AGED CARE LEGISLATED REVIEW

December 2016

Ms Kay Richards
Leading Age Services Australia, National Policy Manager
Leading Age Services Australia (LASA)

Leading Age Services Australia (LASA) is the national peak body representing all providers of age services across residential care, home care and retirement living. We represent our Members by advocating their views on issues of importance and we support our Members by providing information, services and events that improve their performance and sustainability.

Our vision is to create a high performing, respected, sustainable aged services industry delivering affordable, accessible, quality care and services for older Australians.

If you have any questions regarding this submission, please contact Ms Kay Richards, LASA National Policy Manager on 02 6230 1676.
Contents
Leading Age Services Australia (LASA) ................................................................................................................2
Contents ............................................................................................................................................................. 3
The LASA Member Survey .................................................................................................................................. 4
1. Submission Details ......................................................................................................................................... 5
2. Response to Criteria in the Legislation ........................................................................................................ 6
  2.1 Whether unmet demand for residential and home care places has been reduced .......................... 6
  2.2 Whether the number and mix of places for residential care and home care should continue to be controlled ............................................................ 9
  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 .............................................. 12
  2.4 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 ...... 15
  2.5 The effectiveness of arrangements for regulating prices for aged care accommodation .......... 19
  2.6 The effectiveness of arrangements for protecting equity of access to aged care services for different population groups ........................................................................ 21
  2.7 The effectiveness of workforce strategies in aged care services, including strategies for the education, recruitment, retention and funding of aged care workers ........................................... 24
  2.8 The effectiveness of arrangements for protecting refundable deposits and accommodation bonds .................................................................................................................. 32
  2.9 The effectiveness of arrangements for facilitating access to aged care services .......................... 34
3. Other comments ............................................................................................................................................. 37
4. References .................................................................................................................................................... 38
Introduction

Leading Age Services Australia (LASA) thanks you for the opportunity to comment on the Consultation Paper for the Aged Care Legislated Review. LASA is a strong advocate for enhancing the lives of older Australians and our vision is for a high performing, sustainable aged care industry delivering affordable, accessible, quality care for older Australians.

The following submission takes the format of the Consultation Paper and directly answers the questions posed in the Paper. Our answers are informed by a survey undertaken by LASA of our LASA Members.

The LASA Member Survey

LASA conducted a survey of its Members about the Living Longer, Living Better reforms to inform its response to the Aged Care Legislated Review. The survey was conducted during November, 2016.

The majority of the respondents to the survey represented medium sized services, residing in metropolitan areas of Australia, with a vast majority describing their operating model as not-for-profit.

Many services completing the LASA survey offered residential care and home care services.
1. Submission Details

1.1 What is your full name?

First name

Kay

Last name

Richards

1.2 What stakeholder category do you most identify with?

Peak body - provider

1.3 Are you providing a submission as an individual (go to question 1.4) or on behalf of an organisation (go to question 1.5)?

Organisation

1.4 Do you identify with any special needs groups?

No

1.5 What is your organisation’s name?

Leading Age Services Australia Ltd

1.6 Which category does your organisation most identify with?

Aged Care Provider Peak Body

1.7 Do we have your permission to publish parts of your response that are not personally identifiable?

☑ Yes, publish all parts of my response except my name and email address

☐ No, do not publish any part of my response
2. Response to Criteria in the Legislation

2.1 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.

What we currently know:

- Approximately 1.3 million age care services were delivered in 2015-16. The great majority received home-based care and support, and relatively few lived in residential care.
- The Australian Government specifies a national provision target of subsidised operational aged care places for every 1,000 people aged 70 years or over, known as the aged care provision ratio. In 2015–16 this figure was 113.2.
- The aged care provision ratio is set to grow from the current level to 125 by 2021–22. As the number of places increases, the balance of care types within the ratio will also change. The target for home care packages will increase from 27 to 45, and the residential target will reduce from 86 to 78. In addition, a restorative care target of two places has been implemented.
- However, a capped system is in place that restricts consumer access and choice.
- Occupancy rates in residential care are less than 93% for metropolitan, inner and regional outer. Less than 87% in regional remote and regional very remote.
- In 2013-14, the average occupancy rate for Level 1 Home Care Packages across all States was just 48.4%, with the national average occupancy rate for Level 4 Packages being 90%. This indicates the lack of interest in L1 Packages as they do not compare to what is seen as better value from the Commonwealth Home Support Programme (CHSP).
- In 2015 the national occupancy rate for HCP was 85.8% (all package levels).
- More than 640,000 older people received home support through the CHSP.
- 285,432 older people received support through the Commonwealth-State HACC program (Victoria and WA).
- 56,852 people received residential respite care, of whom 29,538 (approximately 52%) were later admitted to permanent care.
- 88,875 people received care through a home care package.
- 234,931 people received permanent residential aged care.
- People also accessed care through flexible care programs and other aged care services. Some people received care through more than one program.
Interestingly, the LASA Member survey results demonstrated various responses when asked if unmet need for *residential places* has been reduced following the introduction of the LLLB reforms.

![Survey Results Chart]

Further investigation revealed significant differences in response by operating model: Private providers were more likely to disagree (50%) than not-for-profit providers (25%). There was much more uncertainty within the not-for-profit providers (38%) than Private (28%).

Comments indicate that unmet demand has not been reduced by the Reforms. Issues raised included:

- In residential services, unmet need has not been reduced.
- Services are still maintaining waiting lists.
- People are staying at home longer so this has naturally reduced demand, not the reforms.
- Demand is influenced by cost of entry, rather than bed availability.
- There is unmet demand for planned respite.
- There are delays or confusion experienced with Assessments or My Aged Care (MAC).
- Residents with low Aged Care Funding Instrument (ACFI) may remain on waiting lists.
- There is an increase in supported residents.
- There are vacancies, but not in areas where people want the service – such as inner metropolitan areas.

When asked if unmet need for *home care places* has been reduced following the introduction of the LLLB reforms, respondents were again divided. However, the majority of comments indicated that there are still waiting lists and identified the lack of Level 3 and 4 packages, and a bottleneck effect at Level 2 packages. One comment identified possible issues with the quality of rural packages.

