NATIONAL AGED CARE Alliance

Aged Care Reform: How Effective So Far?

The State of Play in Aged Care Reform: Achievements & Challenges

DISCUSSION PAPER

November 2025

About the National Aged Care Alliance

The National Aged Care Alliance (the Alliance) is the leading coalition of National aged care peak bodies in Australia. Our members represent the core constituencies involved in the delivery of federally funded aged care services: consumers, service providers, unions and professional bodies.

We work together to establish a more positive future for aged care in Australia. We exist to advocate for older and ageing people to be at the centre of an aged care system that delivers high quality services. This includes a needs-based approach that ensures equitable outcomes and access to services and support, whilst embracing the diverse characteristics and life experiences of people who need aged care services now or in the future, including their family, friends and carers. The Alliance champions a human rights-based approach to aged care.

We proactively influence and shape ongoing reform of the aged care and interconnecting systems, such as health, housing and disability that support older and ageing people.

Acknowledgements

The National Aged Care Alliance acknowledges the Traditional Owners of Country throughout Australia. We acknowledge Aboriginal and Torres Strait Islander peoples were the first sovereign Nations of the Australian continent and its adjacent Islands. We pay our respects to their Ancestors and their descendants, who continue cultural and spiritual connections to Country.

About this paper

This paper has been funded by the Commonwealth of Australia and produced for the National Aged Care Alliance by Ian Yates of CONSULT.AGEING. The recommendations in this discussion paper aim to generate further consideration of the relevant issues, both within the National Aged Care Alliance and externally. The paper was written prior to and published after the implementation of the new Aged Care Act on 1 Nov 2025.

Ownership of intellectual property

Contents

1. Background and Context

The current reform process is generally regarded as having originated with the Royal Commission. However, a significant amount of reform finds its origins prior to the Royal Commission. Some of the key more recent[1] examples include:

- The Final Report of the 'Alternative Aged Care Assessment, Classification System and Funding Models' study, commissioned by government and the (precursor to AN-ACC, was released in February 2017, followed by other work including the Residential Utilisation and Classification Study (RUCS) during 2018 and reported February 2019; followed by an extensive trial of the AN-ACC, which was then introduced 1 October 2022[2]
- The Australian Law Reform Commission's report on Elder Abuse, released in May 2017, covered a number of aged care matters including creating a serious incident response scheme, staffing ratio increases and reform, reducing use of restrictive practices, reforms in decision-making arrangements, and creating a Code of Conduct[3]
- In June 2017 the Senate referred to the Community Affairs Committee an Inquiry into the effectiveness of the Aged Care Quality Assessment and Accreditation Framework for report by November 2018. This reported in October 2018 with recommendations to review and improve ACFI, legislate 24/7 nursing, improved SIRS, support for Carnell-Paterson recommendations, mandatory expanded QIs, restrictive practices, star ratings and wider access to OPAN services[4]
- The Aged Care Legislated Review (Tune Review) -September 2016- September 2017, presented 38 recommendations on aged care planning, funding, financing and services reform[5]
- The Review of National Aged Care Regulatory Processes (Carnell-Paterson) reported in October 2017 and made many major recommendations including an independent ACQSC, a mandatory and expanded Quality Indicators program, a star ratings system, greater use of unannounced visits, stronger action against restraint and better complaints handling. A new ACQSC was announced in April 2018[6]

[1] The current reform process has its major antecedents in the Productivity Commission (PC) inquiry into aged care, which produced its Final Report "Caring for Older Australians" in 2011, which was the precursor to the Gillard Government (Mark Butler led) 'Living Longer. Living Better' reform package passed in 2013. Most of the PC recommendations were not implemented, but aa 'mid-term review of the 10-year package was built into the Living Longer. Living Better Act. Much of the current reform agenda traces back to the PC. However here we deal only with reforms efforts immediately preceding the Royal Commission.

[2] https://www.health.gov.au/our-work/AN-ACC/about

[3] https://www.alrc.gov.au/publication/elder-abuse-a-national-legal-response-alrc-report-131/

[4] https://www.aph.gov.au/Parliamentary_Business/Committees/House/Former_Committees/Health_Aged_Care_and_Sport/AgedCareFacilities/Report

[5] https://www.health.gov.au/sites/default/files/legislated-review-of-aged-care-2017-report.pdf

[6] https://www.health.gov.au/resources/publications/review-of-national-aged-care-quality-regulatory-processes-report?language=en

- The 2017 Productivity Commission report on Reforms to Human Services released in March 2018 included recommendations on better palliative and end of life care in aged care, and better aged care /health care interfaces[7]
- In December 2017 the government referred to the House Standing Committee on Health, Aged Care and Sport an 'Inquiry into the Quality of Care in Residential Aged Care Facilities'. The Committee tabled its Report in October 2018[8]. The Report made 14 recommendations including 24/7 nursing, a process for linking staffing and care standards, a star rating system and various other Carnell/Paterson recommendations, more funding for OPAN services and a stronger consumer focus
- 'More Choices for a Longer Life' was the centrepiece package of ageing and aged care reforms in the 2018 Budget. About half the 42 budget measures were for aged care, including a Navigators trial, a major increase in Home Care Packages, the creation of an independent Aged Care Quality and Safety Commission, funds for palliative care and mental health in aged care, creation of a single assessment service, an improved My Aged Care, and the end of the Aged Care Approvals Round and bed licences[9]
- The Aged Care Workforce Taskforce Final Report 'A Matter of Care', presented in October 2018, presented an integrated set of 7 strategies, with a 14-point plan for improving the aged care workforce, which lead inter alia to the Aged Care Workforce Industry Council (since closed) the creation of Aged Care Research and Industry Innovation Australia (ARIIA) at Flinders University, and the Remote Workforce Accord[10]
- In October 2019 the federal government responded to the House Standing Committee on Health, Aged Care and Sport Report (above). The government referred to a number of the above initiatives and noted that in the time between the Minister making the referral to the Committee in December 2017 and the government response the following reform initiatives had progressed:
    - the introduction of unannounced visits for re-accreditation
    - the establishment of the Aged Care Quality and Safety Commission incorporating Quality and Complaints
    - the establishment of a process to publicly name providers who obstruct the resolution of payments
    - the introduction of new Aged Care Quality Standards and support to assist with transition
    - a new Single Charter of Aged Care Rights
    - the introduction of the National Aged Care Mandatory Quality Indicator Program and the commencement of the development of two additional indicators under the program

[7] https://www.pc.gov.au/inquiries/completed/human-services/reforms#report
[8] https://www.aph.gov.au/Parliamentary_Business/Committees/House/Former_Committees/Health_Aged_Care_and_Sport/AgedCareFacilities/Report
[9] https://archive.budget.gov.au/2018-19/additional/essentials.pdf
[10] https://oia.pmc.gov.au/sites/default/files/posts/2021/09/A-matter-of-care-australia-s-aged-care-workforce-strategy.pdf

- legislation to reduce inappropriate use of physical and chemical restraint
- the publication of open disclosure and clinical governance frameworks
- the development of measures to improve the use of medicines in aged care including the use of psychotropic medicines
- the provision of funding for a trial of integration of pharmacists into Aged Care in the ACT
- preparatory work to develop a Serious Incident Response Scheme
- improved access to psychological services in Residential Aged Care Facilities
- the Aged Care System Navigator trials to provide new ways to help older Australians who have difficulty engaging and understanding the aged care system, and
- a pilot of innovative technologies to improve care for people living with dementia.

There were more things happening – both within/by government and beyond the government/ parliamentary space (e.g. in NACA, COTA, OPAN, ACFA), but the preceding list is only designed to indicate key initiatives.

The list is also only a summary, essentially the “headlines” of each initiative. A detailed examination of all these reports, Budget measures, etc. demonstrates a considerable continuity between those initiatives and the considerations and often the recommendations of the Royal Commission. The Royal Commission was established in a context of substantial formal efforts to initiate reform in aged care over the immediately preceding period. If we went back further in time, we would see similar continuities over longer periods. Change has been slow in aged care.

Royal Commission

The Royal Commission was announced in September 2018, commenced during October, issued its Interim Report ‘Neglect’ on 31 October 2019, and its Final Report, ‘Care, Dignity and Respect’ on 1 March 2021.

It was a major exercise, with over 10,500 submissions, over 600 witnesses at 26 hearings over 99 days, 12 community forums with over 2400 people, 13 roundtable discussions, and extensive commissioned research.

The Final Report contained 148 recommendations, although some of these were alternates where the two Commissioners made different recommendations. The Royal Commission gave its Final Report to government on 1 March 2021.

The Coalition government delivered a comprehensive response and funding in the 2021 Federal Budget on 11 May (it had begun preparations in October 2020). The majority of recommendations were accepted and funded, some were to be further considered, and a number (some key) were not accepted. Funding of $17.7 B was committed over the Forward Estimates, which later grew to over

$19B by early 2022 after measures in the Mid-Year Economic and Fiscal Outlook (MYEFO). Many recommendations were actioned either by direct government action, and others in the 'Aged Care and Other Legislation Amendment (Royal Commission Response No. 1) Act 2021'.

The Coalition Government Introduced the 'Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Act 2022', which was to implement a significant number of other measures, but this was not passed by Senate before the 2022 Federal Election. It became the first Act of the new Labor government in August 2022, with one omission and one addition.

The then Labor Opposition made aged care a major issue in May 2022 election, especially aged care workforce measures, including increased award wages, and several other issues. After the election, the new government passed the (slightly amended) 'Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Act 2022', supported higher award wages in submission to the Fair Work Commission, and then funded the increase that the FWC granted, funded and then legislated the Inspector-General of Aged Care, and pursued implementation of most of 2021 Budget measures. The new Aged Care Act and Support at Home were delayed by a year initially to 1 July 2024, then by another year, but both have now been enacted. Their commencement was recently deferred again to 1 November 2025.

2. What's been achieved to date and what challenges have emerged in relation to those?

This section of the Discussion Paper works through a list of reform measures, the progress and effectiveness of which was discussed with NACA members through a written survey, online workshops with each of the constituency groups and an in-person workshop with NACA members at its May meeting. Input was also received from other sector stakeholders, and through government and sector documentation and discussions (both online and face to face).

