Royal Commission into Aged Care Quality and Safety

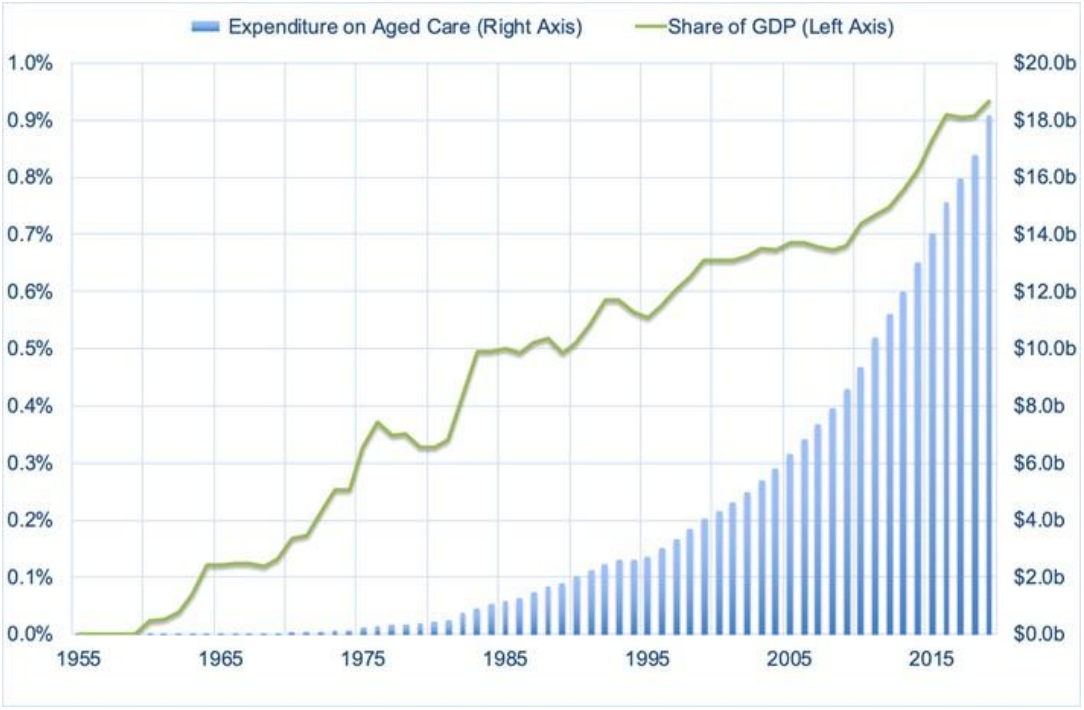
EXPENDITURE CONSTRAINTS AND MAJOR BUDGET MEASURES

Summary

In 1954-55, the Australian Government expended £0.4 million on the aged care needs of older Australians. At the time, that amount was equivalent to just under 0.01% of GDP. By 2018-19 this had increased to $18.2 billion (or 0.93% of GDP) (see Figure 1).[1]

Australian Government expenditure on aged care increased, in nominal terms, by a geometric average of 27.2% each year in the thirty years between 1954-55 and 1984-85 and then by a geometric average of 8.4% each year in the thirty-four years between 1984-85 and 2018-19. In terms of share of GDP, Australian Government expenditure on the four major aged care programs increased by 0.017 percentage points each year, on average, in the thirty years between 1954-55 and 1984-85 and then by 0.013 percentage points each year, on average, in the thirty-four years between 1984-85 and 2018-19.

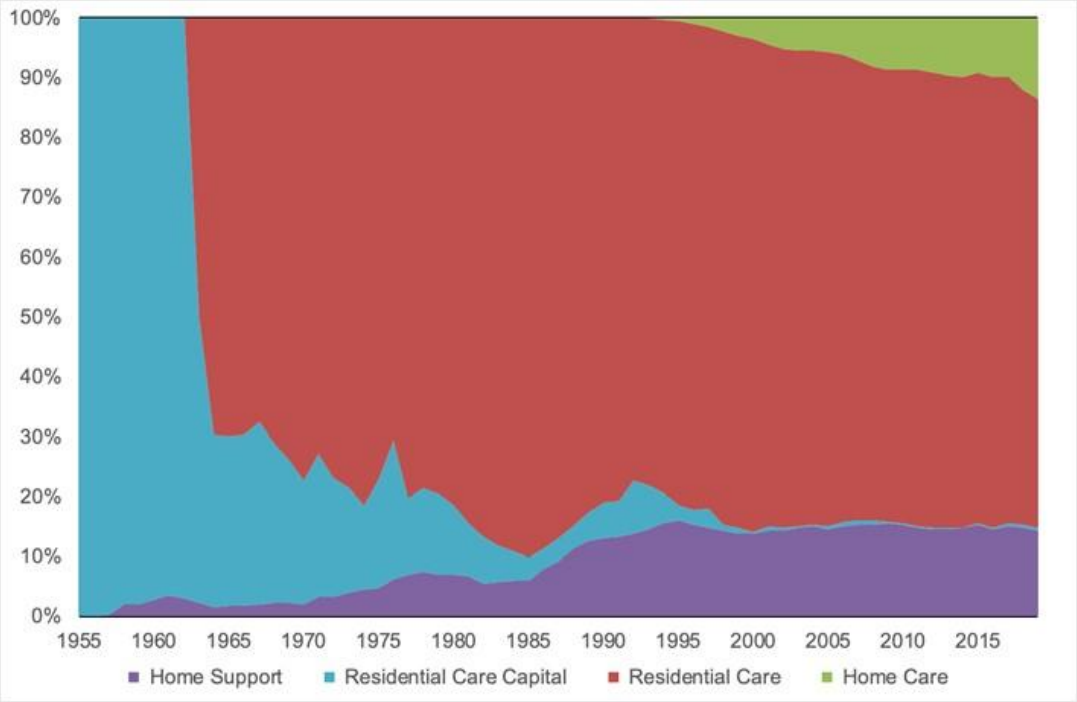
Figure 1: Australian Government Expenditure on Aged Care, 1954-55 to 2018-19



[1] Note, The analysis in this paper is concerned with the four major aged care programs:
- capital assistance for residential aged care from 1954-55;
- home support services from 1956-57;
- residential aged care from 1962-63; and
- home care services from 1991-92.

