



**DEPARTMENT OF HEALTH**  
**AGED CARE LEGISLATED REVIEW**

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SUBMISSION

5 December 2016



## ATTRIBUTION

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## ABOUT ACSA

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Aged & Community Services Australia (ACSA) is the leading national peak body for aged and community care providers. It represents church, charitable and community-based organisations providing housing, residential care, community care and home support services to older people, younger people with a disability and their carers. ACSA members provide care and support in metropolitan, regional, rural and remote regions across Australia.

Mission-based and other not-for-profit aged care organisations are responsible for providing services to those older Australians who are most in need. As at 30 June 2016 not-for-profit organisations delivered about 56 percent of residential aged care services and 82 percent of home care packages in Australia.<sup>1</sup>

These organisations are visible and highly accessible in the community and as a result, the public relies on them for service, support and care. The broad scope of services provided by ACSA's membership and the leadership they display gives it unique insights into the challenges and opportunities that come with the ageing of the population.

## ACSA CONTACT

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<sup>1</sup> '2015-16 Report on the Operation of the *Aged Care Act 1997*, Department of Health; pp.31,45.

### INTRODUCTION

The explanatory memorandum for the *Aged Care (Living Longer Living Better) Bill* 2013 included the following two statements:

‘In April 2012, the Prime Minister and the Minister for Mental Health and Ageing announced a 10 year aged care reform package to build a better, fairer, more sustainable and nationally consistent aged care system. The reforms give priority to providing more support and care in the home, better access to residential care, additional support for those with dementia and strengthening the aged care workforce.’

‘This Bill amends the *Aged Care Act 1997* to give effect to major components of the *Living Longer Living Better* reforms. The changes arising from this Bill fundamentally reform the regulation of aged care to provide for sustainable funding, expanded workforce capacity, higher quality of care, improved access and strengthened protections for care recipients.’

*Living Longer Living Better* has been a significant reform of the aged care system. Much has been achieved or is in progress, particularly more home care packages and increased consumer choice and control. However, other aspects such as that of sustainable funding and expanded workforce capacity have not been met.

While the primary focus of the legislated review is on what has been achieved as a result of the *Living Longer Living Better* reforms it will be important for the review to make recommendations for future action that will ensure sustainability and quality of aged care well into the future. ACSA considers it is essential that momentum be maintained for a better, fairer, more sustainable and nationally consistent aged care system.

ACSA supports an aged care system that is consumer-driven, market-based and less regulated as outlined in the Aged Care Sector Committee’s Aged Care Roadmap released earlier this year.

A combination of government funding and user-pay options will facilitate the provision of aged care and support services, with older people able to select care at home or a residential care setting according to their needs and preferences.

In those areas where there are additional challenges to deliver the necessary services and options for older people, such as rural and remote communities and groups with special needs, different approaches are required.

### 1. WHETHER UNMET DEMAND FOR RESIDENTIAL AND HOME CARE PLACES HAS BEEN REDUCED

#### Refer to Section 4(2)(a) in the Act

In this context, unmet demand means:

- a person who needs aged care services is unable to access the service they are eligible for e.g. a person with an Aged Care Assessment Team/Service (ACAT or ACAS ) approval for residential care is unable to find an available place; or
- a person who needs home care services is able to access care, but not the level of care they need e.g. the person is eligible for a level 4 package but can only access a level 2 package.

#### ACSA RESPONSE TO ISSUE 1

**ACSA recommends the Government publish information annually about the level of demand for residential care and home care places; the extent that demand has been met; and therefore the level of unmet demand. This information should be published by Australia-wide, by region and by different groups of older Australians including special needs groups and will enable the level of unmet demand to be tracked over time. ACSA notes the new prioritisation process for the allocation of home care places commencing in February 2017 should provide better information about the level of unmet demand for home care places.**

ACSA is unaware of a current robust data source which provides accurate and timely information about the extent of unmet demand. Paragraph 63-2(2)(a) of the *Aged Care Act 1997* requires the annual report on the operation of the Act to include information about the extent of unmet demand for places. However, to date the level of information needed to provide a clear picture of the level of unmet demand has not been included in these reports.

There is no data that allows this to be determined objectively. However, the following examples suggest that the level of unmet demand has not been reduced.

For example, the 2015-16 Report on the Operation of the *Aged Care Act 1997* shows there were 78,956 operational home care packages as at 30 June 2016<sup>2</sup>. Combined with the 6,445 home care places allocated in the 2015 Aged Care Approvals Round this is well short of the 100,000 expected by 2017.<sup>3</sup>

The Government plans to increase the provision ratio to 125 operational aged care places per 1,000 people aged 70 and over by 2021-22 made up of 78 places for residential care, 45 places for home care and two places for short-term restorative care. The ratio at 30 June 2016 was 113.2 (79.7 for residential care; 31.9 for home care; 1.6 for restorative care) places for every 1,000 people aged 70 years and over which has changed little from 30 June 2011 when it was 112.8 (85.8 for residential care and 27.0 for home care)<sup>4</sup>. This suggests that while unmet demand is not necessarily evidenced, clearly growth is not fast enough.

Another indication that unmet demand has not reduced is the number of applications for places in the Aged Care Approvals Round (ACAR). For example 38,859 applications for new residential aged care places were received for the 2015 ACAR, more than double the amount sought in the 2014 ACAR and about four times more than the 10,940 places allocated. For home care places, 126,808 applications were received for the 6,445 places available. The number of home care places allocated in the 2015 ACAR (6,445) was slightly less than the number allocated in the 2014 ACAR (6,653) in consultation with the aged care sector. A lower number of packages overall were made available to provide more higher level packages (Levels 3 and 4) in line with demand from consumers.<sup>5</sup>

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<sup>2</sup> 2015-16 Report on the Operation of the *Aged Care Act 1997*, Department of Health, table 7, pp.30, 31.

<sup>3</sup> Recognising the substantial unmet demand for home care packages, the Australian Government will increase the number of operational home care packages from around 60,000 to almost 100,000 over the next 5 years' (Implementing the *Living Longer Living Better* aged care reform package: Overview of proposed changes to the *Aged Care Act 1997* and related legislation, Department of Health and Ageing, November 2012, p.8.

<sup>4</sup> 2015-16 Report on the Operation of the *Aged Care Act 1997*, Department of Health, p.4.

<sup>5</sup> Department of Health website – Results of the 2015 Aged Care Approvals Round (ACAR), accessed 15 November 2016.