![Survey Results Chart]
Apart from the LASA survey, there is no clear evidence that unmet demand for either residential or home care places has been reduced.

Unmet demand may be impacted by service availability and capacity within services, in an environment of growing demand.

A capped system, by definition, restricts consumer access and choice. LASA contends that ACAR should be removed to enable an open, competitive market for age services. However, as seen in the hospital system, where everyone is eligible to receive care and service, there remains barriers to entry, such as, waiting lists for elective surgery, early discharge programmes etc.

The Australian community will be the final arbiter as to whether they accept long waiting lists for services targeting the aged population, whether it be in the home or in a residential setting.

While a capped system remains (especially in home care) there should be a more adequate, transparent, objective evidence based prioritisation methodology that will effectively disperse scarce resources.

Unmet need is exacerbated by wait times, that is, the time from registration in My Aged Care, to assessment of need and commencement of service. This is true for both Regional Assessment Services (RAS) and Aged Care Assessment Teams (ACAT). This is also the case for when a person’s need increases, the wait time for reassessment of a package level can be long and this varies across the country.

Another barrier to streamlined access is the means testing arrangements. LASA acknowledges that more complicated assessments will take longer than those that are simpler, however the process can be complicated, confusing and provide inaccurate information where in some cases is contradictory to what the provider receives from what the care recipient receives.

LASA encourages the Review to assess the demand for the package levels with the knowledge that Level 1 packages are more difficult to fill, especially with some consumers considering the contribution required and deciding that the package is of limited value. LASA also notes that of the four packages available, the proportion of Level 1’s utilised is significantly lower than the uptake of the other three levels.
2.2 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.

Within LASA’s Membership there are varying views as to whether the number and mix of places (in residential care and home care) should continue to be controlled.

Forty-four percent (44%) of respondents to the LASA Member Survey agreed on controlling supply, however 27% were unsure. The not-for-profit providers had the greatest uncertainty, and private providers were more likely to agree to controlling supply.

However, LASA has suggested that the industry needs to move from a welfare entitlement model to one that operates from a market base. If the industry moves to a consumer-driven, market based system, it cannot work in the vacuum of a capped system. A market based system will allow more entrants and provide more choice for consumers.

The mix of places in residential care currently means permanent, respite or restorative care types. This does not allow for growth of other care types, for example, palliation and sub-acute care. For these services to be offered, a more targeted approach to funding must be considered.

LASA has previously queried whether the current planning ratios will be able to meet demand, especially with the knowledge that different trends exist in various demographics across Australia. The current provision ratio for the 70+ age group is an inadequate proxy that does not align with residential care utilisation, which is predominantly used by the 85+ age group. The current provision ratio allows for increased allocation of places to home care which is desirable but is not consistent with levels of demand. There are many more people with aged care assessments and home care eligibility than there are places available.
Arguably, historical allocation of Home Care Packages to planning regions, has not reflected need and demand given the enormous variations seen in waitlists across and within regions.

LASA is concerned that rationing will result in some consumers either waiting significant lengths of time for services to commence or deciding not to take up formal services; an outcome that could be detrimental to the consumer. A controlled system does not allow for innovation such as Multi-Purpose Services (MPS) for rural/regional areas, or integrated care in metropolitan (land expensive, cheaper to go vertical).

The years 2014-15 saw a decrease in the number of people entering residential care within seven days of an ACAT approval, with only 9.8% doing so compared with 16% in 2013-14. Similarly, decreases were noted at the one-month and three-month mark with 30.6% and 58.4% respectively. This compared with figures from 2013-14 and 2012-13 suggests that people are not entering residential care as quickly as has occurred in previous years. With regards to Home Care, similar trends are noted, with 58.6% of people commencing Home Care within 3-months of their ACAT approval, compared with the 2013-14 figure of 59.2%. However, the uptake in the first month of the approval did increase with 33.7% in 2014-15 compared to 30.7% in 2013-14. The reasons as to why these trends are occurring is not clear and is likely to be multi-factorial. As flagged by the Productivity Commission, this indicator is under review to try and improve the ability to interpret this information.

LASA welcomed the ceasing of the Aged Care Approvals Round (ACAR) process for Home Care Packages. However, LASA continues to advocate for the abolition of the ACAR for residential care and instead suggests that market forces, the prevailing competitive environment along with consumer need, be the deciding factors to encourage the market growth required over the next 20 plus years. This process, including uncapping supply, would assist in the creation of a more transparent and realistic process.

Others in the industry have suggested that “the current rationed system needs to be replaced by a model which provides a level of Government resources to an older person to support them to live as independently as possible. Giving the resources to the older person enables them to continue to manage their own life and tailor services to meet their specific and individual requirements which will change over time. This will require the aged care service system to shift from its current welfare entitlement model to one which operates from a market basis, driven by the needs and expectations of our ageing population”. This view is mirrored by the National Aged Care Alliance (NACA).
Having said that, LASA Members overwhelming support the premise that rural and remote and areas of thin markets are protected. This is mainly due to the areas having no market forces to justify investment. There is also a mood that suggests residential care should continue to be controlled but not for home care places.

**Survey Question**

In your opinion, should rural and remote and thin market areas be protected to ensure places meet demand?

These varying opinions suggest that the provider experiences different outcomes based on their location. Obviously, services that are well placed with active wait lists would hold a different opinion than a service that has vacancies for either home care or residential places.
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.

As highlighted above, 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. Whereas 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.

LASA contends that to truly participate in a consumer demand system, service providers will need to compete on quality. The consumer will decide the value proposition to service delivery (giving specific consideration to thin market areas) and the market should dictate success (or otherwise) for the provider.

The majority of LASA members completing the LASA survey agreed that further steps need to be taken to change key aged care services from a supply driven model to a consumer demand driven model.

The definition of key aged care services is important. If this is taken to mean ‘traditional’ i.e. residential or home care, then a review of pricing arrangements is essential. To be truly market based, the market must set the price - this is the basic tenant of supply and demand. Under the current model, the funding and financing arrangements are set by Government.

