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Submission to Community Affairs Legislation Committee Inquiry into the Aged Care Bill 2024 and related initiatives

Thank you for the opportunity to provide a submission to the Community Affairs Legislation Committee Inquiry into the Aged Care Bill 2024 and related initiatives. This introduction summarises my professional and academic background. The following sections then address selective key issues that the inquiry is considering.

I am Adjunct Professor of Health Services Research at the University of New South Wales and at the Queensland University of Technology. I am also the Director of my own private consulting, evaluation and advisory company.

I was the inaugural Professor of Health Services Research and Foundation Director of the Australian Health Services Research Institute (AHSRI) at the University of Wollongong, positions I held from 1997 until my retirement from the University of Wollongong at the beginning of 2023.

In 2008 I was awarded an Honorary Life Fellowship of the Australasian Faculty of Rehabilitation Medicine for my contribution to the development of rehabilitation in Australia. In 2010 I was awarded an Honorary Life Membership of the Australian Healthcare and Hospitals Association for my contributions to the Australian health system. In 2015 I won the Professional Award of the Health Services Research Association of Australia and New Zealand for my services to the profession of health services research.

I was made a Member of the Order of Australia in 2024 for my contribution to the community through my research and development work. I am on the Board of NSW Meals on Wheels and on the National Suicide Prevention Office Advisory Board.

I have undertaken extensive work in the aged care system over the last two decades. I designed the national funding model for residential aged care and worked as an adviser to the Aged Care Royal Commission.

I have authored over 600 articles, papers and reports on wide-ranging health service and health system issues including health care management, health outcomes, information systems and funding of the Australia and New Zealand health and community care systems. I am internationally recognised in particular for my work in casemix classification development, funding system design, consumer/patient reported outcome measurement and value-based health and social care. I am well known for my cutting edge work in palliative care, rehabilitation, mental health and aged care.

I have led casemix classification and funding system design programs in Australia and internationally since the early 1990s. In addition to the Australian National Aged Care Classification (AN-ACC) for residential aged care, I developed the Australian National Subacute and Non-Acute Patient (AN-SNAP) classification which is now the Australian national standard for palliative care, rehabilitation, geriatric



evaluation and management, psychogeriatric and maintenance and supportive care in Australia. Most recently I developed a new ambulatory care casemix classification for the Kingdom of Saudi Arabia.

I have led two major studies that are directly relevant to the Aged Care Bill. The first is the 'Resource Utilisation and Classification Study' (RUCS), which was commissioned by the Commonwealth Department of Health following an earlier study that I led in 2017. The 2017 study evaluated alternative aged care assessment, classification system and funding models for the residential aged care sector. The aims of the RUCS were to identify the characteristics of aged care residents that influence the cost of the care they receive; to identify the factors that drive the cost of care; and to develop a new classification and funding model for residential aged care.

The second study was commissioned by the Royal Commission into Aged Care Quality and Safety (the Commission) and involved an analysis of international and national staffing profiles in order to better understand how staffing can be improved in Australia. This included a literature review on international and national models of staffing in residential aged care facilities and a quantitative analysis of Australian practices benchmarked against the standards in use in other countries. The staff ratios and levels that I recommended based on this study have now been adopted by the Government as the Australian national standard.

I believe that my broad experience of over more than 40 years, in combination with the specialist work I have done in aged care in recent years, makes me qualified to provide an expert opinion on the matters being considered by the Community Affairs Legislation Committee Inquiry into the Aged Care Bill 2024.

Overview

The new Aged Care Act is welcome and is long overdue. I will leave others to comment on the detail of the proposed new Act while I focus on issues to do with implementation.

My overarching comment is that the new Aged Care Act simply entrenches the existing aged care system, albeit with minor wording and technical changes. To describe this as the biggest reform in decades is simply misguided. The changes being proposed are marginal improvements on the status quo. Any marginal improvement is welcome. But these changes do not address the fundamental problems underlying aged care. It is inevitable that aged care will be back in crisis within a few years.

Aged care as a social good and not just a market

Included in this submission is an attachment that contains a copy of an article I wrote and that was published in John Menadue's Pearls and Irritations on 4 April 2024. The headline is "Albanese government wedged on aged care". Having now seen the draft legislation and the proposed administrative and financial changes being proposed, I am disappointed to conclude that nothing has changed.

The final section of that article sets out the need for a courageous aged care reform agenda and national leadership. To quote it:

'There is no problem with wealthier older people paying more for their care in old age. However, increased user charges must come with big strings attached. It is also essential that aged care is aligned



with a national social housing strategy and that there is improved integration between aged care and health care.

