure that ongoing aged care needs are fully resourced.

To complement these measures, there would also be value in an earmarked aged care levy. This would provide a clear and public commitment to the ongoing funding of Australia's aged care obligations. It would establish an important social contract for the provision of high quality aged care, consistent with the recommendations in this report.

I do not support proposals to fund the entire costs of the aged care system from a fund financed by a hypothecated levy on personal income. I recommend instead an earmarked, non-hypothecated levy, like the Medicare levy, to fund a substantial part of the investment required to implement our recommendations to improve the quality and safety of aged care.

25.2 Alternative arrangements for financing aged care

Alternative arrangements for financing all or part of the costs of an aged care levy were canvassed in our Consultation Paper 2, *Financing Aged Care*.[1] While there was some support for a hypothecated levy to fund aged care in submissions provided in response to the Consultation Paper and in evidence, there were also very strong arguments against such an approach. In its response to our Consultation Paper, COTA Australia was concerned about the inflexibility of hypothecated taxes, arguing that:

> A more fully hypothecated levy designed to fully cover aged care could also become inflexible, constraining and perhaps not politically attractive to all taxpayers in the long term. Hypothecated levies are also not immune to changes in economic circumstances if tied to personal or corporate incomes.[2]

The Australian Treasury told us that it was not supportive of a hypothecated levy.[3] The Australian Treasury considered that hypothecating taxation revenue for a specific purpose, such as aged care, can limit a government's spending flexibility and inhibit its ability to manage its cash flows most efficiently. The Australian Treasury's view is that aged care should continue to be funded from general revenue.

I am concerned that any move to fund the bulk of aged care costs through a hypothecated levy on incomes would shift the burden of financing aged care costs from the much broader general revenue base to personal income tax taxpayers alone, and would require substantial increases in marginal tax rates for all income taxpayers.

Given the ageing of the Australian population, a levy rate set to fully finance the entire aged care system over a thirty-year period would represent an income transfer from younger taxpayers to older people about to enter aged care. The younger generation would

effectively be paying for current aged care costs and the aged care costs of baby boomers. This raises profound questions of intergenerational equity.

The Productivity Commission considered, and rejected, the case for a contributory social insurance scheme for aged care in its 2011 report *Caring for Older Australians.* The Productivity Commission concluded that 'the opportunity to smooth the higher costs associated with the bulge of baby boomers has largely passed'. [4] It is now too late to raise enough revenue to support baby boomers, the youngest of which will be aged 65 years by 2030. Professor Mike Woods, who led the Productivity Commission inquiry, confirmed in evidence to us that this is still his view.[5]

Mr Campbell Ansell of Ansell Strategic also told us that changes in Australia's demographic profile meant that the opportunity to address intergenerational inequities through a social insurance system has been missed. [6] Mr Arthur Koumekelis, a legal practitioner advising on aged care matters and a son of people receiving aged care, agreed that the time has passed to introduce social insurance.[7] Chartered Accountants Australia New Zealand reached a similar conclusion.[8]

I agree with these arguments. I consider that any proposal to fund the bulk of aged care costs through a hypothecated levy on individual taxable incomes, as part of a funding mechanism that would require today's taxpayers to pay more than the emerging costs of aged care, will jeopardise the widespread public acceptance of our recommendations to improve the quality and safety of our aged care system. Importantly, I am not convinced that such a mechanism is required to support the improvements in the quality and safety of care that we are seeking.

25.3 An aged care improvement levy: an investment in quality and safety

In my view, the continued financing of aged care through general revenue supported by revised means testing arrangements in Chapter 22 provides a simpler, more flexible and more equitable basis for long-term funding of the aged care system.

Overall, responses to our Consultation Paper favoured the continuation of a mixed funding approach comprised of taxpayer funding and user contributions on a 'pay as you go' basis. There was also strong support for some ongoing user contributions based on the principle that those with the means should pay and those without should be supported.

It is unnecessary to refinance the entire aged care system. All that needs to be done now is to finance the improvement in aged care services that we recommend in this report to provide a much better standard of aged care. As an intrinsic part of the social contract, the Australian Government would continue to finance aged care services from general revenue, providing additional funds to cover demographic changes, wage and cost increases and other system enhancements over time, while people receiving aged care make appropriate contributions to accommodation and other aged care services as their means permit.

Although responses to our Consultation Paper revealed a range of views around the desirability of a special aged care levy as a part of this financing mix, there was some support for a Medicare-style levy for aged care.[9] The Older Persons Advocacy Network indicated that in their consultations it was noted that people understand and appreciate the commitment made to all Australians through the Medicare levy and that a similar model could be logically extended to aged care.[10]

The Medicare levy is a non-hypothecated levy that contributes to the costs of Australia's public health system. The levy is a flat 2% of an individual's taxable income and is paid in addition to income tax. While the revenue raised by a non-hypothecated levy is notionally 'earmarked', the Australian Government is not legally obliged to spend those monies only on the purposes identified in the name of the levy. In a practical sense, this is not an issue in relation to the Medicare levy as the funds raised by the levy are far below the costs of the medical benefits and free public hospital treatment provided through the Medicare system.

The benefits of such a levy identified by submissions included greater funding certainty and improved transparency. Submissions indicated that there was widespread acceptance in the Australian community of the Medicare levy and that a similar arrangement for aged care would be appropriate. A number of submissions suggested that public support for the levy would be greater if it were seen as short term in nature, to remediate the obvious failings of the system or to kickstart additional funding for improvement of the system.[11] The Aged Care Guild suggested that:

> a short-term levy should be considered to offer the opportunity to ramp up funding to support the necessary immediate aged care reform which will need to flow from the Royal Commission. Any levy should be time limited.[12]

COTA Australia also acknowledged that a levy might be employed for a relatively short period to provide some certainty in building up the revenue base while another budgetary or financing mechanism is scaled up.[13]

A non-hypothecated levy to fund improvements in the aged care system could be readily accommodated within the current arrangements for financing government activities. Governments in Australia have regularly earmarked new taxes or levies for particular purposes without hypothecating the revenue that they collect. These levies are sometimes established as ongoing sources of funding, such as the Medicare levy and the Passenger Movement Charge. Governments have also established temporary levies to fund particular emergency and high priority purposes. Examples of these levies include the Temporary Budget Repair Levy, the Air Passenger Ticket Levy and the Queensland Flood Levy.