For the industry to adjust to any change, where supply increases (new entrants into the market), providers will require the ability to deliver and charge for more than the current ‘suite’ of services – permanent, respite, restorative. For example, dedicated palliative care places which are funded appropriately and possibly through a block funding mechanism.
Alternative funding options need to be identified, including a review of the current inequity of particular supplements and ‘special’ funding or grant allowances for the use of telehealth in rural and remote regions should be considered. Also, the changing focus on practitioners, for example, Nurse Practitioners, and their access to Medicare Benefits Schedule (MBS) funding items must be reconsidered.

**Funding stability must be achieved for a consumer demand driven model to succeed.**

Greater certainty on funding sources and a sufficient return on capital investment is required to ensure supply is increased.

LASA Members have identified some options to assist to move to a consumer demand driven model:

- Gradually increase the supply of places above the planned target provision ratios to ensure a controlled expansion to a market based system.
- Uncap residential care fees that can be charged by providers in the market, where the ACFI funding becomes a co-contribution rather than a capped subsidy. This would alleviate the fiscal pressure on the Australian Budget, allow the market to set the price, and allow consumers to decide on their relative value proposition.
- The potential for the public and private health insurance sector to fund the gap as it currently does for medical services.
- Changes to be made to Government policy whereby the aged pension income and assets test arrangements encourage behaviour to release home equity and encourage private or Government supported equity home release or reverse mortgage schemes.
- A review of the Schedule of Specified Care and Services which may be too prescriptive and/or ambiguous in its interpretation and may be stifling innovative services being delivered to consumers.

Despite the suggestions above, the 2017 home care changes and the proposed 2018 amalgamation of the CHSP and Home Care will open the market further. Until these initiatives are implemented and evaluated, new reforms for home care should not be considered.

Other LASA member feedback included:

- continued consultation with the sector
- review of current funding models including finalising vacancies between home care and residential
- use of a voucher system – low, medium and high
- finalise the accreditation system changes
- decrease regulation and let consumers choose based on quality
- use a system similar to NDIS
- separate care and accommodation costs with Government only funding care
• review the vacancies rates of Level 1 and 2 packages
• understand the next generation’s needs
• longer term planning from Government
• integrate management systems to reduce manual administrative load
• simplify information, clear support for financially or health disadvantaged, and
• grandparent current home care packages that were awarded by tender.

Although stated above, that to truly participate in a consumer demand system, service providers will need to compete on quality, LASA Members were divided when asked if competition will be based on quality.

The responses were predicated on operating model; private providers were more likely to agree that competition will be based on quality (63%) than not-for-profit providers.

The explanation to this is unclear, however, it might indicate that thin markets (where predominately not-for-profit providers compared to private providers operate), competition is not as obvious as in areas that are well resourced with services (such as metropolitan areas).

Comments in the LASA Member Survey about whether a consumer driven model will be based on quality, identified that quality will only be one aspect. Other issues that will impact on choice will include:

• innovation
• affordability
• marketing
• size of the provider (larger may have more advantage), and
• reputation within the community.

Comments were also made that there is no set definition of quality so it is hard to know what quality from a consumer perspective is.

LASA supports the initiative that home care places are allocated on the basis of need, urgency and length of time waiting. However, access to care, more predominately in home care, will remain an issue until the system is operating in an open market.
2.4 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).

LASA supports the premise that where people who can afford to contribute to the cost of their accommodation and care do so. However, there is confusion by both consumers and providers about the process for applying for a means test, be it for assets and income for residential services, or income for home care.

Many people present to a home care or residential care provider without a means tested outcome, incomplete information, or contrary information to what is provided to the provider by the Department of Human Services (DHS).

We know that delays in receiving a means test outcome are multifactorial. Better communication is needed to support the consumer to know what information is required and how it is provided to the DHS. The onus of communicating this information should not fall to the provider. Delays in receiving an outcome may impact the time to providing services and may also impact the consumer and provider when a debt is accumulated (for either provider or consumer). In many instances, the delay in providing accurate information leaves the provider with a debt that is difficult to recoup, a consumer confused and angry, which is often placed on the provider.

LASA recommends that an option should be made available that allows people to notify the DHS that they have chosen to be ‘means not disclosed’ from the outset. This would not only save consumers, providers and the DHS time but would also eliminate subsequent and unnecessary administration process. Although this is essentially already available, the mechanism to do this is to complete the means testing form (SA457). The confusion is that people are told that if they choose to be ‘means not disclosed’ they do not need to complete the form.

The current means testing arrangements are capped. This is often disadvantageous to consumers and providers alike. A review of the MTA formula by including the full value of the primary residence is required. A review of the caps is also required by raising the cut off points for partially supported and fully supported residents. This is especially significant when a care recipient has already reached their lifetime cap prior to entry to residential care.
Aged care providers are the administration and collection point for the Government’s means testing arrangements, for which they are not adequately reimbursed. The LLLB reform changes have generated significantly more residents that require quarterly means testing fee updates. The fee updates are cumbersome, time consuming, paper-based and resource intensive to administer, and leave aged care providers vulnerable to bad debts that are difficult to recoup, especially from former residents’ estates.

With recent means testing outcome difficulties, many providers are reluctant to enter into resident agreements (and therefore can delay entry to care) until a correct assessment of assets and income are clear. LASA has patiently worked with the departments of Health and Human Services to fix outstanding problems. The system must continue to be improved to offer surety to both the consumer and the provider.

The issues that surround means testing have been regularly brought to the attention of both the DHS and the Department of Health (DoH). Both departments have finally acknowledged the problems, but failed to adequately resolve the process issues.

LASA members have an interesting variation in views on whether the process for means testing arrangements are effective, including an assessment of the alignment of charges across residential care and home care services, with 44% agreeing that arrangements are effective. And even more interesting, is the fact that this is inconsistent with the responses to a question posed regarding confusion and burden. The LASA Member Survey asked: - “Is there confusion about the process for applying for a means test, be it for assets and income for residential services or income for home care?”

Results indicate that there is very strong opinion (83%) that consumers are confused about means testing and just under 50% indicated providers are also confused.

**Survey Question**
The process for means testing arrangements are effective, including an assessment of the alignment of charges across residential care and home care services.