But these changes alone will not be enough to put aged care on a sustainable footing going forward. The reality is that aged care will never be a real competitive private market, the mere idea is simply an illusion. Aged care will always be substantially funded by taxpayers with consumer contributions representing only a small fraction of the total cost. A sustainable aged care system starts with recognising that reality.

A sustainable aged care system necessarily includes a bill of rights, a commitment to equity and a future aged care levy to sit alongside the Medicare levy. An aged care levy can be designed in a way that would not create further intergenerational inequity. For example, it would be possible to introduce an aged care levy or insurance scheme that does not kick in until a taxpayer turns 40.

But first things first. There is no point considering options such as a levy while aged care continues to be framed as a competitive private for-profit market. The electorate would not accept paying extra taxes to fund uncapped profits for providers. Yet taxpayers will continue to fund the majority of aged care costs regardless of the financing arrangements. Reframing aged care as a taxpayer funded social good is the essential first step in genuine and sustainable reform.'

In my view the proposed new Aged Care Act and associated changes represents a lost opportunity to genuinely fix aged care once and for all. I have no doubt that, within only a matter of years, the sector will be back in crisis and that aged care will require a substantial injection of taxpayer funds. Among other issues, the numbers announced by the Government as part of this reform simply don't add up.

Financing and funding: the numbers don't add up

The government claims that the net impact of the changes is a massive \$12.6 billion saving over the next 11 years.

As a result of the reforms, the government is claiming that, by 2034-35:

- Annual growth in spending on aged care over the decade will decline from 5.7% to 5.2%. This is in the context of the significant wave of baby boomers who will enter aged care over the next decade.
- Aged care spending as a share of GDP is projected to decline from 1.5% of GDP to 1.4%, even as the number of participants and the quality of care increase.

The Government currently pays 76% of residential care costs and 95% of home care costs. The government claims that these will fall to 73% and 89% respectively.

The government further claims these considerable savings to government will be borne by half of the people using aged care. These claims include that:

- Half of new residents will not contribute more under the new consumer contributions:
- All "fully supported" residents will not contribute more.
- Seven in ten full pensioners will not contribute more.
- One in four part pensioners will not contribute more.



Having analysed publicly available population and income data from the Australian Bureau of Statistics and superannuation data from the Association of Superannuation Funds of Australia Limited (ASFA) and the Australian Prudential Regulation Authority (APRA), I do not find these figures to be credible.

Table 1 shows the typical annual charges that are implied in the proposals for a self-funded retiree in residential care. The figures in this table are based on the resident electing to pay a Daily Accommodation Payment (DAP). The suggestion that any significant number of self-funded retirees have more than \$120,000 per annum to contribute to their aged care really needs to be tested. It is simply not plausible based on the data I have analysed, particularly as the family home is exempt.

Table 1 *Typical annual charges for a self-funded retiree in residential care*

Component	Calculation	Cost per annum
Accommodation	Daily Accommodation Payment (DAP) option	\$62,700
Basic Daily Fee	85% of single pension	\$23,200
Hotelling supplement	Means tested contribution calculated as 7.8% of assets over \$238,000 or 50% of income over \$95,400 (or a combination of both), up to a limit of the Hotelling Supplement (\$12.55 per day, as at September 2024)	\$4,581
Clinical care		\$0
Non clinical care	Non-clinical care contribution (NCCC). This component only is capped at 4 years of payments or \$130,000 whichever comes first	\$36,923
Total	DAP option	\$127,404

In relation to home care charges, Table 2 shows the co-payments that are proposed. In reviewing this table, it is important to highlight that clinical care represents only a minority of the care that people receive in the community. The major needs are for services to support independence and everyday living, both of which will incur considerable consumer co-payments.