This is not a compendium of all reform measures or Royal Commission recommendations – that is done by the Inspector- General of Aged Care (IGAC), whose 2025 Progress Report will now be with government. Rather, this is an attempt to identify where measures have, however implemented, had positive effects or outcomes, and whether there are also issues arising from those measures that may have been negative, or require additional review, consideration or action. There is also not unanimity about the effectiveness of all measures discussed, which is noted where it occurs.

In addition to recognising positive improvements, the focus is on issues that have arisen because of reform measures whether already implemented or currently underway – regardless of whether those issues are caused by commission or omission. Later sections of the paper deal with reform measures

(usually Royal Commission recommendations) the implementation of which is still in progress, and then consideration of recommendation not progressed and the implications of this.

It is important to state that much has been achieved for the sector, government and taxpayers, and to some degree for older people and families receiving support and care. As many sources have already indicated, including the 2023 and 2024 Progress Reports of the Inspector-General of Aged Care, the scale and scope of implementation of the recommendations of the Royal Commission is comparatively unprecedented in the history of Royal Commissions. Despite political rhetoric, it has also been remarkably bipartisan. That is not to diminish concerns expressed by the sector in this paper, but it needs to be acknowledged.

This is a massive change agenda, and all change tends to have unexpected and/or unintended consequences, and when you have scores of reform measures in a short period of time there is a much greater probability of those happening. These are matters that need consideration and, in most cases, future action, but they do not necessarily detract from the gains that have been made.

It is also important to note that many of the issues that have arisen are interrelated and indeed often interdependent. In addition, the reform process consists of a very large number of reform measures, each of which has an individual effect, but which collectively can have an overall impact that is different than the sum of individual effects due to things like unexpected and unintended interactions (e.g. care minutes on allied health) or cumulative impacts that no one had (or perhaps could have) precalculated (e.g. total regulatory impact).

Increased Award Wages – Government Funded

There is broad agreement that the significant increases[11] in Award wages, which are still being rolled out in stages, and the funding of these by government, has produced positive (some say very positive) effects on staff attraction and retention, and on staff morale, and that both of these have had some positive impacts for older people receiving care.

The degree to which attraction and retention has improved does vary, and it can be influenced by other factors such as geographic location, poor management or organisational culture, or in some contexts organisational scale (e.g. having HR staff). There is ongoing discussion about whether and how government can assist in regard to some of these factors (e.g. geographic), whereas others are clearly organisation specific responsibilities.

[11] 11 It's interesting to note that the FWC 'interim' increase of 15% was the same as the recommendation in the 'A Matter of Care' report from 2018 - delayed by 5 years.

There have been issues with staff not being covered (fully or partially) by FWC decisions and government supplements not necessarily covering all costs or instances of providers not fully passing on funded rises. These are likely early implementation issues.

While Award wages have and will continue to improve until mid-2026, this is flowing through to other employment arrangements and is well argued that these increases are not a long term 'fix' for aged care remuneration, or for the attraction and retention of an aged care workforce. To address these in the longer term more attention to workforce planning (across the whole care sector, not just aged care), is required including enhanced education, training and continuous professional development, and new models of care that provide for degrees of specialisation (alongside general capacities) and career paths that reflect and incentivise these. And all of this will need to be incentivised and rewarded in remuneration levels and provided for in funding arrangements.

Care Funding, including the Australian National Aged Care Classification (AN-ACC) funding model and the Independent Health and Aged Care Pricing Authority (IHACPA)

Direct increased funding by government; the introduction of the AN-ACC; and the creation of IHACPA are all measures that have led overall to both increased resources in residential aged care and home care, and also a new trajectory for funding review and growth over time. In general these are regarded as positive improvements for the residential sector, especially with IHACPA-recommended indexation rather than Treasury and Finance setting increases in line with COPO[12]. There have been real value increases in funding, even taking into account additional requirements for spending.

- **Independent Health and Aged Care Pricing Authority (IHACPA)**

  The creation of IHACPA is widely regarded as one of the most important reform measures because of its potential to ensure real value of subsidies is maintained, and to over time make financial provision for higher standards of care and innovation.

  There is a substantial view that IHACPA is still in early days and there are well-founded concerns about its information sources/ data sets / sampling sizes for both residential and home care, and the depth of its understanding of the difference between aged care and hospital care, the need for example for adequate allied health service provision beyond current levels, etc.

[12] One of the key sector grips about aged care "indexation", if it could be called that, was that it was usually determined by the Department of Finance in relation to the Commonwealth Own Purposes Outlays (COPO) indexation, which was deliberately set low to deliver "efficiency".

There is also anxiety about how it will assess the need for the introduction of higher quality services and cost them. This has implications for innovation, productivity and continuous improvement toward excellence. This is a matter of government policy about IHACPA's brief, as well as for IHACPA itself.
In principle there is strong support for IHACPA to be given the power to set pricing and subsidies, not just recommend them to government (with the previous comment being a caveat on that at present). Consumer advocates have argued for IHACPA to have a role in setting price caps.

There is also a question about setting pricing /subsidy levels so that there is room for negotiation of above-award or above average wages as part of developing new models of care, more efficient service delivery, higher skills, etc. From published IHACPA documents to date it is unclear whether IHACPA intends to address the issue of incentivising and rewarding best practice high quality care.

- **Australian National Aged Care Classification (AN-ACC)**

  While the AN-ACC funding model is generally regarded as an improvement on the previous ACFI, for a variety of reasons including the 50% bulk base rate, there are a number of specific but important issues about its appropriateness in practice in relation to the needs of older people and the resources providers need to provide high quality care.

  - There is strong concern that the AN-ACC classification does not adequately identify dementia and therefore data about the incidence of dementia in residential care is now inferior to that gathered under ACFI. This is a concern given that dementia care is clearly "core business" for aged care. How assessments translate into classification is also not transparent to many in the sector, including dementia specialists.
  - There is a strong concern that AN-ACC's 'branching' methodology often does not properly identify critical issues in relation to people with severe cognitive issues who are still mobile. High quality care of older people with significant dementia who are fully or largely mobile, or have a range of behaviours that are not properly addressed become "challenging" can require substantial resources, but the AN-ACC classification does not provide this.
  - Within the palliative and end of life care community there is a strong argument that it is grossly inadequate to only assess palliative care needs at entry with AN-ACC 1. People already in care who move into palliation should be reassessed and appropriate resources allocated. This is vital not just for appropriate care but also accurate data. Data about palliative and end of life care has declined under AN-ACC compared to ACFI.

- There are ongoing and very broadly agreed concerns that the use of the MMM classification in conjunction with AN-ACC understates the costs of aged care provision outside metropolitan areas, and especially in the regions. While there are significant funding supplements for more remote areas (MMM6 and MMM7) there are not for MMM2 and MMM3 regional areas, but many costs for care provision in these areas are higher than MMM1 metropolitan.

Independent Economic Advice on the Sector

The 2021 abolition of the Aged Care Financing Authority (AFCA) removed the only statutorily independent advice on funding and aged care. The Department became the source of advice, but it was neither independent nor appropriately resourced for the task.

IHACPA has a brief to independently recommend pricing but is not equipped and mandated to provide broader economic advice on how to develop the sector. There are a variety of issues in this space including:

- It will take some time for the new co-contributions in residential care and Support at Home to have an impact on the economics of the sector, and to see how they function in practice. There should be independent monitoring and evaluation of its efficacy, adequacy and equity
- It is unclear if the new regime creates capacity for residential care growth in numbers that appear to be needed to meet demand (noting that there are questions over the future shape of residential care)
- There needs to be an open discussion about including a profit margin in government pricing, to ensure that organisations can remain sustainable and viable in the long-term, and attract the necessary investment.

24/7 Nursing and Care Minutes

24/7 nursing is widely regarded as being as close to universally achieved as possible. For many, better providers 24/7 was the norm prior to reforms but for others it means increased clinical support to other staff and older people.

The stepped introduction and funding of mandatory 215/44 care minutes in residential care is widely agreed to have increased staff contact time with residents and improved staff capacity and morale, and confidence in aged care. On whether there are improved outcomes for residents some believe there are, others are “hopeful” there will be improvements but think there is limited evidence as yet. Overall (apart from the impact on allied health and lifestyle staff discussed below) this is regarded as a positive measure needing to be fine-tuned due to some of the issues described below.

Staffing to 100% of the care minutes for regulatory purposes can only be done in the real world of frontline service by staffing to at least 102%, or data backed experience suggests probably to about 105%, to take into account fluctuations in actual rather than rostered attendance, constant changes in resident numbers and composition, and other practical variables. It is likely that some/many providers who report precisely 100% compliance are not in fact compliant. Government needs to fund to 105%.

There are somewhat similar issues with 100% compliance with 24/7 nursing. There is a significant cost difference between 99% compliance and 100%. Consideration of a narrow target band (e.g. 98%-102%) and acceptable back-up measures for time limited provision should be discussed (e.g. telehealth, nearby on-call nurse). There are practical issues with achieving 24/7 in all situations, and some examples of providers reporting 100% compliance when that was not being achieved.

It is recognised that there are some providers misreporting by including staff who should not be included (noting there are some genuine definitional questions), or by claiming worker scarcity when geographically and operationally peer organisations are able to attract staff. However, there is concern that announced government measures to address this will have negative impacts on future focused providers running innovative models of care, and/or penalise providers staffing to 100% but subject to inevitable variation on the ground day to day.

The minutes only apply to Registered Nurses (RNs) and Personal Care Workers (PCWs) and a minor proportion of Enrolled Nurses (ENs). ENs should be included in the ratios in a meaningful way. The current percentage cap is incompatible with the practicalities of rostering at the coalface.

The fact that minutes only apply to RNs, PCWs and a minor proportion of ENs has led, it is widely agreed, and data supports, to insufficient provision of Allied Health staff and a loss of Lifestyle staff and ENs, to the detriment of appropriate care for residents. Care minutes in Allied health is complex. Some providers have increased utilisation of allied health staff in response to AN-ACC funding changes, while many others reduced the use of allied health in response to Care Minutes.