**Survey Question**
Is there confusion about the process for applying for a means test, be it for assets and income for residential services or income for home care?
This uncertainty may be clouded by process problems rather than the policy itself. For example, when asked if the process was overly burdensome for providers and consumers there was a significant number of respondents who agreed the level of burden is very high for consumers (82%) and slightly less so for providers (71%). Similarly, there was overwhelming agreement that there are delays in receiving a means test outcome (86%).

One policy implication, is the difficulty of rural consumers in trying to sell their home, this impacts their ability to receive an accurate means test assessment as circumstances change with including the asset of the home or not. Other feedback LASA has received include the concern around conflicting statements to consumers and providers, incorrect assessment outcomes, and that special needs groups, such as people from culturally and linguistically diverse (CALD) backgrounds, and others do not understand the means testing arrangements.

The current means testing thresholds and asset eligibility for residential care needs reviewing to include a greater proportion of the value of the primary residence (if not full inclusion). Also, consumers should be able to choose to be ‘means not disclosed’ upon admission, to eliminate the unnecessary administration process and time required to confirm the consumer’s intention.

LASA suggests that the Accommodation Contribution assessed as payable by a partially supported resident be mutually exclusive of a facility’s Supported Resident ratio and/or significant refurbishment status. This would have the benefit to Government of requiring partially supported residents to contribute the full (undiscounted) amount that they have already been assessed as having the means to contribute towards their care needs. This would also eliminate the need for inexplicable fee increase/reimbursement (and the requirement to offer RAC/DAC choice) based on changes in a facility’s Supported Resident ratio, and also eliminates the requirement for issuing quarterly correspondence to these residents. This will improve payment certainty for residents and eliminate a major administrative overhead for providers.

Feedback indicates that prior to the implementation of the confusing means testing arrangements, a discussion with a consumer in relation to cost would take approximately 15
minutes to explain the provider’s charges. The time has now extended to one to two hours. In an environment where providers should not (and cannot) provide financial advice, trying to assist a consumer to understand the position they personally will be in, is now far more difficult than in the past.

Other feedback LASA has received is that Government should be in the position to recoup means tested amounts and not the provider as the current system places the provider at risk for bad debts.

LASA would appreciate clarity in relation to ‘charges’. The only reference to charges is in the Transitional Provisions Act 1997 and they are ‘accommodation charges’. Is there a proposition to introduce another type of payment in residential services – a charge?
2.5 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.

A key component of the transition towards implementation of the age care reforms has been to broaden the capital base available for industry by allowing Refundable Accommodation Deposits (RAD) to be charged to all residents who have sufficient means to pay them.

An unnecessary component of this reform has been the introduction of an Aged Care Pricing Commissioner (the Commissioner). The Commissioner is charged with approving RAD prices above the arbitrary Ministerial threshold of $550,000 and approving extra service fees. The intent appears to be to provide some level of consumer protection; the effect however serves only to introduce an unnecessary level of compliance burden with no evidence of any consumer protection. In fact, the Commissioners Annual Report 2015-2016 reported that there have been no formal refusals to approve applications (for higher accommodation prices). In addition, as at 30 June 2015, there were 972 approved aged care providers nationally, operating 2,681 services (residential aged care facilities) with a total of 192,370 places. Of this total, the Commissioner approved applications since the new regulations took effect in 2014 from 112 aged care providers (11.5% of all providers) representing 215 services (8% of all services). These applications have been for approximately 12,780 distinct rooms in services.

With a budget of $1.179M, it is difficult to justify this spending given there is a level of homogeneity in the size, quality and amenity of the accommodation offered within particular price parameters in metropolitan cities. In other words, the open competitive market is working.

With the value for the resident remaining a key focus in the assessment of applications, there seems to be no reason to continue with red tape burden.

LASA therefore suggests the abolition of the role of Commissioner with any savings applied to enhancing residential subsidies. Such abolition would naturally and coincidentally also remove the threshold for accommodation pricing approval with all RADs listed in equal manner on the My Aged Care website and other company based promotional platforms.

Significant uncertainty is also created via the provision of the 28-day decision period for a resident to determine how they wish to fund their accommodation, i.e. whether by RAD or Daily Accommodation Payment (DAP) or both. This compromises the decision-making process for a provider as to whether they offer a place, as they cannot be certain of the ‘terms’ of the residency, and thus adds an unnecessary layer of risk to capital and cash flow.
planning. Providers should have a clear understanding of the methods by which they are paid by consumers prior to admission. The administration and confusion that subsequently occurs far outweighs any implied benefit for consumers and there are sufficient consumer protections legislation. Of those answering the LASA survey, almost all comments provided were in favour of the abolition of the 28-day rule. Some suggested that the decision on how to pay (RAD, DAP or combination) should be made upon the receipt of the means test outcome. Some comments suggested that consumers don’t always decide by this time (28 days) and that it is hard for the provider to enter into contracts without knowing what the consumer may decide.

With the Government controlling recurrent funding for residential care operational costs via ACFI subsidies, providers should be able use higher accommodation pricing to cross-subsidise operational services and to provide more innovative bundled services to the consumer. Under a market based system, and in a strong competitive market place, providers will set the price and the consumer will decide upon the relative value proposition.

There is mixed opinion among LASA Members about whether Government should continue to regulate pricing.

The above chart was in response to the question that the arrangements for regulating prices are effective.

Private providers were more likely to disagree (48%) than not-for-profit providers (23%). There was much more uncertainty within the not-for-profit providers (38%) than private (16%).

When asked if the ‘threshold amount’ for accommodation pricing be abolished there were equal proportions of LASA Members that said yes (40%) to no (38%). However, 22% were unsure. LASA contends that the ‘threshold amount’ for accommodation pricing should be abolished for the above reasons.
2.6 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.

LASA supports the premise that funding initiatives be person focused, based on measurable outcomes, and recognises that there are numerous reasons why a difference in care delivery can affect outcomes, specifically for people living in rural, remote regions and areas of thin market.

The true cost of care should be identified for all people receiving care and specifically those people requiring specialist care and services\(^8\), while the Government should commit to reducing red tape to streamline the identification of people requiring specialist care and services.