Table 2 *Percentage charges for older people receiving Support at Home*

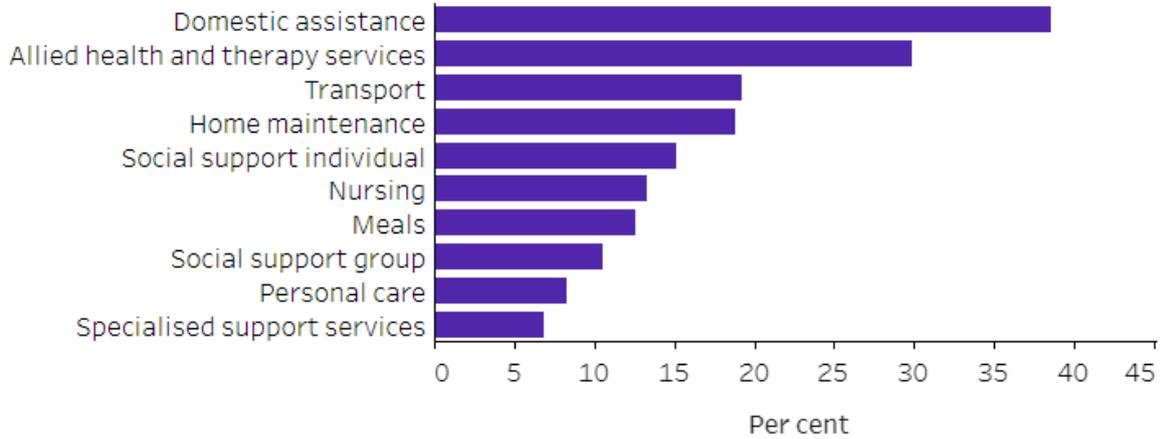
Income source	Clinical care	Independence	Everyday living
Full pensioner	0.0%	5.0%	17.5%
Part pensioner and Commonwealth seniors health card eligible	0.0%	Between 5% and 50% depending on income and assets	Between 17.5% and 80% depending on income and assets
Self-funded retiree	0.0%	50.0%	80.0%

This can be seen clearly in Figure 1 which was produced by the Australian Institute of Health and Welfare.¹ Domestic assistance is the most commonly required service. Clinical care (allied health and nursing represent) only a small proportion of the services that people living at home are receiving. This is unlikely to change into the future.

¹ https://www.gen-agedcaredata.gov.au/topics/people-s-care-needs-in-aged-care#Care_needs_in_the_community



Figure 1 *Proportion of home support recipients using ten most commonly used services 2022-2023*



Source: Aged care data snapshot 2023.
Note: Only the top ten home support services are listed.
GEN-agedcaredata.gov.au

It appears that there has been a failure to recognise that older people with the means to do so already make a substantial contribution to the cost of their care. While existing consumer payments represent only a small percentage of the cost of aged care, they already represent a significant percentage of the savings that older people hold, especially because the family home is exempt.

The more likely scenario is that very few aged care recipients are in a position to pay the substantial capital and other charges embedded in these reforms. This is particularly the case based on an analysis of the most recent data on incomes, pensions and superannuation held by older people.

Figure 2 summarises ABS population data and pension data for people aged 65 years and older. It will be seen that 58.5% of all older people are on a full or part aged care pension. But this figure is misleading as it includes more than 2 million Australians in age groups with a very low need for aged care.

Figure 2 *Population and pension data people 65 years and older*

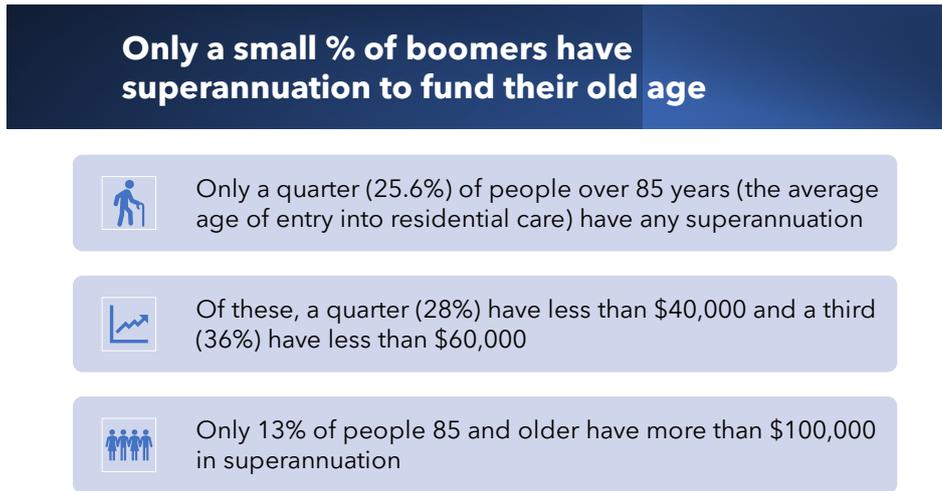
As age increases, so does the percentage on the aged pension

Age group	Population	Aged pension	Percent
65-69	1,090,818	342,890	31.4%
70-74	1,190,130	690,820	58.0%
75-79	980,493	653,985	66.7%
80-84	616,377	464,010	75.3%
85-89	364,607	291,295	79.9%
90 and over	209,078	163,190	78.1%
Total	4,451,503	2,606,195	58.5%



The average age of entry into residential care is 85 years and, among the oldest age groups, nearly 80% are in receipt of a government pension. There are two main reasons to explain this. One reason is that people use up their superannuation (as they are meant to do) and then move to the pension. Another is that men are more likely to have superannuation and more likely to have larger contributions. Men die at a much younger age than women.

