

# Supporting health professionals and system administrators to recommend suitable alternatives to residential aged care for younger people

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## Final Report, August 2024

Prepared for The Department of Health and Aged Care (DoHAC)



**Australian Government**  
**Department of Health and Aged Care**



**THE  
BEHAVIOURAL  
INSIGHTS  
TEAM**

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# Glossary of terms and acronyms

Acronyms	
ACAT	Aged Care Assessment Team
AFA	Ability First Australia
AI	Artificial Intelligence
BIT	The Behavioural Insights Team
CHSP	Commonwealth Home Support Programme
COM-B	Capability, Opportunity, Motivation, and Behaviour model
DoHAC	Australian Government Department of Health and Aged Care
GP	General Practitioner
HCP	Home Care Package
ILO	Individualised Living Options
MBS	Medicare Benefits Schedule
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
PHN	Primary Health Network
RAC	Residential Aged Care
SDA	Specialist Disability Accommodation
SIL	Supported Independent Living
YPIRAC	Younger People in Residential Aged Care

Terms	
<b>Disability</b>	A permanent impairment that substantially reduces an individual's mobility, communication, socialising, learning, or self-care capacities, making it difficult for them to take part in work, study, or social life. <sup>1</sup>
<b>Health professional</b>	A GP, nurse, medical specialist, allied health professional, or person who is otherwise qualified to provide health diagnoses, treatment, care, or advice.

<sup>1</sup> National Disability Insurance Agency. (2023). [Do you meet the disability requirements?](#)

<b>High care support needs</b>	Needs arising from any significant impairment in an individual's mobility, communication, socialising, learning, or self-care capacities – which may not be classified as a disability under the NDIS – but which make it difficult for the person to take part in work, study, or social life.
<b>Housing and care support options</b>	Accommodation alternatives to RAC for younger people, which may or may not be supported by funding. These alternatives can include living in a specialised facility, or living in one's own home, with part-time or full-time support from relatives, carers, support workers, or other health professionals.
<b>Stakeholder</b>	An organisation that represents the interests of, provides funding or services to, or creates policy or legislation for, younger people, health professionals, or system administrators.
<b>System administrator</b>	A My Aged Care ACAT delegate, NDIA YPIRAC planner, or AFA system coordinator, who makes decisions or recommendations that influence whether younger people enter or exit RAC.
<b>Younger person</b>	<p>An individual aged under 65* who is living with disability and/or high care support needs.</p> <p><i>*Except where explicitly noted, our definition of 'younger people' includes people aged 50 to 64 who are either 1) Aboriginal and Torres Strait Islander persons, or 2) persons experiencing homelessness.</i></p>

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the Freedom of Information Act 1989  
by the Department of Health and Aged Care



# Executive summary

## Background

The Australian Government has committed to the Younger People in Residential Aged Care (YPIRAC) target of **no people under the age of 65 living in residential aged care (RAC) by 1 January 2025**.<sup>2</sup> This target will be supported by a new *Aged Care Act*, in which individuals aged under 65 will be ineligible for access to Commonwealth-funded aged care (with exceptions made for people aged 50 to 64 who are either 1) Aboriginal and Torres Strait Islander persons, or 2) persons experiencing homelessness).<sup>3</sup> Younger people with disabilities or high care support needs will instead be supported to seek more age-appropriate housing and care support options, with those younger people already living in RAC being able to exercise their choice to remain in RAC if they prefer.

As of 31 December 2023, **1,470** people aged under 65 live in RAC.<sup>4</sup> To support the successful transition of these younger people into more age-appropriate housing and care support options, it is crucial to **shift the behaviour of health professionals and system administrators** who make decisions about or give recommendations to younger people considering entering, exiting, or remaining in RAC. To this end, the Australian Government Department of Health and Aged Care (DoHAC) commissioned The Behavioural Insights Team (BIT) to determine how DoHAC and other stakeholders should develop and disseminate **training and education materials** – and explore other **structural reforms** that may be needed – to encourage health professionals and system administrators to recommend age-appropriate housing and care support options for younger people.

## Methodology

Focussing on the Australian context, we gathered data on the knowledge, attitudes, and practices of stakeholders (who have a ‘macro’ view of YPIRAC) and health professionals and system administrators (who have a ‘micro’ view of YPIRAC). This involved:

- Conducting a series of **interviews with stakeholder representatives**
- Administering a **survey of health professionals and system administrators**
- Generating and testing **personas of health professionals**

The primary aim of these activities was to understand the *internal capability* (knowledge and skills) and **motivation** (attitudes and habits) factors, as well as *external opportunity* (structural and environmental) factors, that influence a health professional or system administrator’s decision to recommend RAC versus alternative housing and care support options.

<sup>2</sup> Royal Commission into Aged Care Quality and Safety. (2021). [Final report: Care, dignity and respect](#).

<sup>3</sup> Australian Government Department of Health and Aged Care. (2023). [Who will be able to access aged care under the draft new Aged Care Act](#).

<sup>4</sup> Australian Institute of Health and Welfare. (2023, December). [GEN Aged care data: Younger people in residential aged care](#). This figure of 1,470 excludes the 246 Aboriginal and Torres Strait Islander people aged 50-64 living in RAC, who will remain eligible for RAC under the new Aged Care Act.