Another example which suggests that unmet demand has not been reduced is in the ACT. The ACT public health services quarterly performance report for June 2016<sup>6</sup> reports that for 2015-16 there were 10,662 total occupied bed days in the Canberra Hospital for nursing-home type patients, which was a 25 percent increase on 8,546 days in 2014-15. In 2012-13 the number was 4,390.<sup>7</sup> A nursing-home type patient is defined in subsection 3(1) of the *Health Insurance Act 1973* as a patient who has been provided with accommodation and nursing care, as an end in itself, for a continuous period exceeding 35 days.

The following two tables from the Australian Institute of Health and Welfare<sup>8</sup> also suggest that unmet demand may not have reduced in recent years. While ACSA understands that elapsed time does not reflect waiting times for packages it is the only data that provides any indication of the time from assessment to service delivery.

**Table 1: Elapsed time between approval and entry into permanent residential aged care (as a cumulative proportion)**

	2011–12	2012–13	2013–14	2014–15
≤ 7 days	18.2	18.1	16.0	9.8
≤ 1 month	44.3	43.9	41.2	30.6
≤ 3 months	69.9	69.2	66.7	58.4
≤ 9 months	89.3	88.2	86.7	81.3

**Table 2: Elapsed time between approval for and entry into CACP/Level 1 or 2 Package and commencement (as a cumulative proportion)**

	2011–12	2012–13	2013–14	2014–15
≤ 7 days	10.7*	9.9*	8.2	9.4
≤ 1 month	39.1*	35.1*	31.0	33.6
≤ 3 months	69.5*	65.4*	59.5	57.6
≤ 9 months	93.6*	92.1*	87.1	80.1

\*Community Aged Care Packages (CACPs)

## 2. WHETHER THE NUMBER AND MIX OF PLACES FOR RESIDENTIAL CARE AND HOME CARE SHOULD CONTINUE TO BE CONTROLLED

Refer to Section 4(2)(b) in the Act

In this context:

- the number and mix of packages and places refers to the number and location of residential aged care places and the number and level of home care packages allocated by Government; and
- controlled means the process by which the government sets the number of residential care places or home care packages available.

<sup>6</sup> ACT Public Health Services Quarterly Performance Report June 2016, p.13.

<sup>7</sup> ACT Public Health Services Quarterly Performance Report June 2015, p.13.

<sup>8</sup> Australian Institute of Health and Welfare; Residential aged care and Home Care 2014-15 supplementary data; accessing aged care services figure 1 and figure 2.

### 3. **WHETHER FURTHER STEPS COULD BE TAKEN TO CHANGE KEY AGED CARE SERVICES FROM A SUPPLY DRIVEN MODEL TO A CONSUMER DEMAND DRIVEN MODEL**

Refer to Section 4(2)(c) in the Act

In this context:

- a supply driven model refers to the current system where the government controls the number, funding level and location of residential aged care places and the number and level of home care packages;
- a consumer demand driven model refers to a model where once a consumer is assessed as needing care, they will receive appropriate funding, and can choose services from a provider of their choice and also choose how, where and what services will be delivered.

#### **ACSA RESPONSE TO ISSUES 2 AND 3**

**ACSA considers the number and mix of places for residential care and home care should not be controlled. ACSA considers that further steps could be taken to move from a supply driven model determined by government to a consumer demand driven model.**

The increasing consumer choice changes for home care commencing in February 2017 are an important component in freeing up controls. Under these arrangements funding for a home care package will follow the consumer, replacing the current system where home care places are allocated to an approved provider for a particular location or region. As a result providers will no longer have to apply for new home care places through the Aged Care Approvals Round. Government will control the cost to the budget of these new arrangements by determining who the government will pay subsidies for and for how much.

ACSA supports the Aged Care Sector Committee's Aged Care Roadmap destination of a single aged care and support system that is market based and consumer driven, with access based on assessed need. As noted in the Roadmap this will allow the market to determine the nature, location and quantity of services with the Government no longer regulating the number or distribution of places.

ACSA understands that there are many considerations in deregulating residential aged care and that moving to a fully deregulated environment will take time. As an interim step, Government could move to deregulate locational supply allowing providers to build services where there is consumer demand. In this model Government would still control the overall number of places allocated but would not dictate where they are built. Government has made the first step towards this by allocating places on a state basis in the current ACAR. A second stage would see beds allocated nationally (in much the same way as home care packages will be allocated from February 2017) with providers determining the appropriate locations for new beds.

Government has expressed concern about deregulation on the basis that it may disadvantage rural and regional areas. ACSA strongly supports the importance of local service provision in such areas and suggests they are excluded from the deregulation of locational supply in the initial stages. During this time a new funding model should be developed that will make the provision of aged care in rural and regional Australia more sustainable and attractive.

While monitoring of the deregulation of locational supply occurs and a new funding model is developed ACSA believes that it is likely that government intervention may be required to ensure sustainability.

Such government intervention could take the form of either direct provision of aged care services by government and/or the government paying aged care providers to provide services. However it is essential that any government intervention does not impact on the operation of the market. For example the government should not provide aged care services in a community where there are aged care providers operating.

Also see comments later in this submission in relation to funding options for aged care in regional, rural and remote areas.

#### 4. THE EFFECTIVENESS OF MEANS TESTING ARRANGEMENTS FOR AGED CARE SERVICES, INCLUDING AN ASSESSMENT OF THE ALIGNMENT OF CHARGES ACROSS RESIDENTIAL CARE AND HOME CARE SERVICES

Refer to Section 4(2)(d) in the Act

In this context:

- means testing arrangements means the assessment process where:
  - the capacity of a person to contribute to their care or accommodation is assessed (their assessable income and assets are determined); and
  - the contribution that they should make to their care or accommodation is decided (their means or income tested care fee, and any accommodation payment or contribution is determined).

#### ACSA RESPONSE TO ISSUE 4

**ACSA considers that means testing arrangements (both income and assets) should apply consistently for both residential care and home care and that all income and all assets should be treated equally.**

**It is likely that growth in funding of aged care will have to come from consumer contributions rather than government subsidies. Current and future Governments need to be open and honest with the Australian people and be prepared to make hard decisions around the prioritisation of public funding of aged services and revenue raising.**

**ACSA considers providers should receive (either from government or the consumer) all agreed fees for services provided.**

**ACSA suggests the review consider how to resolve inconsistencies between Commonwealth Home Support Programme and home care package user contribution regimes, especially as we move towards integrating the two programs from 2018.**

ACSA agrees with the suggested destination in the Aged Care Roadmap of sustainable aged care sector financing arrangements where the market determines prices; those who can contribute to their care do; and government acts as the safety net and contributes when there is insufficient market response.

For too long Aged Care – in particular residential care – has been designed and financed as a separate part of Australians' lives instead of as a continuum of the rest of their life. The same issues apply: where they will live; the healthcare they will need; the services they want and how they will support themselves to provide these for themselves.