As Figure 2 illustrates, the mix of aged care services funded by the Australian Government has changed significantly since 1954-55, although residential aged care continues to account for the vast majority of the expenditure.

Figure 2: Australian Government Expenditure on Aged Care, 1954-55 to 2018-19



Australian government expenditure on aged care has not kept pace with demand since at least 1984-85 because of two main factors:

- The growth in number of aged care places was linked to the 70+ population, whereas demand for aged care was more closely correlated to the 80+ population; and
- An annual efficiency dividend has been imposed on aged care providers since 1996-97 through the Commonwealth Own Purpose Outlays/Expense arrangements.

The estimated impact of these two factors is summarised in Table 1.

Table 1: Impact of constraints on aged care expenditure

	Expenditure	% of GDP	Increase
Historical Expenditure	$18.180 b	0.93%	
Adjust for 80+ population growth	$22.851 b	1.17%	25.7%
Adjust for 80+ population growth and efficiency dividend	$27.971 b	1.44%	53.9%

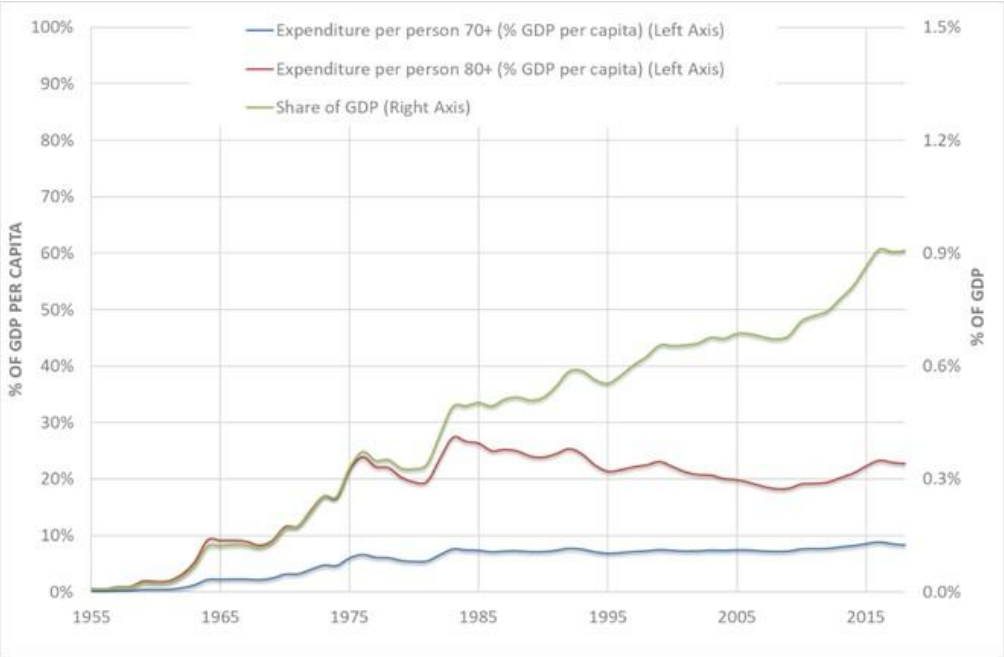
That is, the current level of Australian Government expenditure on aged care would be $9.791 billion more than it actually is if the planning arrangements had ensured that expenditure grew with the demand population and if subsidies had been increased in line with provider input costs.

Discussion

Figure 3 shows the history of Australia Government spending on the four major aged care programs (Residential Aged Care (recurrent and capital funding), Home Care, and the Commonwealth Home Support Program and its predecessors) against three key metrics:

- Expenditure as a share of GDP;
- Expenditure per person in the 70+ population expressed as a share of GDP per capita; and
- Expenditure per person in the 80+ population expressed as a share of GDP per capita.

Figure 3: Australian Government Expenditure in Aged Care, 1954-55 to 2018-19



Between 1963-64 and 2018-19, Australian Government expenditure on aged care grew from 0.12% of GDP to 0.93% of GDP. However, a change in the share of GDP spent on an activity is not necessarily related to a change in the quality of coverage of the services supported by that expenditure. This is especially true if the demand population for those services grows at a different rate to the population as a whole.

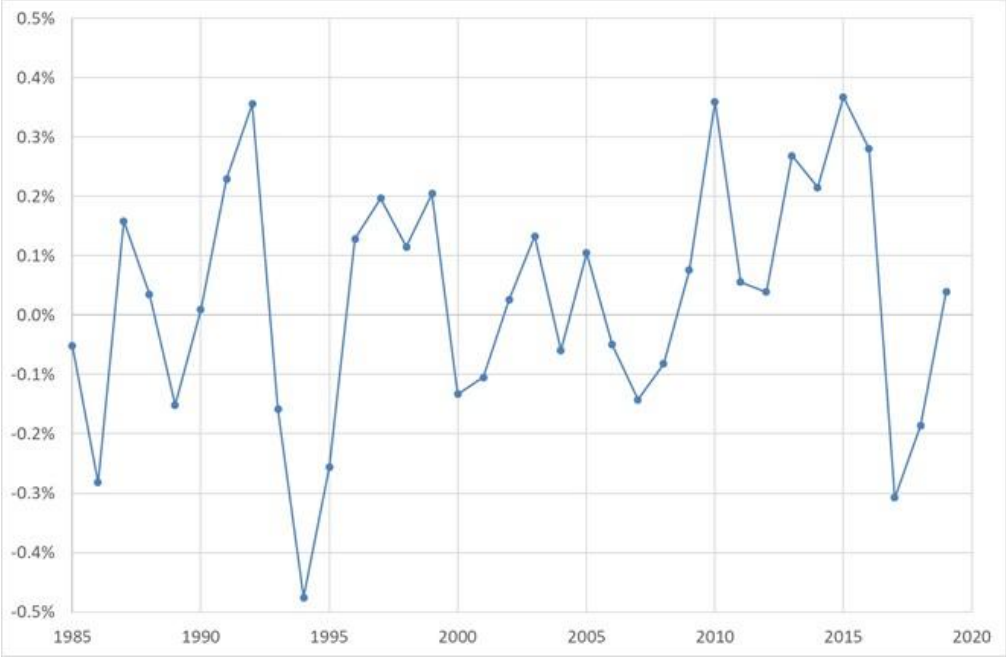
Gross Domestic Product (GDP) per capita shows a country's GDP divided by its total population. *Ceteris paribus*, an increase in GDP per capita is correlated to a real increase in standards of living. On average, total expenditure in respect of an individual cannot, across the entire economy, be greater than 100% of GDP per capita. Quantifying expenditure on an individual for a particular purpose (for example, aged care) in terms of the share of GDP per capita represented by the expenditure therefore allows for an analysis of the extent to which the quality of the services supported by that expenditure (in terms of quality or quantity/coverage) has moved in line with general living standards. Moreover, quantifying the expenditure by the hypothetical demand