## Interviews with stakeholder representatives

We conducted 21 virtual interviews with 25 representatives from 18 stakeholder organisations, including members of the YPIRAC Sub-Joint Agency Taskforce and YPIRAC Stakeholder Reference Group. Our aim was to gather insights into stakeholders' knowledge of and attitudes towards the YPIRAC targets and to understand factors influencing health professionals' and system administrators' recommendations for housing and care support for younger people. Using thematic analysis, we identified key themes from the qualitative data, focusing on both shared and unique viewpoints to represent the full range of stakeholder perspectives.

## Survey of health professionals and system administrators

We administered an online survey that yielded responses from 184 health professionals and system administrators who make decisions that influence whether younger people aged under 65 enter or exit RAC. Our aim was to identify trends in the respondents' knowledge, attitudes, and practices regarding housing and care support options for younger people under 65. We analysed the survey data descriptively, which provided an overview of the landscape of health professionals and system administrators in Australia.

## Personas of health professionals

While health professionals can share common characteristics, they may cluster into groups, or 'personas', based on the values, motivations, and cognitive biases driving their patient care decisions. As a result, behaviour change strategies that work for some health professionals will not necessarily work for all. To help tailor our recommendations to maximise the likelihood of sustained behaviour change, we sought to understand what personas exist among health professionals who make decisions about housing and care support options for younger people with disabilities or high care support needs. We used BIT's artificial intelligence (AI) driven persona generation tool, *PersonifAI*, to generate a set of hypothetical personas and then tested which of the hypothetical personas resonated most strongly with the health professionals in our survey sample.

## Findings

We identified 12 key findings through our research activities. We classified each finding as either a **capability** (knowledge and skills), **opportunity** (structural or environmental), or **motivation** (attitudes and habits) factor that influences a health professional or system administrator's decision to recommend RAC versus alternative housing and care support options. These factors are summarised below:

- **Capability factors.** Health professionals have limited knowledge of the upcoming legislative changes designed to support the YPIRAC targets. These health professionals, alongside system administrators, also struggle to identify suitable alternatives to RAC for younger people. When they do identify alternative options, some health professionals and system administrators lack the knowledge and resources to effectively support younger people to access these options.

- **Opportunity factors.** When supporting younger people to access suitable alternatives to RAC, health professionals are constrained by the short supply of such alternatives, narrow funding eligibility criteria, and small funding packages. Time pressures and complex referral and application systems also make it difficult for health professionals to support younger people to identify and access suitable alternatives.
- **Motivation factors.** When recommending housing and care support options, most health professionals are driven by a motivation to provide compassionate care to younger people. Health professionals may believe that RAC facilities will offer the best care, or may take into account a younger person's preference for RAC over other alternatives. Sometimes, a health professional's decision to refer a younger person to RAC is the result of habit rather than reflective motivational factors. More broadly, stakeholders support the rationale behind the YPIRAC targets, but have concerns about feasibility, sustainability, and unintended consequences.

## Recommendations

We focussed our recommendations on potential **training and education opportunities and channels** to support health professionals and system administrators to make the most age-appropriate housing and care support decisions and recommendations for younger people. We recommend that DoHAC:

- **Co-design a consolidated decision tool that will help health professionals identify suitable RAC alternatives for younger people.** This addresses the finding that many health professionals lack knowledge of suitable alternatives to RAC for younger people, in part due to the fragmented naming conventions, eligibility criteria, and funding pathways across government programs and jurisdictions.
- **Empower staff in system navigation, coordination, and liaison roles with the resources they need to be experts in traversing the health, disability, and aged care systems.** This addresses the finding that younger people and their families face barriers in accessing housing and care options without support from health professionals. However, these health professionals are not well-positioned to navigate the full range of funding and services across the health, disability, and aged care sectors.
- **Train health professionals to identify trigger points for early intervention, to help younger people plan for their future housing and support needs before it's too late.** This addresses the finding that health professionals, when under pressure to make urgent referral decisions, may default to referring younger people to RAC. This can be due to habit, limited capacity to explore alternatives, or long waiting lists for more suitable options.
- **Educate GPs and allied health professionals about how to claim for time spent exploring suitable alternatives to RAC with younger people.** This addresses the finding that health professionals can perceive exploring suitable RAC alternatives with younger people as non-billable work, leading to the perception of a lack of capacity to provide this support during work hours.
- **Provide clear guidance to stakeholders about how they can best support the YPIRAC targets now and beyond the 1 January 2025 deadline.** This addresses

the finding that stakeholders, despite endorsing the YPIRAC initiative, are sceptical about the feasibility of the targets and uncertain about what will happen after the January 1 2025 deadline.

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## Background

*“Aged care, by its very nature, is designed for older people... The Royal Commission heard multiple accounts from younger people who have been, or remain, in residential aged care. They spoke of the social isolation, neglect, loss of function, sense of hopelessness and grief.”<sup>5</sup>*

– Royal Commission into Aged Care Quality and Safety, 2019.

Residential aged care (RAC) is not an appropriate setting for younger people aged under 65. In response to findings from the Royal Commission into Aged Care Quality and Safety interim report, the Australian Government has committed to the Younger People in Residential Aged Care (YPIRAC) target of **no people under the age of 65 living in RAC by 1 January 2025** (see Recommendation 74).<sup>6</sup> The Australian Government Department of Health and Aged Care (DoHAC) is leading efforts to achieve this target. The target will be supported by a new *Aged Care Act* (see [Appendix A](#) for detail), in which individuals aged under 65 will be ineligible for access to Commonwealth-funded aged care (with exceptions made for people aged 50 to 64 who are either 1) Aboriginal and Torres Strait Islander persons or 2) persons experiencing homelessness), including RAC.<sup>7</sup> Younger people with disabilities or high care support needs will instead be supported to seek more age-appropriate housing and care support options, with those younger people already living in RAC being able to exercise their choice to remain in RAC if they should prefer.