The next generation will have accumulated capital in two tax advantaged assets - superannuation and the family home. These need to be interchangeable to allow Australians to provide as much as they can for themselves.

Government needs to consider how they can support consumers and remove inequitable hurdles, both real and perceived, to unlock the equity in their home to pay for their ageing. There are opportunities for Governments to support creative usage of superannuation, and the interplay with home equity, to support planning and paying for the supports needed as an individual ages.

Means testing arrangements (both income and assets) should apply consistently for both residential care and home care and that all income and all assets should be treated equally. ACSA supports the annual and lifetime caps which assist consumers who have higher than average care needs in a year or lifetime noting that the level of the caps will need to be reviewed.

ACSA considers the current means testing arrangements are inequitable. For example, the existing capped value of housing assets at \$159,631.20<sup>9</sup> which is used in the assets test. Regardless of the average house prices in the region the same cap applies across the country. A resident in rural Tasmania with a house worth \$200,000 (but capped at \$159,631.20) will be over the threshold limit and will probably be asked to pay a full

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<sup>9</sup> <http://www.myagedcare.gov.au/fee-estimator/residential-care/form>

refundable accommodation deposit but might have actual total assets of not much more than the \$200,000. A similar resident from a mainland capital could have a house worth \$800,000 and because of the cap will be assessed at the same level of assets but once their house is sold would have significantly greater actual assets available.

It is also important that means testing arrangements are able to be administered efficiently, effectively and consistently so that consumers and providers know in advance what consumers will pay and what subsidies government will pay towards consumers' care. The current arrangements administered by the Department of Human Services fall well short of this. The attached ACSA paper sent to the Department in October 2016 illustrates a number of issues with the current arrangements resulting in confusion, stress, consumers deciding not to receive aged care services because of higher than expected fees, increased administration costs for providers and providers being out-of-pocket either for a time or permanently.

ACSA welcomes the Government's recent announcement of the replacement of the IT system to deliver reliable and accurate health, aged care and veterans' payments.<sup>10</sup> This review should consider the IT system design when making recommendations about changes to the fees and charges regime.

In the future, the key relationship for providers will be with consumers. The current systemic issues, such as incorrect assessments resulting in incorrect fees being charged are impacting on the development of this relationship as the consumer holds the provider responsible. In fact some providers are now bearing additional costs as consumers give up on the DHS system and ask providers to navigate or fix issues.

While providing greater choice for consumers in how they pay, the system of refundable accommodation deposits (RADs), refundable accommodations contributions (RACs), daily accommodation payments (DAPs) and daily accommodation contributions (DACs) is overly complicated. Attempting to explain this to a new resident or their family is difficult (particularly at a time of high emotional stress for them). Generally not all of the required financial information is available to providers at the time of admission which means that they cannot provide definitive figures but by necessity have to give rough approximations; this further complicates the process which has to be revised when clearer financials become available.

Periodic reviews of means tested information is often not communicated to providers until several months after their effective date requiring time consuming calculations and adjustments in the form of credits/additional charges.

There does not appear to be any mechanism by which the Department of Human Services is advised how much of a RAD/RAC a resident has paid. Consequently advice regarding fees is often incorrect increasing confusion for all concerned.

Whether these issues can be fixed easily or not is unknown. It is possible that the current arrangements are so complex that there would be merit in considering alternative simplified arrangements subject to consistency between residential care and home care and all income and all assets.

Regardless of the approach taken, ACSA considers providers should receive (either from the government or the consumer) all agreed fees for services provided. Essentially once the consumer reaches agreement with the provider about the amount of fees for the services to be provided, the funding split of those fees between the consumer and the government is a matter for the consumer and government with the provider being paid in full and on time for services provided.

This might mean, for example, that where government determines a consumer should pay higher fees than previously advised, that determination should be prospective and take effect no earlier than say four weeks after government advises both the consumer and the provider of the new higher fees.

Fees in packaged care need to be reviewed and reset. Currently a consumer on a Level 1 Package could end up paying the same as a person on a higher package and receiving more services. The fee is set based on the income test and often bears little relationship to the services provided. This has exacerbated the perverse incentives between CHSP and packaged care which means that clients can receive more services at a lower cost from the CHSP. This anomaly must be addressed as a matter of urgency.

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<sup>10</sup> <https://www.mhs.gov.au/media-releases/2016-10-19-digital-payments-it-system-replacement>

## 5. THE EFFECTIVENESS OF ARRANGEMENTS FOR REGULATING PRICES FOR AGED CARE ACCOMMODATION

Refer to Section 4(2)(e) in the Act

In this context:

- regulating prices for aged care accommodation means the legislation that controls how a residential aged care provider advertises their accommodation prices.

### ACSA RESPONSE TO ISSUE 5

**ACSA notes the current arrangements provide transparency of accommodation prices supporting consumer choice. However, consistent with the Aged Care Roadmap and as noted above, ACSA supports an approach where the market determines price; those who can contribute to their care do; and government acts as the safety net and contributes where there is insufficient market response.**

**Consistent with this, ACSA does not see the need for Government to regulate to protect wealthy older people, as currently occurs, via the requirement to seek Aged Care Pricing Commissioner approval of RADs above \$550,000.**

ACSA considers that publishing prices for accommodation and choice of mode of payment provides price transparency, increased competition and serves the interests of consumers. However, as the outcome of a purely market-based system may result in aged care not being available in some places that the community considers it should be available, government intervention will be required. This is particularly likely to be the case in rural and remote areas of Australia.

General consumer protections (for example contract and consumer law) should be allowed to operate reducing the need for additional regulation and regulators for the aged care industry. The role of the Aged Care Pricing Commissioner needs to be reviewed in this context.

## 6. THE EFFECTIVENESS OF ARRANGEMENTS FOR PROTECTING EQUITY OF ACCESS TO AGED CARE SERVICES FOR DIFFERENT POPULATION GROUPS

Refer to Section 4(2)(f) in the Act

In this context equity of access means that regardless of cultural or linguistic background, sexuality, life circumstance or location, consumers can access the care and support they need.

In this context different population groups could include:

- people from Aboriginal and/or Torres Strait Islander communities;
- people from culturally and linguistically diverse (CALD) backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- people who are veterans of the Australian Defence Force or an allied defence force including the spouse, widow or widower of a veteran;
- people who are homeless, or at risk of becoming homeless;
- people who are care leavers (which includes Forgotten Australians, Former Child Migrants and Stolen Generations);
- parents separated from their children by forced adoption or removal; and/or
- people from lesbian, gay, bisexual, trans/transgender and intersex (LGBTI) communities.