population for the services (or a proxy for those services) controls for increases in expenditure driven by increases in the demand population. As a result, changes in a variable like “Government expenditure per person in the proxy demand population expressed as a share of GDP per capita” allow an analysis of the extent to which expenditure has increased in line with demand from a quantitative perspective and in line with community standards from a qualitative perspective.

Australian Government expenditure on aged care per person in the 70+ population (measured as share of GDP per capita) also grew between 1963-64 and 2018-19, from 2.21% of GDP per capita to 8.35% of GDP per capita. However, as Figure 1 shows, expenditure per person in the 70+ population (as a share of GDP) was relatively constant between 1981-82 and 2009-10, fluctuating between 6.5% and 7.5% of GDP per capita. Over the last four years, since 2015-16, expenditure per person in the 70+ population (as a share of GDP) has been declining.

Between 1984-85 and 2018-19, expenditure per person in the 70+ population (as a share of GDP per capita) declined in 14 of the 35 years (see Figure 4).

Figure 4: Historical Expenditure – Change in Expenditure on Aged Care per Person Aged 70+ (as a share of GDP per capita)



Until 1984-85, aged care supply had been largely unconstrained by the Australian Government. The aged care planning ratios were meant to ensure that growth in new residential places was in line with growth in the aged population and to provide a sustainable framework for planning aged care services in the context of an ageing population. They were also meant to ensure an appropriate balance of services, including services in residential care for people with lower levels of need, and to directly link the planning of care to the numbers of older people in a region. The government committed itself to maintaining the national provision ratio of 100 residential care places for every 1000 persons aged seventy or older.

At that time, combined hostel and nursing home places ranged from 81 per 1000 people aged at least seventy in Victoria to 115 per 1000 people aged at least seventy in South Australia. This gave an average provision 100 per 1000 aged at least seventy. While, at the time, there was no generally accepted optimum level of provision of places and beds there were a number of indications that the then current provisions in Australia were sufficient for the then and projected needs. In particular, by 1985, a market had been operating for the provision of residential aged care services for more than 30 years. This market, moreover, had operated without any direct supply side controls. The Commonwealth, that is, did not limit entry by service providers into the industry. While it is possible that a shortage of capital funding or an inappropriate level of Commonwealth subsidy would have acted as indirect supply controls there is no evidence that either of these conditions obtained. Indeed, there were no limits placed on the fees that providers could charge residents it is unlikely that such indirect supply controls were strong. Arguably, therefore, the level of residential aged care provision in place in 1985 was demand driven and was meeting that demand.

Other indicators that demand had been satisfied included international comparisons, which showed that Australia was among the highest provision countries, although not the highest. There was also mounting concern that elderly persons were prematurely seeking residential care services of greater intensity than they needed because of the lack of support and assistance which could be provided in their own homes. Moreover, evaluation of existing waiting lists indicated that the number of persons who needed immediate placement was very low.

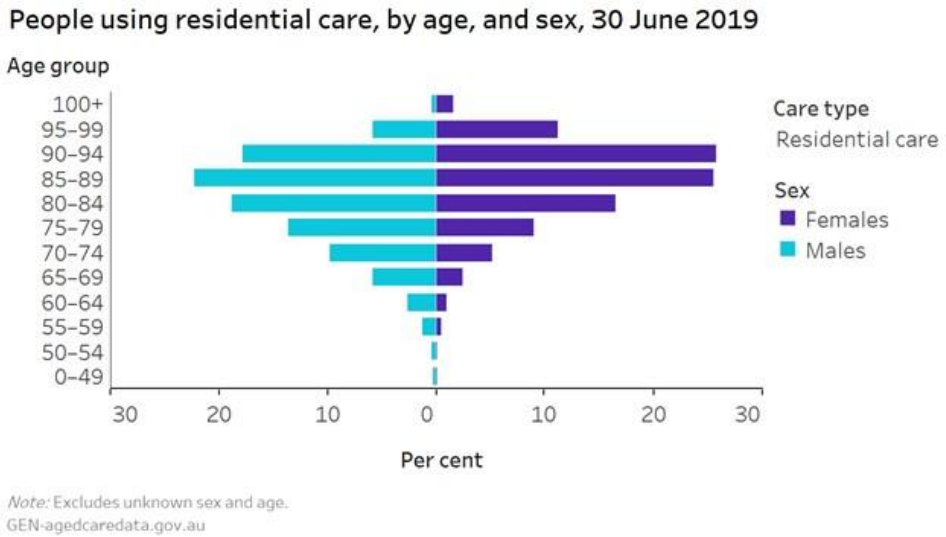
Another important change was that a specific number of extensive nursing care beds should be allocated to each state each year for aged persons assessed as highly dependent on nursing care. Only patients occupying these beds would attract Commonwealth nursing home extensive care benefits. The number of extensive care beds to be allocated was to be based on a ratio of 40 places per 1000 people aged at least seventy. At that time the number of extensive nursing care residents per 1000 aged at least seventy was reasonably constant, ranging from 35 per 1000 people aged at least seventy in New South Wales to 49 per 1000 aged at least seventy in West Australia, with all States averaging 39 per 1000 people aged at least seventy. The number of high dependency residents in nursing homes tended to be constant as a proportion of the aged care population in all States, irrespective of total bed provision levels. On this basis it seemed reasonable at the time to set as a planning assumption a uniform standard of 40 places per 1000 people aged at least seventy in each state as a maximum number of beds to be occupied by aged persons classified as highly dependent on extensive nursing care.