Figure 3 Superannuation profile of people 85 years and older



Financial capacity to pay the significant increases in charges that are proposed needs to be calculated based on the age of those people who need aged care, not on all people 65 and older. The average age of entry into residential aged care is 85 years and Figure 3 profiles superannuation among this older age group. Only 13% of people aged 85 and over have more than \$100,000 in superannuation. Superannuation savings of \$100,000 will barely pay for one year in residential care under the proposed new fee structure.

By age 85, three quarters of people are on a pension and two thirds of these are on a full pension. The idea that part pensioners and self-funded retirees will generate \$12.6 billion of savings for the government over the next decade is simply not plausible.

I recommend that the Inquiry request the detail of the economic modelling that was undertaken and the assumptions that were made in the process and that the Inquiry subject this economic modelling to independent review.

Even if the projections that underpin the government projections are correct, taxpayers will continue to fund the lion's share of aged care. Minister Mark Butler recognises this. In an interview on ABC Adelaide on 18 September, he said: "Currently, taxpayers fund about 95% of the cost of home care. Once these changes are in place, taxpayers will still fund 89% of the costs of home care. So still, the vast bulk of the system is funded from the Budget, so from existing taxpayers who are working right now."²

² https://www.theweeklysource.com.au/aged-care/aged-care-providers-ready-to-go-with-new-bed-development-following-reforms-butler?utm_campaign=The%20Weekly%20Source&utm_medium=email&_hsenc=p2ANqtz-9xlnLRnf7dKWZhdUOcXQHeFuJQwSoeKSURdAXmtZJnKMI5q9JOrWRnDy3Ei04L3njxRwo_cjt7fKk37vamevlw182Yg&_hsmi=325323564&utm_content=325323564&utm_source=hs_email



The reality of aged care is that taxpayers will always have to contribute at least 80% of the costs of aged care. This is the case whether aged care is delivered as a social care system or as a private-for-profit market.

The alternative to the model embedded in the proposed new Aged Care Act is a social care system which would cost taxpayers significantly less and deliver safer and better care than an aged care market model.

Accommodation charges

The government has announced that the lifetime cap on consumer contributions will be lifted to \$130,000. However, this lifetime cap only applies to what the government refers to as the Non-Clinical Care Contribution (NCCC). **There is no lifetime cap on accommodation charges or other costs that consumers will pay.**

The government plans to maintain the current approach whereby consumers get the choice of paying for accommodation via either a Refundable Accommodation Deposit (RADs) or a Daily Accommodation Payment (DAP). The two major changes to the RAD are that providers will now be able to charge \$750,000 without seeking approval and that the RAD will now be only partially refundable. If a person pays a PRAD (Partially Refundable Accommodation Deposit) of, say, \$750,000, they will not receive the whole sum back when they leave aged care. The provider will be eligible to keep 2% per annum or, in the current example, \$75,000 if the resident stays for 5 years.

The DAP is based on the RAD for the specific home that the resident moves to. The government will continue to set a maximum permissible interest rate (MPIR), which is the interest rate used to calculate a DAP. The MPIR is set well above commercial interest rates and the Inquiry may wish to explore why this is the case. It is currently 8.36% per annum, close to twice the official interest rate.

Continuing with the example of a person moving to aged care with a room price of \$750,000, the DAP is calculated at 8.36% per annum:

$$\text{DAP} = 8.36\% \times \$750,000 \text{ per annum} = \$62,700 \text{ per annum} = \$172 \text{ per day.}$$

Neither the MPIR nor the room price are linked to the actual cost of capital. The government sets the MPIR without needing to justify it or link it to official interest rates and providers are free to charge what the market can bear up to \$750,000 without needing to justify it.

I recommend that the Inquiry investigate the basis on which the MPIR is set with a view to recommending that it be linked to the official interest rate. I further recommend that the Inquiry explore the way that capital is funded in countries with mixed provision systems including Japan and the Netherlands.

Support at Home

Table 3 summarises the profile of people currently using aged care. Of the 1.3 million current aged care recipients, almost two thirds are in receipt of services funded and delivered through the Commonwealth Home Support Program (CHSP). With only one third as many care recipients as CHSP, the Home Care Package (HCP) is the second largest element of the aged care program. Only 14% of care recipients are in residential care but this 14% represent about two thirds of all aged care funding.