To strengthen the commitment to improving the quality and safety of aged care as part of the Australian social contract, I am recommending that the current arrangements be enhanced through the introduction of an ongoing non-hypothecated, earmarked levy. This levy should be known as the 'aged care improvement levy'. In my opinion, an appropriate rate for the new aged care improvement levy would be 1% of taxable personal income.

While the levy would be charged on individual incomes, all Australians would benefit from the improved quality and safety of aged care, consistent with our fundamental vision of universal access to aged care services, regardless of whether they had the opportunity to contribute directly to the cost of those services.

A Medicare-style levy along these lines would retain the simplicity, flexibility and efficiency of the current taxation system while providing an additional public commitment to the ongoing funding for the investments required to improve the quality and safety of aged care. The new aged care improvement levy will give taxpayers greater assurance about the investment in the quality and safety of aged care in this country that we are asking them to make.

We know that people are willing to pay more tax for a quality aged care system.[14] A study undertaken on our behalf by Flinders University on the views and preferences of the general public for quality of care and future funding showed community support for the introduction of a levy for aged care financing.[15] There were three key findings regarding aged care financing:

- The vast majority (87%) either 'agreed' or 'strongly agreed' that the Australian Government should provide more funding for aged care.
- Most members of the general public indicated that they would be willing to support aged care quality improvements by paying more tax. The majority of current income taxpayers (61%) indicated they would be willing to pay more income tax to support a quality aged care system.
- On average, these taxpayers were willing to pay an additional 1.4% per year to ensure that all Australians in need have access to a satisfactory level of quality aged care, and an additional 3.1% per year on average to ensure that all Australians in need have access to a high level of quality aged care.[16]

Australians are a generous people who will willingly contribute to improvements to the aged care system if they are convinced that the funds will be well directed. But they will want to see how their taxes are being used. An earmarked levy of 1% to contribute to funding the improvement that we are seeking in quality and safety will provide assurance for the public that the necessary investments will be made and will provide transparency about how these funds are employed.

A levy of this amount will make a significant contribution to meeting the costs of our aged care recommendations. Where there are extra costs, they should be met by the Australian Government from general revenue. In addition, the costs to the health and disability systems arising from our recommendations should also be met by the Australian Government from general revenue and from the National Disability Insurance Scheme respectively. Older people are entitled to access health and disability services outside the aged care system and their access to those services should not be dependent on the aged care improvement levy.

The earmarked aged care improvement levy will complement the current Australian Government funding of the aged care system through general revenue. While I recognise an earmarked levy would form only a part of the broader mix of general revenue, it is an important mechanism to achieve public support and improve transparency and accountability. It should be viewed as a modest investment in the urgent measures necessary to prevent continuing harm to older people and to improve the quality and safety of the system. It is not, of course, a substitute for the Australian Government's continuing obligation to fund from general revenue the growth in the system expected over coming decades to accommodate the ageing of the population, or its obligation to fund from general revenue continuing enhancements in the quality and safety of the system into the future.

Recommendation 144: Introduce a new earmarked aged care improvement levy

Commissioner Briggs

1. **By 1 July 2022, the Australian Government should introduce legislation to Parliament to establish an aged care improvement levy of a flat rate of 1% of taxable personal income. The levy imposed should be levied, and paid, for the financial year commencing on 1 July 2023 and for all subsequent financial years until the Parliament otherwise provides.**
2. **The legislation introducing the levy should be based on the *Medicare Levy Act 1986* (Cth).**

25.4 Conclusion

Our recommendations are designed to deliver high quality and safe aged care. The current level of Australian Government aged care funding is inadequate and does not cover the cost of providing high quality aged care. Our research has shown that Australians understand this and are prepared to support additional funding to finance the aged care system appropriately. The most straightforward way to do this is to introduce a new aged care improvement levy at the time the new aged care Act is introduced on 1 July 2023.

Endnotes

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26. Oversight, Implementation and Monitoring

> I've sat with the Royal Commission into deaths in custody. I've sat with the Bringing Them Home hearing; right? And out of all of them, hardly anything gets done, and is this one going to be the same?[1]

26.1 Introduction

Our inquiry into the quality and safety of aged care in Australia has revealed systemic flaws which in turn have caused a substandard level of care. In this volume, we have made a number of interconnected recommendations primarily aimed at the Australian Government. These are designed to reform the aged care system in far-reaching ways.

The Australian public is entitled to know how the Australian Government will implement our recommendations. Implementation is the primary measure of the effectiveness of a royal commission or public inquiry.[2] If the Government is not going to implement one or more of our recommendations, the public is entitled to know why. There should be ongoing monitoring and reporting arrangements to support the effective and transparent implementation of our recommendations.[3] These recommendations are intended to ensure that the Australian Government is accountable publicly for its responses to our prescriptions for change.

There are four aspects to the recommendations we make in this chapter. First, we propose a mechanism by which our recommendations can be implemented. Reforms of the magnitude we propose are complex and their implementation requires careful planning.[4] Because we differ on the most appropriate institutional arrangements for governance of the future aged care system, there are two versions of this mechanism, which flow through to other recommendations. However, we share the view that dedicated implementation arrangements are vitally important.

Second, we wish to see an independent statutory office holder charged with monitoring the implementation of the recommendations in the staged manner that we recommend and summarise later in this chapter. In our report, we propose the establishment of an Inspector-General of Aged Care. We are of the view that the Inspector-General will be well placed to perform this vital role of monitoring in the years ahead, together with the other roles that we have set out for them in this report.