### Where does RAC sit within the aged and disability care systems?

The Commonwealth government is the primary funder of aged care services in Australia. **My Aged Care** is the single entry point for access to government subsidised aged care services, which includes RAC. Through My Aged Care, an individual is screened (online, over the phone, or in person at select Services Australia service centres), then assessed in person before being referred to an appropriate subsidised aged care service. These services include:<sup>8</sup>

- **Commonwealth Home Support Programme (CHSP):** Funding for one or two entry level support services that enable an older person to live independently at home. The cost of these services should not exceed a Level 1 Home Care Package.<sup>9</sup>
- **Home Care Package (HCP):** Funding for coordinated support services that enable older people with more complex needs to remain living at home. This can include health services (e.g., nursing), personal care (e.g., bathing, toileting, dressing, grooming), domestic assistance (e.g., cooking, cleaning, gardening, maintenance),

<sup>5</sup> Royal Commission into Aged Care Quality and Safety. (2019). [Interim Report: Neglect—Volume 1](#).

<sup>6</sup> Royal Commission into Aged Care Quality and Safety. (2021). [Final report: Care, dignity and respect](#).

<sup>7</sup> Australian Government Department of Health and Aged Care. (2023). [Who will be able to access aged care under the draft new Aged Care Act](#).

<sup>8</sup> My Aged Care. (n.d.). [Apply for an assessment](#); Services Australia. (n.d.). [Assessment for aged care](#); Royal Commission into Aged Care Quality and Safety. (2021). [Final report: Care, dignity and respect](#).

<sup>9</sup> My Aged Care. (n.d.). [Commonwealth home support programme](#); Australian Government Department of Health and Aged Care. (2023). [Commonwealth home support programme program manual 2023-2024](#).

community access and transport support, and home modifications. There are four package levels which vary based on the level of care required, with the government currently contributing \$28.14 per day (\$10,271.10 per annum) for a Level 1 package and \$163.27 per day (\$59,593.55 per annum) for a Level 4 package.<sup>10</sup>

- **Out-of-home care:** Other accommodation options for older people who can no longer live safely in their own home. This includes RAC. Subsidy values for RAC are determined based on a means assessment of the applicant's income and assets. Applicants who are fully subsidised are only required to pay a basic daily fee, which currently cannot exceed \$61.96 per day (\$22,615.40 per annum).<sup>11</sup>

According to the My Aged Care website, both RAC and HCP funding are currently available for "a younger person with a disability, dementia or other care needs not met through other specialist services".<sup>12</sup> Access to this funding for younger people is subject to certain legislative requirements, outlined in [Appendix A](#). In contrast, CHSP funding is currently only available for older people aged 65 or above, or individuals aged 50 years or older (45 years or older for Aboriginal and Torres Strait Islander people) who are experiencing homelessness or at risk of homelessness.<sup>13</sup>

While there are currently funding options for younger people with disabilities or high care support needs through RAC and HCP, My Aged Care is primarily designed to service the needs of older Australians. Accordingly, the new Aged Care Act (currently projected to come into effect 1 July 2025) will introduce a uniform eligibility criterion across all My Aged Care services, whereby younger people aged under 65 will no longer be able to access Commonwealth-funded aged care (including RAC) unless they are aged 50 to 64 and either experiencing homelessness or are an Aboriginal or Torres Strait Islander person.

Younger people with disabilities or high care support needs will instead be supported to seek more age-appropriate housing and care support alternatives to RAC and explore funding options through the National Disability Insurance Scheme (NDIS), which is administered by the National Disability Insurance Agency (NDIA) and purpose-built to support people aged under 65 living with disabilities.

The NDIS has several access requirements. Participants of the scheme must:<sup>14</sup>

- **Be under the age of 65.**
- **Be an Australian citizen, permanent resident, or Protected Special Category Visa holder.**
- **Have a disability caused by a permanent impairment, which can be intellectual, cognitive, neurological, sensory, physical, or psychosocial.**
- **Require disability-specific supports to carry out daily activities.**

<sup>10</sup> My Aged Care. (n.d.). [Home care packages](#); My Aged Care. (n.d.). [Home care packages costs and fees](#).

<sup>11</sup> My Aged Care. (n.d.). [Aged care homes](#).

<sup>12</sup> My Aged Care. (n.d.). [Aged care homes](#); My Aged Care. (n.d.). [Home care packages](#).

<sup>13</sup> My Aged Care. (n.d.). [Commonwealth home support programme](#).