Table 3 *Profile of people using aged care in 2023*

Service	Number 2023	Percent
Commonwealth Home Support Program (CHSP)	816,132	64%
Home care packages (HCP) - 4 levels	258,374	20%
Permanent residential care	184,163	14%
Respite residential care	8,072	1%
Short-term restorative care	1,374	0%
Transition care	3,099	0%
Total	1,271,214	100%

This table will surprise anyone reading through the material that the government released when it introduced the bill and publicly launched its proposals for changed administrative and financial arrangements. While CHSP delivers services to 74% of people in recipient of care at home, CHSP is barely mentioned.

The two existing home programs (CHSP and HCP) are very different in how they are regulated and funded.

CHSP is a grant-funded program which funds well-known services such as Meals on Wheels, community transport and day programs for socially isolated older people as well as some allied health and services such as respite, home nursing and home modifications. CHSP evolved from a previous cost shared program called Home and Community Care (HACC). It has traditionally involved state and local government service providers as well as not-for-profit organisations including churches, civic and non-government organisations. It is no secret that public servants in the Department of Health and Aged Care have a strong dislike of this program and have wanted to kill it off for some years.

HCP is a program that allocates a budget to an individual consumer rather than funds to an aged care agency. It is based on market principles where care recipients are 'purchasers' who can shop around in the private for profit and the non-profit market. While some HCP services are delivered by non-profit organisations, the majority of the growth in HCP is in the entry and expansion of for-profit providers.

The focus of the current government community aged care reforms is on establishing a new Support at Home (SAH). Planning for SAH pre-dates the Aged Care Royal Commission and its roll out is now several years behind schedule.

Table 4 summarises the core of the SAH model. Care recipients will be assessed and assigned to one of 8 classification levels. The assessment is additive in design. The more needs the person has, the higher the level. 10% of the funds for each person will be automatically quarantined for 'care management'. This 10% has been deducted from the indicative funding of each class to calculate the figures in the table. It is important to note that these figures are inclusive of the modelled consumer contributions. Consumer contributions will range from 0% to 80% of each service. There are also two time-limited programs called 'Restorative Care' and 'End of Life Pathway'.

The final column in this table shows the indicative service hours at each level. The highest (Level 8) will fund about 17 hours of care at home a week. With 168 hours in a week, a person on a Level 8 package can expect to have onsite support for no more than about 10% of the time. This might be sufficient to delay entry into residential care for someone with a co-resident partner/carer or a support person who



lives very close to them. It is questionable whether this will be enough to delay entry into residential care for a person who lives alone or a couple who are equally frail with high care needs.

Table 4 Proposed funding of new Support At Home program (including consumer charges)

Support Classification	Per year (after 10% case management fee)	Per quarter (after 10% case management fee)	Per week (after 10% case management fee)	Approx hours per week
1	\$9,900	\$2,475	\$190	2
2	\$14,400	\$3,600	\$277	3
3	\$19,800	\$4,950	\$381	5
4	\$27,000	\$6,750	\$519	6
5	\$36,000	\$9,000	\$692	9
6	\$43,200	\$10,800	\$831	10
7	\$52,200	\$13,050	\$1,004	13
8	\$70,200	\$17,550	\$1,350	17
Restorative Care (12 weeks)		\$5,400	\$450	6
End of life Pathway (12 weeks)		\$22,500	\$1,875	23

The HCP is now to be rolled into the new SAH program from 2025. However, it already appears to be well behind schedule for a July 2025 start date at this stage.

The original plan was that CHSP would be rolled into SAH at the same time. Minister Mark Butler is commended for his decision in 2023 to not include CHSP in the 2025 SAH rollout. It is not well suited to SAH and, with three out of four home care recipients receiving CHSP services, it is too big to risk failing by inclusion in SAH. The current plan is that CHSP will be rolled into SAH 'no earlier than 2027'.

In my opinion the Support at Home program is very poorly designed from both a provider and a consumer perspective. While it meets the needs of the public servants administering the scheme, it is administratively inefficient, creates the wrong incentives and will not meet the needs of current and future consumers. The approach to individualised funding that underpins it is more about transferring financial risk from government and providers onto older persons than it is about giving improved choice and control to older people or improving the quality and range of services they receive. It will certainly not reduce demand for residential care.

In this context, it would be prudent for the Inquiry to further investigate the proposed design of SAH and consider recommending that:

1. The Commonwealth proceed to develop a comprehensive Support at Home Aged Care (SAHAC) program. It would have two service delivery options, not one as currently proposed. The same range and quantum of services would be the same in the two options, the only difference is in how each option is managed and funded.
2. CHSP be reinvigorated as the not-for-profit *Grant-funding* service delivery option within SAHAC.
3. HSP be renamed as the *Personalised funding* service delivery option within SAHAC.
4. A person needing aged care would be assessed with the new aged care assessment tool. The assessment would be proportional to the service being requested. For example, if someone



needs only transport or meals, the assessment is a simple online or over the phone assessment and only one or two sections is completed.