Third, we address the transition from the current aged care system to the new system that will replace it. We recognise that parts of the aged care sector have been through a number of major changes in recent years, including a new regulator and a new set of Quality Standards. A number of these changes have been implemented during the life of our inquiry. The many further changes that we recommend will need to be implemented flexibly and sensitively.

Commissioner Pagone emphasises that, by 'flexibly and sensitively', he does not mean that the Government can implement the changes in a way that is not in line with the principles outlined in our report. Government must not simply announce its response to the recommendations and move on without genuine change. Government must account fully for its response to our recommendations and must explain to the Australian people why it decides, if it does decide, not to accept a recommendation or to accept it only 'in part' or only 'in principle'. The Government should also specifically and clearly explain why and how it is confident that high quality aged care will be available to those who need it where it has decided not to implement our recommendations.

Fourth, we make a small number of recommendations that are the responsibility of others to implement, and we expect the Government to monitor and report on progress in that regard.

In this chapter, we outline the arrangements that we consider are necessary to support the full implementation of our recommendations. We see the reforms that we recommend being implemented in four phases, namely:

- **Phase One:** urgently addressing some important deficiencies with the current arrangements, and begin establishing structural changes to support the reforms and the future operation of the aged care system. Timeframe: from delivery of report of this report to 31 December 2021.
- **Phases Two and Three**: rebuilding the institutions, legislation, funding, service delivery, culture and regulation of the aged care system to focus on delivering high quality aged care and support so as to improve the health and wellbeing of older people. Timeframe: 1 January 2022 to 31 December 2023.
- **Phase Four**: delivering a demand-driven, entitlement-based aged care system to allow for dignified living in old age, and begin reporting on the ongoing effectiveness of the aged care system. Timeframe: commencing no later than 2024.

Finally, while this chapter is necessarily focused on the process of implementation and transition, we make the point that process is vastly different to achieving outcomes. The successful implementation of our recommendations will depend on older peoples' experience of the aged care system improving significantly and on the outcomes achieved progressively for older people. For our reforms to make a genuine difference, the System Governor and the Inspector-General of Aged Care should be targeting in their evaluation work the impacts and outcomes for older people and their effect on older people's wellbeing, health, personal care and quality of life.

26.1.1 Approaches of other inquiries to implementation

The importance of the implementation of recommendations to the success of a royal commission or inquiry has been identified previously. In particular, previous inquiries have made recommendations for the establishment of mechanisms to maximise the chances of the successful implementation of their recommendations and to ensure public accountability. We have taken these experiences into account in this chapter.

The 2009 Victorian Bushfires Royal Commission is widely seen as a success because of the implementation of nearly all of its recommendations.[5] That Commission's *Final Report* recommended that an independent monitor or the Victorian Auditor-General oversee the progress of implementing its recommendations.[6] The Victorian Government appointed an independent Implementation Monitor who was tasked with delivery of a report by 31 July 2012. The monitor, former police Commissioner Neil Comrie AO, APM, delivered a further three reports.[7] In 2013, Mr Comrie's role was subsumed into a more general emergency management oversight role: the Inspector-General of Emergency Management.[8]

In a detailed examination of a number of Australian and overseas public inquiries, including the Victorian Bushfires Royal Commission, Dr Alistair Stark, lecturer in public policy at the University of Queensland, observed that 'inquiries can create mechanisms that will ensure that their lessons are actually institutionalised in the first instance and this can keep them alive, at least across the short-to-medium term'. Such mechanisms will mean that recommended changes 'have a greater chance of being hardwired into policy, legislation, and organisational components across the longer term'.[9]

The Royal Commission into Institutional Responses to Child Sexual Abuse's 2017 *Final Report* produced an entire volume dedicated to implementation: 'Beyond the Royal Commission'.[10] The purpose of the recommendations in that volume was 'to ensure that governments and institutions are held publicly accountable for their responses to these recommendations'.[11] It noted that 'Royal Commission reports are not self-executing documents' and 'without the commitment of governments to the implementation of our recommendations, the full benefit of the considerable investment made in the Royal Commission will not be realised'.[12]

Recommendation 17.1 of the Royal Commission into Institutional Responses to Child Sexual Abuse required a formal response to its *Final Report* from each of the Australian Government and State and Territory Governments within six months. Recommendation 17.2 was that the various governments report on the implementation of the recommendations by tabling five annual reports in their various parliaments. Finally, that Commission recommended that the Australian Government should initiate a 10-year review which should report on the implementation of the recommendations and 'advise on what further steps should be taken by governments and institutions to ensure continuing improvement in policy and service delivery in relation to child sexual abuse in institutional contexts'.[13]

It must be stressed, however, that regular reporting is not enough. Commissioner Pagone notes that the Royal Commission into Aboriginal Deaths in Custody made a number of recommendations about the need for ongoing reporting on the implementation of its recommendations.[14] These have been followed to an extent but the recommendations of that Royal Commission have not been fully implemented. The Australian Institute of Criminology noted in its 2018–19 statistical report that in the 28 years since that Royal Commission, 295 Aboriginal and Torres Strait Islander people had died in prison. In 2019, the imprisonment rate for Aboriginal and Torres Strait Islander people was 12 times the rate for other Australians and has increased by 35% since 2009 as compared with an increase of 26% for non-Aboriginal and Torres Strait Islander people.[15]

We have noted elsewhere that a failure to implement recommendations has been too common following inquiries into aged care. That is why we emphasise that reporting is a necessary, but not sufficient, requirement to impose upon government to ensure that our recommendations are implemented in a timely manner.

26.2 Oversight

In November 2020, the Australian Government reported to Parliament in response to the first recommendation of our special report *Aged care and COVID-19*.[16] It reported that each of the six recommendations were accepted by the Australian Government and explained what it had done to give effect to the recommendations. We consider that the Government should similarly report in response to the recommendations in our Final Report. The report should indicate whether each recommendation directed to the Australian Government is accepted, accepted in principle, rejected or subject to further consideration. The report should also include some detail about how the recommendations that are accepted will be implemented and should explain the reasons for any rejections.

