



Royal Commission
into Aged Care Quality and Safety

AGED CARE REFORM: PROJECTING FUTURE IMPACTS

RESEARCH PAPER 11

SEPTEMBER 2020

The Royal Commission into Aged Care Quality and Safety was established by Letters Patent on 8 October 2018. Replacement Letters Patent were issued on 6 December 2018, and amended on 13 September 2019 and 25 June 2020.

The Honourable Tony Pagone QC and Ms Lynelle Briggs AO have been appointed as Royal Commissioners. They are required to provide a final report by 26 February 2021.

The Royal Commission releases consultation, research and background papers. This research paper has been prepared by Deloitte Access Economics for the information of Commissioners and the public. The views expressed in this paper are not necessarily the views of the Commissioners.

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Aged care reform: projecting future impacts

A report for the Royal Commission into Aged Care Quality and Safety

July 2020

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Glossary

Acronym	Full name
ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Instrument
AIHW	Australian Institute of Health and Welfare
AN-ACC	Australian National Aged Care Classification
ANZSIC	Australian New Zealand Standard Industrial Classification
CES	Constant Elasticity of Substitution
CHSP	Commonwealth Home Support Programme
CMS	Centres for Medicare and Medicaid Services
CTP	Capacity to Pay Cohorts
DESE	Department of Education Skills and Employment
DOH	Department of Health
DSS	Department of Social Services
DTTL	Deloitte Touche Tomatsu Limited
DVA	Department of Veterans Affairs
EN	Enrolled Nurse
FTE	Full Time Equivalent
GDP	Gross Domestic Product
GFS	Government Finance Statistics
GP	General Practitioner
GVA	Gross Value Added
HCP	Home Care Package
HILDA	Household Income and Labour Dynamics
HTML	Hyper Text Markup Language
IO	Informal Only care
LHS	Left Hand Side
NCVER	National Centre for Vocational Education Research
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
PAYG	Pay As You Go
PCA	Personal Care Assistant
RHS	Right Hand Side
RN	Registered Nurse
SDAC	Survey of Disability Ageing and Carers
VHC	Veterans' Home Care

Executive summary

The terms of reference of the Royal Commission into Aged Care Quality and Safety (the Commission) includes consideration of the future challenges and opportunities for delivering accessible, affordable and high quality aged care services in Australia in the context of changing demographics and preferences, in particular people's desire to remain living at home as they age.

In its interim report the Commission identified a pattern of societal neglect surrounding aged care that has left services fragmented, unsupported and underfunded. There is a need for significant reform to improve the quality of aged care and ensure older Australians have access to the care they need.

Understanding how potential reforms might impact on the operations of the sector, its workforce and required levels of funding are important parts of the overall picture of the future of aged care in Australia. With that in mind, the Royal Commission asked Deloitte Access Economics to develop a detailed economic scenario model of the aged care sector to help inform the Commission's work.

The model is designed to consider the impact of policy change over the period to 2050 presented relative to a baseline scenario defined by the assumption that current aged care policy will remain unchanged. It's acknowledged that policy will change over time which is why the baseline scenario should be viewed as a neutral reference case rather than an attempt to accurately forecast the future of the sector. The baseline does not attempt to incorporate policy changes that have or may come about as a result of Coronavirus (COVID-19) on the aged care sector or the broader economy.

Australia's future aged care needs – baseline scenario

The baseline scenario foresees strong growth in demand for care across residential aged care, Home Care Packages (HCP) and the Commonwealth Home Support Program (CHSP) as the Australian population ages. The rise in demand is tempered by an improvement in the physical health of older Australians over time and it is expected that a preference for ageing in the home will persist.

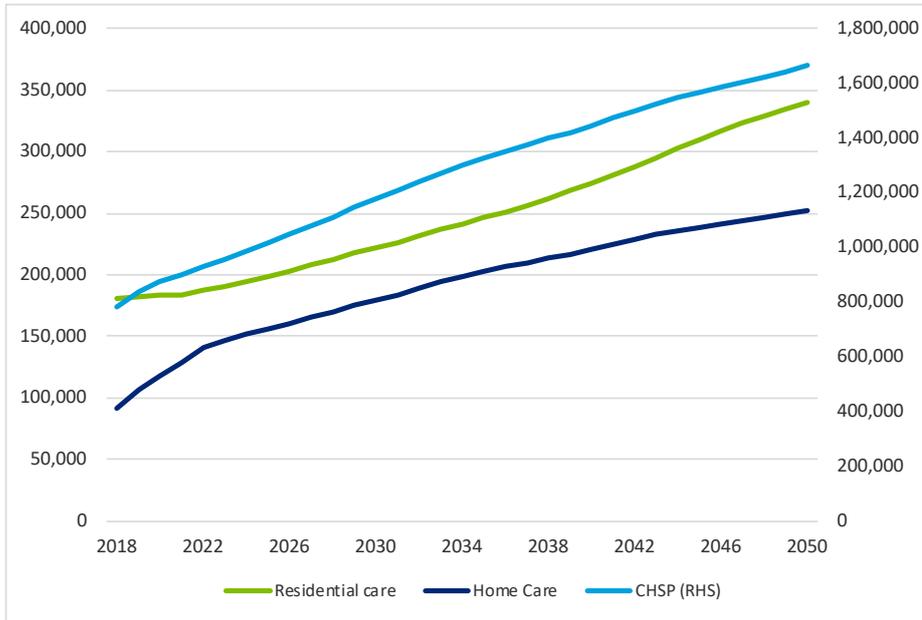
The Commonwealth Home Support Programme will remain the largest program in terms of recipients to 2050. However, Home Care Packages will experience the strongest growth, particularly in the early years given a significant rise in the supply of packages under currently announced policy.

Quality of care is expected to gradually rise over time and productivity improvements enables this to occur despite a slow reduction in staff time spent with each care recipient per day.

Workforce pressure is expected to persist in the sector as demand for workers grow significantly faster than economy wide employment growth. This will induce wages to rise faster in this sector than the broader economy to attract qualified staff.

With this in mind, not only will a larger number of older Australians require care, but the cost of that care will rise as the sector grapples with rapid growth.

Figure A: Aged care recipients in major programmes – baseline



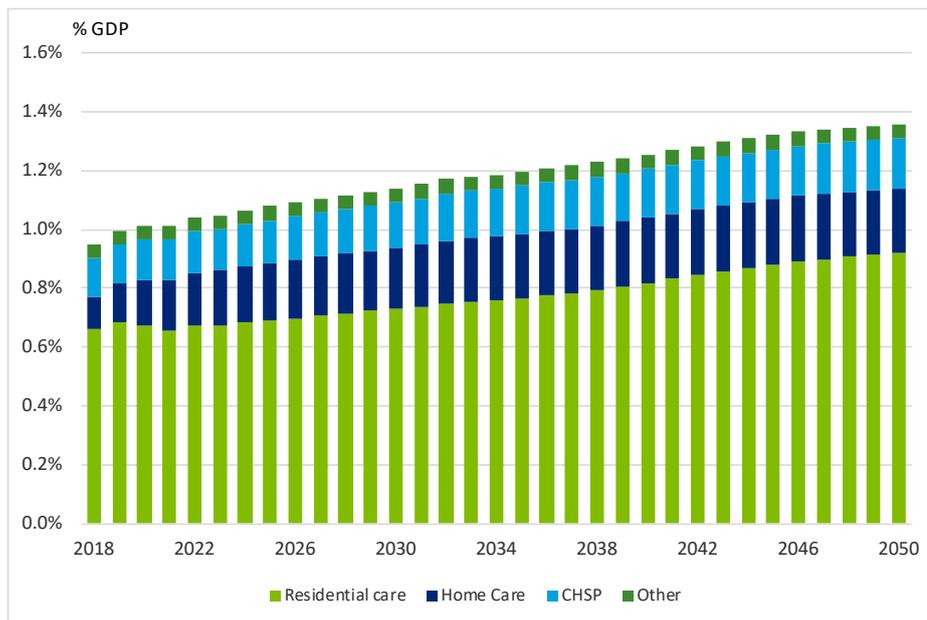
On the other hand, older Australians will also be better placed to contribute to the cost of their own care as the superannuation system matures. And the cost burden is further reduced as people shift from residential aged care to Home Care Packages.

On balance, the result of these trends is that government funding of aged care will take up a growing share of national income over time.

Notably, the expected rise in costs relative to the size of the economy is lower than projected in the 2015 Intergenerational Report¹. This is due to the fact that the baseline scenario accounts for the improvement in disability rates over time and a preference away from Residential Care towards less resource intensive Home Care Packages.

¹ https://treasury.gov.au/sites/default/files/2019-03/2015_IGR.pdf

Figure B: Commonwealth expenditure on aged care by program - baseline



A package of reform for high quality care

The package of reforms presented in this report includes a number of potential options aimed at improving aged care in Australia. These are options that staff of the Commission have asked Deloitte Access Economics to model in order to understand the future impact of changes to the aged care system. The options have been incorporated into a single set of results outlining an alternative future for aged care in Australia.

The scenario considers the impact of a package of wide-reaching reforms which the Royal Commission is considering. The reforms cover:

- Improvements to care quality, staffing and training
- Aspects of regulation and system navigation
- Availability of different types of care
- Health service provision
- Funding levels and allocation mechanisms

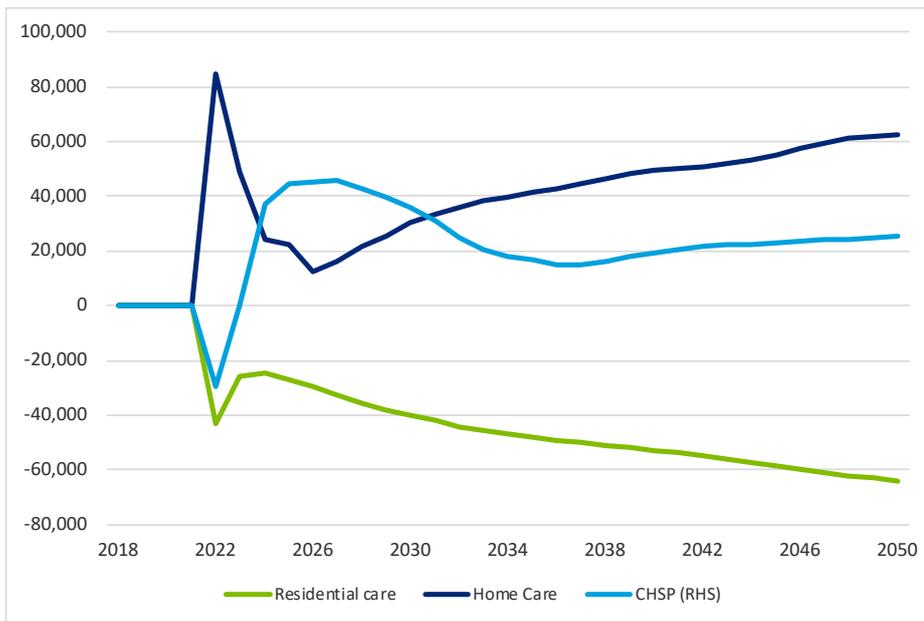
It should be noted that under this package of reforms aged care continues to be provided through three main programs: residential care, HCP and CHSP. Integration of these programs is not one of the options considered and may alter the results.