However, it is clear the use of Allied Health staff across the sector is inadequate, as the Royal Commission found, and that the Royal Commission's call for measures to increase the use of allied health in both residential and home care has not occurred. While Allied Health provision does not lend itself (whereas Lifestyle might) to current minutes, benchmarks need to be established, and work done on mandatory expectations and their monitoring. The ACQSC must play its role in ensuring the Standards include a requirement for increased provision of Allied Health, as well as appropriate monitoring.

The government has responded by including reporting on ENs, Allied Health and Lifestyle staff in the new Quality Indicator from April 2025. It remains to be seen what the impact of this will be, as it is not as readily quantifiable as Care Minutes. It is noteworthy that the introduction of mandatory Care

Minutes for RNs and PCWs was accompanied by funding increases to enable them to be met. Government has claimed in recent years that there is sufficient funding in AN-ACC to meet required EN, Allied Health and Lifestyle requirements. This is contested by many providers and professionals.

It is also important to note that the focus to date of the Care Minutes measure has been quantitative, so in general "more of the same", rather than qualitative. A qualitative approach, which some leading providers have done, but most not as yet, sees increased staffing creating opportunities for rethinking models of care staffing that will improve the quality of care and of outcomes for older people. Work needs to be done on incentives, recognition and reward for providers developing new and better models of care utilising increased staffing.

The Registry of Senior Australians (ROSA) staff have recently published research from the early stages of Care Minutes which found that despite the rise in care staffing levels, the authors found no association between care minutes and residents' experiences or quality measures.[13] The findings highlight the complexity of aged care reform and the need for further research to understand the right balance of care minutes, skill mix and models of care to enhance care quality and resident safety.

"A holistic view to care quality is needed, beyond just meeting staffing targets. Adequate training, staff retention strategies, and tailored models of care that meet individual resident needs are all important for policymakers to consider," said ROSA's Associate Professor Harrison.

Workforce Development Measures and Issues

The Royal Commission presented a number of workforce related recommendations, some of which have been fully or substantially actioned (e.g. increased wages, Care Minutes), some partially (e.g. comprehensive workforce planning), and some not at all as yet (see Section 4 of this paper). In addition, government has created a number of measures designed to increase workforce numbers, including targeted free TAFE places and several immigration focused programs. Some of these measures have been welcomed.

There is widespread sector agreement that workforce development is the current major challenge, the next strategic phase of the reform process. Some of the aspirations, concerns, and issues are briefly discussed here, noting that workforce is also the subject of a separate NACA Discussion Paper which will develop it in more detail; and is the theme of the IGAC's 2025 Progress Report on the Royal Commission which we understand to now be with government.

[13] https://news.flinders.edu.au/blog/2025/05/23/aged-care-staffing-levels-on-the-rise-but-is-it-helping/?utm_campaign=sprout&utm_content=1748940998&utm_medium=_organic-social&utm_source=linkedin

The goal now needs to be the development of a much more professional workforce, comparable to the rest of the healthcare workforce. The assumption that older people in aged care can be properly cared for by an untrained workforce has its roots in ageism and must change.

A more professional workforce is also one key to longer term workforce attraction and retention. Unless it proceeds we will be in the same place in the medium term as we were before the Royal Commission. Professionalisation includes development of career paths, specialisations, continuous professional development opportunities, etc.

Employer investment into workforce development is a fundamental matter, the degree of which varies considerably across the sector. This includes investment in building knowledge and skills, but also strong leadership in creating a safe working environment and culture, addressing issues such as racism, discrimination and bullying, and an enabling environment promoting collegiality, agency and supportive relationships. These are not things government can make happen, but it can incentivise, ensure its funding provides headroom for training and development, and reward.

Government and sector both need to invest in more multi-level (from workplace through to sector levels) workforce planning which at the sector level needs to be in fact multi-sector for the whole care workforce/care economy, not just aged care. Governments and sectors need to create a care workforce development strategy that puts an end to sector by sector competition and poaching. This needs to be led by a high level, expert, inclusive workforce development body supported by governments and the sector.

Dementia Measures

Government has implemented the Royal Commission recommendations on dementia support pathways and specialist dementia care services. The IGAC 2024 Progress Report advised that these recommendations have been accepted in full and substantially progressed. However, sector feedback has been that knowledge of, and impact of, these measures is patchy for a variety of reasons, including due to the role of PHNs in implementation of the pathways, rather than a national approach. Also, sometimes the focus is too narrow, not recognising and encompassing, for example, spiritual and cultural needs.

There are a variety of other Commission recommendations in other areas that relate to achieving quality dementia care that are not bundled with the explicit dementia recommendations – not surprising given that dementia is core business and therefore comes into every aspect of aged care. The following are many of the issues raised by the sector, with the exception of restraints (which is one of the dementia section recommendations) which is dealt with after these issues.

Overall, there is quite broad feedback that dementia care has not substantially improved since the reform process began. Some believe we may have gone backwards overall because of systemic factors such as how AN-ACC treats dementia. In brief the issues include:

- Staff levels have increased but in general the amount of skills training in dementia care has not (noting that training time is not permitted to be counted toward care minutes).
- There are no mandatory minimum staff training requirements in dementia, which should be seen as core business, as should palliative care, and cultural safety and inclusivity for all. This is a critical issue. Furthermore, it is likely that the dementia training included in Certificate 3 is not sufficient for the knowledge and skills needed to provide high quality care to most people with dementia in aged care.
- Providers have noted that the exclusion of training time from Care Minutes does tend in many cases to mitigate against voluntary training take up. Mandating training provisions and minimum through to optimal qualifications, and providing financial support for these, should be a government role and responsibility
- The AN-ACC classification methodology does not adequately identify dementia and often does not provide adequate resources (e.g. for people with severe cognitive issues but still mobile). Note that how assessments translate into classification is not transparent to the sector.
- There is clear and growing evidence that some people with complex needs are not being accepted into many services (especially residential) due to concerns about staffing capacity and regulatory risk (e.g. star ratings, SIRS, restraints, etc) in terms of managing complex needs.
- There is no consistency in understanding of what constitutes high quality dementia care.
- The impact of mandatory care minutes only for RNS and PCWs has overall reduced use of allied health and lifestyle services which are as important for people with dementia as clinical care.
- There is a lack of awareness of dementia support pathways among people with lived experience, and many health professionals.
- Specialist dementia care has not improved in regional and rural areas.
- There are questions about accuracy of SIRS reports on issues relating to dementia, which are under-reported.
- Residential (AN-ACC) funding is inadequate for delivery of high-quality support for people with high and complex needs.
- We have less information about the incidence of dementia and its progression in people already in services.

Restraint Measures

Measures to reduce the use of chemical and physical restraint in aged care were among the very first enacted and have been a substantial focus of the ACQSC with both support services and compliance activity. The issue of informed consent is subject to interim legislative measures that were due to expire December 2024 but have been extended to 2026.

Officially there has reportedly been a significant reduction in the overall use of inappropriate restraints. There was evidence from the ACQSC's early actions to raise restraint issues with providers, especially prescribed pharmaceutical restraints, that there was a greater awareness and a reduction in use. However, reports from researchers, advocates, families and residents indicate that is not universal, and quite obviously across the sector some practices are unresolved. There may also be some unintended consequences from the pressure to remove restraints.

- The use of locked dementia wards remains widespread and the accepted norm in practice, despite being classed as an environmental restraint
- Reports of both physical and chemical restraint being used without family consent continue to be made by families and advocates
- Anecdotal reports from family members and some advocates point to providers asking them to consent to restrictive practices without any detailed information about attempted alternative measures, or clinical risks
- At least some of the reluctance of providers to accept older people being discharged from hospital with 'challenging' behaviours, and who are often being chemically and physically restrained in hospital, relates to concern about the regulatory environment around restraints (plus staffing capacity /skill concerns) and its impact on providers status -leading to people being left in hospital
- On the other hand, and as an unintended consequence, there are anecdotal reports of some ultra-cautious providers withholding already prescribed medication for severe pain, when the need for an increase in PNR frequency is clearly indicated
- When providers seek to comply with limited or no restraint, but lack the knowledge, skills, and experience to put in place best practice alternatives, that this can result in sub-optimal care and an increase in reportable incidents.

Palliative and End of Life Care Measures

If high quality dementia care is core business of aged care, so is high quality palliative and end of life care, which affects us all. The Royal Commission did not have a major stand-alone focus on palliative care, but did cite better access to it as a key named aspect of better access for people in residential care to State and Territory health services, and alongside dementia care as required mandatory

training for all aged care staff. Neither recommendation has been fully adopted or implemented by governments, although there has been more support for voluntary training.

In the sector's view the situation with palliative and end of life care is not dissimilar to that if dementia care. Experts in this field are positive about the limited initiatives that have been implemented but do not yet see consistent signs of improved palliative care and are only mildly optimistic that improvement will happen. Some providers are improving models of care for palliative and end of life care, but many/most are not. Some of the issues include:

- Staff levels have increased but in general the amount of training in palliative care has not. There are good training programs, but they are not mandatory and do not contribute to care minutes, leading to limited take-up. There are also risks for providers in providing training to new staff and them then leaving (for one of numerous reasons). These issues should not be insoluble with cooperation among all players.
- There has been no clear emergence of new models of care that might introduce more specialised palliative care skills in key staff.
- Palliative care is not included in the single assessment process or in any other assessment except AN-ACC-1. There are some proxies, but accurate assessment and data are vital to ensuring needs are met with appropriate services.
- It is inadequate to only assess for palliative care needs at entry with AN-ACC 1. There should be an assessment for people already in care who move into palliation. This is vital not just for appropriate care but also accurate data. Data has declined under AN-ACC compared to ACFI.
- There are no mandatory minimum staff training requirements in palliative and end of life care, which should be seen as core business.
- Data is not being collected that would enable an accurate understanding of whether palliative care services are improving or going backwards.
- The lack of progress in achieving better integration between the health and aged care systems will particularly impact palliative and end of life care, bedevilled by Commonwealth/State issues anyway.

Voluntary Assisted Dying (VAD)

A related issue in this area is Voluntary Assisted Dying (VAD), now that it is legal in all States and the ACT. Obviously, people receiving home care services or residents in residential aged care have the same rights as any citizen (even if not always honoured in practice by the health system), including access to VAD if they meet legislated eligibility criteria. However, issues that can arise include a particular services or staff opposition to VAD on religious or other belief grounds, training for staff in supporting a VAD eligible participant, and privacy and respect issues among residents.