It was envisaged that moderately dependant persons would be moved to hostels with an improved range of personal care services and that ultimately all nursing home beds would be extensive nursing care beds. It was envisaged that the remaining 60 places per 1000 people aged at least seventy, then distributed between ordinary nursing care and hostels, would become predominantly

hostel places. This would then cause the average dependency level of hostel residents to rise. Thus, it was intended that any pressure in the system would be exerted downwards so that people with low dependency needs who might seek hostel admission would be more likely to remain in the community with alternative forms of support.

By 1994-95, three quarters of the residents of hostels and two thirds of the residents of nursing homes were aged 80 or older. A further 12.9% of hostel residents and 15.8% of nursing home residents were aged 75-79. As Figure 5 illustrates, by 2018-19, very few residents of aged care homes are under the age of 75.

Figure 5: Age Distribution of Residents of Aged Care Home, June 2019



The significant increase in real expenditure per person in the 80+ population (measured as a share of GDP capita) in Figure 3 between 2010 and 2015 is a result of recent changes to the planning ratios. In 2007, the target ratio was set at 113 places per 1000 persons aged 70+, comprising 44 places for high-level residential care, 44 places for low-level residential care and 25 community care packages. Under the Living Longer Living Better reforms, additional levels of funding were made available for home care packages in 2013 (although the highest level available was not increased). A revised ratio, reflecting the increasing focus on home-based care, the removal of the high and low care classification in residential aged care and increased demand from an ageing population, was set at 125 places per 1000 persons aged 70+, comprising 80 residential care places and 45 home care packages to be reached by 2021.

It also reflects the increasing frailty of the population receiving care. Between 2000-01 and 2018-19, the average subsidy payable for home care packages increased from $13,961 per annum to $25,245 per annum in 2018-19 prices. That equates to an increase in subsidy levels of 80.8% or 3.3% on average each year in real terms. Over the same period, the average basic subsidy

payable in residential aged care increased from $40,032 in 2000-01 to $69,114 in 2018-19. That equates to an increase in subsidy levels of 72.6% or 3.1% on average each year in real terms.

The impact of the mismatch between the demographic drivers of supply and demand can be illustrated by examining expenditure per person in the 80+ population (as a share of GDP per capita). Expenditure per person in the 80+ population also grew in real terms between 1964-65 and 2018-19, from 9.15% of GDP per capita to 22.99% of GDP per capita. However, expenditure per person in the 80+ population has also been declining in real terms since 1982-83 as Figure 3 shows. Expenditure per person in the 80+ population (as a share of GDP per capita) declined in 19 of the 35 years between 1984-5 and 2018-19.

The provision ratios for aged care have increased significantly in recent years, so that the number of people receiving aged care services has increased more rapidly than the 70+ population. These increases in supply are accounted for in the data analysed in this paper. However, there is strong evidence that the current levels of supply are not satisfying demand. Evidenced, in particular, by the waiting list for Home Care Packages and in particular for high level home care packages. It is this mismatch of demand growth and supply growth, even taking into account recent increases in provision, which account in part for the decline in expenditure on aged care per person in the 80+ population (as a share of GDP per capita)

Figure 6: Historical Expenditure – Change in Expenditure on Aged Care per Person Aged 80+ (as a share of GDP per capita)

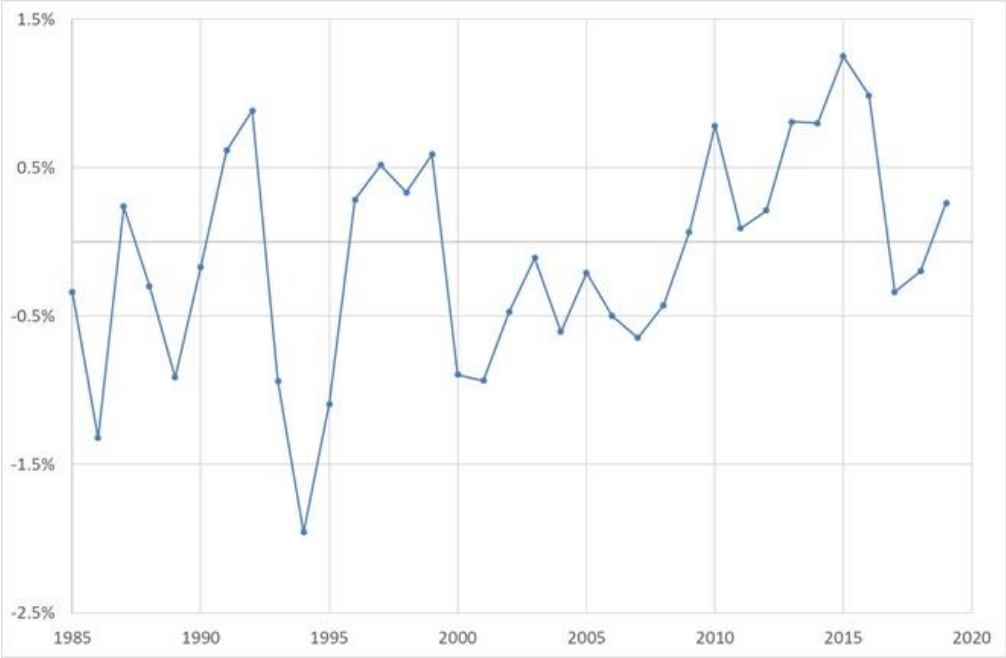
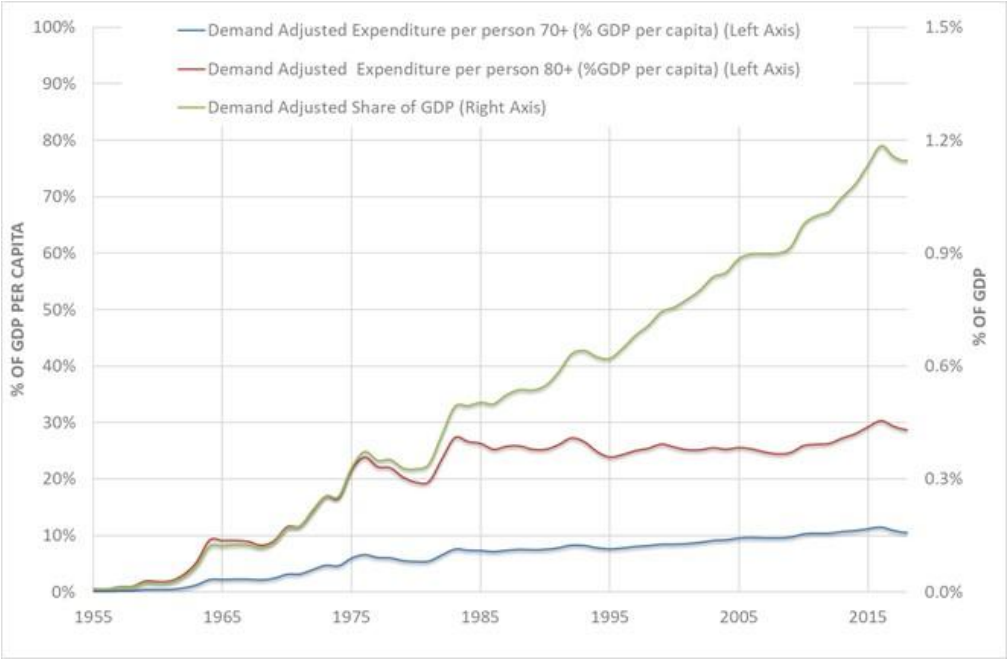