Much of the reform package is focused on improving the quality of care available to aged care recipients – particularly in Residential Care – and increasing the availability of Home Care Packages. Most of the changes come at a cost to the Australian Government – some through the aged care system and a smaller amount through Medicare and other government programs.

The reform package encourages a greater number of people into the aged care system and causes a significant shift in the allocation of recipients across programmes. In particular, there’s a substantial shift away from Residential Care towards Home Care Packages.

The modelling has considered an increase in residential care staffing to 3, 4 and 5 star levels in the CMS system². Changes in recipient numbers for the 4 star scenario are presented in Figure C, with the changes starting in 2022. Residential Care recipients reduce immediately as a larger number of potential new recipients choose to stay in community care and the sector faces significant workforce constraints in response to the implementation of mandated increases in staff time per recipient. The workforce constraint is rapidly unwound but the ongoing preference for Home Care Packages grows over time.

Figure C: Aged care recipients, change relative to baseline - 4 star scenario



Source: Deloitte Access Economics Modelling

Recipients of Home Care Packages rise rapidly as existing supply caps in the programme is unwound and a number of services previously provided under CHSP are shifted to Home Care Packages. However, the balance between these two community programs shift in the following years as recipients favour CHSP to a greater degree given the programme has become free of charge for recipients. This effect subsides over time and is completely removed around 2030 at which point the CHSP program services all eligible individuals.

From a quality perspective, the reform package causes a substantial rise in the quality of care provided in Residential Care and the highest Home Care Package level 4 to support recipients with the highest needs.

The reform package exerts additional pressure on the aged care workforce, particularly for enrolled nurses as care requirements rise. Wages in the sector rise to attract more workers from other sectors and through additional training.

² A nursing home quality rating system developed by the Centers for Medicare & Medicaid Services in the US (see <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/FSQRS>)

Increasing demand for aged care, increasing quality requirements and a tighter workforce all leads to increases in the cost of care. However, the shift away from resource intensive Residential Care towards Home Care Packages tempers the overall level of funding required for this package of reforms.

The scenario specifies that aged care providers will be fully compensated for additional costs incurred due to the policy changes described above. As such, the Government bears the full cost of the reform package.

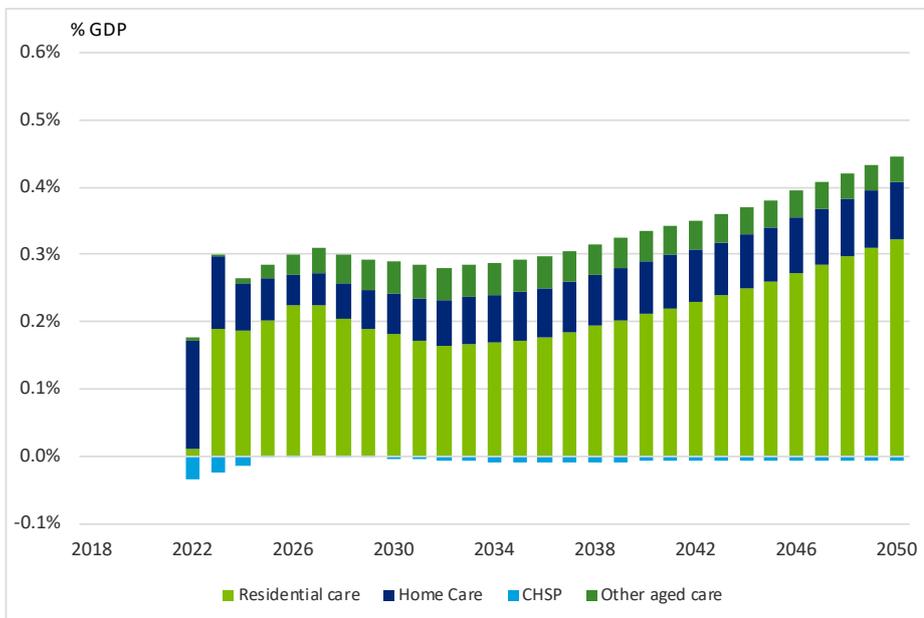
Taken together, the reforms in this package see the sector incur additional costs in 2050 of:

- 0.3% of GDP or around a fifth of the projected baseline aged care budget in the 3 star scenario.
- 0.5% of GDP or around a third of the projected baseline aged care budget in the 4 star scenario.
- 0.8% of GDP, or around half of the projected baseline aged care budget in 2050 in the 5 star scenario.

In each case that total includes additional health expenditure outside of aged care amounting to approximately 0.04% of GDP.

Expenditure on Residential Care sees the biggest increase, despite fewer recipients. Spending on Home Care Packages also rises strongly relative to the baseline, but lower costs per recipient relative to residential care limit the overall increase in that program.

Figure D: Government cost of aged care reform package – 4 star scenario



There's a large variety of ways government can fund the additional expenditure required for the reform package including: implementing a new tax, increasing existing taxes, broadening the base of existing taxes or cut expenditure in other areas. The scope of this analysis only considers two funding options: an increase to the Medicare Levy or an equal increase to income tax rates across all thresholds.

Assuming that: the required increase in tax rates will remain steady over the forecast period, and a Commonwealth bond rate of 3% per annum prevails for the forecast period, then the results included in Table A will ensure there's no material change in government debt over the forecast period due to the proposed package of reforms.

Table A: Required percentage point changes to tax rates

Funding option	Reform package		
	3 star	4 star	5 star
Increase in Medicare levy	0.51%	0.89%	1.31%
Increase income tax	0.58%	1.01%	1.48%

Source: Deloitte Access Economics Modelling

This is a substantial rise in tax rates. As a comparison, the Medicare Levy was recently raised by 0.5% to cover part of the cost of the NDIS. Income taxes will need to be increased by a slightly higher rate than the Medicare Levy because it covers a lower base due to the income tax free threshold that is in place.

Deloitte Access Economics

1 Introduction

1.1 Background

The terms of reference of the Royal Commission into Aged Care Quality and Safety (the Royal Commission) includes consideration of the future challenges and opportunities for delivering accessible, affordable and high quality aged care services in Australia in the context of changing demographics and preferences, in particular people's desire to remain living at home as they age.

In its interim report the Commission has identified a pattern of societal neglect surrounding aged care that has left services fragmented, unsupported and underfunded. There is a need for significant reform to create the better future aged care system which Australians aspire to.

Understanding how potential reforms might impact on the operations of the sector, its workforce and required levels of funding are important parts of the overall picture of the future of aged care in Australia. With that in mind, the Royal Commission asked Deloitte Access Economics to develop a detailed model of the aged care sector over coming decades to explore the future economic and budgetary implications of various reforms.

Detailed modelling is an important tool for understanding the impact of alternative policies on a system as complex as Australia's aged care sector. A consistent view of the future requires the simultaneous analysis of the need for care, the cost of that care, financing arrangements and the required workforce.

1.2 The reform agenda

This report considers the impact of a package of wide-reaching reforms which the Royal Commission is considering. The reforms cover:

- Improvements to care quality, staffing and training
- Aspects of regulation and system navigation
- Availability of different types of care
- Health service provision
- Funding levels and allocation mechanisms

1.3 Structure of the report

This report outlines the model and its results. It is organised into five chapters:

- Chapter 2 provides a brief outline of the model.
- Chapter 3 explores a potential future for aged care in Australia under current policy settings.
- Chapter 4 describes the impact of the package of reforms which the Royal Commission is considering to create a better future aged care system in Australia.
- Chapter 5 considers possible options for the additional funding required to support those reforms.

2 Methodology

Australia's aged care system is complex, and the range of potential reforms examined in this report is wide.

A detailed model that represents the relationships that drive outcomes in the aged care system is an important tool for analysing alternative futures for the sector.

Deloitte Access Economics has developed a detailed macroeconomic group model. It does not track individual outcomes but instead identifies outcomes across a large number of groups defined by a wide range of characteristics. For example, the model identifies the number of Australians aged 70-74 who have a profound core activity limitation but do not have dementia.

Such a model has the advantage of being informed from the top down by robust macroeconomic assumptions, in addition to bottom up analysis of the aged care industry based on more than 21,000 groups of care recipients.

The model is designed to consider the impact of policy change over the period to 2050. While it projects the future of aged care under current policy settings it is not a forecasting model and is not intended to accurately predict outcomes in the short term.

2.1 Model overview

Rather than simply projecting current arrangements forward, the model we have developed determines the demand for and supply of care based on a combination of prices, preferences and policy.

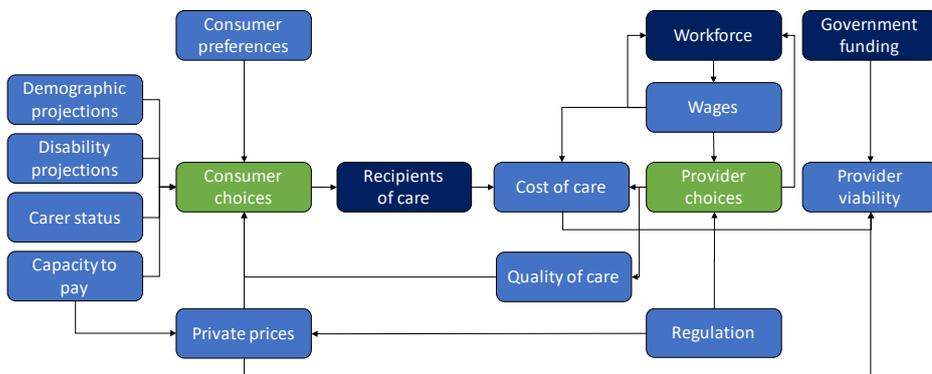
Within the model core there are three types of agents:

- Individuals, who are divided into two groups:
 - Recipients of care who remain in care from the previous period and do not make choices.
 - New recipients entering care in the current period, who make demand choices across the various programs available to them.
- Providers, who make a choice as to:
 - How much care to supply to all recipients.
 - Which inputs to use to produce that care.
- Governments, who make choices around:
 - Supply targets relating to each aged care program (including the option to remove those targets altogether).
 - Regulations applied to providers' activities and profits.
 - Government funding for each aged care program.
 - Regulated private prices for each aged care program

Decisions by each type of agent have implications for the choices made by the other two, with some of these choices being made simultaneously within the model.

An outline of the key relationships in the model is provided in Figure 2.1 below.

Figure 2.1: Key model relationships



Consumer choices

The model takes key demographic projections as an important starting point. These set out the future path of the Australian population by age and gender and make assumptions about future rates of age specific disability.

When combined, these projections provide a foundation for the overall level of ‘need’ for care.