What we know is that with some of the special needs groups (for example, the homeless or risk of homelessness) there needs to be an acknowledgement of the different models required to meet the needs of this client group. For example:

- extension of the homeless or hardship supplements,
- once key criteria are met, automatic application of the financial hardship assistance for basic daily care fee, and
- consideration of a form of block funding is required.

There remain unrecognised additional costs for services for people with diverse and special needs, including rural and remote services. Cost is often seen as a deterrent to entry and equity release schemes should be developed to ensure that those who need care and services can afford them.
The National Aboriginal and Torres Strait Islander Flexible Aged Care Program provides flexible and culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their home and community. There are approximately 29 services funded under the program, with the majority located in very remote or remote areas. Services funded under the program deliver a flexible mix of residential and community-based aged care services that change as the care needs of the communities vary. The flexibility shown in this program should be considered for other different population groups.

With significantly more than 50% of residents in residential aged care having dementia (90,000+ people) and with almost half those with dementia also having a diagnosis of mental illness, it is obvious that dementia services are no longer ‘niche’ but a core component of care and service delivery for residential age services. However, for those people with severe Behavioural and Psychological Symptoms of Dementia (BPSD), their families and carers, additional support is required.

We know that the subsidies currently paid via the ACFI do not fully capture the cost of care needs of all residents and especially those exhibiting severe and complex behaviours. This gap has not been quantified, however with a growing number of older Australian’s expected to develop dementia with comorbidities, there is strong grounds for a comprehensive investigation to assist in the development of evidence based funding of services for residential, home and community care.

There is however, industry acceptance that dementia care is core business for age care providers, and LASA contends that palliative care services are also core business. However, specific, and specialist funding is not available for palliative care services provided in home or residential care, nor for advance care planning processes.

There is also a lack of recognition for the costs of CALD appropriate care services.

A small, but nonetheless important cohort of people is the young with a disability. Increased funding for the recognition and transfer of young disabled people out of aged care services (as relevant) and into appropriate disability housing is required. Where the young person wishes to receive age services, there needs to be individual consideration of the specific needs of each person and how they can access the care and services they require.

A significant number of LASA members identify as providing services to different population groups with 69% identifying as servicing those who are financially or socially disadvantaged. Other larger groups include veterans of the Australian Defence Force and those who identify as part of the CALD population.

Of these providers, comments on the effectiveness of arrangements for protecting equity of access for these people include:

- the need for acceptance of diversity in rural areas
- the lack of interpreters,
- people from CALD backgrounds or those with limited education not understanding the MAC system.

Feedback from providers include the lack of cultural competency by MAC staff, and the lack of specific facilities for CALD and ATSI groups.

Despite the ACFI User Guide stating that ACFI funding focuses on the main areas that discriminate care needs among residents and on care needs related to day to day, high frequency need for care, it is apparent that the current funding does not support the specialist needs that some residents require in residential care. Nor does the current funding cover the needs of different population groups receiving home care, be it through a package or via the Commonwealth Home Support Programme. These concerns could be interpreted as barriers to access to services for different population groups.

There is no true evidence to indicate that current arrangements for protecting equity of access for different population groups are effective. The LASA Member Survey suggests that respondents did agree that the arrangements are effective (51%), but what is confusing is that 26% disagreed and a large proportion, 23% were unsure.
2.7 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.

LASA Members overwhelmingly do not support the premise that current workforce strategies are effective.

In fact, LASA contends that there are no strategic initiatives that tie workforce issues, including education, recruitment, retention and funding of workers, together.

The removal of the Payroll Tax Supplement, fringe benefit tax components, the Workforce Development Fund and the Dementia and Severe Behaviours supplement in residential services, has adversely impacted workforce attraction, retention and development.

Despite the work undertaken by the Aged Care Sector Committee, and others, the Department of Health’s view, presented to the Future of Australia’s aged care sector workforce Inquiry, is:

"In the aged care system, the Government’s continuing role in supporting the aged care workforce is that of a ‘facilitator’, making way for consumers to be exercising choice in managing their own care and support, and in relation to the system as a whole. Through the Department of Health, the Government’s role in supporting the aged care system entails setting policy, legislation and fit-for-purpose regulation with appropriate funding that supports providers to meet their responsibilities and obligations relating to older people as consumers of aged care services."

The Department states: “Providers are responsible for attracting, retaining and supporting the development of appropriately skilled and flexible workforces.”

Providers are well aware of their responsibility to attract, retain and support the development of an appropriately skilled and flexible workforces. What they are not responsible for is the quality of the training provided through the Vocational Education Training (VET) or university sectors.

The Australian Skills Quality Authority Website states: “Vocational education and training (VET) enables students to gain qualifications for all types of employment, and specific skills to help them in the workplace.”

The outcome of Government’s ‘facilitation’ role and the inability of some providers in the VET sector to meet their responsibilities is an industry that view workers wanting to enter the aged care workforce as, demonstrating a lack of experience, even if qualified. This is a universal view across geographical areas.

Training and education through accredited courses is highly variable and poor training can leave students unequipped for the job which may lead to poorer outcomes for the care recipient.

The Department’s presentation at the Inquiry stated that: “the Aged Care Act does not prescribe the qualifications required by staff, or the number of staff required to be employed by aged care providers. There is considerable diversity in staffing arrangements across aged care services. This suggests that there is no single optimum staffing level or mix that meets all circumstances in providing quality aged care. In this context, Commonwealth legislation governing the operation of the aged care sector does not include mandatory staffing ratios.”

LASA’s view is that the Aged Care Act does prescribe particular aspects of qualifications required to undertake certain activities which result in funding allocation. For example, the prescription of who may undertake particular care delivery to meet ACFI requirements and items in the Quality of Care Principles Schedule of Specified Care and Services.

With an adverse view of aged care, amplified by government and media, this discourages new entrants, and providers have been forced to undertake their own quality assessment, especially of those graduating from the VET sector, and also employ a range of strategies to assess work readiness:

- Interviews
- Reference Check
- Clinical assessments
- Monitoring performance while on placement
• Employment of a quality officer to interview consumers
• An administration manual for recruitment
• Employ as casual first – “try before you buy”
• Assessing during Student placements
• Work experience at grade 12
• Practical performance tests
• Computer skills
• Competency testing

Once employed, a range of activities are required to support new staff:

• Orientation and induction
• Training
• Online training
• Mentor programs
• Individual plans
• Graduate programs
• In house education
• Buddy system
• Orientation
• Clinical placements
• Dementia training
• Education modules
• Placements

Some employers comment that they upskill their own workers or have good relationships with preferred providers.