However, it also needs to be noted that under VAD legislation, people with progressed dementia (and others who are considered not to have legal capacity) do not have a right to access to VAD. Neither can advance care directives to be made for VAD, and nor can a medical treatment decision maker prepare or authorise one on behalf of a person for whom they have legal appointed authority for treatment decisions. The decision-making authority is not extended to VAD. The very high prevalence of dementia in residential aged care populations, as this paper points out for other reasons, means there are many residents who do not have legal rights to access VAD.[14]

Access to Aged Care

Access to the system is a fundamental issue. Even if the system remains flawed, access is vital for care. The Royal Commission presented a range of recommendations to improve access into the system and to services within it, from the policy architecture of aged care, to sets of recommendations in relation to population cohorts (such as First Nations people), to specific initiatives to do with My Aged Care (MAC) and public awareness.

You cannot access a system you do not know about. There has not been a systematic information campaign about accessing aged care since the concerted campaign when My Aged Care (MAC) was created. Too many people do not know about what the aged care system can offer them and how to access it, especially disadvantaged people such as many First Nations people, many people in CALD communities, people in rural and remote areas, low income and unemployed people, homeless people, and people with disability. Targeted measures are needed to overcome the differing barriers and ensure greater equity of access.

Issues raised by the sector include:

- Many people, including people with otherwise good capacity to access services, find My Aged Care a challenge. Many other people find it impenetrable. It is recognised that the IGAC has a major review of MAC ongoing to which many in the sector have provided information, and the sector looks forward to it being completed and released.
- The second and major impediment to access is getting an assessment. There has been a mixed response to the new Single Assessment Service (SAS). The creation of the SAS is important, after several previous attempts to create it. However, wait times for assessment are unacceptably long, and there are many verified examples of wait times that exceed what the department says are the outlier maximum times. Widespread reports from older people,

[14] Legislative provisions for VAD, advance care plans and alternative decision makers differ between the jurisdictions. This text is based on the Victorian legislative frameworks, but we understand is broadly similar in other jurisdictions.

families, advocates and providers are that waiting times have significantly blown out since the SAS started, which is a major concern.

- Another concern raised across the sector is the quality and volume of assessments being done by phone, rather than in person. In some situations, phone assessments are necessary but they are not the preferred mode and can lead to incorrect or incomplete conclusions. Many people find it hard to articulate their care needs or are hesitant in describing their home environment. The norm should be face to face and preferably in home.
- Questions and concerns continue to be raised about whether the new SAS and the Integrated Assessment Tool (IAT) are always properly identifying allied health needs (noting the diversity of allied health services) and making appropriate referrals. This needs to be monitored and the focus of an early review.
- Wait times are longer in the community than the hospital. Perversely, the quickest route to an aged care assessment is to get the person into hospital.
- The third access barrier is between being assessed (and receiving the assessment) and getting granted a “ticket” – to a CHSP service that has a service available; or finding a Home Care Package provider; or finding your preferred residential care provider – and then receiving the service. Widespread experience is that this wait is also increasing.
- Provisions in the new Aged Care Act will help address the total ‘wait time’ from MAC registration to receipt of appropriate services, but benchmarks need to be set for each step and funding provided to ensure these are met without a lag period. The Royal Commission said no longer than a month from assessment to allocation; there needs to be a maximum wait time from registration to assessment.
- There are additional barriers for people with complex needs or so-called ‘challenging’ behaviours, as a person living with dementia, or coming out of hospital with a variety of complex clinical or cognitive needs. This includes people on levels of restraint medication that are not acceptable in aged care. There is also urgency for people in hospital trying to get a home care package to return home.
- It must also be noted that for First Nations people outside of Aboriginal controlled organisations there are specific issues of distrust, racism and lack of culturally safe services (see later section on First Nations matters).
- It should also be noted that access to aged care is affected by things like housing (or lack of), mental health, social isolation, poverty, cultural background, language and literacy, and more. The Royal Commission recommended (Rec. 4) the development of an integrated long-term support and care system for older people. This has not been progressed - referred to again in section 5 of this paper.

Major architectural access issues are addressed in section 4 of this paper in relation to the HCP waiting list, the crisis in access to CHSP, and the emerging crisis in access to residential care.

Food, Nutrition and Dining Experience

Although the Royal Commission did not make extensive recommendations on food, nutrition and dining, they were a key focus of its urgent recommendation (Rec.112) – regarding immediate changes to the Basic Daily Fee. It recommended, and government implemented, an immediate increase of $10 per week (carried forward into AN-ACC) on the condition that providers report annually on a number of aspects of food expenditure, and on numbers of residents experiencing unplanned weight loss or dehydration. These are published by the Department. The Department also provides a number of resources which are intended to encourage providers to improve food and nutrition provision. A more strongly worded Standard will apply from 1 November.

Whether there has been any significant improvement in this area is unclear. However, anecdotal feedback from older people, families and advocates, on balance, seems to indicate it has not been. Resident Experience surveys (themselves the focus of significant criticism about their methodology and utility) show the food was the least positive aspect of aged care experience identified by residents, with no improvement over time. In open response questions, food was the highest area of suggested improvements – and most suggestions were about pretty basic quality issues. Food remains one of the top 10 complaints in residential care, noting only a minority of formal complaints are by residents.

A detailed academic research study in 2023[15], provided as part of consultation for this paper, concluded that in the 10 facilities in the study 40% of residents were malnourished, with 34% mildly or moderately malnourished and 6% severely. It also found that current measures used in aged care such as BMI and weight loss have low sensitivity to malnutrition and pointed to the urgent need for much better malnutrition screening. Given other studies show over half residents with dementia are at risk of malnutrition, this is a major and urgent issue.

Current measures to address this are based on regulatory compliance, which is problematic in this area, and voluntary use of resources that are random in intent, not systemic in approach, have limited take up and are low impact. There is also little evidence of resident engagement in food programs, let alone them being resident-led. Groups like the Lantern Alliance – the national community of practice organisation representing over 1,500 sector stakeholders argues

for the “urgent need to adopt and scale systemic, evidence-based, and resident-centred solutions”, such as those the Alliance has developed.[16]

Food and meal experience is quite central to many people's quality of life in aged care, both in home and residential settings, but especially residential where personal agency tends to be less. Issues are

[15] https://www.mdpi.com/2227-9032/12/13/1296
[16] https://lanternalliance.com.au/

regularly raised by older people, families and advocates abut issues like lack of culturally appropriate food unless it is a specialised service, and even, for example, decent vegetarian meals.

Both in residential and home care, including SAH planning, the lived experience perspectives of older people about food, nutrition and dining need to be central and of equal standing with the views of dieticians, nutritionists and management. It is also crucial to engage care staff in the process, not just staff directly involved in the meals process.

Stronger Standards

The Royal Commission recommended a review and revision of the Aged Care Standards, and this has been achieved. The new Standards, while still to come into force on 1 November, have been well received by both older people and advocates, and providers. They are regarded as having been built on the current Standards, with more specification and elucidation, containing improvements that have the potential to result in higher standards of care, depending on other factors.

There are also very positive views about the process of their development, and development of the guidance material, although there is some comment that the latter is perhaps too long and detailed. There has also been some frustration that the delays in the new Act coming into being and operation has delayed the implementation of the new Standards, when the sector had prepared and was ready for them.

The caveat to the positive reception of these Standards is the concern among many providers that the Standards will operate in an excessively compliance driven regime/culture, rather than a continuous improvement regime, with reward for excellence.

Governance

The Royal Commission took on board the representations to it that many of the issues with the quality of aged care required a much stronger governance regime among aged care providers (among other reforms). The Commission finally gave weight to that analysis, which had not been widely accepted before and not acted upon by government.

The new provider governance requirements and support initiatives have in general been welcomed and largely embraced. Some providers observe that they already had such or similar arrangements in place (e.g. clinical advice). A few do not agree with prescription, but most have found the requirements positive and well supported by the ACQSC. However, while older people and advocates have welcomed the consumer input provisions, they say it is yet unclear how meaningfully they have been implemented by some providers.

There is some concern that the strong, and appropriate, priority given to clinical governance may imply that non-clinical support and care is less important and significant. The point is not to diminish a strong clinical focus, but to elevate matters such as social connection, spiritual and emotional well-being, intellectual and creative engagement, participation and contribution, agency and participation have equal priority.

Strengthening of the Aged Care Quality and Safety Commission (ACQSC)

The Aged Care Quality and Safety Commission has recently been strengthened through legislated additional powers, and increased resourcing and funding. This has largely reflected the needs identified by the Royal Commission and the Tune Capability Review.

This has generally been welcomed in the sector, in the hope that it will lead to a more effective and consistent regulator. There has been a similar welcoming of the new Regulatory Strategy developed by the ACQSC, which is still to be fully implemented but has been well articulated.

There are however a couple of significant caveats:

- Both providers and older people, families and advocates remain concerned about the complaints processes (albeit from different perspectives). Consumer advocates have welcomed the provisions in the New Act regards the Complaints Commissioner, but improving the complaints management process is clearly still seen as a work in progress
- As noted earlier, many providers believe that the regulatory environment is too focused on compliance rather than continuous improvement; and that the whole system does not provide incentives for achieving excellence, noting that whether the new model of graded assessment will start to move in this direction is unclear at present.

Issues relating to the degree of regulation and its impact

Community, media and political pressures, as well as the Royal Commission, has led to a dramatic increase in regulation. Providers have raised concerns about unnecessary increases in red tape, and the cost and burden of excessive regulation.

Issues noted in this area include:

- Providers who have historically been more accepting of regulation are currently reporting that regulatory compliance is taking a substantial portion of management and professional time and is a significant issue raised by professional and management staff who choose to leave.
- There are many, many reform measures. Regulatory compliance with each of them may seem (and even be) reasonable on its own, but cumulatively the impact has become onerous.