<sup>14</sup> National Disability Insurance Agency. (2023). [Am I eligible?](#)



The value of a participant's NDIS plan is determined based on their support needs, which are assessed using evidence provided by health professionals.<sup>15</sup> Currently, NDIS planners review this evidence and build the participant's plan from line items listing each required support.<sup>16</sup> A participant's plan can theoretically take on any value depending on the needed supports. When the plan exceeds certain value thresholds, it must be approved by a planner with higher delegation authority.<sup>17</sup> Once the plan is approved, the participant (or their nominated plan manager) can draw down on their funding to directly pay for disability supports.<sup>18</sup> If home and living supports are funded, the NDIA manages the plan and providers claim funds directly from the NDIA.<sup>19</sup> When RAC is funded in a participant's plan, funds are exchanged directly between the NDIA and DoHAC via a cross-billing arrangement.<sup>20</sup>

## What does the pathway to RAC look like for younger people?

To access My Aged Care services, including RAC, an individual must either submit an application or be referred by a health professional. This application/referral can be submitted either online or over the phone. To submit their application online, the individual must declare they "are 65 years or older (50 years or older for Aboriginal or Torres Strait Islander people)". Those who do not meet this criterion but are "on a low income, homeless or at risk of being homeless, and aged 50 years or older (45 years or older for Aboriginal and Torres Strait Islander people)" are instead advised to contact the My Aged Care Contact Centre. Presumably, health professionals referring an individual to My Aged Care encounter similar age-based eligibility restrictions when submitting an online referral for a younger person, though this is unclear as the requisite forms are only accessible to health professionals.<sup>21</sup>

### My Aged Care referral options for health professionals

Health professionals have three routes to making a referral for their patient to undertake a My Aged Care assessment. Notably, the health professional cannot refer patients to a specific aged care stream (e.g., to HCP rather than a RAC):

- **Online referral form (20 min):** The health professional can submit a digital form to make a referral online. This is available to all health professionals as well as system administrators and support staff, including 'GPs, medical specialists, and nurses', 'Hospital professionals and admin staff', 'Community health professionals', 'Aged care service providers', 'Aged Care Assessment Teams', 'Community workers', and 'Other health practitioners'.<sup>22</sup>

<sup>15</sup> National Disability Insurance Agency. (2023). [How do we decide what reasonable and necessary supports to include in your plan?](#)

<sup>16</sup> Following the 2023 NDIS Review, there are a number of [proposed reforms](#) to the needs assessment and budget setting processes.

<sup>17</sup> Australian National Audit Office. (2020). [Decision-making controls for NDIS participant plans.](#)

<sup>18</sup> National Disability Insurance Agency. (2024). [Ways to manage your funding.](#)

<sup>19</sup> National Disability Insurance Agency. (2023). [What aged care fees and charges can we fund?](#)

<sup>20</sup> NDIS Quality and Safeguards Commission. (2022). [Part B: Overview of NDIS registration \(Residential aged care toolkit\).](#)

<sup>21</sup> My Aged Care. (n.d.). [Apply for an assessment](#); My Aged Care. (n.d.). [Services for health professionals](#); Services Australia. (n.d.). [Assessment for aged care.](#)

<sup>22</sup> My Aged Care. (n.d.). [Make a referral.](#)

- **General Practitioner (GP) e-referral** (5 min): This is available to GPs only. The GP can submit a streamlined version of the online referral form that is connected to the patient's electronic medical record stored within the GP's practice management system.<sup>23</sup>
- **Contact Centre phone call**: The health professional can call the My Aged Care Contact Centre on 1800 200 422 to make a referral over the phone. This is available to all health professionals.

Once a younger person is put in touch with the My Aged Care Contact Centre, the pathway they follow depends on whether or not the younger person is an NDIS participant. Depending on this pathway, the younger person will engage with key system administrators.<sup>24</sup>

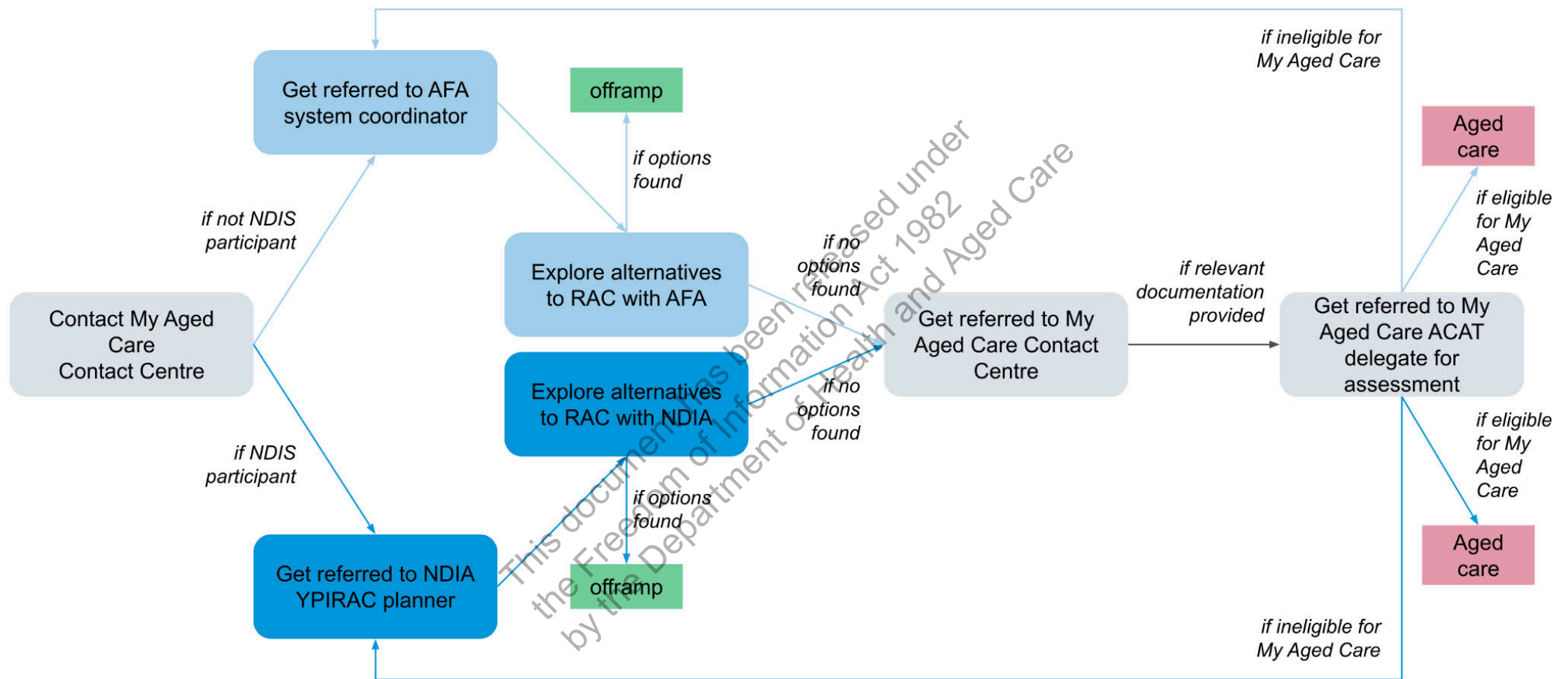
- **Ability First Australia (AFA) system coordinator.**
- **NDIA YPIRAC planner.** These planners currently sit within the Aged Care and Hospital Interface branch of the NDIA, which is divided into separate teams for supporting a) younger people who are at risk of entering RAC, b) younger people who are already living in RAC (including those who entered while under age 65, but who are now aged over 65), and c) younger people who are being discharged from hospital and were previously living in RAC or are at risk of entering RAC. These planners are supported by other officers such as health liaison officers and accommodation officers.<sup>25</sup>
- **My Aged Care Aged Care Assessment Team (ACAT) delegate.**