Recommendation 145: Report on recommendations

By 31 May 2021, the Australian Government should report to Parliament about its response to the recommendations in our final report. The report should indicate whether each recommendation directed to the Australian Government is accepted, accepted in principle, rejected or subject to further consideration. The report should also include some detail about how the recommendations that are accepted will be implemented and should explain the reasons for any rejections.

The Inspector-General for Aged Care will then be responsible for monitoring the implementation of the recommendations. The Inspector-General should have the resources and powers necessary for that task and should report to the responsible Minister and to the Parliament at least every six months on the implementation of the recommendations for as long as the Inspector-General considers necessary.

In addition, the Inspector-General of Aged Care should undertake independent evaluations of the effectiveness of the measures and actions taken in response to the recommendations of the Royal Commission, at intervals of five and 10 years after the tabling of the Final Report.

26.3 Implementation

Implementation of the reforms on the scale that we propose is transformational and will take genuine commitment by government. Even with such commitment, implementation of the necessary changes can be disrupted by many factors. Many of our recommendations are dependent on the successful implementation of other recommendations. For example, our recommendation about minimum staffing levels in residential aged care cannot be implemented without reform of the funding system. A number of our recommendations have very tight timeframes and will require urgent action on several fronts, including working with State and Territory Governments and other bodies. Delay in the implementation of the reforms that need to come first will disrupt the implementation of later ones. It is also necessary to cater for unforeseen disruptions by building flexibility into the mechanisms for implementation of the reforms.

There must be clear accountability for implementation. Implementation must be monitored constantly, reviewed regularly and have the continuous backing of the Government. The attention of political leadership will likely shift with crises, elections and other pressing challenges, but securing government and ministerial engagement for seeing the change through is essential. For this reason, we recommend that the Inspector-General of Aged Care conduct independent evaluations of the effectiveness of the measures and actions taken in response to the recommendations. These evaluations should occur five and 10 years after the tabling of our Final Report**.**

The Australian Department of Health has had responsibility for formulating aged care policy for many years. It will continue to play a key role under our proposed new system, although how extensive that role will be will depend on which of our governance models is implemented.[17]

Commissioner Pagone considers that it is appropriate for an entity other than the Department to be given responsibility for implementing the Royal Commission's recommendations. He proposes a new unit dedicated to the specific task of implementation of system-wide reform. The unit should be part of the Department of the Prime Minister and Cabinet and should be properly staffed and resourced to implement and direct implementation of the Royal Commission's recommendations. This implementation unit should, in the short term, be constituted under administrative arrangements. In due course, if the Australian Aged Care Commission is formally established under statute, from that point onward it would become the implementation authority and would carry on the work of implementation.

Consistent with Commissioner Briggs's recommendation that the Australian Department of Health and Aged Care step up and take a much stronger leadership and stewardship role of the aged care system, she considers that an implementation taskforce should be established within the Department of Health and Aged Care and should be responsible for implementation of our recommendations.

While we differ about who should have responsibility for monitoring the implementation of our recommendations, we agree on the importance of the matters outlined in this chapter and on the importance of coherence and transparency in implementation. In this chapter, we refer to the body responsible for implementation, regardless of which approach is adopted, as the 'implementation body'.

Whether the implementation body is located in the Department of Health and Aged Care or the Department of the Prime Minister and Cabinet, it will need a strong leader who is supported by a steering committee of deputy secretaries from relevant existing policy agencies. These policy agencies may include:

- Department of the Prime Minister and Cabinet
- Department of the Treasury
- Department of Finance
- Department of Health and Aged Care
- Department of Home Affairs
- Department of Social Services
- Department of Education, Skills and Employment
- Attorney-General's Department
- Department of Veterans' Affairs
- National Indigenous Australians Agency.

The implementation body must have adequate time and resources to undertake the implementation work. It must be in a position to work quickly to identify and mobilise the necessary skills, resources and systems across government and the wider aged care sector to support implementation.

In Recommendation 148, we recommend that the Inspector-General of Aged Care should monitor and report on the work of the implementation body. We propose that the office of the Inspector-General of Aged Care be established by legislation as a matter of priority and no later than 1 July 2021. This should not await the passage of the new Act but should be effected by a standalone Bill. The drafting task appears relatively straightforward on the basis of available precedents.[18]

26.3.1 Framework for implementation

In undertaking their work, the relevant officers and bodies described in our recommendations should be guided by the following framework for the implementation of our recommendations. It will be necessary that those implementing our recommendations have a clear understanding of the basis for each recommendation. The basis for each recommendation has been described in the preceding chapters and the context for them in the other volumes of our report.

The Implementation Monitor for the 2009 Victorian Bushfires Royal Commission identified that implementing the policy intent of the recommendations may sometimes be more important than strictly following the letter of a recommendation. In 2018, the Implementation Monitor for that Royal Commission, Mr Neil Comrie AO, APM, explained:

> With the development of better technology and further research, in a number of instances we actually found that there was a better way to do something than what the State had originally committed to. That's where I was able to exercise my judgment and say well, on the one hand, while the State has committed to do A, B is in fact the better way of achieving this outcome. So it was—I guess you could say it was a dynamic environment where we weren't locked in.[19]

The approach to implementation needs to be adaptive. Those charged with implementation need to recognise that the policy will be shaped and reshaped at all phases of implementation and that there will be significant behavioural and cultural change required of government, providers and to the broader Australian society.

In implementing our recommendations, the Australian Government will need to communicate its intentions frequently, clearly and in a timely manner. As part of the implementation process, the Government will need to consult with those people receiving aged care, their families, their carers, their friends and their advocates, as well as with aged care providers, the aged care workforce and other bodies that represent the various interests in the sector. This consultation and collaboration will necessitate clear communication about what is happening and when.

We consider that a phased approach should be adopted in the implementation of our recommendations. This phased approach should be guided by a transparent transition and implementation plan. This plan needs to be sufficiently flexible and be capable of adaptation should the need arise during implementation, especially if there are delays in the legislative process.