- Government needs to work with the sector to review the current need for each regulatory reporting requirement, how it is used, its frequency, etc. These should be reviewed on a regular basis.
- Government needs to view regulatory reporting as a two-way street. Government demands a huge amount of data from the sector and should be providing information back to the sector (deidentified) that can act as benchmarking and/or enabling information for providers.
- Regulatory compliance obviously involves costs. These need to be carried initially by providers, but over time they will be built into the pricing structure on which IHACPA recommends. This means in the medium to long term the costs of regulatory compliance will tend to be carried by government through its subsidies, and by older people and families through co-contributions. It is therefore in government's interest (and taxpayers) to regularly review and test the regulatory requirements.

Care finders

A Care Finders program was recommended by the Royal Commission. The 'Care Finders' program implemented by government is much narrower in scope than the Commission recommended. It is broadly welcomed by the sector, but:

- It is regarded as too limited in scope, so too many people who need it and would benefit from it miss out. It also does not sufficiently reach some constituencies it officially targets, who are significantly excluded from the system for a multiplicity of reasons.
- It is not promoted, so there is a lot of feedback from older people and advocates that many people who need it do not know about it.
- It is designed on the premise that care finders are needed by exception, whereas the reality remains that most people have difficulty understanding and navigating the aged care system, and MAC remains a major problem for most.
- Culturally safe care finder models must be led by Aboriginal controlled organisations to effectively and safely support Aboriginal and Torres Strait Islander people.
- Therefore 'care finders' needs substantial scope uplift and much greater resourcing.

Advocacy services

The substantial strengthening of advocacy services through OPAN is widely welcomed, noting that this had been a recommendation of the Carnell/Paterson Review back in 2017, so long overdue. However, there are real questions about whether even more resources are required to ensure all who need this support can know about and access it. This should be one focus of the IGAC's 2026 (or later) major review of the reforms.

Star Ratings

Star Ratings was enacted as an early reform measure by the then new Labor government and Minister, despite its development being very limited at the time. There were repeated verbal commitments to it being rapidly improved, but that did not begin to happen until after there was publicly sustained critique.

Star Ratings should be a key choice tool for older people and families and should create incentives to improve among providers. However, at present there is a wide lack of confidence in it, it is not being used much, and there are clear significant flaws and limitations in its design. It is also still restricted to residential care, despite promises that it will be extended to home care. It is therefore not of value as a choice tool for the vast majority of older people using aged care and their families.

There is advocacy organisation support for the fact that a Star Ratings system exists and for its potential, but providers and many commentators (including the OIGAC) are both critical of its methodology and widely report that it is rarely used by older people and families to decide on a facility. It is acknowledged that following an external review, and consultation on changes, that the current Star Ratings program is being improved. However, many of the critiques remain, including major technical issues to do with sample sizes, risk adjustment, collection bias, and inappropriate methodology.

Older people and advocates also point out that no matter how good a star rating or any similar system is, it can only assist in consumer choice and provider competition if there is actually sufficient diversity of, and volume of supply of services that there is meaningful choice. At present there is insufficient supply of residential care overall, and in many places there is no choice of providers. At present star ratings would have more choice impact if they existed for Home Care Package providers, as despite the huge overall waiting list, there is a competitive market in many areas.

There would appear to be a strong case for a co-design process to fully review and redesign the Star Ratings scheme, starting with its objectives and whether there are other means of achieving them.

Diverse communities in aged care

‘Diverse communities’ is a descriptor for a very wide variety of groups in our population, some of whom share similar characteristics, but others of whom are objectively very different from each other. Examples of aspects of diversity include:

- Diversity of primary languages spoken (CALD)
- Varied cultural backgrounds and current practices (CALD)
- Religious and non-religious faith diversity

- People of diverse sexual orientation, gender and bodies (LGBTQIA+)
- Varied geographic and topographic locations
- Experiences of personal or community trauma / removal / loss
- Varying physical, intellectual and emotional capacities
- Care leavers and people affected by separation and adoption
- Varying access to economic and social resources, including housing[17]

Importantly, within such groupings as above there is invariably considerable diversity. For example only, the aged care experience of an immigrant community that has been in Australia for many decades and in large numbers will tend to be significantly different to that of recent immigrant groups in relatively small numbers. The same point can be made about all the above examples of diversity.

The transformation of aged care that the Commission's report advocated would they argued result in a system that was "person-first – care and supports which address physical, social, psychological, cultural and spiritual needs" and achieved "inclusiveness- recognition of a person's diverse characteristics and delivery of culturally safe and trauma-informed care."[18] Many more similar references can be found throughout the Final Report.

Nevertheless, it is arguable that the Royal Commission significantly 'underdid' diversity. The transformed aged care system the Commission recommended would honour and provide for diversity, as it would provide excellence in dementia care, palliative care, First Nations care, etc. However, we are nowhere near to achieving that system yet, and the pathway toward it needs to be a mix of measures that are universal in nature together with specific remedial initiatives that are required to address barriers and gaps impacting variably on diverse communities of people. The Commission recommended less of these initiatives in relation to addressing lack of attention to and action on diversity than it did in some other areas.

Even given that, there has not been great progress on diversity in the reform process – in fact in policy terms stakeholders believe we may have gone backwards compared to the work that was being undertaken under the auspice of the former Aged Care Sector Committee.

The Aged Care Diversity Framework and associated Action Plans are still 'current', but it is unclear how these are related to the broader reform process. They should be regularly reviewed and progress against them evaluated. Action on them, and inclusivity generally, should be considered in, for example, the necessary revamp of Star Ratings.

[17] First Nations peoples are deliberately not included in this non-exclusive list, although the principles behind a diversity-positive policy focus do apply to First nations experience. See the following point for a discussion
[18] Royal Commission, Final Report. Volume 1, p97

The system also needs consistent collection, reporting, and use of diversity data (i.e. CALD indicators: language use/preference/proficiency/competency/literacy), culture, migration history, religion/spiritualty, social capital vs social isolation.

Diversity is not an "and also", something to be considered alongside "mainstream" care, or an optional extra. Diversity is mainstream and must be a part of everything we do in aged care, not something separate. We need to make sure it is built into all parts of the system and that there are clear ways to measure progress in achieving this. Concerningly, it appears that take up of Specialisation Verification by providers is quite limited. This needs to be reviewed.

First Nations Aged Care

The Royal Commission presented an integrated suite of recommendations on improving aged care for Aboriginal and Torres Strait Islander People. While most of those were accepted by government in whole or part, progress on implementation has been very slow, given their importance. Government belatedly appointed an Interim First Nations Aged Care Commissioner in January 2024. The Commissioner, Andrea Kelly undertook an extensive consultation process with First nations communities round Australia and reported to government in December 2024 on 'Transforming Aged Care for Aboriginal and Torrens Strait Islander People'.[19]

The Commissioner found that: *"Not enough has changed for Aboriginal and Torres Strait Islander people since the findings of the Royal Commission, 4 years ago. The National Agreement[20] provides a transformational framework to change the way governments work with Aboriginal and Torres Strait Islander people, organisations and communities to deliver culturally safe and responsive aged care services…. the Government has made some important changes to the way it works and its policies and programs relating to Aboriginal and Torres Strait Islander aged care …(and)… the department is one of the leading Commonwealth departments in responding to the National Agreement. However, I heard the frustrations of communities and ACCOs that the promise of the National Agreement is not translating fast enough to real improvements on the ground."*

The Commissioner reported that "Aboriginal and Torres Strait Islander people described the current aged care system as being largely culturally unsafe, not supportive of their cultural wellbeing and needs, alienating, difficult to understand and challenging to access."

Some of the specific key findings of the report were that:

[19] https://www.health.gov.au/resources/publications/transforming-aged-care-for-aboriginal-and-torres-strait-islander-people?language=en
[20] https://www.closingthegap.gov.au/national-agreement

- Aboriginal and Torres Strait Islander people entering the aged care system face additional barriers and challenges compared to other Australians.
- Many aged care services are culturally unsafe for Aboriginal and Torres Strait Islander people.
- There is a lack of flexibility in the aged care system and services to respond to the needs of older Aboriginal and Torres Strait Islander people.
- There is a lack of culturally appropriate communications to support Aboriginal and Torres Strait Islander people's understanding and access to the aged care system
- Aboriginal and Torres Strait Islander people are often disconnected from Country, or Island home, as they age.
- Culturally unsafe complaints processes can be difficult to understand and navigate.
- There is a significant lack of Aboriginal and Torres Strait Islander specific data inhibiting informed policy and program decisions.
- The Royal Commission and National Agreement provide a framework for transformational change.

Of some note is the Commissioner's finding that: *"Aboriginal and Torres Strait Islander people often prefer to access aged care, health and wellbeing services delivered by Aboriginal Community Controlled Organisations (ACCOs). … When ACCOs provide place-based, locally led and culturally safe services to Aboriginal Torres Strait Islander people, the outcomes are far better. Services delivered by ACCOs are designed to meet the needs of Aboriginal and Torres Strait Islander people and protect their cultural needs and safety."*

In its response to the NACA Survey for this paper the National Aboriginal and Torres Strait Islanders Ageing and Aged Care Council (NATSIAACC) also particularly emphasised the need to support and work with Aboriginal Community Controlled organisations and to adapt policies and processes to be culturally safe and appropriate.

After pointing out that the number of older Aboriginal and Torres Strait Islander people aged 65 years and over almost doubled between 2011 and 2021 and will increase by two thirds in the next decade, the Commissioner concluded that: *"A wholescale new approach is required, demanding the development of a long-term transformative plan, designed in full partnership with Aboriginal and Torres Strait Islander community-controlled representatives. A 10-year transformation plan is needed to articulate the aspirations of older Aboriginal and Torres Strait Islander people, with a clear vision for what transformation looks like, and a strategy to achieve that vision. This plan should contain a real dollar investment, as well as underpinning data to inform decision-making and accountability for delivery."*

This paper endorses the findings of the Commissioner's report to government and commends it to the sector. There is much for the wider sector to learn from these findings, and much in the report that

government should both implement as proposed in the First Nations context and consider the applicability of for the wider aged care reform process, including in the implementation of the new Aged Care Act.

Oversight and Consultative/Advisory Bodies

The establishment of the independent position of Inspector-General of Aged Care and the independent Office (IGAC/OIGAC) and the creation of the National Aged Care Advisory Council (NACAC) and the Council of Elders (CoE) is generally welcomed, with some caveats:

- The Council of Elders community engagement activities received positive comments, with some questions as to whether there has been a degree of "departmental capture".
- There is a view from some sector constituents that NACAC, and to some degree the CoE, are "black boxed" regarding the advice they provide and what information their advice is based on. Questions have also been asked about the impact of their advice on policy.