The model also projects access to informal carers among older Australians. Access to a carer can increase the range of care options open to individuals and influence the type of aged care they choose.

Projections of incomes and assets inform the ‘capacity to pay’ of individuals in the model which, together with government means testing rules, determines the price those individuals face in the aged care system.

The model then allows each combination of age, disability, carer status and capacity to pay to make choices based on:

- Their preferences across care types.
- The price they face.
- The quality of care available to them in each aged care program.

First, they choose between Residential Care and remaining in the community. If they choose to remain in the community, they then choose a form of community care – with no formal care at all being an option in that choice.

Provider choices

The model includes a range of choices by providers that determine the amount of care provided and what that care costs – subject to the regulatory constraints placed on them by government.

It estimates the efficient cost of providing a unit of care within each of the aged care programs. Costs are based on choices around how to deliver care and are based on the price and quantity of the individual inputs used – like the wages of nurses for example.

As skilled care labour is a key component in the delivery of aged care the module includes detailed workforce projections that estimate the number of workers in each of three categories of labour:

- Care Management, Registered Nurses and Allied Health Professionals
- Enrolled and licenced nurses and other allied health.
- Unlicensed personal care staff

Each of these categories has different training requirements and wages, and the three types are combined into teams to form the labour component of the delivery of care.

The model incorporates flows into and out of the pool of active aged care workers which are related to the wages applying to each category of care staff. Higher aged care wages lift enrolments in training courses, while improvements in wages relative to health and disability care result in changes in the net flow of workers into and out of the aged care sector.

Within the model, emerging shortages in skilled labour can limit the total amount of aged care that is provided.

The productivity of each type of care labour is linked to the share of workers meeting a specific qualification requirement, meaning a more qualified pool of workers can lead to higher productivity within the model.

Government choices

The government plays an important part in the funding and regulation of aged care in Australia and choices around how both regulation and funding evolve are an important feature of the model.

Funding arrangements for aged care are modelled in detail, along with the means tests and other rules which determine the private price of care in each program.

The government also decides on minimum standards which can apply to the delivery of care by placing a lower limit on the amount of each type of input that goes into determining the cost of care.

Quality of care

Quality is an exceptionally difficult concept to measure as the perception of quality will differ from person to person. In this model quality of care is defined as the quantity of care received by an individual in an average day.

To estimate this the model uses a measure of 'points' of care delivered. This estimate is calibrated such that the number of points of care delivered is consistent with basic subsidies paid – a key indicator of care need in the current aged care system. For example, in the base year the total number of points produced each day in residential aged care is equal to the average daily amount of ACFI subsidies paid in that year. In the future the number of points per recipient may differ from subsidy amounts due to changes in policy or productivity.

The model allows for increases in productivity over time, meaning the number of 'points' of output is not the same as the quantity of inputs used. Higher efficiency means fewer inputs can be used to deliver the same number of 'points'.

Points per recipient per day is one factor in assessing care 'quality', with lower levels of provision at a given level of care need potentially representing a poorer outcome for recipients. There are of course other factors influencing care quality but they are not the focus of the model.

An alternative measure of quality that's also reported is a simple estimate of the average staff time allocated to each care recipient per day. This measure highlights the importance of human interaction to the quality of aged care, but doesn't capture the ability of technology and other productivity enhancing measures to improve quality of care for a given staffing level.

Putting it all together

The model combines the various choices into a set of outcomes in each financial year. For each program the model projects:

- The amount of new demand and the total number of recipients.
- The amount of care delivered to each recipient.
- The total cost of delivering that care.
- The number and mix of workers required.
- Care quality as measured by the number of 'points' per day.
- Total public and private funding for care.
- Financial outcomes for providers.

Budget aggregates are compiled from funding information around aged and disability care and combined with simple assumptions about other spending and revenue to estimate the budget balance.

2.2 Data sources

The model uses a range of data sources to estimate an internally consistent dataset for the 2017-18 financial year.

While more recent data are available in some cases the model database is designed to capture all of the required data in a way that is consistent with the model's design. This requires a range of techniques to manipulate and combine data sources:

- In some cases different sources are used for aggregate outcomes and detailed distributions.
- In others related estimates from different datasets need to be made consistent. For example, the model needs to ensure that providers' expenditure on delivering aged care is consistent with government expenditure, private contributions and provider financial outcomes.

Topic	Data source(s)
Demographics	ABS Australian Demographic Statistics 3101.0 Deloitte Access Economics' DEMM demographic model
Disability and carer status	Survey of Disability Ageing and Carers (SDAC) NDIA data on recipients and plan values NDIA projections of recipients to 2030
Health expenditure	AIHW
Aged care expenditure	DOH expenditure (subsidies and supplements) data DVA, DSS Portfolio Budget Statements 2019-20
Government revenues and expenditure	ABS Government Finance Statistics 5512.0 ABS Taxation Revenue, Australia 5506.0
Aged care recipients	Survey of Disability Ageing and Carers (SDAC) AIHW Gen Aged care data AIHW custom request
Aged care workforce	National Aged Care Workforce Census and Survey 2016

	<p>AIHW National Health Workforce Dataset DESE Higher Education Statistics –2016-2018 Section 8 Special Courses NCVER VOCSTATS, Program enrolments and completions 2016</p>
Aged care provider financials	<p>Stewart Brown survey as extended by the Royal Commission. ACFA Seventh Report on the Funding and Financing of the Aged Care Industry</p>
Economic aggregates	<p>ABS Labour Force Survey 6291.0.55.003 ABS Labour Force Survey 6202.0 ABS National Accounts 5206 ABS Wage Price Index 6345.0 ABS Consumer Price Index 6401.0 Deloitte Access Economics forecasts using the DAEM model</p>
Incomes and assets	<p>Household Income and Labour Dynamics (HILDA)</p>

3 Australia's future aged care needs

Aged care is projected to undergo substantial change over the next three decades, even if policy settings remain the same.

In this chapter we examine the trends driving that change and the model's projections of future aged care provision.

It's acknowledged that aged care policy will change in the future, as it has in the past. That's why the forecast presented in this chapter should be viewed as a neutral reference case to be used to contextualise the impact of proposed policy changes, rather than an attempt to accurately forecast the future of the sector.

3.1 Population ageing

Australia's population is expected to grow and to change over coming decades.

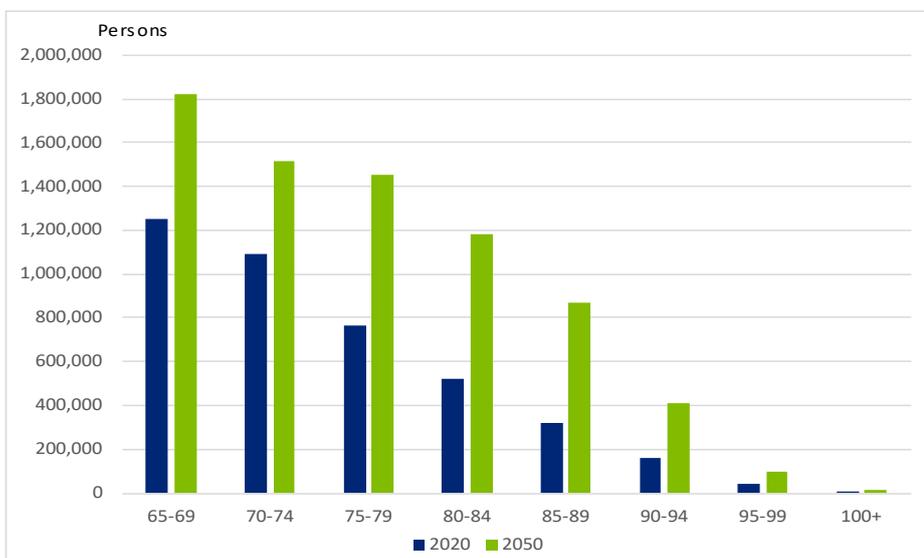
Australians are living longer and that trend is expected to continue, leading to a rapid increase in the number of older Australians.

That has implications for the demand for aged care. With older Australians making up a greater share of the community there will be increasing demands on the sector.

The modelling undertaken as part of this project uses Deloitte Access Economics' own demographic projections.

These projections are based on expected trends in births, deaths and migration which lead to substantial increases in the number of Australians in the oldest age groups.

Chart 3.1: Changes in the population aged 65+



Source: Deloitte Access Economics modelling

Within that group the greatest changes will be among the oldest age groups, who are also the most likely to require aged care. The number of Australians aged 65-69 will increase by around one-third but those aged 85 and over will more than double.

At the same time a smaller share of the Australian population will be of working age. That will place pressure on the economy and on government Budgets as there will be fewer workers for each Australian retiree than there are today.

The combination of increased demand for aged care and an economic and budget challenge highlights the importance of getting aged care policy settings right so that Australians can expect quality care that is both sustainable and affordable.

3.2 The need for care

An increasing number of older Australians is an important long term driver of demand for aged care but changes in the health of older Australians will also play a role.

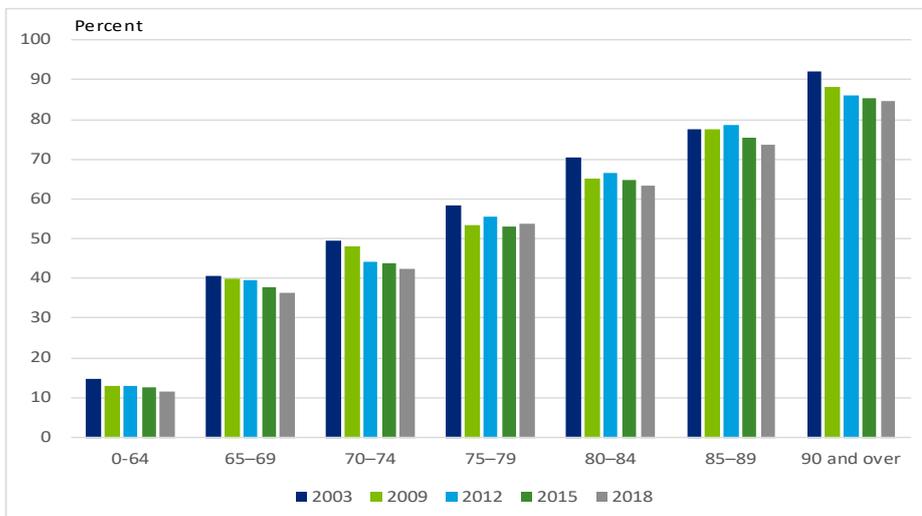
Within the model the health status of each age and gender group is tracked via a set of disability rates linked to the level of functional limitation faced by individuals as defined in the ABS Survey of Disability Ageing and Carers (SDAC).

There are five levels of functional limitation identified in the data (none, mild, moderate, severe and profound). The model divides each of these groups into those with dementia and those without for a total of ten different disability groupings for each age and gender in the model.

Predicting future patterns of disability and dependency among older Australians is a complex task. There has long been debate about whether increasing life expectancy means living longer, healthier lives or simply living for longer with current levels of disability.