The reforms that we recommend will require major changes in policy and operations for the entire aged care system over an extended period of time, and will need to be carefully managed. Above all, the transition must ensure continuity of aged care services for all people who need them.

Recommendation 146: An implementation unit

Commissioner Pagone

1. **Pending the establishment under the new Act of the Australian Aged Care Commission, an administrative unit or body should forthwith be established by the Australian Government (through the Australian Department of the Prime Minister and Cabinet) and properly staffed and resourced to implement and direct implementation of the Royal Commission's recommendations (implementation unit).**
2. **From the commencement of the new Act, the Australian Aged Care Commission should implement and direct implementation of the recommendations of the Royal Commission.**

Recommendation 147: An implementation taskforce

Commissioner Briggs

The Australian Department of Health and Aged Care should promptly establish a taskforce to implement and direct implementation of the Royal Commission's recommendations, supported by a cross-department Deputy Secretary Steering Committee on Aged Care Reform.

Recommendation 148: Evaluation of effectiveness

1. **The Inspector-General of Aged Care should monitor the implementation of recommendations and should report to the responsible Minister and directly to the Parliament at least every six months on the implementation of the recommendations.**
2. **The Inspector-General of Aged Care should undertake independent evaluations of the effectiveness of the measures and actions taken in response to the recommendations of the Royal Commission, five and 10 years after the tabling of the Final Report.**
3. **The Inspector-General of Aged Care should report on these evaluations five and 10 years after the tabling of the Final Report.**

26.3.2 Timeline for implementation: institutional arrangements

In Chapter 2, on the governance of the aged care system, we each make recommendations about the governance of the new aged care system and about establishment of the institutions that we consider will improve the system.

We differ on the institutional form that certain aspects of these governance arrangements should take in the new system. The model that Commissioner Pagone recommends—the Independent Commission model—involves greater independence from the Australian Government of the institutions that he proposes should govern the system. The model that Commissioner Briggs recommends—the Government Leadership model—supports greater independence in certain areas such as standard setting, quality regulation and pricing, but a stronger role for government leadership overall supported by reformed existing institutions. Commissioner Briggs considers that this will deliver aged care reform quicker and more effectively.

We set out in the following table the dates by which the institutional arrangements under our respective models are to take effect.

Date	Independent Commission model (Commissioner Pagone)	Government Leadership model (Commissioner Briggs)
	A Minister remains responsible for aged care and the Portfolio Minister for the relevant portfolio continues to have responsibility for aged care in Cabinet	Cabinet Minister for Health and Aged Care Department of Health renamed Department of Health and Aged Care
1 July 2021	Australian Aged Care Pricing Authority	Independent Hospital and Aged Care Pricing Authority
1 July 2021	Inspector-General of Aged Care established	Inspector-General of Aged Care established
1 July 2021	Australian Commission on Safety and Quality in Health Care becomes the Australian Commission on Safety and Quality in Health and Aged Care	Australian Commission on Safety and Quality in Health Care becomes the Australian Commission on Safety and Quality in Health and Aged Care
1 July 2021		The Council of Elders established
1 July 2021	Aged Care Advisory Council established by administrative means to assist the implementation body	
By 31 December 2021	Aboriginal and Torres Strait Islander Aged Care Commissioner appointed by administrative arrangement	Aboriginal and Torres Strait Islander Aged Care Commissioner appointed by administrative arrangement
1 July 2022		Aged Care Quality and Safety Commission abolished and Aged Care Safety and Quality Authority commences
1 July 2023	Australian Aged Care Commission established by the new Act	
1 July 2023	Aged Care Advisory Council established by the new Act	

26.3.3 Timeline for implementation: policy reforms

We propose that the Australian Government should implement our policy reforms in four phases. There is necessary overlap between the phases and some decision-making will be required by the implementation body.

In Phase One it will be necessary for the Government to determine which institutional model will be adopted. This decision will in turn inform Phases Two and Three.

We accept that the detail of implementation is a matter for the Australian Government. We do not want to be overly prescriptive. Our recommendations should be read and understood having regard to the purpose of each of them and the content of our report as a whole.

Phase One—Urgent

The first phase of implementation includes urgent reforms. Phase One will run until the end of 2021, a period of 10 months from delivery of this report to the Governor-General. The urgent reforms require immediate action for reasons which are explained elsewhere in our report.

During this phase we expect that the Home Care Package waiting list will be cleared and by the end of it there will be no younger people entering residential aged care except in exceptional circumstances. The Inspector-General of Aged Care will be appointed during this phase as will the Aboriginal and Torres Strait Islander Commissioner.

One of the key tasks of the Inspector-General is to monitor and report on progress of the implementation of our recommendations. For this reason, the Australian Government should prioritise the administrative appointment and legislative establishment of the office of the Inspector-General of Aged Care. The Inspector-General should report to the responsible Minister and to the Parliament at least every six months on the implementation of the recommendations, commencing on 26 August 2021.