The other advisory body raised by some members of the sector was the Aged Care Workforce Industry Council, which was launched in January 2019, backed by industry peaks and funded by industry and government to oversee the implementation of sector workforce strategy set out in the 'A Matter of Care' report. The disbandment of the Council has left a gap in consultation and oversight on workforce strategy.

3. Reform Measures Still in Progress

It is obviously recognised that significant reform measures are still in process and that their effectiveness cannot be judged from an evidence-based approach at this time. These include:

New Aged Care Act

The new Aged Care Act is the critical and pivotal reform vehicle. It sets out objectives, principles, rights, system architecture, and more. Some provisions in the Act have been previously legislated or required by government regulation and therefore can be assessed. However, many aspects of the new system have not been in place and will take time to assess.

The new Aged Care Act was only passed by parliament on 25 November 2024, after extensive consultation and negotiation with the Opposition, especially about the new regime of user co-contributions. Although enacted considerably later than anticipated the Act still provided for a 1 July 2025 commencement, which was a very short 'runway' for the scale and scope of changes it requires.

There was broad welcoming of the passage of the new Aged Care Act across the sector. That said, there remained different views about the content of the Act with many views about how it could be improved. However given the repeated delays with development and negotiation of the Act there is wide relief that it is in place.

The more immediate concerns have been with the implementation schedule and processes. Other than provisions contained in earlier legislation, already implemented and now incorporated in the new Act, much of the Act's provisions require subordinate legislation, or Rules, for implementation. Much of this had not been finalised less than a month before it was to come into force, making preparations for operationalising it, and communicating it, practically impossible. In addition, government financial assessment and provider payment systems were not complete.

On 4 June the government announced that commencement of the Act would be delayed until 1 November. The decision was largely welcomed across the sector as providing the opportunity for timely finalisation and testing of Rules, new systems and information provision to older people and families.

What the sector is urgently asking of government is for a "roadmap" for the four extra months until commencement on 1 November, setting out when Rules will be released, when systems tested, when communications will roll out, and so forth. A roadmap is being sought in particular for Support at Home, probably the most substantive area of operational change in the Act, which is discussed below.

Support at Home Program

The new Support at Home program (SAH), in particular, is overarchingly a creation of the Act, but equally or more so will be shaped by Rules, with no final Rules having yet been released.

There are significant levels of disagreement with the program's design. A major short-term concern is the inadequate notice of its regulatory design so close to the commencement date. Some argue it should be postponed.

Much of reformed system design, especially for SAH (but not limited to it), is designed to control government expenditure, rather than focused primarily on the needs of individual people needing support and care. This will continue as Commonwealth central agencies now have substantial influence over aged care policy. Policy advocacy needs to respond to this like for like, not ignore it. Advocacy would also be stronger if there is collaboration and coordination across the human services sector's components, so that aged care and disability, for example, are not explicitly, or more often implicitly, made to compete, and lessons learnt in each are shared with all.

Since SAH is not yet in place these concerns and issues are to some degree anticipatory although concerns about the basic architecture deal with settled policy design. Issues include:

- There are a number of major concerns with the SAH co-contributions arrangements. These are dealt with under separate heading below.
- A basic concern about people with dementia having to pay for non-clinical care, with most clinical care being co-contribution free (some allied health services attract co-contributions), when often they do not require major clinical care but for whom independence and everyday living services are essential to their support in continuing to live in the community.
- Removal of the Dementia and Cognitive Supplement is likely to result in disadvantage for people with dementia. It is a critical component of the current funding system for access to needed support services.
- Palliative care experts have major issues with the SAH end-of-life pathway, while welcoming in principle the creation of such a pathway. Some of those concerns are obvious to anyone involved in care – people do not all die on schedule. Without listing all the concerns they include restrictive eligibility, inflexible and limited time frame (people will not be offered it until very late as a result), assessment wait times, lack of education and training among home care providers, and more.
- The SAH assessment process and services framework is a substantial break with existing arrangements, is driven as much (or more) by financial/fiscal considerations within government than by a person-centred approach to individualised and enabling support and care. The new program needs to be independently and expertly monitored and evaluated.
- There is strong sector concern about the 10% of package value limit on Care Management, which is widely regarded by finance experts as significantly too low. It is argued that the limit, if there must be one, should be 15%. It is understood that 10% was not the Department's recommendation and is a central government decision.
- There is also strong concern about the annual and lifetime caps in the Assistive Technology and Home Modifications Scheme within SAH. The Scheme itself is warmly welcomed as potentially streamlining access to these supports, but the caps are regarded as inadequate .
- Another concern is the proposal for SAH pricing to be limited to face-to-face time rather than client-attributable time, which is expected to particularly impact a number of allied health services.
- If home care is to continue to grow then it needs to be able to deliver quite high-level clinical care, including allied health, in the home. That will require significantly higher levels of package funding than SAH currently anticipates.
- There is substantial concern about the proposed integration of the Commonwealth Home Support Program (CHSP) into SAH, which is to occur "not before 1 July 2027". This change will be even more significant for CHSP services than the transition from HCPs to SAH. It

requires extensive and intensive co-design and consultation, detailed planning well in advance, and support to the 1,000+ providers of services to over 800,000 people. A detailed and realistic roadmap needs to be co-designed by government and SAH and CHSP stakeholders over coming months and then followed.

- Many ethno-specialist services are in CHSP rather than HCP, so this transition is going to be of critical importance to CALD communities. If these services are not maintained in whatever form the combined program takes there will be substantial negative impacts on CALD older people.

Co-Contributions

The new financial Co-contributions regimes for residential and home care are supported by many providers, both in form and because they are bipartisan. Some providers and finance experts have questions about whether the new regime will generate sufficient extra funds. On the other hand, there is concern among other providers about whether the SAH co-contributions will result in people not receiving supports they really need.

Older people and some of their advocates are more critical of both residential and SAH regimes, although the strongest antagonism is directed to the SAH user charges.

There is wide questioning across the sector about what the government defines as “personal care” in SAH not being given the same financial status as what it defines as “clinical care”. While services like cleaning, meals, and gardening can be justified for co-contributions based on financial capacity because they are things people otherwise self-provide, no-one seeks showering assistance as a personal preference, nor is it something people self-purchase by choice. There is not agreement across the sector about what is “clinical care” and there is need for a conversation about this and agreement on a definition.

Older people and advocates are very concerned that the criteria and process for seeking ‘hardship’ status are onerous and will result in people not applying and not receiving services.

It will be important to closely monitor the impact of the new co-contributions in real time to see how they work in practice. It is unlikely that the new regime is so perfect that it may not require adjustment.

First Nations co-contributions

The current co-contribution model may disproportionately disadvantage Aboriginal and Torres Strait Islander Elders. This is not only an issue regarding people with low income, limited financial literacy, and distrust of government systems. There is a key cultural issue. From the perspective of Aboriginal and Torres Strait Islander providers, it is culturally insensitive and in some respects, shameful, to ask

Elders and older people to personally contribute money. Requiring providers to request 'co-contributions' from their own community Elders and older people as a condition of continuing care reflects a deep misunderstanding of cultural protocols, where such a request is seen as highly inappropriate and disrespectful.

The other side of the coin is just as concerning: if an Aboriginal and Torres Strait Islander Elder or older person cannot afford to contribute, how might this reflect on them personally? What impact could this have on their standing within community, or on their relationship with their provider? This policy inclusion not only places Elders in a culturally compromising position, it risks creating shame, disempowerment, and division. It is a deeply inappropriate measure within the aged care system.

Therefore, from various perspectives there is a vary material risk that co-payments, especially for essential personal care, could result in First Nations Elders going without the support they need, exacerbating inequities. A culturally safe hardship system co-designed with ACCOs is essential.

New Aged Care Regulatory Model

The New Aged Care Regulatory Model is also a creation of the Act but with much of its detail set out in regulation. How it operates in practice will be critical to a smooth transition.

The National Worker Registration Scheme

This is still in design phase, after being deferred from its initial inclusion in the 'Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Act 2022'. It is an important lynchpin in several aspects of workforce growth and professional development. This measure could also currently be included in section 4 if it does not progress.

4. Recommended reforms that have not been progressed and some implications of this

A number of reform proposals recommended by the Royal Commission, most of which are substantive and significant, have not been accepted and/or progressed by government. Their absence from the reforms also has significant consequences.

The full suite of reforms not progressed is recorded in the Inspector-General of Aged Care's (IGAC) 2024 Progress Report, and the implications of key proposals not progressed explored in detail in several chapters of the Progress Report[21].

This section identifies some of the key missing reforms and outlines briefly their implications.

Clear the Home Care Packages (HCP) Waiting List (Rec. 39)

Significant progress was made initially in the 2021 Budget response to the Royal Commission with large increases (40,000 per year) in HCP allocations budgeted. This follows several years of escalating HCP allocations, culminating in close to 40,000 in the 2020/21 year. As the new HCPs flowed out the waiting list decreased to under 29,000 by 30 June 2023. People with high priority assessments were receiving an HCP in under a month and the average wait time was under 6 months (3 months for a Level 4).

However, over the last 2 years we have seen a major blow out in waiting list numbers and wait times. With the number of new HCPs drastically reduced to 9,500 for the 2023/24 year, numbers grew to 42,000 by 30 September and have continued upward every quarterly report thereafter, despite new HCPs in the 2024/25 year rising to 24,100.

The latest official figures are 83,000 on 31 December 2024 with official wait times of 9-12 months for Levels 1, 2 and 3, and 12-15 months for Level 4. Thankfully high priority assessments still receive their package in a month. The estimated waiting list at 30 June 2025 based on 2024 growth rates will be 100,000 people, and if the government persists, as announced, in not releasing any new packages until SAH starts on 1 November the wait list then will be at least 120,000 – the equal highest it has ever been.

The government has committed to releasing 83,000 new packages in 2025/26 after SAH starts. This will clearly be inadequate to clear the HCP wait time as the Royal Commission recommended. Indeed, without more than the promised 83.000 packages being released, by 30 June 2026 the wait list is likely to be a minimum of 60,000 people and potentially more as the numbers of people 85+ escalate.