<sup>23</sup> My Aged Care & HealthLink. (n.d.). [My Aged Care e-referral](#).

<sup>24</sup> National Disability Insurance Agency. (2023). [Process for younger person considering entering residential aged care](#); Australian Government Department of Health and Aged Care. (2023). [Principles and guidelines for a younger person's access to Commonwealth funded aged care services](#).

<sup>25</sup> This insight regarding the composition of the YPIRAC teams and roles within the NDIA was gathered from stakeholder interviews.





### For younger people who are *not* NDIS participants

Non-NDIS participants are referred to AFA, who are a not-for-profit alliance between 15 of Australia's leading disability service providers.<sup>26</sup> An AFA system coordinator will first test the younger person's NDIS eligibility if appropriate. If they are eligible for NDIS funding, the younger person will be referred to an NDIS YPIRAC planner and supported to progress along the NDIS pathway (see [For people who are NDIS participants](#) section below). If they are not eligible for NDIS funding, the AFA system coordinator will explore housing and care support options with the younger person. If alternatives to RAC can't be found, or if the person declines the options that the AFA system coordinator offers, the AFA system coordinator will provide an evidence document called *AFA Summary Report - Younger People at Risk of Entering Residential Aged Care*, which outlines the options that were explored for the younger person. The younger person can then use this document to apply for a My Aged Care assessment via the My Aged Care Contact Centre, where they will be referred to the ACAT if suitable. If the assessment by the ACAT delegate deems the younger person ineligible for My Aged Care services, AFA will assist the younger person to explore other housing and care support options.

### For younger people who are NDIS participants

NDIS participants are referred to an NDIA YPIRAC team, who are dedicated to helping younger people connect with NDIS funded housing or care support options that will allow them to live independently. An NDIA YPIRAC planner will explore housing and care support options with the younger person. If alternatives to RAC can't be found, or if the person declines the options that the NDIA YPIRAC planner offers, the NDIA YPIRAC planner will provide an evidence document called *Exploration of Home and Living Supports*, which outlines the options that were explored for the younger person. The younger person can then use this document to apply for a My Aged Care assessment via the My Aged Care Contact Centre, where they will be referred to the ACAT if suitable. If the assessment by the ACAT delegate deems the younger person ineligible for My Aged Care services, the NDIA will assist the younger person to explore other housing and care support options.

## What alternatives to RAC are available for younger people?

Younger people who are funded by the NDIS<sup>27</sup> may have access to the following housing and care support options to support them to live outside of RAC:<sup>28</sup>

- **Specialist Disability Accommodation (SDA):** Dwellings designed to make access easier for people with extreme functional impairment. SDA typically involves living with a small number of other NDIS participants. Funding covers the cost of the

<sup>26</sup> The Australian government committed \$26.8 million for AFA to establish a national network of up to 40 YPIRAC system coordinators. This contract with AFA is due to expire at the end of 2025. See: Ability First Australia. (2022). [Ability First Australia: 2022 Annual review](#); Department of Health and Aged Care. (2024). [Younger people in residential aged care – Priorities for action](#).

<sup>27</sup> Our policy scan did not clearly reveal the housing and care support options available to younger people who are not NDIS funded. Therefore, we explored these options in subsequent project activities.