On this question the evidence is inconclusive for Australia, but there is some evidence that age-specific disability rates are falling over time.

Chart 3.2: Age specific disability rates over time

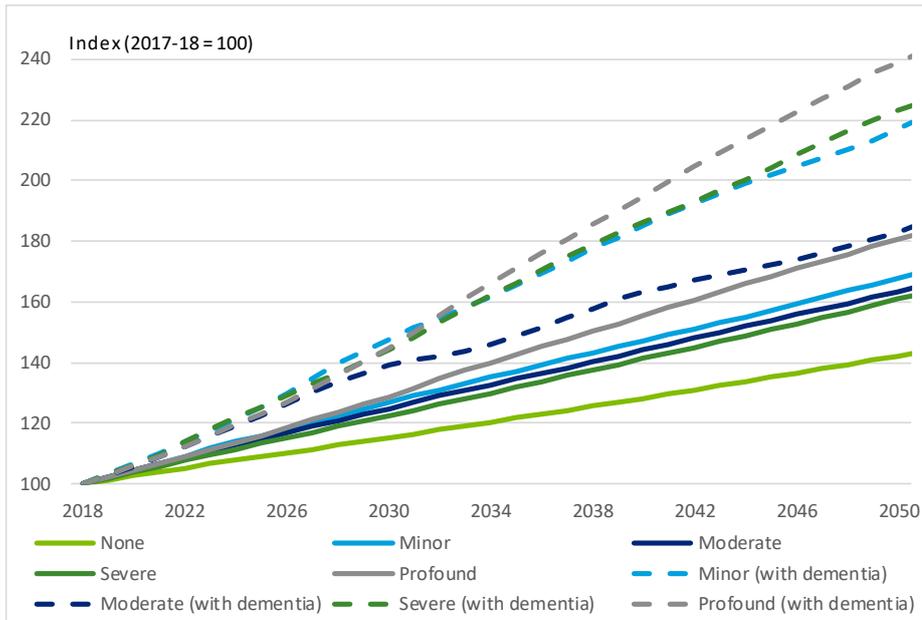


Source: ABS Disability, Ageing and Carers, Australia: Summary of Findings, 2018 (Cat. No. 4430.0)

That is, a 75 year old today is healthier than a 75 year old was 15 years ago.

We conservatively assume that only some of this improvement continues. Still, an ageing population will result in a substantial increase in the number of Australians with each level of functional limitation, with dementia becoming an increasing concern.

Chart 3.3: Disability rates for Australians aged 65+



Source: Deloitte Access Economics modelling

3.3 Aged care provision

In the baseline scenario the model assumes that a range of existing arrangements continue into the future:

- The supply of aged care continues to be subject to regulation in the same way that it is today. That is, the Australian Government’s planning framework grows the supply of aged care places in proportion to the growth in the population aged 70 and over³.
- Funding arrangements continue with regular indexation of government subsidies and supplements paid to providers based on movements in prices and wages.
- Private prices for care are calculated based on existing means testing rules.

The existing means testing rules are applied to a future population where changes to the age structure and care needs of the population are resulting in changing demand for aged care over time.

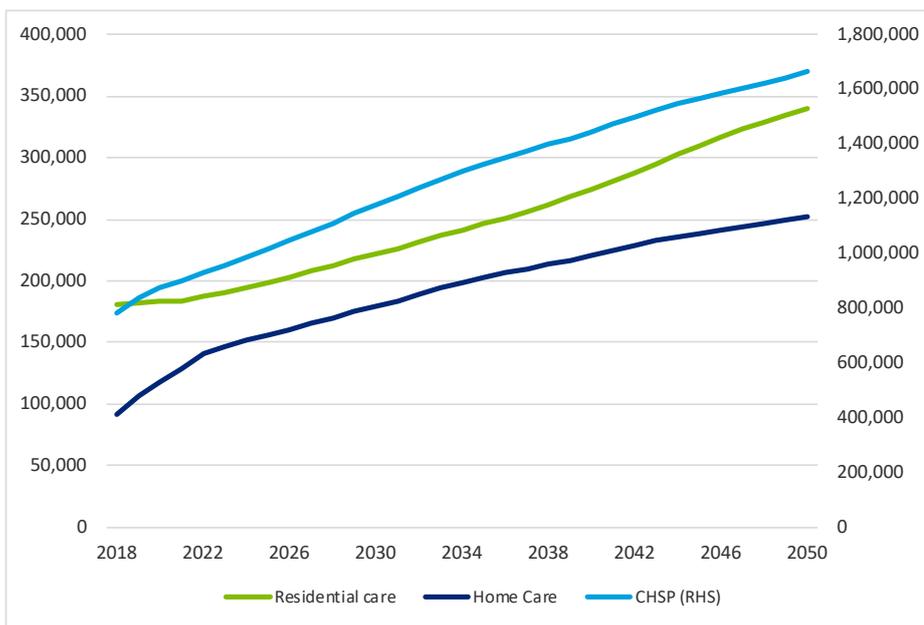
³ Provision of HCP is assumed to rise to 45 per 1000 people aged 70 or over by 2021. Provision of Residential Care packages are assumed to fall to 78 places per 1000 people aged 70 or over by 2021.

Preferences too are changing. In particular, the model assumes a continued increase in the number of older Australians wanting to receive aged care at home rather than enter a Residential Care facility.

Using information on the rules applying to the sector, the care needs of the population and the preferences of older Australians, the model projects future recipients for the three main aged care programs:

- Residential aged care
- Home Care Packages (HCP)
- The Commonwealth Home Support Program (CHSP)

Chart 3.4: Aged care recipients by program - baseline



Source: Deloitte Access Economics Modelling

All three aged care programs are expected to grow through to 2050, however recipients won't grow as fast as the population aged over 65 given the expected improvement in disability rates.

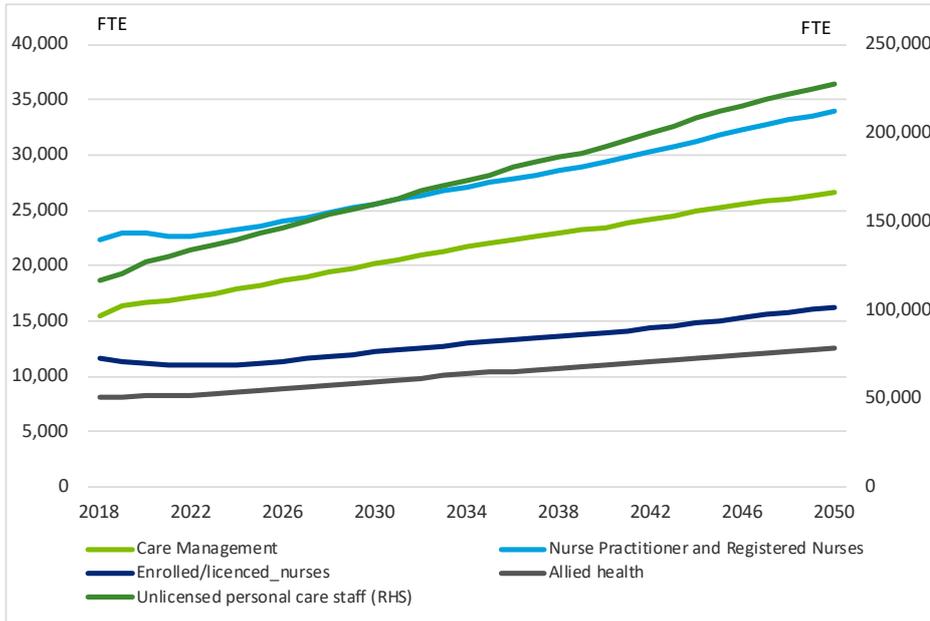
CHSP will remain the largest program measured by recipients, but HCP are expected to grow the fastest. While this program will still be subject to supply caps in the baseline, there is a substantial increase in the level of that cap over the early years of the projection period. Combined with a changing preference from residential aged care towards HCP this results in strong growth in HCP over the next few years under current policy. This preference towards HCP means the forecast for residential aged care recipients is substantially lower than the forecast Government provision of places by 2055.

3.4 Aged care workforce needs

A growing demand for aged care means a growing demand for skilled workers to provide that care.

Aged care is a sector that relies on trained staff to deliver the care older Australians need.

Chart 3.5: Aged care workforce - baseline



Source: Deloitte Access Economics Modelling

Unlicensed personal care staff will continue to represent the largest employment group and play a critical role in the delivery of care in the baseline scenario. We expect HCP to require the strongest growth in staff as a result of the overall growth in recipients as well as an increase in average care needs.

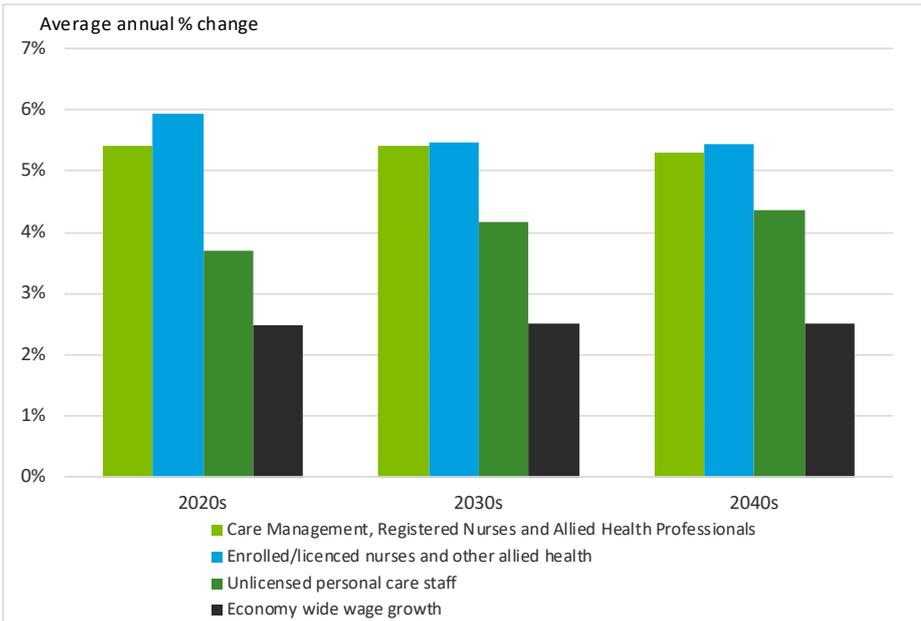
Overall, Australia’s aged care workforce is projected to grow significantly faster than the broader economy. That has implications for future care costs as rapid demand growth will put pressure on the skilled workforce over time.

In the baseline it is assumed that 30% of new workers in the sector are sourced through skilled migration, with the remainder attracted by higher wages via a combination of new trainees and transfers from the health and disability sectors. Despite the inflow of skilled migrants, attracting new workers to the sector is expected to require wages to lift from current levels – particularly as the sector will compete with the NDIS in the next few years. As wages are rising in health and disability care that too will put pressure on aged care costs.