The government has also announced that once SAH commences it plans to bring the wait time for packages down to 3 months and then keep it at 3 months or less. This is a positive step forward if realised, but it is not guaranteed and does not fulfill the Royal Commission recommendation.

The government makes the point with every release of quarterly wait list figures that 99% of people waiting have either got a lower-level package or have been approved for CHSP services as if that

[21] E.g. IGAC 2024 Progress Report June 2024 Ch 1 Access and Navigability- the system architecture. The IGAC 2025 Progress Report presumably also catalogues again recommendations accepted, partly accepted or not accepted, and is expected to have a special focus on workforce.

means it is not so bad to wait. In fact, only a small proportion are on a lower package (under 18,000 of 83,000), and being approved for CHSP does not mean you get services, or anywhere near what you need.

There are multiple negative implications of the way HCPs have been managed, including:

- It is obvious that around 100,000 older people who government agrees need support and care are currently being denied it, to the detriment of their health, agency and well-being. Reducing that to 60,000 in a year reduces the numbers but not the negative consequences for those denied support.
- A majority of these people will have informal carers who absorb, at personal cost, the workload that government has denied them help with, often to the detriment of their health and income, and certainly their well-being.
- Lack of HCPs places huge pressure on the Commonwealth Home Support Program (CHSP), which government explicitly claims is available as an alternative, although more often than not services are actually not available.
- People who need only CHSP services find they are not available due to the pressure from people on the HCP wait list.
- People who do not receive an HCP or CHSP services deteriorate more rapidly and either prematurely enter residential care, or need additional primary health care and tertiary health care, at extra cost to Commonwealth and State governments.
- The unpredictability of HCP supply means providers cannot plan effectively, recruit and train staff, etc. It creates and inefficient, less productive care system.
- At a time when restoring public confidence in aged care is a goal, excessive wait times for HCPs, with all its costs on individuals as families, undermines that. The wait times are a much-raised issue in many community events and settings.

A demand-driven aged care system based on assessed need (Rec.41)

This was a key Royal Commission recommendation. Aged care should be like the age pension – if you meet the assessment criteria, set by government, you should receive the service immediately. The Commission was explicit that government should forward plan so that supply meets demand. This is not happening.

- HCPs are rationed, although we are told government policy is for the wait list not to extend beyond three months once SAH starts – but that is not legislated so can slip or be modified by simple government decision (e.g. under competing Budget pressures). The impact of that has been described in the previous discussion of the HCP Waiting List.

- CHSP funding has no mechanism for supply meeting assessed demand. Research has proven provision of low level supports as soon as need is assessed creates beneficial outcomes for the older person and reduces demand for costlier higher-level care. However, CHSP has always been rationed, but without the accountability of a single national waiting list as exists for CHPs. At present demand for CHSP substantially exceeds supply.
- While residential care will no longer be formally rationed through bed licences and the Aged Care Approvals Round, government funding is still capped by the overall residential care provision ratio which in the 2023/24 Budget was reduced from 78.0 to 60.1 beds per 1000 people over 70 years. (Actual provision is currently below 60 as providers have not been building net new beds).

There is no government established or endorsed mechanism for estimating demand and ensuring the conditions for sufficient supply are in place. As noted elsewhere in this paper the Coalition government abolished the statutory independent Aged Care Financing Authority

(ACFA) created by the Labor government as part of the Living Longer Living Better amendments to the Age Care Act. ACFA could have undertaken this role. Its function shave not been replaced.

Without a demand-driven system the outcome is many people missing out on support and care, as is happening now in CHSP, HCP and residential care, with the latter now beginning to be critical. It will continue under SAH. It is dysfunctional to achieving a more efficient, productive and equitable aged care system.

Mandatory minimum staffing qualifications (Recs. 48, 78, 80 and 81)

While government has supported a variety of staff development training initiatives, it has not implemented key Royal Commission recommendations on mandatory minimum qualifications, which have been argued for over many years by unions and consumer advocacy bodies. This is another matter that also received strong and repeated comment by the IGAC22[22] during 2024, who made the point that we regulate the minimum qualifications required for someone to do electrical work in our homes, but not for people in whose care we entrust loved ones with dementia and needing palliative care. This has negative outcomes for older people in care, and for the many staff who know they do not have the skills and experience to best care for the older person.

It is acknowledged that achieving this is not simple, it requires support systems, agreement on minimum qualifications (Cert. 3 may not be sufficient for high quality care for dementia and palliative care, for example), a registration scheme that incorporates training records, and resourcing – which

[22] E.g.https://parlinfo.aph.gov.au/parlInfo/download/committees/commsen/28461/toc_pdf/Community%20Affairs%20Legislation%20Committee_2024_10_03_Official.pdf;fileType=application%2Fpdf#search=%22committees/commsen/28461/0000%22 Thursday 3 October 2024, p3

government must either directly fund or fund through AN-ACC and require compliance. However it is essential to a transformed high quality aged care sector.

A new single, seamless aged care program (rec.25)

Government has explicitly rejected this central Royal Commission recommendation "given the fundamental differences in the nature and cost of care provided in a residential care facility compared with community-based care". The barriers between the service stovepipes continue, and older people are denied the services they need and prefer[23]. Yet the sector is increasingly moving to a blurring between home care and residential, and retirement living is becoming a significant component of the care economy. Real person-driven care means the older person being able to access the service mix that best meets their needs, whatever their living arrangements.

Increased allied health provision on both residential and home care (Recs.36 and 38)

The Royal Commission saw allied health as essential to a more reablement focused aged care system. It requires qualified professional assessment in a timely manner and delivery by appropriately qualified allied health professionals for each professional (a physiotherapist is not an OT). The Commission explicitly called for more allied health provision in both residential and home care. As noted in section 2, provision has decreased in many parts of the sector. The need for a greater focus on and priority for allied health has been noted in a number of other parts of this paper, including AN-ACC, Single Assessment and Care Minutes.

As discussed earlier in the paper the implementation of RN/PCW care minutes has in many cases resulted in significant decline in allied health (and 'lifestyle') provision (as well as ENs). Yet allied health support is also an essential component of high-quality dementia care and palliative and end of life care.

Improved health and aged care interface and seamlessness, and appropriate health care provision, including a Seniors Dental Scheme (Chapter 9)

The Royal Commission placed considerable emphasis on the need for a much better interface between aged care and the health system, including the access of people in aged care to good primary health care through a specific set of changes to Medicare, to dental care through a Senior

[23] E.g. IGAC 2024 Progress Report pp19-20

Dental Benefits Scheme, better access to palliative and end of life care, to mental health services, to telehealth and to outreach services from tertiary care to aged care, and more.[24]

While there has been some progress on a number of these recommendations, or variations of them, the general view and experience of the sector has been that change, where it has occurred, has been slow and incremental.

The sector, and many other stakeholders, are particularly concerned about the failure to implement the recommendation for a Senior Dental Health Benefits Scheme (Rec.60). This paper will not reprise the disturbing evidence of the extensive negative health and lifestyle impacts of poor dental and oral health, and its incidence in older people with limited financial resources. The need for such a scheme, at least (inclusion of dental in Medicare would be better) is well known by the current government, as from Opposition it proposed such a scheme in the 2019 Federal Election.

In terms of these recommendations overall, the Joint statement of February 2024[25] to clarify the roles and responsibilities of the Commonwealth and the States and Territories for the delivery of health care for people receiving aged care services is widely regarded as not helping the intent of a better integrated system which is frequently and demonstrably dysfunctional for the older person, and more importantly, of addressing the failures of the current system. It is an overview, not a roadmap for improvement.

Increased aged care awareness and information strategies (Recs. 26 and 27)

While there has been increased consultation and publicly available information on the reform process, the Royal Commission's recommendations for a systematic approach to better engaging older people and the public generally in understanding of, discussion and involvement in aged care planning and provision has not happened. There is an urgent need for a community wide strategy that incorporates in an integrated way specific lenses on First Nations and diverse communities.

5. Key strategic observations, questions and issues for ongoing reform

At this stage in the reform process, in addition to identifying specific implementation issues that need to be addressed, it is timely to try to step back and reflect on some system-wide considerations about where we have come from, where we are now, and where we should be going. These are strategic

[24] See the Royal Commission, Final Report Volume 1, Chapter 9 Better Access to Health Care
[25] https://www.health.gov.au/sites/default/files/2024-02/joint-statement-to-clarify-the-roles-and-responsibilities-for-the-delivery-of-health-care-for-people-receiving-aged-care-services.pdf

issues which are often not given the importance they play in identifying and achieving solutions to the challenges the sector, and government, both face. The following are not in any priority or sequential order; they need to be considered in a three- or four-dimensional context. These are not answers, these are briefly articulated matters that are often noted as issues, sometimes discussed, but which really need detailed attention, focus and action.

Improvement but not yet transformation

The reform measures to date have definitely improved the system that existed when the Royal Commission was called, but it is still basically the same system. Many of these measures were on the agenda before the Royal Commission but reform lacked strong momentum. The Royal Commission provided that momentum to government in particular but did not necessarily 'move the dial' for all providers.

While the system has improved - although it is currently not possible to measure by what degree (see later) – the reform measures to date have not transformed that system into one that continuously aspires to excellence and is overwhelmingly consumer-driven. It remains to be seen whether we are on a pathway to doing so, for example, what momentum the new Act will create. However, there is not an agreed transformative vision or set of goals.

What is being achieved? How do we know?

There is some tendency in the reform process to see it as 'addressing problems', rather than creating a clear and agreed pathway to positive outcomes for people in aged care that can be clearly articulated, with agreed criteria that can be measured and evaluated. It would be an aggregation of such outcome measures that would constitute the building blocks of a transformative vision of what aged care can be.

There is a definitive tendency in government to think that "we have legislated to fix that" and assume and assert that the issue has been dealt with, especially if it has received significant funding. The experience on the ground may be different but those messages tend to be filtered out or not taken as seriously as they should be by government. It often takes another 'crisis' for the issue to be revisited. A limited number of measures are evaluated, a few are reviewed after a period (usually after complaints reach a certain level), but overall, there is no objective way of knowing what has or has not been achieved.