<sup>28</sup> National Disability Insurance Agency. (2023). [Living in and moving out of residential aged care](#).

dwelling itself, not any support services the person may require while living in the dwelling.<sup>29</sup>

- **Supported Independent Living (SIL):** Ongoing support with personal care, domestic duties, and transport for people with high care support needs who are living in their home but require some level of help all the time, including overnight. SIL typically involves living with a small number of other NDIS participants. Funding covers the cost of support services the person requires while living at home, not the cost of the home itself. Funding does not include nursing, medical, or palliative care support.<sup>30</sup>
- **Personal care supports:** Support with personal care, domestic duties, and transport for people who are living in their home but do not require SIL.
- **Individualised Living Options (ILO):** Assistance with choosing suitable housing and setting up a system of supports that will enable the individual to live safely in this home. ILO can involve living independently, with friends, or with a host. Funding covers the cost of support services the person will require once they have found a suitable home, not the cost of the home itself.

## Where do we currently stand on the 2025 YPIRAC target?

*"With only six months to go, the current government is unlikely to meet the 2025 target."*<sup>31</sup>

–Di Winkler, CEO and founder of the Summer Foundation

The most recent data published by the Australian Institute of Health and Welfare<sup>32</sup> shows that as of 31 December 2023, **1,470** people aged under 65 are living in RAC (this excludes the 246 Aboriginal and Torres Strait Islander people aged 50-64 living in RAC, as these individuals will remain eligible for RAC under the new Aged Care Act). Among these 1,470 younger people, 62% are aged 60-64, 24% are aged 55-59, 13% are aged 40-54, and 1% are aged 18-39.

The number of younger people aged under 65 living in permanent RAC has been trending down since the earliest figures published by the Australian Institute of Health and Welfare.<sup>33</sup> Crucially, the proportion of exits due to death or hospitalisation has decreased from 83% in 2019 to 63% in 2023; and the proportion of exits due to returning to family or home has increased from 12% in 2019 to 19% in 2023. Between 31 December 2022-2023, the number of people aged under 65 living in RAC decreased by 31% (661 individuals). While this is substantial, it is worth noting that a reduction of this size between 31 December 2023-2024 would not be sufficient to achieve the target by 1 January 2025.

<sup>29</sup> National Disability Insurance Agency. (2021). [Specialist disability accommodation explained.](#)

<sup>30</sup> National Disability Insurance Agency. (2021). [What does supported independent living include and not include?](#)

<sup>31</sup> Winkler, D. (2024). [The government is not on track to get every younger person out of aged care by next year. What now?](#) The Conversation.

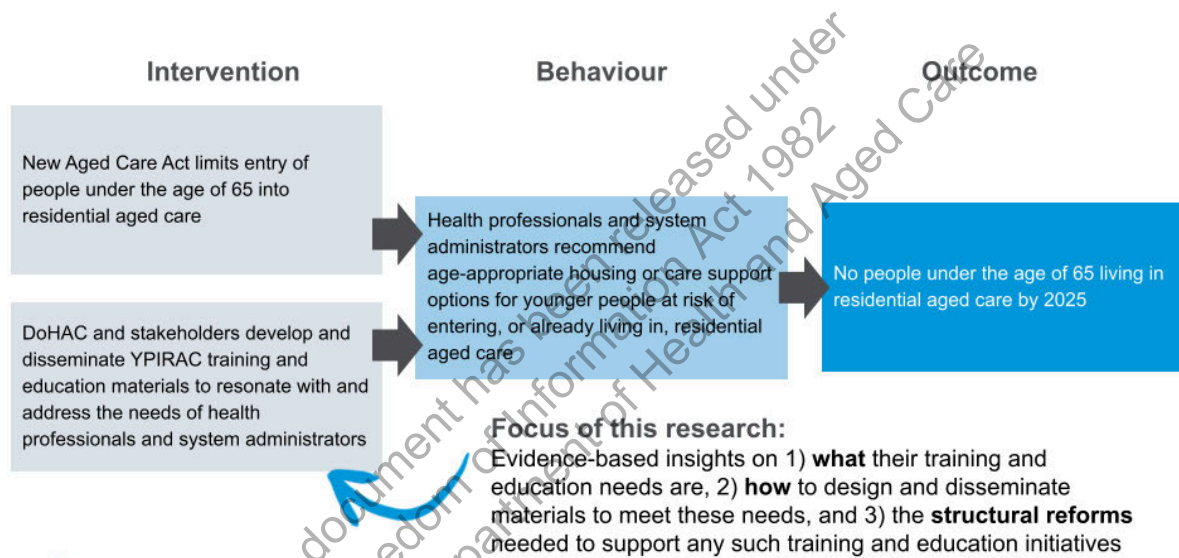
<sup>32</sup> Australian Institute of Health and Welfare. (2023, December). [GEN Aged care data: Younger people in residential aged care.](#)

<sup>33</sup> Australian Institute of Health and Welfare. (2023, December). [GEN Aged care data: Younger people in residential aged care.](#)

Further statistics pertaining to the 2025 national YPIRAC target can be found in [Appendix B](#).

## Project objectives and scope

DoHAC understands that the introduction of new legislation alone will not be sufficient to achieve the 2025 YPIRAC target. To support the successful transition of these younger people into more age-appropriate housing and care support options, it is crucial to **shift the behaviour of health professionals and system administrators** who make decisions about or give recommendations to younger people considering entering, exiting, or remaining in RAC. To this end, DoHAC commissioned The Behavioural Insights Team (BIT) to determine how DoHAC and other stakeholders should develop and disseminate **training and education materials** – and explore other **structural reforms** that may be needed – to encourage health professionals and system administrators to recommend age-appropriate housing and care support options for younger people.<sup>34</sup>



Focussing on the Australian context, this project aimed to answer several research questions by gathering data on the knowledge, attitudes, and practices of stakeholders (who have a 'macro' view of YPIRAC) and health professionals and system administrators (who have a 'micro' view of YPIRAC):<sup>35</sup>

<sup>34</sup> This project arose out of DoHAC's border commitment of "\$3.6 million... to deliver targeted education and training packages for general practitioners, clinicians, social workers, families and carers, and others that support and influence the decision making of YPIRAC. The education and training packages will promote an understanding of age-appropriate alternatives to residential aged care for younger people". See: Australian Government Department of Health and Aged Care. (2024). [Younger people in residential aged care – Priorities for action](#).

