

IPS Closed-Door Workshop on “Aged Care Service Models: Challenges, Trade-offs and Policy Responses”

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On 22 April 2016, the Demography and Family cluster at IPS hosted a delegation from Opal Aged Care, Australia’s second-largest aged care provider. The delegation comprised members of the Opal Aged Care Board, including its Chairman, Professor Peter Shergold, and Managing Director, Gary Barnier. Also in attendance were representatives of Australia’s largest life insurance company, AMP, and investment firm GK Goh Holdings, which partners with AMP in Australia.

Directions in aged care in Australian public policy

The workshop began with a presentation by Professor Shergold, an Australian academic and former public servant, who provided an overview of the aged care landscape in Australia, the challenges it is facing and expectations for the future. Currently, there are over 2,000 providers of aged care in Australia, including the government and providers from the private sector and the community sector that are contracted by the government. The aged care industry is valued at 1% of Australia’s GDP and accounts for about 4% of government expenditure, or approximately A\$14.2 billion.

The majority of operators provide home care, which consists of two main programmes. One is the Commonwealth Home and Community Care (HACC) programme, where about 1,700 providers deliver basic services such as home nursing, respite care and assistance with meals and transport to about 750,000 people. This costs around A\$1.8 billion, or approximately A\$2,400 per recipient annually. The second is the Home Care Packages (HCP) programme, which delivers packages that are tailored to people’s needs following a needs assessment. About 500 government-approved providers deliver the HCP programme to 66,000 recipients at a total cost of around A\$1.3 billion or A\$20,000 per recipient each year.

The aim of such home care services is to help people age at home for as long as possible. This meets the preferences of many older persons in Australia and also costs less for taxpayers. However, like Singapore, increased life expectancy in Australia has intensified the care needs of the elderly. The prevalence of dementia in Australia has also risen. The pool of unpaid, informal caregivers in Australia has also shrunk in recent years. As such, the demand for residential care has grown. About 1000 operators provide residential care to

200,000 people at an annual cost of A\$15 billion, which amounts to around A\$75,000 per person per year. Professor Shergold added that 25% of those aged 85 years and above rely on residential care, particularly for the last 18 to 36 months of their life.

Australia’s aged care sector is facing a number of challenges. It is highly regulated and constrained by the Australian government, whose sudden budgetary decisions can have unexpected implications on the financial sustainability and profitability of the sector. It is also an immature sector that is dominated by non-profit providers, many of whom operate on a very small scale. Furthermore, there is little market competition as Australians are not fully aware of the choices that are available to them.

Professor Shergold also stressed that there are many trade-offs involved in the provision of aged care, such as the trade-off between price and quality; between provision by the public, community and private sectors; and between the level of government subsidy versus personal contribution. There are also fears that deregulation and stimulating further market competition in the arena of aged care could lead to a spike in costs.

In terms of the public policy agenda, Professor Shergold noted that despite the existence of substantial government subsidies in aged care, there is still an expectation that citizens should bear more of the costs of aged care on a means-tested basis. The Australian government has also rolled out Consumer-Directed Care (CDC) where citizens are given the opportunity to choose the providers and services they want and access additional services if they are willing to pay for them. CDC exists for home and disabled care and has already been planned for residential care. The Australian government is also pushing for greater market transparency in the aged care sector. They have launched the My Aged Care online platform to provide consumers with comprehensive information on available aged care services so as to generate market expectations and stimulate market competition.

In the future, Professor Shergold said he anticipated that the government would play a more facilitatory role, with the private sector delivering more aged care services. However, the government is concerned about a public backlash from people who believe that aged care should be a community service and not motivated by profit. There is also the issue of less efficient providers who find it more difficult to retain their clients given the increased competition. They are also wary of skyrocketing aged care costs as the proportion of elderly in Australia rises. Professor Shergold also noted that the government might roll back its funding for residential care in the coming years. Despite this, as about two-thirds of home and residential care providers are achieving a net profit, he believed that overall market sentiment towards managing the risks of providing aged care is still positive.