## ACSA RESPONSE TO ISSUE 6

**ACSA acknowledges there are strategies within residential and home based aged care programs designed to facilitate access to services for different population groups, referred to under the *Aged Care Act 1997* as 'people with special needs'. ACSA believes that many of these strategies are aimed at raising awareness of the needs of these specific population groups but still assume that these consumers are able to connect with and navigate the aged care system in the same way as all older people. ACSA suggests that in many circumstances this is not the case and additional on the ground support is needed for these consumers to make contact with and navigate the aged care service system. The current strategies are falling short of achieving equitable access for these specific population groups in the community.**

Under the *Aged Care Act 1997* one of the objectives is to facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location. The Commonwealth Home Support Programme (CHSP) is the entry level in-home aged care programme which is not governed by the Act but recognises the same special needs groups as defined under the Act as well as the provision of care and support for people living with dementia as core business for all providers.

There is limited data available to determine the effectiveness of the current strategies. The latest 2015-16 Report of the Operation of the *Aged Care Act 1997* outlines the Government strategies for each of the special needs groups however it provides little comprehensive data about the impact of these strategies and the outcomes for specific population groups. The allocation of specific places in residential care and home care as part of the Aged Care Approvals Round (ACAR) is one strategy that has had limited monitoring and reporting over time and ACSA would question the value of this type of strategy without any ongoing scrutiny.

The *2014-15 Report of the Operation of the Aged Care Act 1997* included data for the Commonwealth HACC program (part of the CHSP since July 2015) for the 2014-15 period, indicating that 3.4 percent of HACC recipients identified as Aboriginal and Torres Strait Islander. The HACC program had as one of its core strengths the provision of flexible local services for local communities. Access and assessment was largely provided through local service providers who were part of the community and consumers and families felt comfortable making direct contact.

Since July 2015 all consumers of CHSP have accessed aged care through the My Aged Care gateway, the new system of access to aged care, which is a phone or web based system providing information, assessment of eligibility and referral to a Regional Assessment Service (RAS) for a face-to-face assessment where necessary. This more formalised approach has not been embraced by all the community and particularly people from some of the special population groups. There is a wealth of anecdotal information and stories about consumers opting out of the system because of its complexity and impersonal nature or continuing to access directly through service providers. This is particularly an issue for many people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander people and people from rural and remote locations. In many instances local service providers are supporting these clients through My Aged Care with no additional funding or recognition of the impact on resources and outputs.

Since February 2016 any clients wanting to access the Home Care Package (HCP) program must also make contact with My Aged Care and work through the same process and then receive a referral to the Aged Care Assessment Team (ACAT) for a comprehensive assessment. In many areas with high populations of people from CALD or ATSI communities there were local arrangements with ACATs to facilitate the assessment process for these clients. These arrangements are no longer in place and it is unclear to ACSA at this point how many people from these specific population groups are accessing the HCP program.

Recent changes to aged care legislation will mean that from 27 February 2017 there will no longer be any specific allocations within the HCP program. Prioritisation and allocation of home care packages will be managed nationally through My Aged Care based on time waiting and level of priority. While ACSA welcomes greater choice and decision making for the consumer under these reforms there is also concern about the impact of operationalising the reforms, particularly on the specific population groups. This will need to be closely monitored by Government and the sector.

ACSA proposes that there are a number of issues for rural and remote consumers in relation to equity of access to the aged care system. Two of the major issues for consumers and providers are the current funding model and travel costs to deliver home based services. ACSA highlighted to Government that the previous

classification system for the viability supplement was out of date and was not targeting the people with the greatest need. The Government announced changes to the viability supplement for rural and remote providers in the 2016-17 Budget and will modify the classification system used to allocate the viability supplement, replacing the outdated model currently in use. Commencing 1 January 2017 Government will invest an additional \$102.3 million over the next four years.

There has been mixed reactions from the sector in relation to the new classification system. ACSA supports the 'grandfathering' arrangements introduced to ensure that services that would otherwise be disadvantaged by the new arrangements will continue to receive their current level of funding until such time that they are eligible for an equivalent or higher rate of funding under the new arrangements. It is imperative these arrangements remain in place as, with other funding changes to the ACFI, viability of rural and remote providers is particularly vulnerable.

Key findings of the Aged Care Financing Authority (ACFA) Report on the Financial Issues Affecting Rural and Remote Aged Care Providers February 2016 included:

- *Providers operating in rural and remote areas face extra challenges in their financial operations. They generally have higher cost pressures and lower financial results.*
- *The impacts of greater geographical isolation affect a number of areas, including: workforce costs to engage and retain staff; travel; freight; access to allied health professionals; limited internet coverage in some areas and limited catchment areas resulting in smaller scale facilities/services.*

The higher cost of operating in rural areas ultimately has an impact on service provision for consumers. Providers often experience higher costs for staff; travel; freight costs increasing cost of goods and services; access to professionals; technology connectivity and limited consumer numbers resulting in smaller scale facilities/services. Travel and wages costs associated with long distance travel to attend a consumer's home in rural and remote locations reduces the level of service that a consumer can receive from their package. This places consumers choosing to remain living in their homes in rural and remote areas at a disadvantage and does not protect their equity of access to services, regardless of location, as specified under the Act.

The ACFA Report also noted 'there would appear to be scope for many providers to improve their operations and performance. Findings of earlier ACFA work are relevant in ways to improve. Strong leadership and management and a willingness to find innovative collaborative solutions are likely to see improved results'.

Given the increasing pressure on rural and remote services with higher overall operating costs and ongoing industry reforms, ACSA proposes that Government support an industry restructuring package. Many other industries have been supported by Government when faced with major reform or restructure and aged care is no different in terms of its economic value for regional, rural and remote areas.

Deloitte Access Economics estimates that the direct economic contribution resulting from economic activity generated by the aged care industry was \$13.5 billion in value added in 2014-15. This represents the value of production or the 'economic footprint' attributable directly to the aged care sector in the Australian economy. The direct contribution of the sector is approaching that of other important Australian industries such as residential building construction and the sheep, grains, beef and dairy cattle industry.<sup>11</sup>

In addition to an industry restructuring package a new funding model is needed for rural and regional services which acknowledges the additional, and fixed, costs these providers experience.

One alternative is the funding model for Multi-Purpose Services (MPS). These are block-funded and funding is received whether a bed is occupied or empty ensuring services exist in regions that could not viably support stand-alone hospitals or aged care homes.

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<sup>11</sup>Aged Care Guild, Deloitte Access Economics, Australia's aged care sector: economic contribution and future directions, p.ii.