Overview of Phase One policy reforms

DATE	ACTIVITY
Immediate	An implementation body is established
Immediate	Work on the strategy to develop the integrated system for the long-term support and care of older people commences and a new National Cabinet Reform Committee on Ageing and Older Australians is established
Immediate	The Australian Government expands the National Mandatory Indicator Program as detailed in the 2019 PricewaterhouseCoopers Consultation Paper 'Development of Residential Aged Care Quality Indicators'
1 May 2021	An independent capability review of the Aged Care Quality and Safety Commission commences
31 May 2021	The Australian Government responds to the Aged Care Royal Commission's recommendations
1 July 2021	Inspector-General of Aged Care established
1 July 2021	Australian Commission on Safety and Quality in Health Care becomes the Australian Commission on Safety and Quality in Health and Aged Care
1 July 2021	Commissioner Pagone: The Independent Aged Care Pricing Authority commences
1 July 2021	Commissioner Briggs: The renamed Independent Hospital and Aged Care Pricing Authority commences
1 July 2021	Commissioner Briggs: The Australian Health Practitioner Regulation Agency starts examining whether the occupation of 'personal care worker' should be registered under the National Registration and Accreditation Scheme
1 July 2021	Commissioner Pagone: An inquiry on the adoption of an appropriately designed financing scheme based upon the imposition of a hypothecated levy through the taxation system is referred to the Productivity Commission
1 July 2021	Commissioner Briggs: The Council of Elders is established
1 July 2021	Commissioner Pagone: The Aged Care Advisory Council is established by administrative arrangement
1 July 2021	Aged care volunteers are better aided, the Community Visitor Scheme is renamed Aged Care Volunteer Visitor Scheme and provided additional funding. The National Aged Care Advocacy Program is provided with additional funding.
1 July 2021	Commissioner Briggs: Approved providers are required to demonstrate the appropriate leadership qualifications and development of staff
1 July 2021	The Rural Health Outreach Fund is enhanced to improve access to medical specialists for people receiving aged care
1 July 2021	Beginning of yearly increases in indexation arrangements for residential aged care and home care subsidies and viability supplements

DATE	ACTIVITY
1 July 2021	An increased residential aged care Basic Daily Fee becomes available
1 July 2021	A scheme to fund providers for the education and training of the direct aged care workforce becomes available
1 July 2021	Development of ongoing professional development courses for the aged care workforce commences and a scheme to fund aged care providers for the education and training of the direct care workforce becomes available
1 July 2021	The experiences of people receiving aged care are given greater weight in accreditation and compliance processes
1 July 2021	Commissioner Briggs: The Quality Regulator is required to provide addition information in its public reporting on the effectiveness of the regulatory system
1 July 2021	The Australian Commission on Safety and Quality in Health Care is renamed the Australian Commission on Safety and Quality in Health and Aged Care and commences an urgent of the Aged Care Quality Standards
15 July 2021	The Australian Commission on Safety and Quality in Health and Aged Care is conferred responsibility for introduction, implementation and amendment of aged care quality indicators
1 September 2021	Home care providers are paid on accrual for the services they have delivered or liabilities incurred from Home Care Packages
From 1 October 2021	A new expanded serious incident reporting scheme is established
1 November 2021	The Health National Cabinet Reform Committee to require the Australian Health Ministers' Advisory Council consider and report to it our recommendations relating to access to health care and establish a standing item to be discussed at all meetings of the Council
1 November 2021	A range of amendments to the Medicare Benefits Schedule are made to improve access to medical, allied health and telehealth services for people receiving aged care
1 November 2021	The Pharmaceutical Benefits Scheme Schedule is amended to restrict the prescription of antipsychotic medications in residential aged care
1 December 2021	Aged care staff are required to provide paramedics who are called to a residential aged care facility with an up-to-date summary of the resident's health status, including medications and advance care directives
1 December 2021	The Multi-Purpose Services Program is extended
31 December 2021	The Home Care Package waiting list, otherwise known as the National Prioritisation System, is cleared. A short-term program giving people longer to accept Home Care Packages and linking them to appropriate providers commences.
31 December 2021	The Aboriginal and Torres Strait Islander Commissioner is appointed under administrative arrangement

DATE	ACTIVITY
31 December 2021	The Royal Australian College of General Practitioners amends its accreditation standards to facilitate more general practitioner services to people receiving aged care
31 December 2021	The responsibilities of aged care providers, as well as State and Territory Governments, in the delivery of health care to people receiving aged care services are clearly defined
31 December 2021	Aged care quality monitoring and regulatory powers are increased
By 31 December 2021	The *Quality of Care Principles 2014* (Cth) are amended to clarify the role and responsibilities of approved providers to deliver health care to people receiving aged care
By 1 January 2022	The *Quality of Care Principles 2014* (Cth) are amended to update arrangements on the use of restraints in aged care
By 1 January 2022	The Australian Government establishes the Aged Care Workforce Planning Division that manages an Aged Care Workforce Fund
By 1 January 2022	Approved provider governance is improved and made more transparent. An ongoing program commences to assist approved providers to improve their governance arrangements, including care governance
By 1 January 2022	Local Hospital Network Multidisciplinary Outreach Services are introduced and access to mental health services for people receiving aged care is improved
By 1 January 2022	The Australian Government implement the recommendations of the independent capability review of the Aged Care Quality and Safety Commission
By January 2022	A review of certificate-based aged care courses is undertaken

Phase Two—Rebuild

Phase Two should commence on 1 January 2022 and will encompass implementation of the new policy framework. During this year, key workforce reforms should be introduced, in addition to measures to improve the corporate governance of approved providers. The casemix funding system is to be implemented. A standard dataset and data collection mechanism is to be established. We expect that strengthened enforcement powers will be enacted and quality indicators for care at home implemented.

Overview of Phase Two policy reforms

DATE	ACTIVITY
From 1 January 2022	No person under the age of 45 years lives in residential aged care and no person under the age of 65 years enters residential aged care, other than in exceptional circumstances
From 1 January 2022	Commissioner Briggs: approved providers, and any third parties they contract with, must have policies and procedures that preference the direct employment of workers Quality reviews will assess compliance with those procedures as well as the extent to which independent contractors are used
From 1 January 2022	Additional capital grants for building or upgrading 'small household' models of residential aged care become available
From 1 January 2022	Pharmacists start conducting medication management reviews for people in residential aged care
30 June 2022	Commissioner Briggs: the Aged Care Workforce Industry Council Limited should review skills framework, standardise job design and help support applications to the Fair Work Commission to improve wages in aged care
1 July 2022	Commissioner Briggs: Aged Care Quality and Safety Commission abolished and Aged Care Safety and Quality Authority commences
1 July 2022	The Australian Commission on Safety and Quality in Health and Aged Care commences a periodic review of the Aged Care Quality Standards
1 July 2022	Reporting and benchmarking of provider performance against quality indicators is implemented
1 July 2022	A system of star ratings is developed by the Australian Government and published on My Aged Care
1 July 2022	The strategy for improved public awareness of aged care is implemented
1 July 2022	Requirements are introduced to improve aged care services to people from diverse backgrounds and life experiences, and a standard dataset and data collection mechanism concerning diversity is established
1 July 2022	Care managers are assigned to people accessing residential aged care and, where required, care at home
1 July 2022	Enhanced respite support, social support, and assistive technology and home modification categories of aged care commence Contributions are abolished and combined block and activity based funding for these categories commences
1 July 2022	Any older person accessing the Home Care Packages Program can also access supports from the new respite or social support grant categories
1 July 2022	Requirements to improve aged care services to Aboriginal and Torres Strait Islander people commence
1 July 2022	An interim aged care workforce strategy and planning framework for 2022–25 is prepared