<sup>35</sup> The Department of Social Services is concurrently running a separate research project that engages younger people themselves. In this complementary project, our focus is on health professionals.

Macro view of YPIRAC	Micro view of YPIRAC
<p>These research questions were answered based on <b>interviews</b> with <b>stakeholder representatives</b> from the YPIRAC Sub-Joint Agency Taskforce, YPIRAC Stakeholder Reference Group, and a selection of Primary Health Networks (PHNs), peak professional bodies, and advocacy groups.</p>	<p>These research questions were answered based on a <b>survey</b> of <b>health professionals</b> and <b>system administrators</b> who make decisions or recommendations that influence whether younger people enter or exit RAC.</p>
<ul style="list-style-type: none"> <li>• What do stakeholders know, and how do they feel, about the YPIRAC targets and corresponding legislative changes?</li> <li>• What types of health professionals do younger people interact with when making housing or care support decisions?</li> <li>• What influence do stakeholders have over younger people's housing or care support decisions and over the health professionals who support these younger people?</li> <li>• What capability, motivation, and opportunity factors are contributing to younger people entering or remaining in RAC?</li> </ul>	<ul style="list-style-type: none"> <li>• What do health professionals and system administrators know about the YPIRAC targets and corresponding legislative changes?</li> <li>• What are health professionals' and system administrators' current practices with regard to recommending RAC for younger people?</li> <li>• What do health professionals and system administrators know about the alternatives to RAC for younger people and what resources inform this knowledge?</li> <li>• What capability, motivation, and opportunity factors influence a health professional or system administrator's decision to recommend RAC versus alternative options?</li> <li>• Can we distinguish different 'personas' based on reliable differences in the values and motivations that underlie decisions made by health professionals and system administrators?</li> </ul>



## Methodology

In this section of the report, we describe three streams of research we undertook to understand the capability, motivation, and opportunity factors influencing a health professional or system administrator's decision to recommend RAC over more age-appropriate housing and care support options for younger people.

### Interviews with stakeholder representatives

We conducted 1:1 virtual interviews with representatives from stakeholder organisations who represent the interests of, provide funding or services to, or create policy or legislation for, younger people, health professionals, or system administrators.<sup>36</sup> This included representatives from members of the YPIRAC Sub-Joint Agency Taskforce and YPIRAC Stakeholder Reference Group. Additional interview participants were recruited by leveraging our existing industry connections, as well as the industry connections of interviewees and DoHAC.

Each interview lasted no more than 1 hour. We sought to understand stakeholders' knowledge and attitudes regarding the YPIRAC targets and their perceptions of potential capability, motivation, and opportunity factors that might influence a health professional or system administrator's housing and care support recommendations for younger people. The complete interview guide is shown in [Appendix C](#).

Interviews were conducted between 19 April and 14 June 2024. Across **21 interviews**, we spoke with 25 individuals from 18 stakeholder organisations. The sampling frame is shown below. Organisations listed in *italics* are members of the YPIRAC Sub-Joint Agency Taskforce and organisations listed in **bold** are members of the YPIRAC Stakeholder Reference Group. The participants from the **s47E(d)** and the **s47E(d)** were interviewed together.

Organisations	Interviews	Participants
<i>Department of Social Services</i>	1	2
<i>National Disability Insurance Agency</i>	2	3
<b>s47E(d)</b>	2	2
<b>s47E(d)</b>	1	1
<b>s47E(d)</b>	1	2
<b>s47E(d)</b>	1	1
<b>s47E(d)</b>	1	1
<b>s47E(d)</b>	2	2

<sup>36</sup> Interviews were not strictly '1:1', as the interviewer side always involved both a lead interviewer plus a note taker, and the interviewee side sometimes involved two participants.

s47E(d)	1	1
	2	2
	1	1
	1	1
	1	1
	1	1
	1	1
	1	1
	1	1
	1	1

We analysed interview data using thematic analysis,<sup>37</sup> a method for identifying patterns of meaning within qualitative data. Specifically, we used the framework method,<sup>38</sup> which involved coding interview notes into a matrix, examining commonalities and differences in these codes, and generating emergent themes. As this was a qualitative analysis, we did not attempt to quantify the number or proportion of interviewees who reported each phenomenon. Rather, we attempt to represent the range of perspectives that interviewees described, focussing on both the shared and unique views of our interviewees.