## 7. THE EFFECTIVENESS OF WORKFORCE STRATEGIES IN AGED CARE SERVICES, INCLUDING STRATEGIES FOR THE EDUCATION, RECRUITMENT, RETENTION AND FUNDING OF AGED CARE WORKERS

Refer to Section 4(2)(g) in the Act

In this context aged care workers could include:

- paid direct-care workers including: nurses personal care or community care workers; and allied health professionals such as physiotherapists and occupational therapists; and
- paid non-direct care workers including: managers who work in administration or ancillary workers who provide catering, cleaning, laundry, maintenance and gardening.

### ACSA RESPONSE TO ISSUE 7

In 2012 with the release of the *Living Longer Living Better* document the Government estimated that by 2050 there will be a need for approximately 827,000 aged care workers, up from 304,000 in 2010 and that these care workers will need to be “appropriately skilled and well qualified” if we are to deliver “quality aged care across both the residential and home care sectors”. It suggested that to achieve this goal the capacity of the sector will need to be addressed through “better training, increased wages, changes to the workforce structure, better work practices and improved quality in delivery of care” (2012, page 15). ACSA would argue that a workforce strategy is required.

In 2016, 350,000 aged care employees (202,000 in residential care and 150,000 in community care) deliver services to over one million people through some 2,000 service providers (across Commonwealth Home Support Programme, home care and residential care). This is funded by the Commonwealth Government at a cost of \$17.8 billion in 2016-17.<sup>12</sup> Even in the relatively short five year period between 2007 and 2012 there has been a 34 percent growth in the number of aged care workers, with the greatest growth being in community care. Almost 70 percent of all jobs in aged care are in direct care related roles (page 6). It is recognised that there is an ageing of the aged care workforce, as an example the average age of direct care workers in 2012 was 46.3 years in residential care and 49.3 years in community care.<sup>13</sup>

This significant projected growth in the aged care sector workforce will be a response to the growth in the numbers of older Australians in the 65 years and older cohort which is expected to more than double over the next forty years, increasing from around 3.6 million in 2014-15 to 8.9 million in 2054-55. Consistent with this growth trend is an estimate that 76,000 new residential aged care places will be required by 2023-24.<sup>14</sup>

ACSA believes that addressing the challenges that will come from the predicted significant growth in demand for aged care services requires effective cooperation and a coordinated strategy led by the industry in conjunction with employers, along with Government and other key stakeholders. This was true in 2012 and it remains the case in 2016.

Additionally the Aged Care Financing Authority (ACFA) in its Fourth Report recognises that the aged care workforce is a shared responsibility between the Government and the aged care sector.<sup>15</sup> Deloitte Access Economics in their report states that Government policies in relation to education, employment and immigration have implications for the workforce and that the education sector has a role to play in ensuring their courses are relevant to the skills required in the aged care sector and that they address industry needs. Further to this they stated that as a funder and regulator of the aged care sector, the government has a responsibility “to ensure that the policy environment is sustainable and stable, and will facilitate the growth of a viable industry in the future”.<sup>16</sup>

The 2014-15 ACFA report highlights an increase in wages expenditure since 2013-14 including \$555 million (81 percent) is attributable to a 6 percent increase (\$8.87 per claim day) in the average amount paid per claim day in wages and management fees. This would reflect a combination of factors including wage increases,

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<sup>12</sup> *Australia's aged care sector: economic contribution and future directions*, Deloitte, June 2016, p.2.

<sup>13</sup> Data for Persons Seeking Aged Care, T Robinson University of Canberra.

<sup>14</sup> Deloitte, 2016, p.ii.

<sup>15</sup> Fourth Report on the Funding and Financing of the Aged Care Sector, ACFA July 2016, p.18.

<sup>16</sup> *Australia's aged care sector: economic contribution and future directions*, Deloitte, June 2016, pp.35-36.

increased hours worked per claim day, increased staffing levels and changes in the mix of staff to cater for increased care needs.

There are a number of views that have been expressed across the sector as to what is required within any strategy designed to address the aged care workforce challenge. Suggestions have been proposed by *Living Longer Living Better* (April 2012, p.16), the Productivity Commission (Productivity Commission, 2001, p.347), National Aged Care Alliance in 2012, sector stakeholder groups, peak bodies and indeed ACSA itself through its various submissions and papers - Aged Care Workforce Strategy Framework, ACSA 2016; The Aged Care Workforce in Australia White Paper, ACSA 2013.

These all propose a range of themes that include subjects such as wages, career structures, training and education opportunities, and workforce planning among many others.

We believe there are a range of factors that are driving the need to address a comprehensive and cohesive sector strategy including:

- changing consumer expectations;
- the introduction of CDC into home care;
- the move towards a consumer driven market based sector;
- innovative models of care;
- the introduction of technology to address efficiency;
- skills shortages;
- the challenge of geography (regional, rural and remote);
- changing needs of the consumers (increased acuity and co-morbidities, increased demand for dementia and palliative care services etc.);
- increasing diversity (cultural, linguistic, sexual and gender);
- variability in the quality of training/education;
- competition from other sectors in the health care market (e.g. disability services); and
- the ageing nature of the workforce, among many others.

Therefore ACSA recommends the establishment of an industry-led taskforce that includes Government and sector stakeholders to develop a comprehensive and cohesive aged care workforce strategy that will allow for the long term planning of the sector workforce, that will meet the future needs of consumers and that addresses opportunities and constraints within the aged care workforce sector (including workforce supply, demand and productivity). See the Aged Care Workforce Strategy Framework recently released by aged care provider peak bodies.<sup>17</sup>

## 8. THE EFFECTIVENESS OF ARRANGEMENTS FOR PROTECTING REFUNDABLE DEPOSITS AND ACCOMMODATION BONDS

Refer to Section 4(2)(h) in the Act

In this context:

- arrangements for protecting refundable deposits and accommodation bonds means the operation of the Aged Care Accommodation Bond Guarantee Scheme.

### ACSA RESPONSE TO ISSUE 8

**In considering changes to the Aged Care Accommodation Bond Guarantee Scheme, including consideration of an insurance based solution, ACSA has identified seven principles that options should be assessed against.<sup>18</sup>**

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<sup>17</sup> Aged Care Workforce Strategy Framework; aged care provider peak bodies; November 2016 - <http://www.acsa.asn.au/getattachment/Publications-Submissions/Position-Statements/Workforce-Strategy-framework-Nov-2016.pdf.aspx?lang=en-AU>; accessed 30 November 2016.

<sup>18</sup> *Options for securing repayment of accommodation lump sum payments*, ACS NSW & ACT, August 2016.

Under the *Aged Care Act 1997* the Commonwealth made provision for certain residential and flexible aged care services to charge care recipients accommodation bonds for entry into their services. These bonds (minus certain deductions) were refundable to care recipients on their exit from the service.