LASA purports that a successful worker has the right attitude and attributes to work with older people, and providers have employed a range of activities to assess these qualities:

• Advanced screening tools
• Psychometric testing
• Getting feedback from existing staff
• Working alongside to see how they manage
• Questions at interview
• Reference checks
• Interviews based on values
• Identifying personalities at recruitment
• Selection on aptitude at interview
• Behavioural interview techniques
• IT system with strategic questions requiring responses within predetermined parameters before applicants can be shortlisted

Also, a range of technology is provided to support workers:

• Work mobile phones for care workers - rosters are on the phone, click on & off shifts - clients sign phones
• Online learning platforms
• E - learning mobile technology
• E recruit
• Electronic client files
• Facebook
• Healthconnex
• IPads
• Staff with smart phones
• A learning management system
• The Aged Care Channel
• Interviews by video
• Social media
We know that by 2050 the age services workforce is expected to grow from an estimated 352,100 (2012 estimates) to 827,100 employees.

While nurses are often in demand, their shortage and higher costs have meant that lower skilled community care workers or (residential) personal care assistances make up a vast majority of the direct care workforce (81 per cent and 68 per cent in each sub-sector respectively); the importance of such care workers has increased over time (Centre of Excellence in Population Ageing Research [CEPAR] 2014).12

The workforce, overwhelmingly female, is ageing, with a median age of 50 in community and 48 in residential care, and even higher for Registered Nurse (RN), at 50 and 51 respectively. Almost 60 per cent of the direct care workforce is 45 years and older (National Institute of Labour Studies [NILS] 2012).12

This projected increase in demand for age services cannot be overlooked. Actions and strategies need to be developed to ensure the age services industry has the resources necessary to meet the needs and demands of all older Australians.

LASA is concerned the Government’s cut of 15% to the Aged Care Workforce (Development) Fund, may jeopardise innovation and put quality at risk. With forward estimates predicting that the age services workforce needs to triple in size by 2042, the reduction of available funding to support training and education, in conjunction with the decrease of Aged Care Service Improvement and Healthy Ageing Grants Funds, and the loss of supplements is not supportive to the industry. An available, accessible and appropriately skilled workforce is a fundamental requirement of the growing age services industry. Sourcing and maintaining a sustainable workforce is therefore a significant issue12.

Residential, home and community care providers continue to struggle to access appropriately skilled and available staff. All providers need support, funding and new initiatives so as to adequately fulfil current and future staffing needs.

Research indicates three quarters of residential facilities and half of the community outlets report skills shortages in one or more occupations. It is anticipated that the increasing demand for nursing and allied health professionals in the age services industry will be further exacerbated by increased competition for staff with the staged introduction and upscaling of the National Disability Insurance Scheme (NDIS).

The Intergenerational Report13 predicts that the proportion of Australians aged over 65 participating in the workforce will increase strongly, from 12.9% in 2014-15 to 17.3% in 2054-55. As the report states, “this provides significant opportunity to benefit from the wisdom and experience of older Australians”. As stated in the NILS report14, older direct care workers are seeking ways to maximise the length of their work-lives and contribute to the aged care industry. Further investigation of strategies required to retain older workers for longer may assist in addressing some of the skills shortages in the industry. However, alternative models of care and service delivery also need to be developed to attract a sustainable workforce fit to undertake the tasks required to support older Australians.
receiving age services. This may include extending the scope of practice of those working in the industry, alongside a review of the workforce skill requirements.

With the clear move towards consumer directed care and client determined service outcomes, LASA advocates for a national industrial relations framework that will protect and preserve measures that enable maximum workforce flexibility.

As one LASA member comments: “aged care is an unappealing industry from employee value proposition due in part to low wages, shift work, high administrative loads arising from the regulatory burden, strenuous work environments, industrial relations constraints and limitations on scope of practice. The ability to charge market based residential and home care fees will enable greater funding for a fairer remuneration to recruit an effective workforce and reduce the discrepancy with other sectors competing for the same labour sources.

Government, TAFEs and Universities should fund the expansion of ‘teaching aged care services’ to promote the sector and provide appropriate training for medical, nursing and allied health students and professionals.

Funding to support practical on-the-job training and/or apprentice style ‘buddy shift’ model would provide trainees experience of the aged care sector prior to certification/qualification in an effect to reduce turnover.”

LASA agrees with the NILS Report which states that: “there is significant variation in the management skills and training between care providers. A direct correlation has been noted between these skills and the workplace satisfaction of the direct care workers. A specific issue of note is the concern that the training generally provided is focused exclusively on residential care and does not address the community sector appropriately.”

LASA Members have told us that recruitment is an issue with 57% of respondents to the LASA Member Survey saying that they do have issues with recruitment. They have commented on specific concerns:

- the quality of RNs/ENs and particularly ENs undertaking medication administration
- not enough skilled people seeking work
- poor recruitment agencies
- attracting and retaining RNs and physiotherapist
- attracting staff from CALD backgrounds
- visa limitations
- pay equity
- extensive screening processes means sometimes loose workers to other industries
- issues in attracting staff in rural areas,
• competition between private providers the not-for-profit sector where salary sacrifice options are not available.

However, the survey also identified that some services (35% of survey respondents), suggest they don’t have issue with recruitment.

Secondary to the recruitment of staff, a majority (52%) of services have commented that the reforms have impacted their ability to retain staff.

LASA Members comment that:

• more is expected from care staff, they get burnt out from over work and stress
• funding cuts negatively impact the amount of wages that can be paid
• the ability to pay a wage comparative to the public sector
• with the loss of the dementia supplement key training and skills support to staff have been negatively impacted
• reforms have led to increased compliance and staff perceive the roles as clerical as opposed to hands on caring
• some staff lack the ability with managing a budget and discussing finances with clients
• uncertainty of staff about the future of an organisation and job security
• the aged care market is now considered to have an unstable workforce, and
• the Payroll Tax Supplement has created an unfair double barrel system that is anti-competitive.