This is expected to see wage gains in aged care outpacing those in other industries. Wages for nursing and other skilled staff in aged care rise by an average of around 5.5% per year over the period to 2050 – more than double the economy wide average.

In turn, that combination of a fast growing workforce with higher relative wages will lead to higher overall costs for each aged care recipient.

Chart 3.6: Wages in aged care compared with the wider economy - baseline



Source: Deloitte Access Economics Modelling

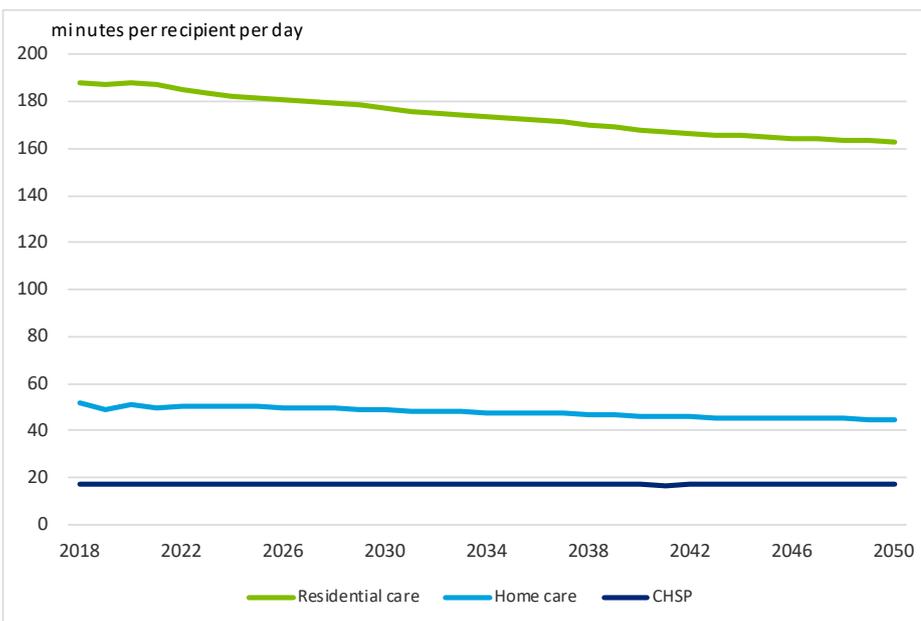
3.5 Care quality

Changes in the level of care available to aged care recipients over time are one important component of assessing the quality of care delivered.

Access to skilled staff in particular is an important enabler of quality care.

Productivity growth in aged care means providers will be able to deliver care with slightly fewer staff in the future, meaning staff time falls slightly over time on average in both Residential Care and HCP.

Chart 3.7: Quality of care: staff time per aged care recipient - baseline



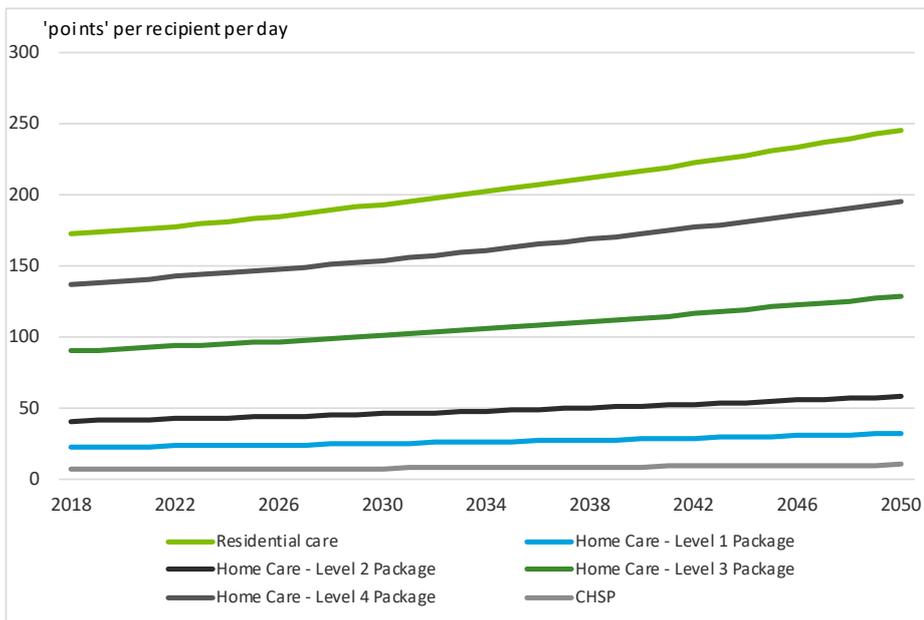
Source: Deloitte Access Economics Modelling

Recipients in CHSP are projected to see relatively constant care quality over time, with some improvements later in the projection period.

A broader measure of quality is estimated using the concept of quality 'points' described in section 2.1 of this document. Under this measure, increases in productivity, training and access to technology are expected to allow aged care workers to deliver higher quality care in the future than they do today.

These projections assume that the overall level of care per recipient in each aged care program rises alongside living standards. This assumption ensures that the quality of aged care keeps up with the rising expectations of older Australians over time.

Chart 3.8: Quality of care: 'points' per aged care recipient - baseline



Source: Deloitte Access Economics Modelling

3.6 Government funding

There are a range of pressures on government funding of aged care over time. Not only will a larger number of older Australians be receiving care, but the cost of that care will be rising as the sector grapples with rapid growth.

On the other hand, older Australians will also be better placed to contribute to the cost of their own care as the superannuation system matures. And the cost burden is further reduced as people shift from residential aged care to HCP.

On balance, the result of these trends is that government funding of aged care will take up a growing share of national income over time.

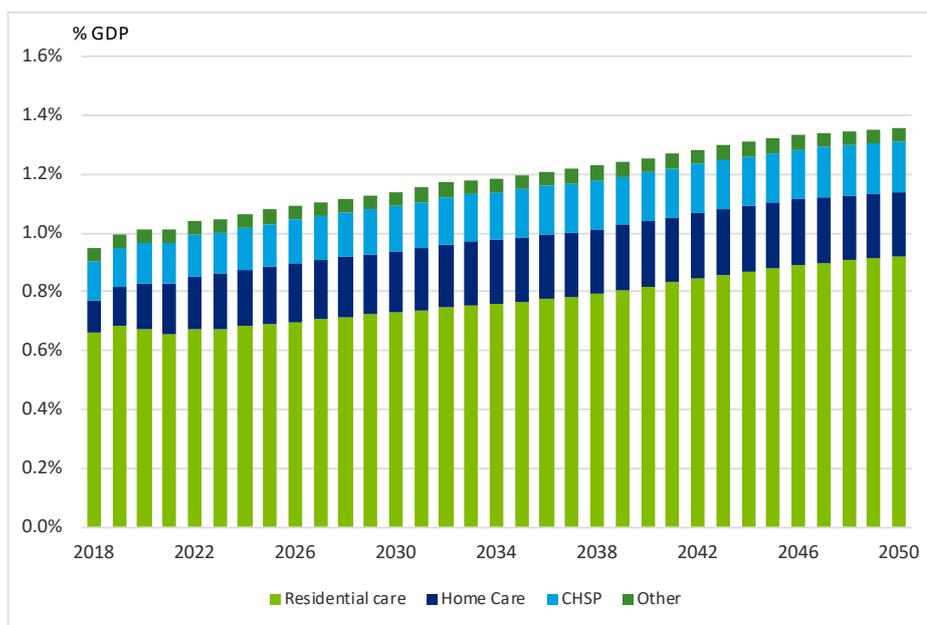
Notably, our expectation is that the rise in costs relative to the size of the economy is substantially lower than projected in the 2015 Intergenerational Report⁴. This is due to the fact that this scenario account for the

⁴ https://treasury.gov.au/sites/default/files/2019-03/2015_IGR.pdf

improvement in disability rates over time and a preference away from Residential Care towards cheaper to fund HCP.

Despite slower growth in recipient numbers, Residential Care will continue to account for the bulk of commonwealth funding for aged care. That said, HCP spending will be rising rapidly over coming decades.

Chart 3.9: Commonwealth expenditure on aged care by program - baseline



Source: Deloitte Access Economics Modelling

Under current arrangements there is no explicit link between the cost of delivering aged care and the level of funding provided by the government and recipients.

That raises the possibility that the industry may receive more or less funding than it needs to deliver the level of care the model projects in the future.

Assessing the adequacy of funding in aged care is complex, and there are many ways in which the information available is inadequate to measure profitability. The model uses available historical data to create its own measures of revenue and cost to project the amount of funding in the system over and above a reasonable rate of return required to encourage investment in aged care.

It indicates that community care providers currently appear to benefit from funding levels that more than justify investment in the sector, while funding levels in Residential Care fall short of what is required for provider sustainability.

That gap narrows early in the projections, but both sectors see declines in profitability in the longer term.

4 A package of reform for high quality care

This chapter describes a full package of reforms designed to improve the quality of care and change the way aged care is accessed and funded in Australia. The package of reforms consists of a number of options that staff of the Commission have asked Deloitte Access Economics to model to better understand the future impact of potential changes to the aged care system.

Results are presented to indicate the impact of this package on the sector and outline the potential cost to government.

4.1 Reforms considered

Constructing a package of aged care reforms requires the Commission to examine many aspects of the aged care system.

The package of reforms presented here includes a number of potential measures aimed at improving aged care in Australia. These are options that staff of the Commission have asked Deloitte Access Economics to model in order to understand the future impact of changes to the aged care system. The options have been incorporated into a single set of results outlining an alternative future for aged care in Australia.

The reforms cover:

- Improvements to care quality, staffing and training
- Aspects of regulation and system navigation
- Availability of different types of care
- Health service provision
- Funding levels and allocation mechanisms

Much of the reform package is focused on improving the quality of care available to aged care recipients – particularly in residential aged care – and increasing the availability of HCP packages.

It should be noted that under this package of reforms aged care continues to be provided through three main programs: residential care, HCP and CHSP. Integration of these programs is not one of the options considered and may alter the results.

Most of the above changes come at a cost to the Australian Government – some through the aged care system and others through Medicare and other government programs.

A summary of the individual reforms included in the scenario is provided in Table 4.1.