The *Aged Care (Bond Security) Act 2006* provides protections to care recipients who are entitled to an accommodation bond refund should the approved provider of the facility in which they reside become insolvent and be unable to refund the bond. The Commonwealth has provision to repay these care recipients the bond balances they are entitled to, and further an associated Levy Act provides for the Commonwealth to be able to seek recovery of these costs from approved providers across the sector.

The *Aged Care (Living Longer Living Better) Act 2013* introduced, with effect from July 2014, new ways for care recipients to pay for their accommodation (i.e. periodic payment, lump sum or a combination of both). In order for the same protections to be applied to care recipients who entered aged care services on or after this date the Bond Security Act and Levy Act were updated. Again if the Guarantee Scheme is triggered and the Commonwealth repays accommodation bonds or payments to care recipients the Commonwealth is able to recover its costs via a levy from approved providers.

ACSA notes that in 2011 the prudential arrangements for accommodation bonds were further enhanced by the introduction of 'permitted uses' of these bond amounts, this process reinforced the role of these payments in financing capital investment in residential care. ACSA understands that as at 2013, the Commonwealth had outlaid an estimated total of \$24 million under the Guarantee Scheme but had not to date sought to recover this from the sector. As at June 2015 ACSA understands that the sector held approximately \$18 billion in resident savings (RADs/Bonds).<sup>19</sup>

In the original package of reforms the Government proposed that approved providers be required to privately insure bonds but on consideration of this determined that "neither the sector nor the market were ready for an insurance based solution".<sup>20</sup> In effect the Government determined to continue with the Bond Guarantee Scheme.

Given the low level of default experienced in residential aged care it is difficult to accurately model and develop an insurance scheme.

ACSA understands that the Government continues to consider changes to the Guarantee Scheme that would reduce the risk to Government of default by approved providers. ACSA understands that this will be more of an issue for Government in a deregulated environment and recommends that the current arrangements remain in place until that time. ACSA supports the view that the Guarantee Scheme provides certainty to care recipients in relation to the return of their accommodation lump sum payments/bonds and that this is a positive outcome for both the general public and also for the sector.

The Guarantee Scheme has to date paid out to care recipients the liabilities owed to them on a number of occasions without imposing a levy on the sector. ACSA understands that as the national pool of refundable accommodation deposits, including bonds, grows (\$18 billion in 2015 – up from approximately \$15.6 billion in 2014) that the Government is going to want to reduce its risk exposure, notwithstanding that it currently is able to recoup this from the sector via imposition of a levy.

In considering changes to the Guarantee Scheme, including consideration of an insurance based solution, ACSA requests that the following principles are taken into consideration by the Government when identifying options:

1. Any change continues to provide a guarantee to care recipients in relation to their refundable deposits.
2. There is minimal cost impact on providers and there is an 'impact assessment' process undertaken for all options considered.
3. There is minimal cost impact on care recipients.
4. Proposed changes do not negatively impact on industry development or viability.
5. In relation to spread of risk across the industry, that consideration is given to how the spread of risk is carried by the industry i.e. whether it is an aggregate collective risk or whether risk is spread according to

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<sup>19</sup> Fourth Report on the Funding and Financing of the Aged Care Sector, ACFA, July 2016.

<sup>20</sup> Response to the Senate Community Affairs Legislation Committee Report on the Aged Care(Living Longer Living Better) Bill 2013, p.7.

criteria that rates approved providers according to pre-determined criteria e.g. their level of debt leverage, high growth strategies etc. The approach taken should not place at risk access to services by consumers particularly in rural and remote regions.

6. The system is simple to operate and manage and associated costs of operating the scheme are low.
7. The cost impact to Government is also low. ACSA believes that there are a number of insurance product options that could be 'on the table' for consideration (including consideration of an industry insurance scheme, provider organised insurance, surety bonds scheme, **consumer insurance options** etc.) and that a joint Departmental and industry representative committee be formed (including representation from the insurance industry) to assess and propose options before Government makes any decisions on this.

## 9. THE EFFECTIVENESS OF ARRANGEMENTS FOR FACILITATING ACCESS TO AGED CARE SERVICES

Refer to Section 4(2)(i) in the Act

In this context access to aged care services means:

- how aged care information is accessed; and
- how consumers access aged care services through the aged care assessment process.

### ACSA RESPONSE TO ISSUE 9

**One of the most significant changes Government introduced to improve access to the aged care system was My Aged Care which now encompasses the My Aged Care Website, Contact Centre, Regional Assessment Services (RAS) and Aged Care Assessment Teams (ACATs). Introduced in July 2013 it has been expanded over the past three years as the 'entry point' to the Commonwealth funded aged care system. There have been numerous system and process issues since the introduction of My Aged Care that have impacted on the effectiveness of these new arrangements for consumers, carers and aged care providers.**

**ACSA seeks further investment by the Government in physical presence/human resources who can act as navigators particularly for those people without family support.**

The intent of the system is to make it easier for older people, their families and carers to access information on ageing and aged care, have their needs assessed and be supported to find and access services. Some of the early implementation issues included:

- Inexperience of contact centre staff and lack of knowledge of the aged care industry;
- Huge demand in numbers accessing My Aged Care;
- The inbound referrals process via fax that had minimal detail provided and created significant delays and back log in the early stages;
- Screening tool still set up for Contact Centre staff to undertake both screening and assessment functions over the phone – very long time on phone, asking questions that were to be completed face-to-face by RAS assessors;
- Limited information and promotion to consumers and the broader public about the existence and purpose of My Aged Care;
- Confusion regarding the process for assessment and referral;
- Provider portal set up issues including initial creation of services and outlets through to limited scope for service details and uploading of provider brochures and information; and
- Provider resistance to change and frustration with the system.

While some of the above issues have been addressed, in December 2016 there are still a number of problems associated with My Aged Care. Although significant system improvements have been made there is more to do to ensure a quality system and process for consumers and providers.

For those consumers and/or their family members who access My Aged Care and are able to clearly articulate their situation, receive the appropriate information, and experience common eligibility screening, assessment and referral to a provider of choice, the system is perceived to be working satisfactorily. However, for many people who do not have family support or are not able to advocate for themselves the Gateway has not improved equity of access. Many consumers still find it difficult to connect with the aged care system and

navigate their way through each step. This is particularly an issue for people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander people, people at risk of homelessness and other vulnerable groups within the community. Many vulnerable older people require coordination/case management type assistance to access and navigate the My Aged Care process. There is room for improvement with the current linking service at the Regional Assessment Service as it is not available uniformly, not well or not at all to effectively support all of the vulnerable people who require it.