Directions in Australian Aged Care: An Operator’s Perspective

Opal Aged Care’s Managing Director Mr Barnier concurred with Professor Shergold that Australia’s aged care sector has until recently been quite supply constrained and lacking in strategy. Mr Barnier said there is a need to build 74,000 additional places and refurbish 100,000 places over the next decade, a task requiring capital of over A\$30 billion.

Even though most Australians prefer to age in-place, Mr Barnier added that there is still a need for residential care facilities because about 1,700 Australians are diagnosed with dementia every week. As a person typically lives with dementia for around 10 years, he or she is likely to spend about two years of that time on average in need of residential care. Individuals are also required to get an aged-care assessment before they are allowed to access residential aged care in Australia.

Mr Barnier explained that the Aged Care Sector Committee of Australia had recently unveiled the Aged Care Roadmap, which consists of recommendations for future reform in Australian aged care. Some of these recommendations include increased transparency in the aged care sector and initiating the conversation on aged care earlier so that consumers are more informed of the options available to them. The Roadmap also underscores that dementia care will be a core aspect of residential aged care.

Currently, many consumers seek residential aged care as a result of an emergency, which creates tremendous stress for the residents and their family members. Mr Barnier added that seeking residential care is often framed as a failure of the family to provide for their loved ones, when in fact the family has normally done more than can be expected. Consumers also lean towards residential aged care as it is better funded than the nursing component of home care in Australia. This is because a productivity benefit is perceived in the latter, where a nurse can tend to many more residents than they normally would be able to in home care.

In the future, Opal’s strategies include revamping its overall aged-care model to replace four-bedded rooms with single or twin rooms. Opal is also planning to offer sub-acute clinical services such as chemotherapy and dialysis. They are also planning to target their services at Australia’s middle market, which consists of people with under A\$500,000 of assets at age 80 years or older. Mr Barnier added that there is an emerging view in Australia that consumers should get to decide on what quality service is. Opal is hence taking steps towards conducting surveys and examining the opinions and preferences of its consumers more closely.

Open Discussion

A participant enquired about the use of social impact bonds in Australian aged care. Professor Shergold responded that social impact bonds are currently not applied in the eldercare sector but are used in out-of-home care for children from dysfunctional families. As this form of care is expensive for the state, the Australian government has, through monetary incentives, encouraged community organisations to raise funds from the private sector or investors to help reduce the frequency of children being placed in out-of-home care. Professor Shergold added that this model could also be applied in aged care, as well as in the areas of disability and mental health issues.

Another participant questioned if more regulation in the aged care sector is necessarily good, and if a major disruption in the aged care sector is anticipated to make room for fundamental changes and improvements in the industry. Mr Barnier agreed that aged care in Australia is over-regulated. In particular, the government expects high safety standards. The supply of beds in the Australian aged care sector has risen by 10% over the last two years

and 10,000 beds are expected to be added in the next year. Mr Barnier expressed his hope that this will stimulate competition, raise consumers’ expectations for quality care and wean the industry off government regulation.

Professor Shergold added that regulation in the aged care sector is misplaced. He noted that the state’s preoccupation with quality often revolves around compliance, processes and safety standards rather than what consumers want and value, such as the freedom to move about or having their pets with them. Professor Shergold proposed that the aged care sector should resemble the hotel industry in this regard, where quality is more reflective of consumers’ preferences.

A participant asked about what Singapore can learn from Australia’s experience with aged care. Professor Shergold noted that consumers’ expectations are rising, often faster than the government’s capacity to respond. For example, consumers are increasingly expecting to stay in single or twin rooms rather than six-bedded rooms in an institutional setting, as was the norm in Australia in the past. Despite being a costly move for the state, Australia did transition to single and twin rooms eventually. Professor Shergold thus opined that governments must be responsive to people’s evolving expectations. Mr Barnier added that attracting high quality leadership is also crucial for the aged care sector as it can attract a good workforce, which can improve the quality of aged care.

A participant expressed that many Singaporeans wish to die in their own homes rather than move to an unfamiliar setting. The participant asked if certain minimum quality standards are set for aged care operators in Australia. Mr Barnier responded that aged care providers are required to meet minimum standards, but most are to do with safety and processes. However, quality is not regulated as it is left up to the market. Professor Shergold added that quality often involves some risk. For instance, if an aged care recipient prefers to stroll outdoors, this is considered to contravene certain safety standards and thus constrains the quality of the recipients’ life in aged care. He stressed that consumer-directed care must therefore start with the consumer.