Reform achievements to date are described predominantly in terms of inputs to support and care, not outcomes achieved. The real test of whether reform is being effective is whether outcomes are better for older people and family carers. We do not at present have an agreed set of key performance

indicators (KPIs) for what improved outcome for older people and family carers looks like, and what goals we should be seeking to achieve. These would then drive meaningful data collection, rather than the collection of large amounts of data that do not inform us about what is or is not being achieved.

There is a significant task before the sector to agree and describe best outcomes, best practice, what "high quality" care means in every area of aged care, etc. And from that will flow implications for how aged care services should be comparatively rated, what levels of service should not be accepted (and how this will be improved over time) and the appropriate levels of education and training required. A major challenge is for all this to happen in a process that is led by and stress tested by older people and families.

More targeted reform measures

The predominant working assumption within government about the overall reform process to date has been that cumulatively the reform measures would "lift all boats". This is clearly not happening in relation to matters covered in this paper like dementia, palliative care, cultural safety, appropriate First Nations reform, CALD services, regional services, and more.

As we move forward to the next phases it would seem we need specific strategies for particular areas of reform that take full account of the barriers to achieving the outcomes needed for the provision of high-quality support and care to specific population cohorts.

This is not a pivot that government can make by itself. It requires a process of co-design with all relevant stakeholders, and especially those from the targeted cohort. And it requires the sector to embrace the pivot and contribute to it on the front foot.

Maintaining and building reform momentum?

The current reform process has already run over a number of years and key elements of the current reforms are still to get underway when the Act commences on 1 November 2025. As this paper demonstrates the sector identifies many implementation issues so far that need attention and require action.

There will be more to come as Support at Home, new co-contributions, new Standards and more roll out into the sector. If we are to then take another step forward into a transformed sector that deals on the front foot with the demographic challenges (both numerically and generational change in expectations) then even greater effort will be required.

Achieving and maintaining such reform momentum will not be easy, either within government or for much of the sector. Within government the new Minister and Department will be primarily focused on

implementing the Act and its components, so getting a focus on the other issues raised in this paper will be a challenge.

Beyond the Minister and Department, the government more broadly will tend to have moved on – aged care was 'done' in the last term. The central agencies will be wary of more 'demands' that translate to Budget pressure.

Government cannot be looked to for the initiatives needed to move beyond current reform to transformation of the system. That is the sector's challenge.

It's just not about Aged Care

Before taking up the transformation challenge further it is important to make the point in this paper that ongoing reform cannot be just about the aged care system. Reform must be about:

- **First, the care economy as a whole** – the Royal Commission focused particularly on the dynamic between aged care and the mainstream health system, but our focus needs to be even broader, across all support and care sectors, especially aged care health and disability, and across all jurisdictions. This is obvious in relation to workforce development where absent a total care economy approach the component sectors have been competing with and poaching from each other. But it also applies to other key challenges such as development of outcome measures, innovate models of support and care, and development of best practice standards. Does the new super Ministry provide an opportunity to commence moving in this direction? On the surface yes, but the sectors will also need to start talking more with each other bilaterally and multilaterally, not just through government.
- Secondly and relatedly but more broadly, we need to develop a strategy for what the Royal Commission called '**integrated long-term support and care for older Australians** (Rec. 4) including the welfare system, social participation, affordable and appropriate housing, high quality health care'. The Commission made this its fourth recommendation because it saw it as fundamentally important. The Commission said it would take a decade to fully achieve an integrated system. Government currently has no mechanism for achieving this. The underdeveloped but potentially useful mechanisms it had in the past no longer exist.
- Thirdly, aged care, and other care economy sectors, need to stop being viewed as only a 'social good' and be seen and treated as a **key component of a modern developed economy**. Issues of workforce development, productivity, research and innovation investment and so forth are both of direct relevance to these sectors, as they are directly relevant to the economic agenda.
  It is incorrect to say that the care sectors inevitably contribute to slowing productivity –they are, and could better be, **key contributors to greater society-wide productivity**

(e.g. the roles and contributions of family carers), but if funded and operated optimally their own productivity would lift considerably. And the productivity of the entire care economy would improve if government invested far more substantially in preventive and restorative measures at scale.

Beyond the Royal Commission (RC)

Following the implementation of the new Act on 1 November it will be time to move beyond a dominant focus on the RC recommendations. They remain important, noting, as set out in section 1, that many have antecedents prior to the RC. Key recommendations that have not been implemented are also of great importance as this paper sets out in section 4. However, some recommendations may be wrong, or limited, or miss the mark. The "test" should no longer be "does this measure implement the RC?" but rather "does this measure achieve better outcomes for older people and their families who need support and care?"

This means we will need a new reform template – perhaps a new Aged Care Reform Roadmap with a clear and agreed destination, and pathways for getting there.

The coming demand and lack of supply

As discussed elsewhere in this paper, the Royal Commission recommended a demand driven, entitlement based aged care system, with assessment criteria set by government and care allocated within one month of assessment – which has not happened. It has also been noted that the current home care package waitlist is estimated at 100,000, that people are struggling to find CHSP services and that residential bed vacancies are difficult to find.

While this current situation is causing widespread concern the short and medium term future look even worse, as the numbers of people entering their 80s increases substantially over the next two decades[26]. The Department's current estimate of demand for residential aged care is 200,000 places now, which will increase to 250,000 by 2030; 365,000 by 2040; and to 400,000 by 2043.[27] There are currently around 210,000 places in operation, many of which will require refurbishment and renewal, and providers are doing that or closing them. Industry sources (e.g. Stewart Brown and Bolton Clarke) project that there is likely to be a net reduction in beds by 2030, rather than a 50,000 net increase.

There are uncertainties; the average age of entry to home care is currently 82 years, entry to residential care is 84 years on average. Will these averages increase, reducing demand? Or will an

[26] https://www.theweeklysource.com.au/issue-100/nowhere-to-go-why-the-future-of-care-is-in-the-home

[27] https://www.health.gov.au/resources/publications/financial-report-on-the-australian-aged-care-sector-2022-23 p127

increase just defer demand slightly if average age of death also increases? Will the shift in demand from residential to home care accelerate even further? Will retirement living options take up the gap (unlikely on current new build experience)? However whichever way those numbers fall the reality is that on present trends demand for aged care is going to substantially exceed supply, and perhaps by a very large numbers of beds, even if government increases home care supply.

The Government and Sector Dilemmas

The relationship between Commonwealth government and the aged care sector is complex, and somewhat dysfunctional:

- First, Government is and will remain the major funder of aged care, still with the capacity to override the independent pricing body, which sets up a push/pull relationship.
- Secondly, government proscribes what the sector can charge for the things that government does not fund – there is no financial market apart from for accommodation in some areas (but not others).
- Thirdly, government controls who can be a provider, who is eligible to receive government subsidies (who can be the customer), and rations supply by funding and other controls over beds, packages and CHSP.
- Fourthly, government sets minimum performance standards, reporting requirements, and auspices and resources the sector Regulator.

Historically the degree of government control of the sector has resulted in 'one size fits all' approaches to aged care provision, which has disincentivised innovation, flexibility and aspiring for excellence. The sector has minimal characteristics of market competition, except in parts of metropolitan areas in periods when supply is closer to demand than it is now.

Government has also historically underfunded aged care quite significantly (the title "Neglect" for the RC Interim Report applied to government as well as much of the sector) and failed to implement most of the key recommendations of its own reviews, up until the Royal Commission.

There has been and continues to be a fundamental lack of trust between government and providers which has long standing historical roots. This needs to be addressed and efforts made to change it. Transformation to a system that strives for and is rewarded for excellence in outcomes, in partnership with older people and families, will not and likely cannot be driven by government, but achieving it requires collaboration (even partnership) between government and sector leadership, which earns public trust and respect over time.

Regulatory compliance is necessary, but it is not sufficient for a high quality, excellence-performing sector

The current system is highly and increasingly minutely regulated and compliance based. Yet there are significant limits to the effectiveness of such a system. Poor quality persists within the sector as older people, families, advocates, many professionals, and whistleblower staff regularly testify. And mediocre quality is still widespread. How do we move to an aspirational system in which defined excellence is the goal and is rewarded financially and reputationally?

- How do we get agreement (or rulings) on what constitutes “best practice” and /or
- “excellence” in aged care services? Until we do that, it is difficult to draw lines below which services are unacceptable.
- What are the barriers to transformation of the system to one that aspires to and generally practices excellence and is predominantly older person driven? The barriers will include issues with government, which needs to learn how to safeguard the community but not put barriers in front of high performance. But there are many barriers within the sector, among providers and professionals. How do we identify and remove them?

There are many questions about the shape of the sector over the medium term. There are examples of significant innovation and redesigning of models of care. But most of what is generally cited is not fundamental change, it is a rejigging of existing provider focused models of care. What will be the future of residential care? Where does retirement living fit in, in conjunction with higher level home care? What are the future models of home care? Regulation (hopefully appropriate and proportionate) will follow the answers to these questions, not drive them.

Sector leadership?

This section of the paper has sought to explore, albeit only in headline form due to scope and scale constraints, some of the strategic agenda that needs to be confronted and resolved for the reform process to move forward constructively, substantively and transformatively.

How does the sector go about doing this itself rather than leaving it to government, which government is unlikely to do as it lacks capacity and incentive, and if it tried is not well placed to get it right. Government does not experientially understand how to run good quality aged care. That is a major constraint going forward.

Past change has been achieved when the sector spoke largely with one voice after much negotiation and leadership effort. That is not currently the case. Where is leadership going to come from? The National Aged Care Alliance (NACA) has played this role before but at that time had a different membership composition and level of engagement from most members. NACA still plays an

important but different role today but needs to consider whether it or another vehicle would be most appropriate to lead a transformation initiative.[28]

28 In brief, in 2008 NACA went through a process to describe its Vision for aged care in Australia and published a document outlining how to get there. After the Productivity Commission inquiry 'Caring for Older Australians' report NACA published a Blueprint for Aged Care Reform and ran the Agewell campaign for several years. Through Co-chaired working groups with government, it helped co-design what became the Living Longer. Living Better reforms in the Gillard government. NACA had about 28 members and meetings were always attended at CEO or Deputy level.