Current issues include:

- Minimal community education – limited promotion of My Aged Care as the entry point to government funded aged care and potential costs associated with receiving services;
- Significant expansion of Contact Centre in a short period of time to meet demand resulted in the recruitment of staff not necessarily experienced or familiar with aged care. Adequate training and support is critical for such staff;
- System capability – technology and process problems;
- Prohibitive restrictions on providers having 'Consent' to assist consumers to access My Aged Care – these restrictions were inconsistently applied and appeared to be outside the normal privacy requirements;
- Rural and remote areas have variable access to technology depending on connectivity and face-to-face assessment is a challenge because of travel;
- Barriers for diverse groups to access My Aged Care (Indigenous, CALD, hearing Impaired, people with dementia, vulnerable, homeless). Many require support with interaction with My Aged Care screening and assessment process. (More detailed discussion at issue 6)
- Time delays from referral to My Aged Care and assessment. This particularly impacts vulnerable older people who may have no other support to follow up what is happening to their referral, putting them at risk if the initial phone conversation with My Aged Care did not accurately reflect the person's situation or if the person's situation changes and this puts them at risk;
- My Aged Care (Contact centre/assessors) not taking notice of instructions in referral regarding who to ring and the time to ring;
- Poor outcomes for users or older people not engaging with My Aged Care at all due to lack of understanding of process;
- Anecdotally duplicated contact and assessment of individuals;
- Inconsistent outcomes from the assessment process – examples include RAS assessors referring a client for several CHSP services (resulting in support at higher than Home Care Package level 1 or 2 care) and the service may be provided through multiple services with little if any co-ordination; ACAT assessors making decisions whether or not to assess based on personal assumptions or outdated views of the programs and services. Examples include deciding if a client is not willing to pay basic daily care fee or income tested fee then no ACAT assessment necessary and referred for RAS assessment;
- In remote regions of Australia (including NT) many consumers are not receiving independent face-to-face assessments from the RAS. The Department has made interim arrangements for the ACATs to complete all assessments. ACSA supports a co-design approach for a future model that meets the needs of rural and remote Australia, including technology where this is workable.
- There is little evidence that My Aged Care has implemented the wellness and reablement approach as proposed. The numbers of referrals to Day Therapy Centres has declined and referrals to providers do not indicate that the assessment or the referral has considered consumer needs and goals based on a wellness and reablement model;
- Very little quality reporting or data provided to the industry. For the first time Government and the industry have the opportunity to review performance and outcomes from one central system but this level of reporting has not yet been made available.

The current information, assessment and referral process is unnecessarily complex particularly for consumers seeking relatively small amounts of service and specifically for the most vulnerable clients including those from special needs groups. ACSA recommends multiple entry points for service provision based on the type and length of service required, similar to the system proposed by the Productivity Commission – Caring for Older Australians Report 2011. Some types of service such as a single transport service do not require a lengthy assessment process and could be accessed directly through service providers with an assessment in

the future if the consumer's needs change and/or they require on-going services. ACSA also proposes a streamlining of the system for those that require a full assessment to one single assessment process, combining both ACAT and RAS functions, through one assessment agency.

This is in fact the original design of the current system but the implementation has not been effective and has worked against this.

## **OTHER COMMENTS**

### **The interface between health and aged care**

It is also important to link health care, including the Primary Health Networks, with aged care services at the local level particularly in rural and remote communities. A common criticism of residential aged care, from families and from state governments, is that when there is a health issue the home calls the ambulance and "abrogates" its responsibility for the resident. A different funding approach would support different staffing/service models potentially avoiding the need for this disruption. This would also create savings in the nation's health system – funded by the Commonwealth Government and delivered by state governments. Such a move is in the interests of all taxpayers and both levels of government. These issues need to be balanced as another common complaint from families is that staff don't send residents to hospitals when they think they should have been.

ACSA supports the development and expansion of integrated health and aged care services that are locally designed and managed.

### **Funding**

With demand for aged care services set to increase dramatically in the coming decades, sustainable and responsible funding mechanisms are critical. Funding must be sustainable and predictable for both providers and the government and meet the full operational and capital costs of delivering safe and secure aged care services.

Rural and remote providers face additional costs in providing aged care including for example cost of food, travel costs and staff remuneration and training costs. These additional costs are not adequately factored into government funding which results in an inequitable system as consumers in these communities receive less care compared to consumers with similar aged care needs living in metropolitan communities. A different funding model is required.

ACSA acknowledges there is an onus on each of us to plan and take responsibility for our needs as we age. This is why consistent means testing for home care and residential care and for all income and all assets is necessary.

The specified care and services schedule must be reviewed so there is clarity about what the Government subsidy covers. Over and above that providers can then charge for additional services in line with existing Government policy. This clarity will also support individuals to have sufficient funds to meet their own aged care costs. Overall this will improve the sustainability of the system.

### **Regulation**

In addition, ACSA is concerned that the current aged care system is over regulated increasing costs and stifling innovation. Government regulation should be limited to those areas which ensure minimum standards of care are provided to all older Australians receiving home care or residential care; refundable accommodation deposits/bonds are safe; and consumers are easily able to find information about the availability and cost of aged care services in their community. Existing regulatory structures should be used where these exist rather than developing aged care specific ones.

### **Implementation**

ACSA is also concerned that the number of recent and proposed aged care changes has not allowed the Government, providers and consumers the opportunity to adequately implement them. Changes need to be

implemented in a measured, orderly and prioritised way by the many different government departments and agencies with aged care or related responsibilities.

### **The Aged Care Funding Instrument (ACFI)**

The Aged Care Funding Instrument (ACFI) has 'blown out' on a number of occasions. Governments at the time have responded in the same way by clawing back funds and using them for other purposes either in aged care or for other purposes.

This first occurred in June 2012, with a 'blow out' over the four year forward estimate period 2011-15 of \$2.3 billion. The then Government redirected the 'blow out' to fund elements of the *Living Longer Living Better* reform package.

In 2015-2016, in response to the higher than expected increase in residential aged care funding, of \$3.8 billion over four years, the Government announced in the 2015 Mid-Year Economic and Fiscal Outlook (MYEFO) and in the 2016-17 Budget changes to residential care funding arrangements.<sup>21</sup>

After the 2015-16 announcement there was significant concern in the sector that the changes would overreach those budgeted by the Government.

Independent financial modelling undertaken by Ansell Strategic<sup>22</sup> estimated the changes to ACFI announced in the 2016-17 Budget would mean a reduction in funding of on average 11 percent once all residents were on the amended ACFI. The review involved 501 aged care homes and almost 39,000 residents.