5. Having been assessed, the older person would be given two options:
 - a. The Grant funding option. The person might be required to make a financial contribution but would not need to manage within a quarterly budget and market model.
 - b. The Personalised funding option. As per the current proposals for SAH, the person will be allocated their own budget to spend each quarter and will be allowed to carry over \$1000 each quarter if it is not all spent.

Based on experience internationally, as well as the experience of older people in the NDIS, it can be expected that about 90% of older people would prefer the not-for-profit Grant funding option and about 10% would prefer the Personalised funding option.

A fallback position if the government is not open to this more flexible and person-centred approach is to recommend that the government maintain its position on CHSP. That is, CHSP will not be rolled into SAH until at least 2027 and that it add the words "if at all".

Perverse and unintended consequences

These reforms will create some perverse and unintended consequences that I urge the Community Affairs Legislation Committee to explore. This is particularly the case for part pensioners and self-funded retirees.

The message that this package of reforms sends to the community is that older people with means should:

- invest in the most expensive family home they can
- draw down the rest of their superannuation by spending up big as fast as they can and
- move to a full aged care pension as soon as possible.

These perverse incentives are not in the interests of either older people or society in general.

At a time when we have a national housing crisis, these reforms incentivise older people to hold onto their family homes and not downsize to something smaller that will better meet their needs as they age. We should be aiming to do the reverse - to help and create financial incentives for older people to downsize as their needs change. This has advantages both for the older people and also for younger people trying to buy into the housing market.

A flow on effect of the substantial increase in charges for residential care is that, in a significant number of cases, they will increase the time that older people spend in public hospitals. We are already hearing anecdotal reports of older hospital patients who require residential care refusing a placement and/or delaying as long as they can because of the cost. A day in a public hospital is expensive for government but free for the self-funded retiree. A day in an aged care home costs government three to five times less but will cost a self-funded retiree up to \$180 and more a day. The Commonwealth can expect to see increasing waiting lists and cost pressures on public hospitals and should anticipate that states and territories will expect financial compensation for the significant additional costs they are likely to incur.



Using publicly funded health and hospital care to avoid aged care with its high fees represents a saving for the older person and for the aged care budget. But it represents a significant increase in costs that must be met by taxpayers and governments. This is indeed poor social and economic policy.

On the other hand, the incentive created by the fee structure of the proposed Support at Home program is that part pensioners and self-funded retirees will increasingly purchase support for everyday living outside the regulated aged care system and instead purchase what they need through the cash economy. When an older person is contributing 80% of the cost, it will be cheaper for them to purchase via the unregulated cash economy. This significantly increases the risk for the older person, especially those with cognitive impairments.

The final perverse outcome I wish to highlight is the impact that this increasing marketisation of aged care will have on community engagement and volunteering into the future. As I outlined above, the government seems intent on destroying the Commonwealth Home Support Program (CHSP) by rolling in into Support at Home some time after 2027. This will have devastating consequences on numerous CHSP services that depend on volunteers. The COVID lockdown damaged most volunteer services and many are still not fully rebuilt. Being rolled into Support at Home will be the final straw. Why would any volunteer wish to continue given the bureaucratic burdens and commercial culture they will need to operate in? Just like care recipients, volunteers do not want to engage in a commercial transaction-based aged care system. They, like older people themselves, value and want to engage in a relationship-based aged care system.

Final questions

I finish by posing questions for members of the Inquiry:

Where do the rights of older people fit into aged care delivered as a competitive for-profit market?

Who will carry the financial risk if the financial projections underpinning these reforms prove to be wrong? How will Government respond if providers lobby within a few years for more funding because the projections on which these reforms rely turn out to be wrong?

Does the Inquiry believe that, just like any real market, aged care 'consumers' can and should 'shop around' for the deal that suits them best? If so, how does this sit with our duty of care to protect society's most vulnerable citizens?

What will happen to those consumers who can't shop around?

Why are we asking taxpayers to pay a substantial profit margin to national and multinational companies?

Given that taxpayers will continue to pay at least 80% of the cost of aged care, why are we asking young people to subsidise aged care through their taxes rather than introducing an aged care levy that does not kick in until the taxpayer is midway through their working life at around 40 years of age?

Why is Australia, one of the richest countries in the world, not delivering a world class aged care system based on principles of human rights and social insurance?



Attachment

Albanese government wedged on aged care

<https://johnmenadue.com/albanese-government-wedged-on-aged-care/> 4 April 2024

With a Medicare-style levy and changes to the treatment of family home both ruled out, the only choice left is more user-pays. But it will not be enough.