Figure 7 below illustrates what would have been the effect if the planning ratio had been linked to the 80+ population rather than to the 70+ population.[2] Under these alternative planning arrangements, Australian Government expenditure on aged care would have grown, between

[2] Note: the population adjustment was not made to the expenditure on Home Support services,

1964-65 and 2018-19, from 0.12% of GDP to 1.17% of GDP (rather than 0.93%). Australian Government expenditure on aged care in 2018-19 would have been $22.851 billion – 25.7% ($4.671 billion) more than was actually spent in 2018-19.

Figure 7: Historical Expenditure – Adjusted to grow places with the 80+ population



Adjusting for this effect, real expenditure per person in the 80+ population (measured as a share of GDP capita) would have been reasonably constant between 1984-85 and 2011-12.

Expenditure on aged care is not just affected by volume; it is also affected by price. The Australian Government has imposed an efficiency dividend on aged care providers since 1996-97. Figure 8 illustrates how subsidy levels have been consistently indexed each year at a lower rate than provider input costs (measured as the weighted (25/75) average increase in the Consumer Price Index and Average Weekly Ordinary Time Earnings).[3] Between 1999-2000 and 2018-19, subsidy levels increased by 70.3% in nominal terms, whereas provider input costs increased by 116.3%.

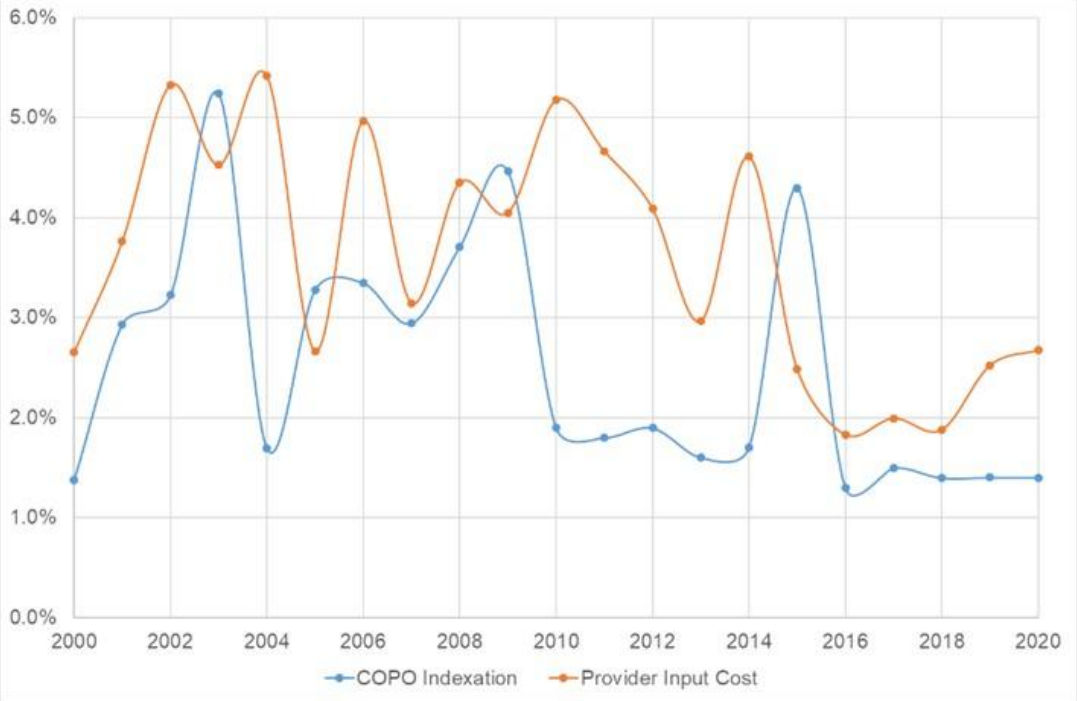
[3] In aged care, the basic subsidy rates are adjusted annually in line with movements in the Commonwealth Own Purpose Outlays (COPO)/ Commonwealth Own Purpose Expenses (COPE). COPO indexation arrangements came into effect in relation to residential aged care funding from 1 July 1996. COPO for residential aged care is weighted 75 per cent for wage costs and 25 per cent for other costs and is calculated using the following algorithm:

COPO% = (annual CPI % x 0.25) + (annual *SNA % x 0.75)

Where SNA = Safety Net / Minimum Wage Adjustment and

SNA% = Safety Net Increase in the minimum wage per week/average weekly earnings.