The analysis evaluated the impact of proposed changes to the ACFI which targeted funding for people with complex health care needs, particularly those receiving treatment for severe pain, chronic disease and medications.

The study also focussed on what the financial impact of funding cuts would mean for the care of highly vulnerable residents and the strategies proposed by providers to address the management of their treatments.

The review found:

- The changes would result in funding reductions significantly greater than estimated by the Government.
- The changes compromise the ability of providers to care for highly vulnerable residents. The full implementation of the changes to ACFI would decrease annual funding per resident by an average of \$6,655 (11 percent). The impact is considerable when compared with the national average return of \$9,244 per resident.
- The changes would impact the ability of aged care providers to address the care needs of the increasing number of aged care residents suffering chronic pain and disease. In order to manage the cuts, more than 80 percent indicated they would need to consider reducing their allied health workforce who provide care services to relieve chronic pain, such as physiotherapy and massage.
- A large proportion of respondents to the survey indicated they would also need to reconsider admitting residents with more complex care needs. This would shift the responsibility for care back to the hospital sector, with flow on negative effects for all health care consumers, State and Territory governments and the acute care sector.

The aged care industry claims the maximum funding they can through ACFI based on the assessed need for an individual resident to support quality care.

There are longer term questions about whether overall aged care funding is sufficient and whether it acknowledges the changed nature of residents – those with longer length of stay with dementia and those with complex health care needs who have short stays.

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<sup>21</sup> <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2016-factsheet48.htm>

<sup>22</sup> [http://www.unitingcare.org.au/images/stories/publications/2016/160628\\_report\\_acfi\\_review\\_report\\_ansell.pdf](http://www.unitingcare.org.au/images/stories/publications/2016/160628_report_acfi_review_report_ansell.pdf)

Because of recent funding instability ACSA believes there should be the examination of new funding methodology which would ensure stability and sustainability of the sector, and has, with other NFP aged care peak bodies, developed principles to guide the development of a new funding model.

### **Principles for Aged Care Services Funding**

The Government is currently undertaking a review of the ACFI with a view to developing a new, more certain and sustainable residential aged care funding model. Not-for-profit aged care provider peak bodies have developed principles to guide the development of any new funding model.

The new funding model should be designed comprehensively, including all current supplements and consideration of arrangements for consumer financial contributions, and be able to be applied across home and residential care (in line with the recommendations in the Aged Care Sector Committee's Aged Care Roadmap for Reform).<sup>23</sup>

The model should be aimed at maximising health and wellbeing and support re-ablement, prevention and restorative approaches to aged care services. Performance should be measured through the achievement of outcomes (not merely inputs or outputs) while funding recognises the cost drivers, such as workforce demands and required skill levels, in achieving the desired outcomes.

Funding should support all consumers based on their assessed needs, including those with special needs. This requires flexible funding allocations, weighted on individual needs to ensure diverse consumers are able to be appropriately supported. The approach should also ensure that specific consumer groups (e.g. rural and remote, LGBTI, CALD, Indigenous, older people living with disability, those with mental health needs or people who are socially isolated) have access to quality support and care. It should further take account of the particular complexities encountered in appropriately supporting consumers with multiple chronic diseases and problematic behavioural patterns.

The model should support consumer choice and control across the continuum, recognising different cost structures in the delivery of aged care services. The model should also recognise that consumer choice, control and flexibility can be achieved in aged care services through models including, but not limited to, the funding following the consumer model that will be implemented for home care packages.

The model should ensure that it can be adapted, where the funding follows the consumer across the continuum of care (home-based, residential and respite etc.), to support longer term planning and goal setting for individuals and to support the integrated aged care system envisaged in the Roadmap. Regulation and application of funding should enable supplementary resource allocation for episodic, short or medium time periods to provide for very specific needs associated with acute episodes of illness, post-acute periods or for palliative care.

Minimising red tape should be a key feature of any future funding model. All possible resources should be allocated to direct service delivery. The funding model should support evidence-based practice and discourage practices that do not deliver tangible benefits to the consumer.

The model should ensure the aged care system is financially sustainable and not prone to financial volatility. Investment in service expansion and innovation to achieve positive outcomes for older people and their families will follow stable and predictable baseline funding, which anticipates projected areas of growth in the number and changing profiles of care needs of residents. The model should recognise a commitment to quality, safety and continuous improvement as standard prerequisites for service providers.

The model should:

- be simple and completely transparent to support trust and engagement between funders, providers and consumers, and to make it easier for consumers to understand and providers to administer;
- support seamless interactions between the sectors that care for older people, including aged care, primary and allied health, and acute care;

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<sup>23</sup> <https://agedcare.health.gov.au/aged-care-reform/aged-care-roadmap>

- represent value for money and affordability for consumers and for government. Those consumers who can afford to pay should contribute to the costs of their care but Government should provide a safety net for consumers who are unable to make a financial contribution;
- recognise that providers need to generate market-based returns, at an appropriate level to support delivery of effective services and to continue to invest in the sector; and
- recognise the need to support those providers who deliver aged care for communities where a local market may not otherwise sustain them.

### **A future funding model**

Government is separately reviewing the ACFI tool. ACSA is seeking that this work results in a funding system that:

- provides certainty and adequacy of funding, including indexation, for providers;
- enables provision of quality services to residents;
- ensures sustainability of, and investment in the aged care system;
- Acknowledges and supports the changing nature of residential aged care with:
  - residents entering at an older age (in 1997-98 average age of 82.2 for females and 79.5 for males [average 81.1 years] to an average of 84.6 years in 2015);<sup>24,25</sup>
  - an increased demand for short term support in palliative care, respite care as well as a growing number of residents with shorter lengths of stay due to complex health care and
  - residents with dementia who stay for longer periods.

The legislated review needs to consider the changing nature of care required in residential care and the outcomes of the ACFI review to ensure an overall system solution to the sustainability of aged care. Changes made in the user pays system and the interaction of those with any new funding system must be carefully considered to ensure they work together.

Funding instrument and user payment changes shouldn't be considered in isolation from the review of the Specified Care and Services schedule and the opening up of the approach to the provision of additional services.

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<sup>24</sup> Department of Health and Ageing, Technical Paper on the changing dynamics of residential aged care prepared to assist the Productivity Commission Inquiry *Caring for Older Australians*, April 2011, [www.pc.gov.au/inquiries/completed/aged-care/residential-care-dynamics/residential-care-dynamics.pdf](http://www.pc.gov.au/inquiries/completed/aged-care/residential-care-dynamics/residential-care-dynamics.pdf)

<sup>25</sup> 2016 Aged Care Financing Authority (ACFA) report on funding and financing of the aged care sector.