The industry needs to understand why recruitment and retention of staff is such a major problem for some services and what activities are supporting those that do not seem to have problems with recruitment and retention.
Sixty-two percent (62%) of LASA Member Survey respondents agree that inflexible awards impacts negatively on the delivery of care and services and have commented on particular problem areas:

- Inability to say a worker has a number of hours across the week, now providers must specify exact hours and days.
- Community staff not being as flexible as consumers would like.
- Limitations on overtime.
- Not being able to accommodate split shifts, minimum hours and shorter working days.
- People with ABNs working for a flat hour fee.
- Difficulties with on call rates, overtime, payment for training days.
- Difficulty with prescribed roles.
- Difficulties with terminating staff where required.
- Restricted movement between work settings home versus residential.
- EBA having to meet the Better Off Overall Test.

As articulated in the LASA Position Statement on Workforce, LASA has identified a number of pathways that can assist in meeting the identified expanding requirements of the workforce. The industry calls for a review of workforce constraints and improved access opportunities with respect to Australian immigration laws. Sensible adjustments and amendments to immigration laws that provide greater access for overseas workers to join the age services industry and opportunities for age service providers to increase their labour pool must be considered. Secondly, transitional funding for displaced workers to encourage and target opportunities within the age services industry must become a priority focus.

All pathways and workforce considerations must ensure sufficient training is available to bridge any language, cultural or other barriers to attracting and retaining a workforce and initiatives need to take into account that the age services workforce needs to be mobile and resourced to meet age service needs in rural, remote and other specific needs areas.

As part of LASA advocacy for employment laws that enshrine workforce flexibility and equity, LASA supports fairness and equity across the industry. LASA encourages Federal and State Governments to ensure all aged care employers are given an equal opportunity to receive/apply for grants, concessions, supplements, and exemptions.

In essence, LASA suggests the following solutions to support the age care workforce, as the current reforms have not been effective:

- a workforce strategy co-designed between industry and Government
• a review of current constraints to better utilise skill mix, enhance career advancement and enable greater flexibility for employers and staff

• funding stability for training and development

• a review of current migration policies to recruit people with a mix of skills and backgrounds, and

• an industrial relations review that must consider the changing care needs of consumers and fundamental shifts seen in other industries to services dictated entirely by consumer demand.

Existing constraints limit flexibility, role advancement and recruitment diversity options. They also limit solutions to workforce shortages specifically relating to flexibility, role advancement and migration / recruitment options.

Other initiatives that support the workforce include enhancing tele health capabilities to avoid unnecessary hospital transfers and to be a resource as needed, an MBS item review to facilitate the employment of nurse practitioners in aged services and partnerships between service providers and tertiary institutions.
2.8 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

The 2015–16 Report on the Operation of the Aged Care Act 1997\(^{14}\) states that “there are strict prudential requirements related to the accounting and handling of bonds and refundable accommodation deposits collected by approved providers. The Department closely monitors how effectively providers are meeting these requirements and conducts an annual review of providers’ prudential arrangements”.

From the Aged Care Pricing Commissioner Annual Report 1 July 2015 – 30 June 2016\(^{15}\) we know that as at 30 June 2015, there were 972 approved aged care providers nationally, operating 2,681 services (residential aged care facilities) with a total of 192,370 places.

Of this total, the Commissioner has approved applications since the new regulations took effect in 2014 from 112 aged care providers (11.5% of all providers) representing 215 services (8% of all services). These applications have been for approximately 12,780 distinct rooms in services. Since a room is generally equivalent to an aged care place in the above-threshold accommodation market, approval has been given for providers to charge higher accommodation payments for 6.64% of all aged care places.

Of these, 74% have been approved in the price range $551,000 to $850,000 as a Refundable Accommodation Deposit. In particular, 42% of all approved rooms are in the range $551,000 to $700,000, and a further 32% in the range $700,000 to $850,000. This proportion has been relatively consistent between years. 10% of all rooms approved exceed $1,000,000. In the context of all aged care places, this proportion is small. Approximately 0.7% of all aged care places in Australia may charge a bond over $1,000,000.

Twenty-three percent (23%) of all approved rooms since 2013–14 are in facilities that have either been newly built or have been subject to a significant degree of refurbishment or extension works. Over time, the number of existing facilities being approved has proportionally decreased when compared with the number of new or refurbished facilities being approved. This is consistent with the need for additional works by industry to meet future demand.

The Commissioner states that “it is encouraging to see a greater degree of consistency in the approach by providers to accommodation pricing above the maximum amount determined by the Minister.”
The current history of triggering the scheme suggests that 0.13% of providers defaulted over 9 years and 10 trigger events have occurred since the introduction of the scheme in 2006 – one event per year.

We also know that the prudential arrangements for providers are thorough, and departmental scrutiny should be able to identify any provider who is at risk of insolvency.

LASA understands that the Government is considering a review of existing Accommodation Bond Scheme arrangements. LASA suggests that the Scheme is not broken, and current arrangements should continue. In other words, there is no requirement for reform to occur in this area.

LASA Member Survey recipients (73%) overwhelming report the current arrangements for protecting refundable deposits and accommodation bonds are effective. They also report the current arrangements should remain in place (68%).

It is accepted that Government currently holds insurance through the Guarantee Scheme, and therefore shoulders any risk associated with the scheme. The numbers above show that the risk is very limited. However, if Government was to change arrangements and force providers to take out their own insurance, there may not be the ability of on-charging to the consumer. One way of recouping the cost of self-insurance would be to increase the price of refundable deposits, however this would also mean an increase in insurance costs – a circular negative outcome.

Another alternative would be that providers would bear the insurance cost – this is not a popular option given the billions of dollars taken out of the industry since 2014. Should the provider bear the costs, this would be money that otherwise would have been spent on care and service delivery.
2.9 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.

The My Aged Care (MAC) System (call centre and website) is now the entry point into aged care services, and is designed to enable consumers to have more choice, control and easier access to services. With a varying degree of success in its implementation, the system is progressively being improved. However, consumers are not yet experiencing a seamless journey through the system.