The long-awaited Aged Care Taskforce report has finally been released. It had been established in mid 2023 with the goal of making aged care "[equitable and sustainable into the future](#)".

Older people contribute now to the cost of their care

In reviewing the recommendations of the Taskforce, the starting point is to recognise that older people with the means to do so already make a substantial contribution to the cost of their care. Aged care consists of three elements and the current approach is that there are different arrangements for each element:

- *Accommodation*: accommodation charges are means-tested. People moving to residential care with the means to do so are expected to fund their own accommodation either in the form of a one-off lump sum Refundable Accommodation Deposit (RAD) or a Daily Accommodation Payment (DAP). [The RAD is refunded when you leave, the DAP is not.](#)
- *Daily living*: a basic daily fee is charged (currently 85% of the pension) for everyday living expenses such as food, linen and cleaning. Homes can charge extra for extra services.
- *Care*: there is a means-tested care fee for all older people receiving care in either their own home or in a residential care facility. [The current means-tested care fee is currently between \\$0 and \\$416.15 a day.](#)

There are annual and lifetime caps on user charges. [The maximum charges a consumer can be charged is capped at \\$33,000 a year or \\$80,000 in a lifetime.](#) All charges are means-tested based on both assets and income. The value of the family home is capped at \$200,000 for the purposes of the assets test.

Options for raising more funding for aged care

There are several broad options for funding increases in a human service such as aged care and these options were available to the Aged Care Funding Taskforce. It was also open to the Aged Care Taskforce to make recommendations that included a mix of options.

One option for increasing funding for human services is to ask taxpayers to pay more, either in the form of a levy or by an increase in the tax rate. Medicare and the NDIS are both funded by way of a levy, with taxpayers contributing to the costs according to their means. The levies that taxpayers pay do not actually cover the full cost, with the rest of the costs being funded from general revenue.

Governments use levies and taxes to fund human services that taxpayers perceive to be a social good. Medicare is the best example. Public schools, disability support, public housing, child protection and justice services are also examples of human services that we as a society all fund as social goods.



Another option to increase funding is that consumers pay more for the services they receive. This can be in the form of higher user charges. But it can also be achieved by changing the means-testing threshold or other technical changes such as how the family home is treated for the purposes of the assets test.

Funding more services by increasing user charges is compatible with a competitive market model of human services. In the context of aged care, increasing user charges makes most sense when the starting point assumption is that aged care is a competitive private market with older people as 'consumers' buying the services they want/need. Increasing user charges will, at least in theory, allow older people to buy more or better services and to move their business elsewhere if they are not getting what they want. While that is the theory, it rarely works like this in practice.

The Aged Care Taskforce

The Taskforce was chaired by Anika Wells, Minister for Aged Care, and was composed of aged care sector representatives, most with vested interests. Its key recommendation is that older people should pay more. This should not surprise anyone.

The Taskforce and the government ruled out both a Medicare-style levy and changes to the treatment of family home. That meant there was no other option but to recommend more user charges.

It made 23 recommendations. In summary, older people with financial capacity will pay more whether at home or in a home. There are no proposals for a policy on profit and no requirement for providers to spend the extra money that people will have to pay on more or better services.

No wonder the aged care sector response to the Aged Care Taskforce is so positive. It is exactly what providers wanted.

The aged care industry is estimating that, if all recommendations are taken up by Government, older people using aged care services will be asked to pay an [extra \\$3.4 billion a year](#). Residential aged care revenue will increase by around \$2.3 billion per year and Home Care by a possible \$965 million.

If the estimate for residential care is correct, that is the equivalent of more than \$10,000 extra per resident per year. Based on estimates by Anna Howe, [only about half of aged care recipients have a capacity to pay](#).

Taking this into account (which the Taskforce proposes) means that the remaining 50% would be required to contribute an average of more than \$20,000 a year on top of what they are already paying.

While user charges currently represent only about 25% of funding for residential aged care home funding (including pension contributions) and 5% of home care funding, they represent a considerably higher proportion of the income of the older people who are paying the contributions.

Rich baby boomers

We baby boomers are the richest generation in history. But there is more to the story.

There are actually two groups of baby boomers and their old age is already very different. Those with good superannuation (largely men) live comfortably in old age, especially if they own their own home. Those without good superannuation (largely women) have little, especially non homeowners.



While many boomers aim to leave their superannuation to their children rather than spend it on their old age, there are many boomers who have never been able to buy a home and who are entering retirement with no superannuation, no secure housing and no inheritance for their children.