DATE	ACTIVITY
1 July 2022	The Aged Care Workforce Industry Council Limited, including the Australian Government as a member, begins mapping and promoting career pathways in the aged care sector
1 July 2022	A registration scheme for personal care workers is established, including mandatory minimum qualifications
1 July 2022	Aged care providers are required to train staff in dementia and palliative care
1 July 2022	A minimum staff time standard in residential aged care is introduced and approved providers are required to publicly report on staffing hours
1 July 2022	Services and support for informal carers are improved and a consultative review of the National Aged Care Advocacy Program commences
1 July 2022	The National Aged Care Design Principles and Guidelines for residential aged care accommodation are released
1 July 2022	Reports on compliance with protocols for discharging residents from hospital to residential aged care are publicly released
1 July 2022	An aged care identifier is introduced to link multiple datasets across health and aged care systems
1 July 2022	Aged care providers universally adopt digital technology and My Health Record
1 July 2022	The National Health Reform Agreement includes explicit commitments by State and Territory Governments to provide health services to people receiving aged care
1 July 2022	A casemix-adjusted activity based funding classification system is implemented for residential aged care, including incentives for an enablement approach to residential care
1 July 2022	Approved providers are given graded performance assessments against the Aged Care Quality Standards
1 July 2022	Aged care providers must deliver standardised statements to people receiving care at home Commissioner Briggs: these statements are to have contact time detailed
1 July 2022	The Australian Institute of Health and Welfare takes on responsibility for aged care data, including data governance and the development of an aged care national minimum dataset
1 July 2022	A dedicated Aged Care Research and Innovation Council is established and funded
1 July 2022	Commissioner Briggs: investment in information and communication technology and architecture commences along with the development of an Aged Care Information and Communications Technology Strategy

DATE	ACTIVITY
1 July 2022	Commissioner Briggs: under the Government Leadership Model, the System Governor becomes the Prudential Regulator and develops prudential standards and a financial reporting framework for the aged care sector
1 July 2022	Commissioner Briggs: legislation is introduced to Parliament to establish an aged care improvement levy at a flat rate percent of taxable personal income commences
1 July 2022	The Inspector-General of Aged Care presents its first annual report on systemic issues in the aged care system
30 Sept 2022	Commissioner Briggs: the Australian Government examines the potential impact of providing additional entitlement to unpaid carer's leave and makes its findings public by 31 December 2022
1 December 2022	A comprehensive National Aboriginal and Torres Strait Islander Aged Care Workforce Plan is developed and funded
31 December 2022	The Australian Commission on Safety and Quality in Health and Aged Care completes the urgent review of the Aged Care Quality Standards, including the details of a new aged care governance standard
By 1 January 2023	The dementia support pathway is established
By 1 January 2023	A Senior Dental Benefits Scheme is established

Phase Three—Build and Operate

Phase Three should commence in January 2023 and include the commencement of secondary reforms that require the steps in Phase One to have been taken. This phase will involve the establishment of the new institutional framework and will involve further policy reform. If the Independent Commission model is adopted, the Australian Aged Care Commission will be established. As part of this phase, the single aged care assessment process will commence.

Overview of Phase Three policy reforms

DATE	ACTIVITY
By 1 July 2023	The Australian Health Ministers' Advisory Council announces its determination of whether to regulate 'personal care worker (health)' or 'assistant in nursing' under the National Registration and Accreditation Scheme
1 July 2023	The new Act commences, introducing new aged care principles, embedding high quality and safe aged care, bringing a focus on the rights of people receiving aged care, changes to fees and contributions, protection for whistleblowers, improved complaints processes and accountability measures The Aboriginal and Torres Strait Islander Aged Care Pathway commences
1 July 2023	Commissioner Pagone: the Australian Aged Care Commission is established
1 July 2023	Commissioner Pagone: under the Independent Commission model, the Australian Aged Care Commission becomes the Prudential Regulator and develops prudential standards and a financial reporting framework for the aged care sector
1 July 2023	Commissioner Briggs: a 'care finders' workforce to advise older people, their families and carers commences
1 July 2023	The Australian Government reviews and publishes a report on specialist dementia care services
1 July 2023	Quality indicators for residential aged care are expanded and quality indicators for care at home are developed
1 July 2023	A single aged care assessment process commences
1 July 2023	Allied health is better embedded in aged care at home assessments and funding processes
1 July 2023 – 1 July 2025	To support the transition to the new care at home categories, the aged care assessment workforce is increased
1 July 2023	Aged care teaching programs are funded
1 July 2023	A community-based Carers Hub network is established, and recognition of, and supports for, primary informal carers improve
1 July 2023	A range of measures improves linkages between health and aged care national minimum datasets
1 December 2023	All older people assessed for aged care in their home should be assessed for both a Home Care Package and the equivalent classification in the new care at home category

Phase Four—Extend and Consolidate

Phase Four should commence no later than 2024. In this phase, the new aged care program, including residential care and care at home service arrangements, will be operational. There will be universal entitlement to aged care based on assessed need. This phase also coincides with the first five-yearly evaluation to be conducted by the Inspector-General of Aged Care, due in February 2026, by which time the reforms that are detailed in our recommendations should be finalised.