Table 4.1: Policy reforms considered in the modelling

Policy reform	Description	Modelled implementation date	Funding impact
Residential care staffing uplift to 3, 4 and 5 star levels	<p>A mandatory rise in staffing levels and minutes per recipient in residential aged care to be consistent with the 3, 4 and 5 star quality level under the CMS 5 star system⁵.</p> <p>It should be noted that the 5 star system is intended to reflect the care needs of residents, and may not be perfectly transferrable to the Australian context as care needs here may differ from those overseas. In addition this scenario assumes that minutes per recipient per day are fixed over time, while the star rating system may require them to increase alongside assessed needs. This would increase the cost of the package.</p> <p>These changes are phased in over three stages.</p>	<p>Phase in of 3 star quality begins on 1 July 2021 and is complete by 1 July 2023.</p> <p>Phase in of 4 star quality is complete by 1 July 2025.</p> <p>Phase in of 5 star quality is complete by 1 July 2027</p>	High
Uncapping HCP	The number of places in each HCP level is determined solely by number of people meeting the eligibility assessment for that level	1 July 2021	Medium
Extended HCP	HCP subsidies are better aligned with the care needs of recipients. The subsidies available in HCP will be higher for people with more complex and intensive care needs that can be safely and appropriately met at home, potentially approaching the levels of care subsidies that would be available in residential care.	1 July 2021	Low
Respite funding	Informal caregivers are provided with 15% more respite services each year over and above existing provision.	1 July 2021	Medium
CHSP/HCP interaction	Services which HCP recipients can access using their HCP are no longer offered in CHSP. The services affected are:	1 July 2021	Low

⁵ A nursing home quality rating system developed by the Centers for Medicare & Medicaid Services in the US (see <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/FSQRS>)

	<ul style="list-style-type: none"> • Allied Health and Therapy Services. • Centre-based Respite. • Cottage Respite. • Flexible Respite. • Nursing. • Personal Care. 		
CHSP fees	All recipient fees for CHSP are removed.	1 July 2021	Medium
Funding controls	Government funding controls are applied in Residential Care to ensure a sufficient share of provider funding is spent to deliver care to recipients.	1 July 2021	Low
Removing RADs	An end to new Refundable Accommodation Deposits (RADs) in Residential Care. Existing RADs are allowed to stay in place.	1 July 2021	Low
AN-ACC funding	Implementation of AN-ACC funding classes to replace existing system.	1 July 2021	Low
Independent assessment of care needs	All new entrants to Residential Care are assessed under the AN-ACC classification on entry and all existing residents are assessed at least annually (twice per year if their care needs change significantly).	1 July 2021	Low
Health initiatives	<p>A range of initiatives to improve health care for aged care recipients. Includes:</p> <ul style="list-style-type: none"> • Designated Care Coordinators in Residential Care. • A new primary care model. • Improved access to allied health. • GP incentives to visit aged care recipients. • Embedding pharmacists in residential aged care. • Multi-disciplinary outreach health services • Enhanced Rural Health Outreach Fund. • Expanded Telehealth in Residential Care. • Subacute rehabilitation. • Mental health treatment plans. • Psychologists in Residential Care. • Dental health services in Residential Care. 	Various	Medium
Mandatory Certificate III	All personal care workers are required to obtain a relevant Certificate III qualification to work in aged care.	1 July 2025	Low

National personal care worker register	All personal care workers are required to sign on to a national register.	1 July 2021	Low
Young people with a disability	Young people with a disability are removed from aged care and placed in specialist accommodation under the NDIS.	By 1 July 2024	Low
Care finders	Teams of My Aged Care case managers provide face-to-face support to people with navigating the system.	1 July 2021	Low
Public guardians	Increased funding for public guardians to support people living away from family.	1 July 2021	Low
Wage parity	Wages in aged care are increased to equivalent wages in the health sector.	1 July 2024	Medium
Immigration measures	Increase skilled immigration for carers and health professionals to address workforce pressures.	From 1 July 2021	Low

4.2 Projected care recipients

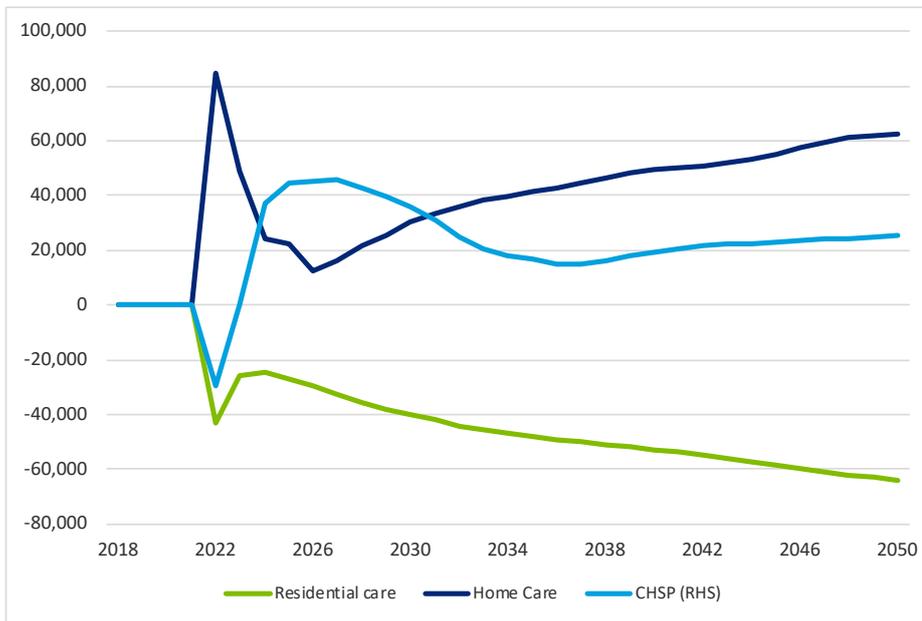
Changes in this scenario have an impact not only on the quality of aged care but also on the number of Australians with access to care and the mix of recipients across aged care programs.

In this scenario, 29,000 more Australians are receiving some form of Commonwealth funded aged care relative to the baseline by 2050. However, there are vastly different impacts on residential and community based care (HCP and CHSP).

As per Chart 4.1, the scenario starts in 2022. Residential Care recipients drops immediately as a larger number of potential new recipients choose to stay in community care and the sector faces significant workforce constraints in response to the implementation of mandated increases in staff time per recipient. The workforce constraint is rapidly unwound but the ongoing preference for HCP grows over time.

Recipients of HCP rise rapidly as existing supply caps in the programme is unwound and a number of services previously provided under CHSP is shifted to HCP. However, the balance between these two community programs shift in the following years as recipients favour CHSP to a greater degree given the programme has become free of charge for recipients. This effect subsides over time and is completely removed in the mid 2030s at which point the CHSP program encompasses all eligible individuals.

Chart 4.1: Change in aged care recipients by program – 4 star scenario



Source: Deloitte Access Economics Modelling

Overall the changes in the scenario reinforce existing trends in the sector, with movements away from Residential Care and toward care in the community.

Similar patterns occur in both the 3 and 5 star scenarios, with minor differences in the take-up of residential care due to different quality levels.

There are many influences on recipient numbers in the scenario:

- The **residential care staffing uplift** sees greater access to skilled staff in Residential Care. As a result older Australians are more likely to want to enter Residential Care in future than they are today. But this effect is tempered by other reforms such as uncapping HCP.
- **Uncapping HCP** expands the number of recipients in that program. Those who would have been on waiting lists due to the supply constraints in the baseline are able to take up the opportunity to receive appropriate care at home. At the same time greater access to HCP gives older Australians the ability to choose to stay at home rather than enter Residential Care. Greater access to HCP is quickly taken up by those who qualify, resulting in a shift away from Residential Care and toward HCP.
- The removal of **CHSP fees** provides an incentive for some to stay in that program rather than moving to a more intensive HCP.
- Addressing the **CHSP/HCP interaction** sees some services removed from CHSP and provided to HCP recipients instead. This has the effect of pushing some recipients into HCP.
- Additional **respite funding** encourages some to become informal carers for elderly friends and relatives, while others are encouraged to stay on and care for longer. Because access to a carer is an important support for those choosing to remain in the community this leads to fewer entries to Residential Care and more care provided at home.
- Removing **young people with a disability** from Residential Care sees a minor shift from Residential Care into the NDIS as they find more appropriate care for their circumstances.

Available supply of care is a critical piece of the puzzle. In this scenario there is pressure on the ability of aged care providers to find skilled staff.

Workforce shortages combine with prescribed minimum staffing levels in Residential Care to create a need to reduce resident numbers sharply in 2022 when the first stage of the staffing level uplift reform is implemented. This pressure is relieved quickly as new workers are brought into the sector.

It is important to note that needs assessment and approval for access to government funded care will be more important than ever in this scenario. With access to CHSP services becoming free to recipients and access to HCP no longer restricted by existing rationing there are fewer limits on the demand for care once approval has been given.

4.3 Aged care workforce requirements

Because improved staffing levels and greater access to aged care require more skilled staff the changes in this scenario come with increased workforce pressures over time.

The Primary drivers of increased workforce demand in this scenario are:

- The **residential care staffing uplift** notably increases staffing levels in residential care which has a substantial impact on workforce demand in the most intensive aged care program. The resulting rise in minutes of care provided to residential aged care recipients are presented in Chart 4.2.
- **Uncapping HCP** greatly increases the number of recipients in this program and calls for more workers to deliver the additional care required.
- **Extending HCP** also provides a minor lift in staffing levels and resulting workforce demand.

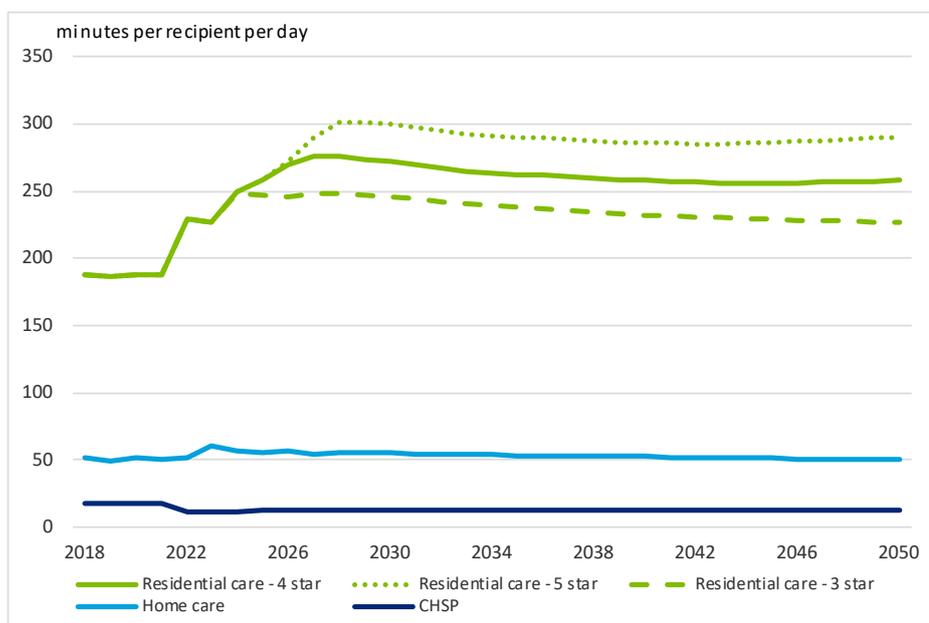
That combination sees greater levels of staffing in Residential Care, while there is only a modest impact per recipient in HCP.