A participant remarked that nursing homes in Singapore often are required to have a quota of beds for lower-income recipients, leading to a situation in which lower-income and higher-income recipients share a room. Mr Barnier explained that the same requirement exists in Australia — about 40% of all places in residential aged care are for people on a full or part pension. There are also places for the homeless, who should be provided with the same quality of care, thus resulting in pensioners and the homeless sharing spaces. Regardless of government requirements, Opal’s strategy is to determine its own minimum acceptable standard for every resident.

A participant shared that in Singapore there are some nursing homes with 15 to 23 people per room, with some residents living in these homes for up to 20 years. The participants also asked how aged care could strike a balance between freedom and safety for the recipients. Mr Barnier replied that while the rooms in Opal have some medical aspects, they are decorated to resemble hotel rooms and can be customised according to residents’ preferences to an extent. Glass crockery is used in dining spaces, although this came with resistance from some staff members who feared that the residents might hurt themselves.

Professor Shergold added that all staff members must be well trained on how to prevent and deal with emergencies in order to improve safety in residential care facilities.

Mr Barnier remarked that rather than being directly tied to the consumer’s well-being, the decision to stay in a single room is often a preference of the consumer’s family. Furthermore, he noted that the number of rooms is less a concern in Australia than the overall purpose and function of aged care. A participant agreed that staying in a single room may not actually be beneficial to the resident’s health and another opined that this may lead to loneliness.

One participant acknowledged that Singapore and Australia face very different space constraints, with Singapore being a very densely-populated urban environment. Moreover, the participant stated that it is generally accepted in Singapore that the lower-income groups should be supported by the government and voluntary welfare organisations (VWOs). There is also an increasing shift in Singapore towards home care, including home nursing and home therapy.

Professor Shergold clarified that the majority of senior citizens live in dense, urban areas in Australia. Providing aged care in the remote, rural parts of Australia is thus a greater challenge in Australia as there is a larger risk of market failure in these areas.

A participant enquired about the ratio of dementia to non-dementia patients and the ratio of the two sexes in Australia’s aged care facilities. Mr Barnier responded that 50% of Opal’s residents have been diagnosed with dementia, and 85% of Opal’s residents are female while 15% of male. Efforts are made to segregate those with severe dementia from other residents.

The participant also commented that, in Singapore, foreign domestic workers are often employed to care for the elderly. Most caregivers tend to be women who have quit their jobs to care for their elderly family member, leaving them with less savings to care for themselves in the future. Just 3% of the elderly in Singapore live in nursing homes and most live at home.

Another participant asked how staff are attracted and retained in Australia’s nursing homes. Mr Barnier advised that retaining staff is crucial. Opal had conducted a survey among its staff members and found that many employees expressed the desire to be listened to and also for more effective leaders. He also stated that there are about 2.7 million informal caregivers in Australia, who he perceives as an untapped pool of talent. These individuals can be attracted to work in the aged care sector through recognising the career opportunities and development this sector can provide them. Professor Shergold also noted that aged care is compensated poorly with few career prospects. He thus suggested envisioning a career structure for aged care and instilling in younger people the idea that working in aged care is worthy and meaningful.

With regard to financing aged care, Mr Barnier explained that there are three main funding streams for residential aged care in Australia — accommodation, daily care needs and nursing needs. Funding for daily care needs comes from people’s pensions at a cost of about A\$45 a day. Nursing funding costs about A\$190 a day on average. The resident can

pay up to A\$100 of this cost if they have the means. Accommodation costs amount to about A\$53 a day, for the 40% of Australians who are full or part pensioners. Australians who are self-funded without a pension are required to pay 100% of accommodation costs, and they may do so either on a daily basis on a market-based pricing scheme or with a 100% refundable deposit of A\$350,000 on entry. In the latter situation, the full amount is paid back to family members upon the passing of the resident. The deposit thus acts as capital for the nursing home, lowering the initial cost of capital.

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