Overview of Phase Four policy reforms

DATE	ACTIVITY
2024	Commissioner Briggs: The Department of Health and Aged Care starts to deliver its triennial 'state of the aged care' reports
1 January 2024	A new voluntary primary health care model to improve access for people received aged care is either trialled or implemented
July 2024	Commissioner Briggs: the Department of Health and Aged Care delivers the first of its annual reports to Parliament on the operation of the new Act
By 1 July 2024	The Disability Discrimination Commissioner and the Age Discrimination Commissioner present their first annual report on the numbers of people aged 65 years or older with disability receiving aged care services equivalent to those available to them under the National Disability Insurance Scheme
1 July 2024	Commissioner Pagone: The first annual report on the operation of the Act is published by the Australian Aged Care Commission
1 July 2024	The new aged care program, including residential care and care at home service and funding arrangements, are operational. A new aged care provider approval and high-level home care accreditation processes commence
1 July 2024	The national audit evaluating services to people from diverse backgrounds and life experiences is completed and commissioning to address gaps in services commences
1 July 2024	Allied health is better embedded in residential aged care assessment and funding processes, including the potential to engage allied health professionals
1 July 2024 until 1 July 2025	Any older people who are still accessing the Home Care Package Program should be assessed for a care at home classification and access the most advantageous of the two
1 July 2024	The Aged Care Provision Ratio is replaced with the new aged care planning regime
1 July 2024	The minimum staff time standard in residential aged care is increased
1 July 2024	People aged over 65 years are able to access disability supports equivalent to those that would be available to them under the National Disability Insurance Scheme

DATE	ACTIVITY
1 July 2024	Funding for a person receiving care at home in accordance with their assessed needs is to be provided but limited to the amount of funding available to them if they were assessed for care at a residential aged care service
1 July 2024	Commissioner Briggs: new funding model for care at home commences
31 December 2024	The report by the System Governor on the extent to which the aged care system is meeting the needs of older people with diverse backgrounds and life experiences is provided to the Inspector-General and the public
1 January 2025	No person under the age of 65 years lives in residential aged care, other than in exceptional circumstances
1 July 2025	A 10-year aged care workforce strategy and planning framework is prepared
1 July 2025	First publication regarding the National Aged Care Data Asset
1 July 2025	Commissioner Briggs: the Australian Government starts to phase out Refundable Accommodation Deposits
February 2026	The Inspector-General of Aged Care completes the five-year report on the implementation of the Aged Care Royal Commission recommendations

26.4 Conclusion

Since the enactment of the *Aged Care Act 1997* (Cth), there have been numerous inquiries and reviews into aspects of the aged care system.[20] Government implementation of the recommendations of these previous inquiries has been patchy. This has been caused, at least in part, by inadequate implementation and monitoring mechanisms.

Government responses to these earlier inquiries have, in some cases, come months or even years after the relevant review or report and some have only partially addressed relevant recommendations. Responses have been expressed in an ambiguous manner. In other cases, even when there has been an expressed commitment to implement change, actual reform has been slow to eventuate and the will for reform has cooled before implementation has been achieved.

As COTA Australia submits, if recommendations are not implemented as quickly as possible, 'history tells us that a highly conservative and change averse aged care provider sector and the fundamental ageism in our community and body politic will combine, as they have in the past, to put fundamental change on the back burner'.[21]

The public is entitled to know how the recommendations we have made as a result of our long and thorough inquiry are being implemented. It is vital that the Australian Government's response to our report is made public and monitored on an ongoing basis by an independent Inspector-General of Aged Care.

Endnotes

1 Transcript, Uncle Brian Campbell, Melbourne Hearing 2, 11 October 2019 at T5712.23–25.
2 Australian Law Reform Commission, *Making Inquiries Report – A new statutory framework*, 2009, p 165 [7.43].
3 See, for example, Royal Commission into the Management of Police Informants*, Final Report,* 2020, Vol 4, p 153.
4 See, for example, Transcript, Nicholas Hartland, Adelaide Workshop 1, 11 February 2020 at T7816.6–10.
5 A Stark, *Public Inquiries, Policy Learning and the Threat of Future Crises*, 2018, pp 122–123.
6 Victorian Bushfires Royal Commission, *Final Report*: *Summary*, 2010, pp 20–21, 37 [Recommendation 66].
7 This appointment was formalised in 2011 with the passage of the *Bushfires Royal Commission Implementation Monitor Act 2011* (Vic).
8 *Emergency Management Act 2013* (Vic), s 64(1)(ba), (ca).
9 A Stark, *Public Inquiries, Policy Learning and the Threat of Future Crises*, 2018, p 123.
10 Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report,* 2017, Vol 17.
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14 Royal Commission into Aboriginal Deaths in Custody, *National Report,* 1991, Vol 1, http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol1/24.html, viewed 22 December 2020.
15 L Doherty & S Bricknell, 'Deaths in custody in Australia 2018-19', *Australian Institute of Criminology*, 2020, p 4, https://www.aic.gov.au/publications/sr/sr31, viewed 21 December 2020.
16 Australian Government, *Australian Government Implementation Progress Report on the Royal Commission into Aged Care Quality and Safety report: Aged Care and COVID-19: a special report*, 2020.
17 See Chapter 2 of this volume.
18 See, for example, Inspector-General of Live Animal Exports under the *Inspector-General of Live Animal Exports Act 2019* (Cth); Inspector-General of Biosecurity under the *Biosecurity Act 2015* (Cth) ch 10, pt 6.
19 Neil Comrie, *Implementation Monitor for the Victorian Bushfires Royal Commission*, quoted in A Stark, *Public Inquiries, Policy Learning and the Threat of Future Crises*, 2018, p 115.
20 Office of the Royal Commission, *A History of Aged Care Reviews*, Background Paper 8, 2019.
21 COTA Australia, Public submission, AWF.670.00031.0001 at 0010.

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