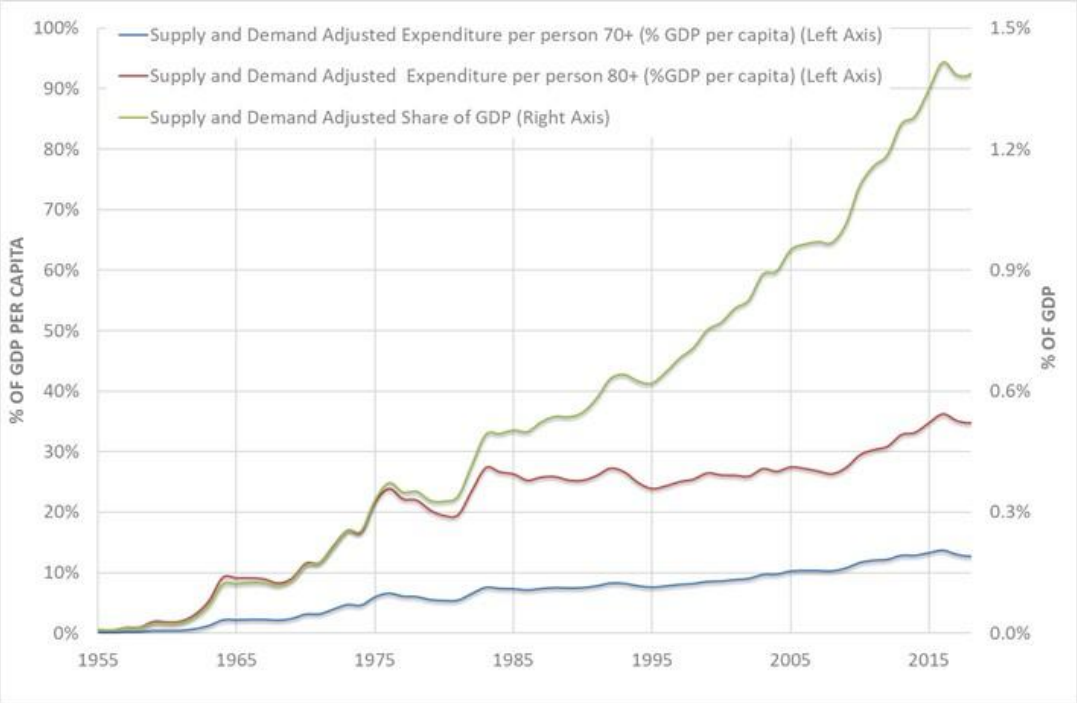
Figure 8: Comparison of the Rates of Growth of Subsidy Levels and Provider Input Costs



The indexation applied to aged care subsidies is a composite index constructed by the Department of Finance that comprises a wage cost component (weighted at 75%) and a non-wage cost component (weighted at 25%). For all Wage Cost Indices the value of the wage cost component is based on the dollar increase in the national minimum wage (as determined annually by the Fair Work Commission) expressed as a percentage of the latest available estimate of average weekly ordinary time earnings (AWOTE) published by the Australian Bureau of Statistics as at November of each year. The value of the nonwage cost component of WCI-9 is based on changes in the Consumer Price Index between the March quarters each year. The effect of the wage component of this index is to undercompensate sectors where the average wage in the sector is below AWOTE. A fairer index would apply the minimum wage percentage increase rather than to divide the dollar amount of the minimum wage increase by the larger AWOTE.

Figure 6 below illustrates what would have been the effect if the planning ratio had been linked to the 80+ population rather than to the 70+ population and if the “efficiency dividend” that results for the COPO algorithm had not been imposed. Under these alternative arrangements Australian Government expenditure on aged care would have grown, between 1964-65 and 2018-19, from 0.09% of GDP to 1.44% of GDP (rather than 0.93%). Australian Government expenditure on aged care in 2018-19 would have been $27.971 billion – 53.9% ($9.791 billion) more than was actually spent in 2018-19.

Figure 9: Historical Expenditure – Adjusted to grow places with the 80+ population and removing efficiency dividend



Additional difficulties

Two other constraints have also been artificially placed on aged care expenditure growth:

- The static nature of the Aged Care Funding Instrument, which has not be recalibrated to the increasing frailty of the residential aged care population; and
- The static nature of the funding levels of the four Home Care Packages, which are fixed except for indexation, whereas the average frailty (and hence expenditure on) aged care residents has increased significantly.

The ACFI is meant to be a casemix classification system. Ideally, a casemix classification system should divide the treatment population into distinct groups, with the people in each group having similar levels of complexity and care needs (and hence similar funding needs). The payment rate for each of these groups is then set at the average cost of people in the group and, on average, the facility would receive sufficient funding to meet the care needs of the residents. Some members of each group might have slightly higher or slightly lower costs but the average would, because of the law of large numbers, work at the facility level. The key requirements for this to work are:

- Casemix groups need to be homogeneous, both clinically and in terms of cost; and
- The treatment population should be spread through the groups – there is little point in having a large number of groups if almost everyone is in a small number of the groups.

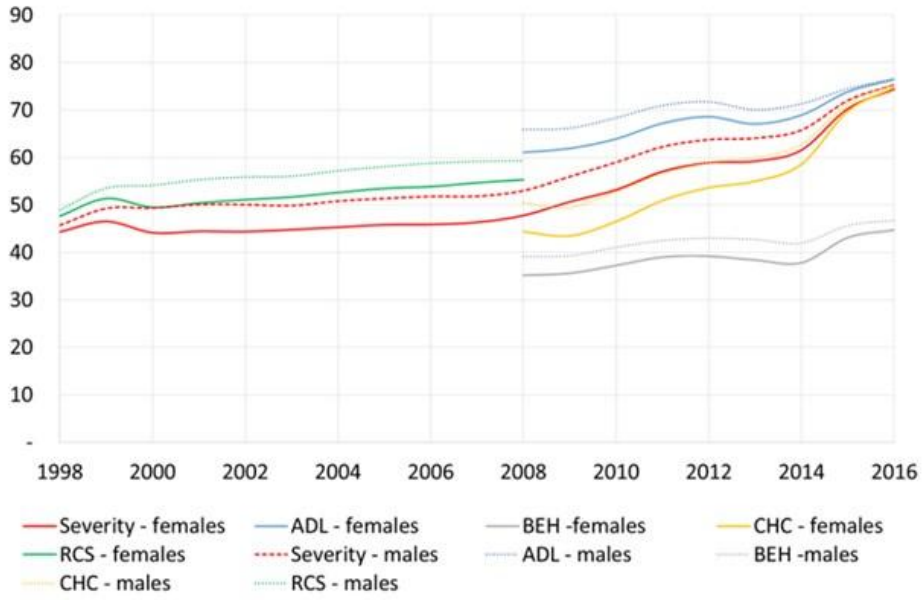
The ACFI no longer satisfies these requirements. Residents are now clumped towards the top of ACFI categories and most categories are now redundant:

- in 2008, only 3.7% of residents were in the highest category – in 2018 this share is 31.1%.
- in 2008, the eight most expensive categories accounted for 21.1% of residents – in 2018, the eight most expensive categories accounted for 59.7%
- In 2008, the single largest category has 6.4% of residents – in 2018 the single largest category has 31.1% of residents
- In 2008, the largest eight categories accounted for 36.1% of residents – in 2018, the largest eight categories accounted for 70.7% of residents
- In 2008, there were only five tiny categories (with less than 0.1%) of residents - in 2018, 24 out of 64 categories were essentially empty.