Varying systems do not ‘talk to each other’, including DHS, DVA and the electronic health record. Information to enable appropriate screening and comprehensive assessment is often missing, which impacts the readiness of providers to commence service delivery.

There is limited financial information which can delay entry into services and consumers do not always understand the personal cost they might be facing.

The ‘drop out’ rate of MAC is extremely high. This creates several issues – the provider ‘disappears’ from view and does not receive a referral; the provider is in breach of the legislation for failing to publish on MAC.

In a functioning consumer-driven, open market, consumers need to have accurate information to help them distinguish providers. The current National Quality Indicator Programme16, although in its infancy, does not provide information that can be used by the consumer (or the provider). General information does not allow the consumer to make an informed decision and often detailed individual financial information (such as a means test outcome) is not provided in a timely manner nor can the outcome of the means test be trusted in all occasion.

As mentioned previously, the 28-day rule may not provide access to services in a timely manner, providers are risk averse to admitting a consumer without appropriate and accurate information.

Many consumers’ identity as ‘special needs’ and the ability to meet these requirements can be difficult, for both home and community care and residential providers, especially when assessments via a RAS or ACAT does not sufficiently use this information.

Many assessments are not complete or provide insufficient information to support the care planning process.

As one LASA Member commented, “there is already evidence to suggest that Aboriginal and Torres Strait Islander people’s (ATSI) and CALD consumers’ engagement with My Aged Care is less than that of other consumers. Increasing Choices will bring a number of changes that are
advantageous to home care consumers, but that adds complexity to choice and control. MAC prioritisation and package portability significantly changes the ways in which all consumers will access services. Historically choice of provider may have been most influenced by whether or not a provider had a vacancy. Soon this will be reversed with consumer choice essential to allocation of a package to the consumer’s provider of choice. There is a need for stronger direct and independent support of consumer choice making, beyond the enhanced information provided through the My Aged Care Service Finder.

It is essential that Increasing Choices will, at a minimum, see proportional participation by people with special needs and that MAC prioritisation processes are favourable to those with special needs. Monitoring of assessment and assignment to service wait times to ensure that consumers with special needs fare as well as others, is essential. Utilising the MAC Service Finder to assist choice of provider is one aspect of exercising choice and control. Package portability and MAC prioritisation are new elements of choice and control that need to be explained clearly to all Home Care Program participants/potential participants from first point of entry to the aged care system and need to be factored into MAC future design.”

Seventy percent (70%) of LASA survey respondents suggest the arrangements for facilitating access to services are effective.

Further data analysis revealed significant differences in response by operating model: private providers were far less likely to disagree (64%) than not-for-profit providers (85%). However, an overwhelming majority (83%) gave a definitive ‘no’ when asked if the MAC system is effective.
Comments pertained to user interface, delays in assessment, and the quality of information derived from the system included:

- people find the system difficult to navigate
- ACAT needs more staff due to the amount of clients referred since MAC started
- CALD clients are finding navigation very difficult, particularly those with cognitive decline
- difficulty obtaining information if the assessment team do not provide file number to a service
- some providers not receiving referrals through MAC
- long wait times for assessment
- inaccurate assessments from people who are not adequately skilled to judge care requirements
- MAC will not talk with service staff even with the resident's permission
- inefficient, poor referral process, and the service finder search engine is often incorrect,
- information on MAC summary does not provide a picture of what the issues are for the person
- more clinical skills are needed for the understanding of a client’s needs, and
- most elderly potential consumers are hesitant to use technology. They would prefer a face-to-face communication.
3. Other comments

In the LASA Survey LASA Members were asked if they had any further comments they would like included in the LASA submission to the Review. Responses are listed below:

- Although Carer Support is the subject of further reforms, pathways to and understanding of respite has been eroded through the introduction of CHSP reforms and My Aged Care.
- Attention needs to be given to all the unfunded staff hours to provide the quality and adequate first contact.
- Consumer directed care requires much more awareness and education, but it has many advantages in terms of meeting individual needs and conserving scarce resources. It is also an opportunity to streamline the regulatory environment so that costs are contained.
- Don’t cut the ACFI. Half the industry will fail and you will lose the diversity of the small providers and that will be very sad.
- Funding model needs to remain but needs to award aged care organisations for their rehabilitation and ability to improve people's lives through care/wellbeing programs - not making it difficult to get higher funding based on the deterioration of a resident.
- Just as mentioned in previous question - quality of information from My Aged Care contact centre and a lot of assessments is poor.
- Means testing is still a very fraught process and is not working well. It is disadvantaging consumers.
- Rural families need access to further financial advice and support when admitting family member. Also those without families are being left too long in the home care situation before being offered residential care.
- System should follow the Roadmap quicker than projected. ACFI should be reduced to one or two levels with dementia and palliative supplements.
- The Aged Care sector needs to be positively promoted, and have equal pay to other sectors to help attract and retain staff to this area. There is too much talk about the ageing workforce but nothing is being done to rectify the inequalities.
- The assumption that aged people can access MAC is a joke -providers are the source of information regarding aged care to consumers on so many occasions which is a significant cost to our business.
- The Government has no understanding of what aged care facility are and how they are run. They have very large blinkers on and should get out and really see what happens. A day in the life of a carer would make them appreciate what we are dealing with.
- The Legislated review was apparently aimed at ‘consumers’, families, advocates as well as the industry. My question is how do these groups even know it is in existence, and if they do how do they respond. The only method appears to be online.
- The reforms are based on false assumptions for many members of the community. Well off people with supportive family and friends can more wisely spend their money and thus their packages are far more valuable than those with no informal supports.
4. References


5. National Aged Care Alliance 2015, Enhancing the quality of life of older people through better support and care, Canberra

6. Aged Care Pricing Commissioner July 2015-June 2016

7. LASA Position Statement 11 Residential Accommodation Pricing
   http://www.lasa.asn.au/member-services/policy-statements/

8. LASA Position Statement 12 Specialist Funding (Supplements) http://www.lasa.asn.au/member-services/policy-statements/

9. Aged Care Funding Instrument User Guide

10. Department of Health Submission
    http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Aged_Care_Workforce/Submissions

11. The Australian Skills Quality Authority


13. 2015 Intergenerational Report