It should be noted that the latter effect is uncertain, as new HCP recipients may have different characteristics to the existing recipient pool:

- New recipients flowing in from residential care may have higher care needs overall, but are likely to be drawn from lower levels of care need within the pool of residential care recipients.
- Those who have been on waiting lists for HCP and receiving services through CHSP may have lower levels of care need on average.

CHSP sees the number of workers per recipient fall as some services are removed from the program, but that work is undertaken in HCP instead.

Chart 4.2: Quality of care: staff time per aged care recipient after reforms



Source: Deloitte Access Economics Modelling

Note: the Residential 3 and 5 star scenarios cause very small changes in care for HCP and CHSP recipients due to workforce constraints. These change are excluded from this chart due to materiality and a desire to optimise the reader’s experience.

Offsetting some of the workforce pressure is the shift in recipient mix away from the staff intensive residential aged care program towards less staff intensive HCP packages.

At the same time there are two changes that are working to increase the supply of available skilled staff:

- Increasing wages compared to those in the broader health sector helps to encourage more workers into aged care.
- Allowing higher levels of skilled migration specific to the aged care sector to cover the same share of additional workforce demand as in the baseline also provides an ongoing boost to workforce supply.

Still, there are further increases in wages in aged care over time in order to help meet higher workforce demand, as seen in Chart 4.4.

Those increases work to lift the cost of care across all aged care programs over and above changes to the quantity of care delivered.

Chart 4.3: Additional aged care workforce required – 4 star scenario

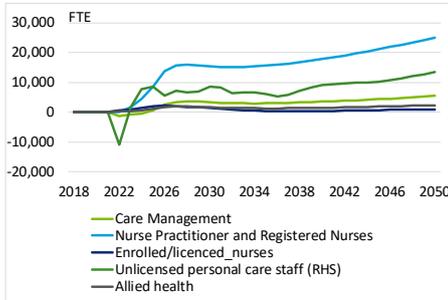
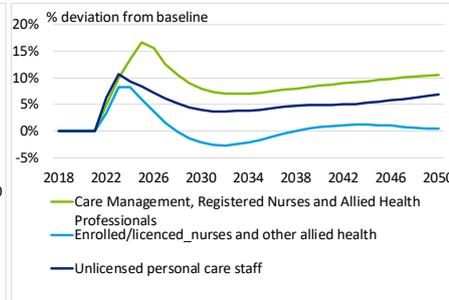


Chart 4.4: Wages in aged care compared with the wider economy – 4 star scenario



Source: Deloitte Access Economics Modelling

The result is an aged care sector with a substantially larger future workforce than in the baseline scenario, with the bulk of those new workers added in Residential Care.

In the short term there is some dislocation as staffing levels rise faster for higher skilled labour than for personal care staff. With Residential Care feeling the pinch on registered nurses in particular, the fall in recipients as the new reforms are introduced results in some idle personal care staff.

Increases in the aged care workforce will continue to draw workers away from other industries and into health and aged care. That said, the primary competition for workers will be with health and disability care – sectors which have their own workforce challenges ahead. Aged care is expected to remain small relative to these adjacent sectors even after the expansion of the workforce projected here.

Table 4.2: Total projected active direct care staff in aged care

		2018	2020	2030	2040	2050
FTE	3 Star	174,329	186,130	238,813	280,059	333,011
	4 Star	174,329	186,130	256,831	301,754	363,530
	5 Star	174,329	186,130	273,274	322,820	392,739
Headcount	3 Star	297,231	319,218	411,097	483,633	573,734
	4 Star	297,231	319,218	439,448	518,000	621,821
	5 Star	297,231	319,218	465,919	552,881	670,346

Source: Deloitte Access Economics Modelling

Table 4.3: Projected active direct care staff in aged care – 3 star scenario

FTE	2018	2020	2030	2040	2050
Care Management	15,479	16,729	19,994	23,715	27,650
Nurse Practitioner and Registered Nurses	22,342	22,896	29,221	34,850	42,880
Enrolled/licenced nurses	11,565	11,116	13,555	14,431	17,305
Unlicensed personal care staff	116,879	127,189	165,812	195,569	231,569
Allied health	8,065	8,200	10,232	11,493	13,607
Total aged care	174,329	186,130	238,813	280,059	333,011

Source: Deloitte Access Economics Modelling

Table 4.4: Projected active direct care staff in aged care – 4 star scenario

FTE	2018	2020	2030	2040	2050
Care Management	15,479	16,729	23,426	26,950	31,946
Nurse Practitioner and Registered Nurses	22,342	22,896	40,911	47,101	58,767
Enrolled/licenced nurses	11,565	11,116	13,468	14,294	17,197
Unlicensed personal care staff	116,879	127,189	167,873	201,013	240,795
Allied health	8,065	8,200	11,153	12,397	14,826
Total aged care	174,329	186,130	256,831	301,754	363,530

Source: Deloitte Access Economics Modelling

Table 4.5: Projected active direct care staff in aged care – 5 star scenario

FTE	2018	2020	2030	2040	2050
Care Management	15,479	16,729	26,051	29,407	35,384
Nurse Practitioner and Registered Nurses	22,342	22,896	49,911	56,071	70,840
Enrolled/licenced nurses	11,565	11,116	15,208	17,959	23,176
Unlicensed personal care staff	116,879	127,189	169,739	205,084	245,589
Allied health	8,065	8,200	12,365	14,300	17,751
Total aged care	174,329	186,130	273,274	322,820	392,739

Source: Deloitte Access Economics Modelling

4.4 Education and training

Wages draw new workers into the aged care sector in this scenario, but most of those workers will need to be appropriately trained in Australia.

The result is an increase in training demand as the sector employs more staff quickly and then maintains a larger workforce over time.

Table 4.6: Projected student graduations in aged care relevant qualifications – 3 star scenario

FTE	2018	2020	2030	2040	2050
Care Management	5,292	5,319	5,713	6,189	6,679
Nurse Practitioner and Registered Nurses	18,522	18,615	19,997	21,662	23,378
Enrolled/licenced nurses	4,982	5,014	5,443	5,925	6,388
Unlicensed personal care staff	24,307	24,140	24,214	24,508	25,357
Allied health	3,159	3,177	3,432	3,728	4,021
Total aged care	56,262	56,264	58,799	62,013	65,823

Source: Deloitte Access Economics Modelling

Table 4.7: Projected student graduations in aged care relevant qualifications – 4 star scenario

FTE	2018	2020	2030	2040	2050
Care Management	5,292	5,319	5,848	6,345	6,862
Nurse Practitioner and Registered Nurses	18,522	18,615	20,467	22,207	24,018
Enrolled/licenced nurses	4,982	5,014	5,438	5,920	6,383
Unlicensed personal care staff	24,307	24,140	24,339	24,681	25,703
Allied health	3,159	3,177	3,467	3,769	4,069
Total aged care	56,262	56,264	59,560	62,921	67,036

Source: Deloitte Access Economics Modelling

Table 4.8: Projected student graduations in aged care relevant qualifications – 5 star scenario

FTE	2018	2020	2030	2040	2050
Care Management	5,292	5,319	5,941	6,459	7,002
Nurse Practitioner and Registered Nurses	18,522	18,615	20,793	22,606	24,506
Enrolled/licenced nurses	4,982	5,014	5,541	6,096	6,664
Unlicensed personal care staff	24,307	24,140	24,458	24,821	25,908
Allied health	3,159	3,177	3,528	3,860	4,204
Total aged care	56,262	56,264	60,261	63,841	68,283

Source: Deloitte Access Economics Modelling

Increased graduations are an important source of workforce growth, but they are not the only source. Reduced flows out of the sector – including those to the health and disability sectors – also play a role.

With this package of reforms making study free for those who wish to take up an aged care qualification government faces both a greater share of the cost of training workers and the added cost of training a larger worker pool.

In addition, the requirement for a Certificate III for all personal care staff will increase training demand – particularly in the short term as existing staff are up-skilled.

Some 10,700 existing personal care staff will need to undertake additional training over 3 years commencing in 2021-22. Those three years see total cost of training to the Australian Government totalling around \$108 million for personal care staff.

4.5 Care quality

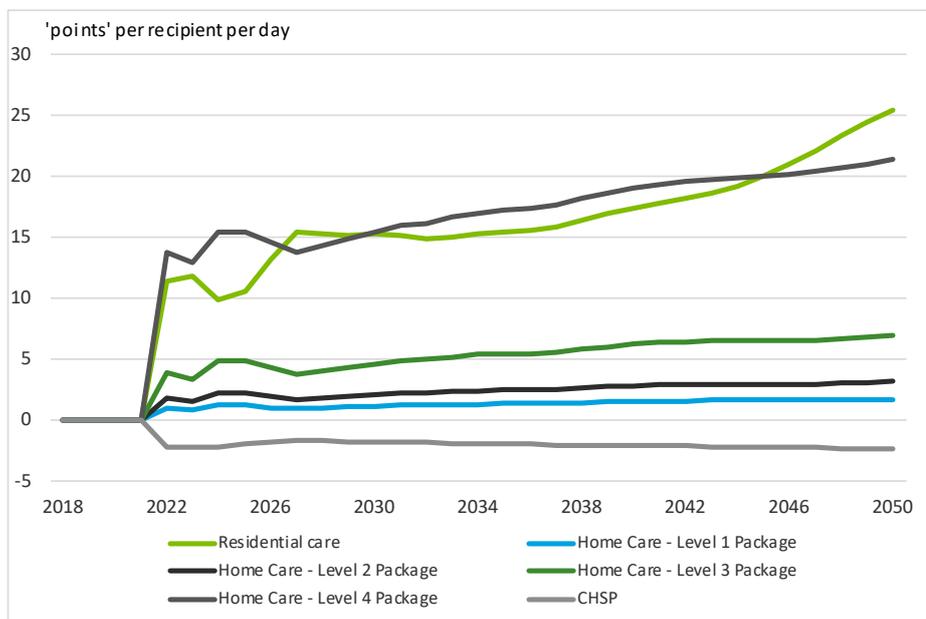
With sweeping changes to individual programs and the system as a whole this package of reforms sees the level of care available to aged care recipients shifting the quality of care delivered.

Quality outcomes are starkly different across the three major aged care programs under this scenario:

- The **residential care staffing uplift** in Residential Care results in a substantial lift in the amount of care per Residential Care recipient.
- HCP sees small increases for most recipients, while **extending HCP** for recipients who qualify for HCP level 4 sees the quality of care for that group rise strongly relative to the program as a whole.
- CHSP sees levels of care decline as some services are absorbed into HCP. This is a reflection of a shrinking set of services rather than a sign that the quality of individual services is falling.

When combined with increased access to care those changes represent genuine improvements in the experience of those most in need of aged care.

Chart 4.5: Quality of care, additional 'points' per aged care recipient – 4 star scenario



Source: Deloitte Access Economics Modelling

Importantly, the scenario sees a shift away from Residential Care and toward community care. That shift sees recipients moving from more intensive to less intensive care. That shift represents the choices of older Australians and there are a range of benefits associated with ageing in the home. Still, it should be noted that there is less aged care being delivered to the average aged care recipient under this scenario than under the baseline.