The average subsidy in 2008 (in 2018 prices) was $122.21 – that is, 55.6% of the maximum possible payment. By 2018, the average subsidy was $177.51 (80.8% of the maximum payment). In brief, the population is much frailer and in need of higher levels of care than when the ACFI was first introduced. Almost certainly the payment rate for the highest category (with 31.1% of residents) is less than the average cost of caring for those residents. This is because the distribution of resident frailty and costs has shifted significantly to the right (higher) over the last two years but the top rate of payment has remained unchanged.

Figure 10 below illustrates how the cap on the maximum rate of the ACFI is now binding on the average subsidy payable.

Figure 10: Average Real Subsidy Level



Absent a detailed costing study, it is not possible to ascertain the exact magnitude of the impact on expenditure of the binding constraint of the maximum level of the ACFI subsidy. However, given that 31.1% of residents were classified at the highest funding level in 2008, a lower bound on the impact of the constraint can be obtained by lifting the classification of half of these residents to a subsidy level above the current highest subsidy level (with the difference equal to the difference between the top two subsidy levels). That would increase the average subsidy of 15.5% of residents by $19.67 per day which would increase the average subsidy overall by $3.05 or 1.6%.

While the extent to which this constraint has impacted expenditure levels to date is unclear, it is absolutely clear that if unaddressed (through a classification system with costs weights that are based on true unconstrained input costs and is regularly reviewed) it will erode the growth in the level of expenditure below that required to meet demand and maintain quality.

A similar difficulty arises because of the static nature of the Home Care package funding levels. Most recipients of the these packages still receive a Level 2 package, whose funding level has not increased in real terms since they were first introduced in the early 1990s. At that time the subsidy level was set at the average cost of hostel care (later the Level 4 package funding level was set at the average cost of nursing home or high level care). The package funding levels have not increased in real terms since their introduction, whereas average frailty rates (and funding levels) in residential aged care have increased considerably. While it is true that the recent changes in the mix of home care packages has increased the average level of funding in real terms, the waiting list data shows that the current mix of packages is not matched with the demand for packages. This, together with the relatively lower maximum level of funding for home care packages, is artificially constraining Australian Government expenditure and hence, together with the other factors analysed in this paper, the extent to which the system can meet the needs of older Australians.

Major policy measures

As well as the implicit savings taken by the funding constraints outlined above, successive Australian Governments have also imposed explicit savings measures on aged care from time to time. Additional, often ad hoc, investments have also been made – including through the temporary bringing forward of the future releases of places, or the swapping of one type of place for another within the provision ratio.

1996-97 Budget – Structural Reform of Aged Care

1996-97	1997-98	1998-99	1999-2000
-$4.2m	-$125.0m	-$164.4 m	-$194.4m

This savings measure introduced the reforms set out in the *Aged Care Act 1997*, including mean testing, the amalgamation of the nursing home and hostel systems and the introduction of the Resident Classification Scale. The reforms also replaced the automatic link between the indexation

of aged care subsidies and wage increases in the sector with the COPO indexation arrangements discussed above.

This measure equated to a 4.5% savings across all aged care expenditure in the 1999-2000.

2006-07 Budget - Aged care and pensions — further harmonisation

2006-07	2007-08	2008-09	2009-17
-$4.2m	-$15.5m	-$222.9m	-$28.8m

This savings measure strengthened the means testing arrangements by deeming any gifts made by a prospective resident totalling more than $10,000 in any financial year, or $30,000 over five years, to still be in the possession of the resident for the purposes of the aged care assets test.

2009-10 Budget - Fairer income testing in residential aged care — ending the 28-day income test exemption

2009-10	2010-11	2011-12	2012-13
-$4.5m	-$10.9m	-$11.8m	-$12.9m

This savings measure strengthened the means testing arrangements by applying the income test for residential aged care from the day of entry, removing the then 28-day delay.

2011-12 Budget - Aged Care — additional community places

2011-12	2012-13	2013-14	2014-15
-$26.6m	-$45.2m	-$55.1m	-$82.1m

The measure temporarily adjusted the balance in the provision rations of high-level community aged care and high-level residential aged care. The measure led to savings for the government because the average cost of high-level community aged care was fixed in real terms and lower than the average cost of high-level residential aged care, which was not fixed.

This measure equated to a 0.6% savings across all aged care in the 2014-15.

2012-13 Budget - Living Longer. Living Better — improving the Aged Care Funding Instrument

2012-13	2013-14	2014-15	2015-16
-$50.1m	-$269.6m	-$365.4 m	-$432.5m

The savings measure adjusted the Aged Care Funding Instrument.

This equated to a 2.9% savings across all aged care in the 2014-15. Note, however, that most of this funding was redirected to other aged care measures.

2012-12 Budget - Living Longer. Living Better — means testing

2012-13	2013-14	2014-15	2015-16
$11.9m	$13.6m	-$107.4 m	-$212.8m

This savings measure introduced an income test was introduced for Home Care packages and a stronger combined income and assets test for residential care.

This measure equated to a 1.4% savings across all aged care in the 2014-15.

2014-15 Budget - Aged Care — Commonwealth Home Support Programme — reduced rate of real funding growth

This savings reduced the rate of real growth in the Commonwealth Home Support Programme from six per cent annually to 3.5 per cent annually. This measure was intended to reduce aged care expenditure by $1.7 billion over six years from 1 July 2018.