Superannuation is only a small part of the solution

While the idea that a major increase in aged care can be funded from superannuation savings is superficially appealing, it is not a realistic solution.

Anna Howe recently highlighted a 2021 report of the Association of Superannuation Funds of Australia stating that 80% of people who died over age 60 had no superannuation left four years before death. While many people have superannuation at retirement, those funds are rapidly depleted.

By age 85 (the average age that people enter residential care), only 20% of superannuants have balances of \$50,000 or more. [That will not be enough to pay for extra aged care for more than a year or two.](#)

Recent wage rises increase the stakes

Large, and completely justified, aged care wage rises have been awarded by the Fair Work Commission, the first 15% on 2023 and the remainder in March 2024. Together, they increase the cost of aged care by about \$14.6 billion over four years.

This is in addition to current expenditure. When consumer co-payments are your only source of funding for growth, those pay rises would require an average consumer increase of more than \$7,000 a year. This would need to be paid each year by the half a million aged care consumers who are estimated to have the capacity to pay. This is on top of existing charges. That is simply not feasible. Government will have to continue to fund the majority of costs.

The Taskforce recommendations won't fix the problem

At best the Taskforce solutions are only a temporary solution. And that is the best case scenario. The reality is that the Albanese government has been firmly wedged on aged care. With a Medicare-style levy and changes to the treatment of family home both ruled out, the only choice left for the Taskforce was to recommend more user-pays. But the reality is that, even with increased charges, it will not be enough. Taxpayers will have to fund the bulk of the increasing costs into the future.

What is not in the Aged Care Taskforce report

The unstated assumption of the Aged Care Taskforce is that aged care is a competitive private market. People 'consuming' aged care should pay more to buy the services they want or need.

There is no recognition in the Taskforce Report that aged care could be better framed as a social good, and not just a market. This would have been consistent with Labor values. But such an option is not even mentioned. Instead, the starting point is an implicit assumption that the [Albanese Labor government is building on the reforms initiated by the previous Howard Coalition government.](#)

Given this, there was no option but to rule out a levy or increases in general taxes to fund increases or improvements in aged care. The Taskforce knew it would not be politically palatable. Not only would a standard additional tax or levy create further intergenerational equity, it would raise bigger issues.



Even the Aged Care Taskforce (comprised of industry representatives) could not bring itself to recommend that taxpayers be asked to pay a levy or more taxes for a for-profit aged care system in which providers are free to take out any extra money as pure profit.

Real aged care reform

Instead of continuing to tinker, it is still possible for the Albanese government to genuinely reform aged care in its next term in government in a way that is consistent with traditional Labor values. Instead of aged care being framed as a competitive for-profit market, Labor would reposition aged care to sit alongside Medicare:

- A national universal access program in which older people are entitled to care based on their needs.
- A publicly funded and regulated aged care system that is agnostic about the legal status of providers. Providers may be government, not for profit or for-profit organisations.
- While consumer co-payments will continue to be paid, the significant majority of costs are, and will continue to be, met by taxpayers.
- A national social care program with public accountability.

Positioning aged care alongside Medicare is an essential step in making aged care sustainable into the future. Medicare is a national publicly funded and regulated program with mixed providers (government and non-government) and some co-payments. Medicare is understood and supported as a public program and enjoys overwhelming public support. This extends to support for paying a 'Medicare levy' and a willingness to pay more for better health care. While there are many private providers, no one would conceptualise Medicare as a private market. Aged care should be no different.

Time for a courageous aged care reform agenda and national leadership

There is no problem with wealthier older people paying more for their care in old age. However, increased user charges must come with big strings attached. It is also essential that aged care is aligned with a national social housing strategy and that there is improved integration between aged care and health care.

But these changes alone will not be enough to put aged care on a sustainable footing going forward. The reality is that aged care will never be a real competitive private market, the mere idea is simply an illusion. Aged care will always be substantially funded by taxpayers with consumer contributions representing only a small fraction of the total cost. A sustainable aged care system starts with recognising that reality.

A sustainable aged care system necessarily includes a bill of rights, a commitment to equity and a future aged care levy to sit alongside the Medicare levy. An aged care levy can be designed in a way that would not create further intergenerational inequity. For example, it would be possible to introduce an aged care levy or insurance scheme that does not kick in until a taxpayer turns 40.

But first things first. There is no point considering options such as a levy while aged care continues to be framed as a competitive private for-profit market. The electorate would not accept paying extra taxes to fund uncapped profits for providers. Yet taxpayers will continue to fund the majority of aged care costs regardless of the financing arrangements. Reframing aged care as a taxpayer funded social good is the essential first step in genuine and sustainable reform.