In other words there is a risk that the preferences of governments and recipients result in individuals receiving less care than they need because of a push to remain at home.

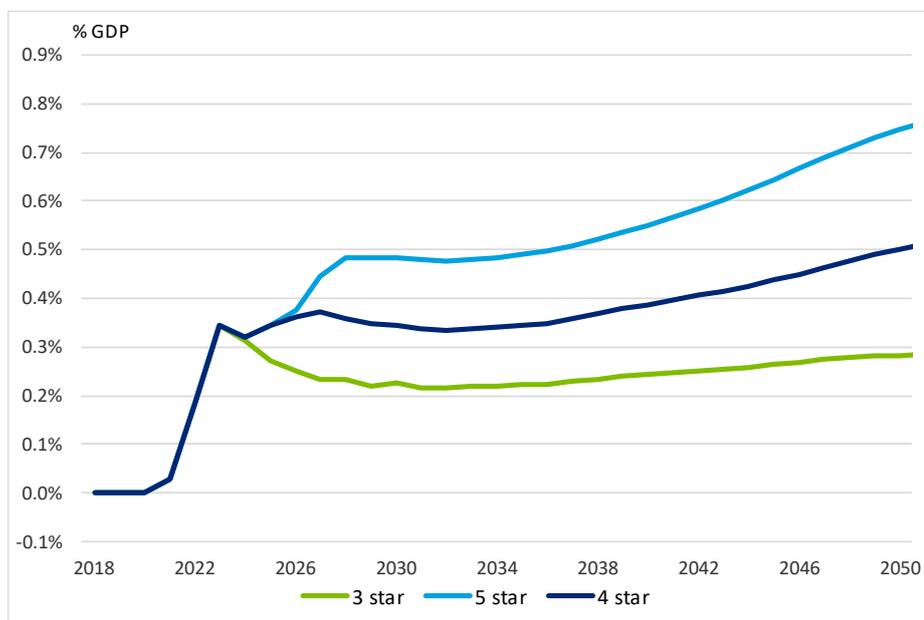
4.6 Implications for the Government Budget

Providing higher quality aged care and greater choice for older Australians requires a substantial investment from the Australian Government.

Taken together, the reforms in this package see the sector incur additional costs in 2050 of:

- 0.3% of GDP or a around a fifth of the projected baseline aged care budget in the 3 star scenario.
- 0.5% of GDP or around a third of the projected baseline aged care budget in the 4 star scenario.
- 0.8% of GDP, or around half of the projected baseline aged care budget in 2050 in the 5 star scenario.

Chart 4.6: Change in total Commonwealth expenditure



Source: Deloitte Access Economics Modelling

There are a number of groups of cost in this scenario:

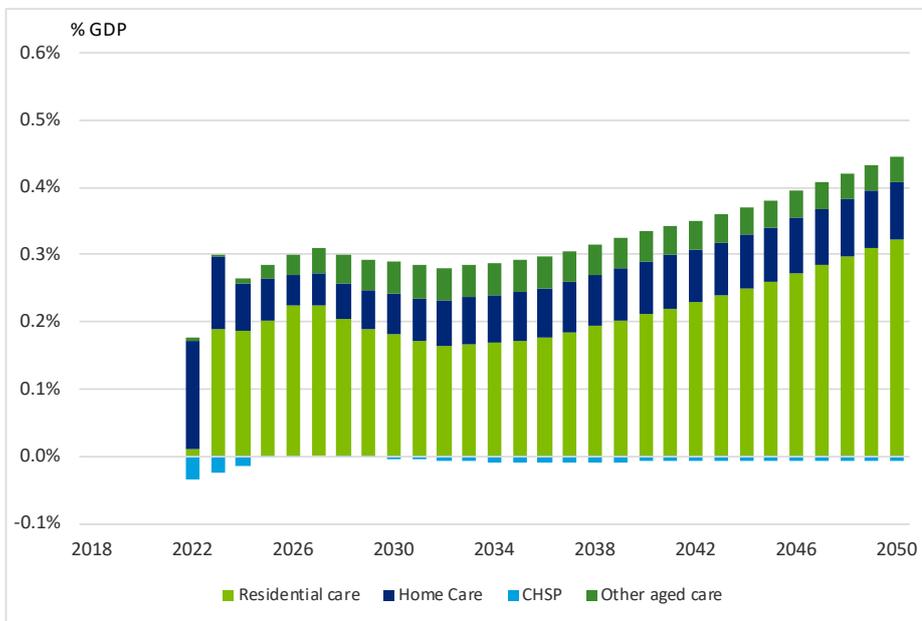
- A range of direct costs to government as a result of new payments and programs.
- Increases in funding as a result of greater access to aged care.
- Added funding to cover increased costs as a result of regulation.

The bulk of additional costs are the result of two policy changes:

- Moving staffing levels to higher star ratings substantially increases the unit cost of Residential Care. These higher costs are passed on to the government via higher funding levels.
- Uncapping access to HCP results in existing funding being extended to many additional recipients who would not receive care under existing policy settings.

Expenditure on residential care sees the biggest increase, despite fewer recipients. Spending on Home Care Packages also rises strongly relative to the baseline, but lower costs per recipient relative to residential care limit the overall increase in that program.

Chart 4.7: Difference from baseline in Commonwealth expenditure by aged care program – 4 star scenario



Source: Deloitte Access Economics Modelling

But shifts in recipients away from residential care and into the community result in offsetting savings as well – savings that are particularly important as the cost gap per recipient between residential care and home care widens.

In the long run the mandatory minimum ratios on staffing levels in residential care limit the ability of productivity gains to reduce costs in the sector. With staff time per resident mandated by regulation there is reduced scope for labour productivity growth under this reform package. This results in costs that rise over time relative to the baseline, where ongoing productivity growth is assumed to be a feature of the aged care sector.

There are also costs that arise outside of the main aged care programs, with respite funding and health interface measures in particular coming at a sizeable cost. In each of the three scenarios health expenditure outside of aged care rises by 0.04% of GDP by 2050.

That said, there is some potential for offsetting benefits where improved access to specialists and allied health professionals leads to reductions in the need for care.

Table 4.9: Projected post-reform Commonwealth aged care expenditure – 3 star scenario

\$m	2018	2020	2030	2040	2050
Residential care	11,959	13,287	25,781	46,845	87,632
Residential respite	350	360	790	1,544	2,917
Home Care	2,032	3,148	8,560	15,355	25,177
CHSP	2,361	2,685	4,766	8,090	13,310
Other	454	559	2,143	3,080	3,800
Total aged care	17,156	20,038	42,039	74,914	132,837

Source: Deloitte Access Economics Modelling

Table 4.10: Projected post-reform Commonwealth aged care expenditure – 4 star scenario

\$m	2018	2020	2030	2040	2050
Residential care	11,959	13,287	29,231	53,708	104,289
Residential respite	350	360	900	1,770	3,472
Home Care	2,032	3,148	8,651	15,561	25,787
CHSP	2,361	2,685	4,885	8,223	13,616
Other	454	559	2,158	3,105	3,839
Total aged care	17,156	20,038	45,825	82,368	151,002

Source: Deloitte Access Economics Modelling

Table 4.11: Projected post-reform Commonwealth aged care expenditure – 5 star scenario

\$m	2018	2020	2030	2040	2050
Residential care	11,959	13,287	33,225	61,299	122,794
Residential respite	350	360	1,022	2,021	4,087
Home Care	2,032	3,148	8,827	15,981	26,777
CHSP	2,361	2,685	4,963	8,349	13,924
Other	454	559	2,173	3,140	3,892
Total aged care	17,156	20,038	50,210	90,790	171,475

Source: Deloitte Access Economics Modelling

5 Paying for high quality care

The reform package considered in this report comes at a sizeable cost. In this chapter we examine two options for funding the reform package: an increase to the Medicare Levy or an increase to income tax rates.

5.1 Funding options

The cost of the reform package is substantial, and it grows over time. By 2050, the reform scenario considered in Chapter 4 will cost between \$20bn and \$59bn in that year alone depending on the star level chosen. That represents between a fifth and a half of the cost of aged care in the baseline forecast and between 0.3% and 0.8% of GDP.

Conceptually, funding to cover the increased cost of aged care can come directly from recipients, be shared more broadly in society through additional government expenditure, or an extension of the existing co-contribution arrangements.

Given the reform package doesn't include any increase in recipients' capacity to pay it's assumed that additional funding must be covered by the government.

There's a large variety of ways government can fund the additional expenditure required for the reform package including: implementing a new tax, increasing existing taxes, broadening the base of existing taxes or cutting expenditure in other areas. Having said, the scope of this analysis only considers two funding options: an increase to the Medicare Levy or an increase to income tax rates.

Table 5.1: Funding options considered

Funding option	Description
Increases Medicare levy	Imposition of a flat rate on top of the existing Medicare Levy
Increase income tax	Equal percentage point increase in PAYG income tax rate at every level

Both options have the ability to raise the required funds, however there are small differences in the required change to rates, fairness and funding certainty to consider.

Assuming that: the required increase in tax rates will remain steady over the forecast period, and a Commonwealth bond rate of 3% per annum prevails for the forecast period, then the results included in Table 5.2 will ensure there's no material change in government debt over the forecast period due to the proposed package of reforms.

Table 5.2: Required percentage point changes to tax rates

Funding option	Reform package		
	3 star	4 star	5 star
Increase in Medicare levy	0.51%	0.89%	1.31%
Increase income tax	0.58%	1.01%	1.48%

Source: Deloitte Access Economics Modelling

This is a substantial rise in tax rates. As a comparison, the Medicare Levy was recently raised by 0.5% to cover part of the cost of the NDIS.

Income taxes will need to be increased by a slightly higher rate than the Medicare Levy because it covers a lower base due to the income tax free threshold that is in place. This is also why an increase to the income tax could be viewed as a fairer way to increase government revenue given there will be no change to the tax payable on income earned below the existing tax-free threshold. On the other hand, an increase to the Medicare Levy will affect the tax payable on all income earned assuming you don't qualify for a Medicare levy reduction or exemption.

In both cases increases to tax rates have consequences for the broader economy. While personal income taxes are relatively efficient compared with some alternatives they can reduce the incentive to work and reduce economic activity. Estimates from the federal Treasury⁶ indicate a marginal excess burden of 0.21 on labour income taxes. That is, on aggregate for every additional dollar raised in income tax, household welfare is estimated to reduce by the equivalent of 21 cents.

Another important aspect of aged care funding to consider is that it's sustainable and stable in the long term. This helps ensure that providers can confidently invest to expand capacity, and workers can invest in the skills and experience required to provide recipients the quality of care required throughout their time in care.

With this in mind, there may be benefits to a funding approach that is transparent and associated strongly with the need to fund aged care expenditure.

⁶ <https://treasury.gov.au/sites/default/files/2019-03/TWP2015-01.pdf>

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