2014-15 Budget - Aged Care Payroll Tax Supplement — cessation

2014-15	2015-16	2016-17	2017-18
-$85.6m	-$181.2m	-$188.1m	-$197.8m

This savings measure removed the Payroll Tax Supplement.

This equated to a 1.2% savings across all aged care in the 2017-18.

2015-16 - Aged Care — Increasing short term restorative care place

2015-16	2016-17	2017-18	2018-19
-$1.1m	-$8.0m	-$15.2m	-$31.9m

The measure incorporated short term restorative care places into the aged care planning ratio from 1 July 2016. The measure led to savings for the government because prior to this measure the restorative care places were funded on top of the provision ratio.

2015-16 MYEFO - Aged Care Provider Funding — revision to the Aged Care Funding Instrument Complex Health Care Domain

2015-16	2016-17	2017-18	2018-19
	-$104.2m	-$156.1m	-$212.6m

The measure was intended to achieve savings of $472.4 million over four years by refining the Aged Care Funding Instrument, through changes to the scoring matrix that determines the level of funding.

This measure equated to a 1.2% savings across all aged care in the 2018-19.

2016-17 Budget - Aged Care Provider Funding — further revision of the Aged Care Funding Instrument

2016-17	2017-18	2018-19	2018-19
-$119.0m	-$229.6m	-$339.5 m	-$463.8m

The measure was intended to achieve savings of $1.2 billion over four years through changes to the scoring matrix of the Aged Care Funding Instrument. The measure also reduced indexation of the Complex Health Care component of the ACFI by 50 per cent in 2016-17.

This measure equated to a 2.6% savings across all aged care in the 2018-19.

2017-18 Budget — Strengthening Aged Care — Commonwealth Home Support Program Funding Arrangements — extension

The measure announced the provision of $5.5 billion over two years from 2018-19 to extend the Commonwealth Home Support Program (CHSP) and Regional Assessment Services (RAS) funding arrangements.

Funding for these programs had already been included in the forward estimates and so the measure had no net effect on the aggregate funding available for aged care.

2018-19 Budget — More Choices for a Longer Life — healthy ageing and high quality care

2017-18	2018-19	2019-20	2020-21	2021-22
$8,2m	-$37.7m	$10.2m	-$2.2m	$2.0m

The measure was intended to implement new policies to support people to stay at home longer, remain healthy and independent for longer, and to improve access to high quality, safe aged care.

The funding for most of the changes announced in the measure was already in the forward estimates for aged care and the measure redirected the funding to new purposes.

2018-19 MYEFO - Strengthening Aged Care - More Places, Lower Fees, Better Access

2018-19	2019-20	2020-21	2021-22
$98.5m	$236.2m	$57.6m	$54,2m

This measure provided $454.9 million over four years from 2018-19 to support older Australians with improvements to residential and home care arrangements.

The long run effect of this measure on aged care expenditure was minor, however, as the majority of the changes consisted of the bringing forward of places already accounted for in future forward estimates.

2019-20 Budget — Election Commitment — Aged Care System Navigators — culturally and linguistically diverse

2019-20	2020-21	2021-22	2022-23
$2.5m	$2.5m	$2.5m	$2.5m

This measure provided $10.0 million over four years from 2019-20 to create a dedicated network of Aged Care System Navigators to assist people and their families from culturally and linguistically diverse backgrounds access the aged care system.

2019-20 Budget — More Choices for a Longer Life — Commonwealth Home Support Programme Funding Arrangements — extension

This measure announced the provision of $5.9 billion over two years from 2020-21 to extend the Commonwealth Home Support Programme (CHSP) funding arrangements. Funding for these programs had already been included in the forward estimates and so the measure had no net effect on the aggregate funding available for aged care.

2019-20 Budget — More Choices for a Longer Life — improving the quality, safety and accessibility of aged care services

2018-19	2019-20	2020-21	2021-22	2022-23
$332,6m	$147.6m	$136.3m	$36.9m	$21.4m

This measure provided $724.8 million over five years from 2018-19 to support older Australians through further improvements to the quality, safety and accessibility of residential and home care services.

The long run effect of this measure on aged care expenditure was minor, however, as the majority of the changes consisted of the bringing forward of places already accounted for in future forward estimates or of one off payments to aged care providers.

2019-20 MYEFO — Aged Care — response to the Aged Care Royal Commission Interim Report and ongoing aged care reforms

2019-20	2020-21	2021-22	2022-23
$132.5m	$213.5m	$170.9m	$63.4m

This measure announced the provision of $623.9 million over four years from 2019-20 to respond to the *Interim Report* of the Royal Commission into Aged Care Quality and Safety, including the three priority areas identified in the report, and build on the Government's recent aged care reforms to improve standards, oversight, funding and transparency in the care of older Australians:

The costs of this measure were partially met from within the existing resources of the Department of Health.

COVID-19 Response Package — ageing and aged care

2020-21	2021-22	2022-23	2023-24
$375.2m	$421.1m	$1.m	-

This measure provided $812.8 million over four years from 2019-20 through time limited adjustments to support older Australians throughout the COVID-19 pandemic.

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2020-21	2021-22	2022-23	2023-24
$135.0m	$148.1m	$105.4m	$72.1m

This measure provided $617.7 million over six years from 2019-20 (including $21.8 million in 2024-25) to further support older Australians accessing aged care by providing additional home care packages and improving transparency and regulatory standards while building on the recent reforms announced in the 2019-20 MYEFO.

The long run effect of this measure on aged care expenditure was minor, however, as the majority of the changes consisted of the bringing forward of places already accounted for in future forward estimates or of time limited payments to aged care providers.

Sources

The expenditure data in this report are drawn from the Annual Reports of the Departments of Health, Social Services and Veterans Affairs (and their predecessors) from 1954-55 to 2018-19.

Data on the characteristics of the recipients of aged care services are drawn from the relevant reports and data sets of the Australian Institute of Health and Welfare.

Population and national account statistics are drawn from the relevant publications of the Australian Bureau of Statistics.

Other historical data and commentary is drawn from Cullen, DJ. (2003). *Historical Perspectives – the evolution of the Australian Government's role in supporting the needs of older people*. Canberra: Australian Department of Health and Ageing.

Information on Budget measures is drawn from the relevant Budget Papers.