## Survey of health professionals and system administrators

We administered an online survey to health professionals and system administrators. Participants were eligible to participate in the survey if they: (1) were at least 18 years of age; (2) currently work as a health professional or system administrator in Australia, or have done so in the past 12 months; and (3) could make decisions in their role that influence whether younger people aged under 65 enter or exit RAC. We recruited participants by distributing the survey link to contacts within DoHAC's professional network and to the following stakeholder organisations whom we had engaged with during interviews:

- NDIA

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•  
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•  
•

s47E(d)

<sup>37</sup> Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>

<sup>38</sup> Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, 13(1), Article 117. <https://doi.org/10.1186/1471-2288-13-117>

- s47E(d)

The survey comprised 20 questions, with an estimated completion time of 10-15 minutes, and was administered via the SmartSurvey platform. We sought to identify trends in the knowledge, attitudes, and practices of health professionals and system administrators when advising younger people about RAC or other more age-appropriate housing and care support options. A copy of the survey is shown in [Appendix D](#).

The survey was open from 14 May to 10 June 2024 and yielded a total of **184 responses**, of which 159 were from health professionals, 20 were from system administrators who were not health professionals, and 5 were from individuals who did not neatly fit our classification but who were in relevant management roles (Local Health District Disability Lead, Mental Health Lead, Director of Nursing, RAC Facility Manager, Health Management). Among the 159 health professionals in our survey sample, 26% (n = 41) were also system administrators. Most survey respondents reported that they work in metropolitan (45%) or regional (49%) areas, with a minority working in remote (6%) settings.

Survey data were analysed descriptively to provide a broad overview of the landscape of health professionals and system administrators in Australia.<sup>39</sup> We note two key limitations that should inform interpretation of results. First, results for the subsample of system administrators should be interpreted more tentatively, given the small subgroup size. Second, participants in our sample self-selected into the survey from an advertisement requesting participation from health professionals who make decisions, referrals, or recommendations that influence whether younger people enter or exit RAC. We expect that the kind of health professional who would sign up for such a survey is more likely to be aware of and interested in the YPIRAC issue, compared to the average health professional who may work with younger people but be less interested in, or aware of, the YPIRAC issue.

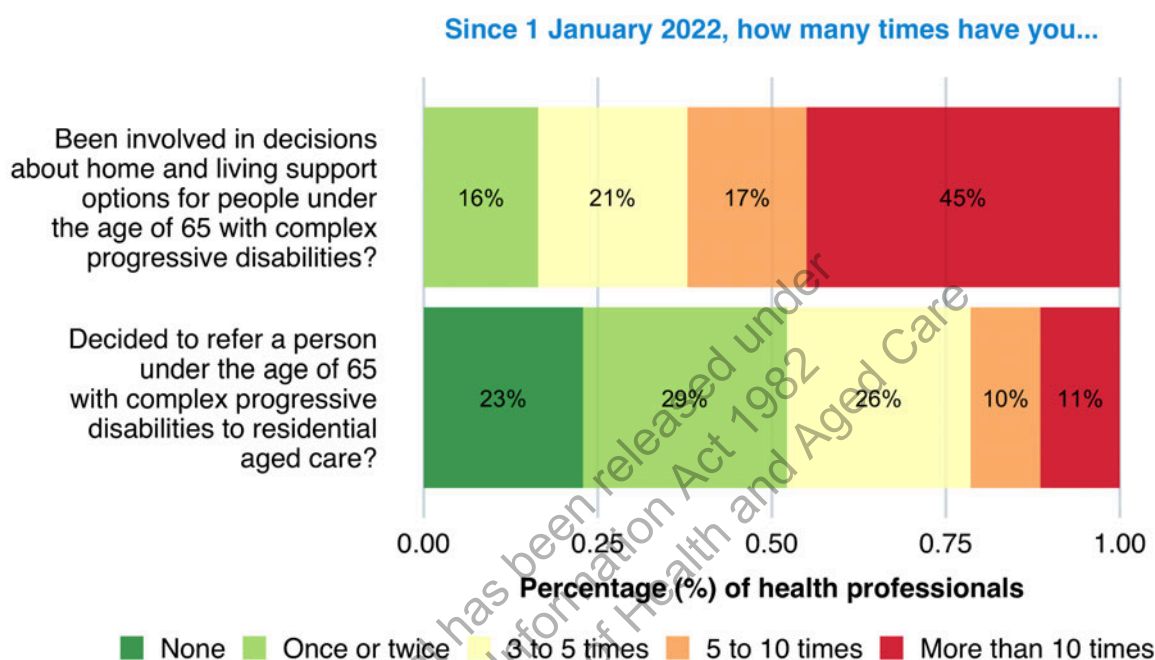
Health professional role	System administrator?		Total
	Yes*	No	
GP	0	11	11
Nurse	17	25	42
Medical specialist	0	14	14
Allied health	23	60	83
Medical registrar	0	1	1
Other	1	7	8
None of the above	20	5	25
<b>Total</b>	<b>61</b>	<b>123</b>	<b>184</b>

<sup>39</sup> All descriptive statistics have been rounded to the nearest whole percentage number for ease of interpretation. Some of the percentages displayed in the descriptive charts may therefore sum to 99% or 101% (rather than 100%) due to this rounding approach.



\*System administrators comprised 36 ACAT staff, 6 NDIA YPIRAC planners, and 19 AFA system coordinators.

All health professionals in our survey sample had been involved in at least one decision about home and living support options for younger people with complex progressive disabilities.<sup>40</sup> Almost half (45%) had been involved in more than ten such decisions and 76% said they had gone through with at least one decision to refer a younger person to RAC.<sup>41</sup>



## Personas of health professionals

While health professionals can share common characteristics, they may cluster into groups, or 'personas', based on the values, motivations, and cognitive biases driving their patient care decisions. As a result, behaviour change strategies that work for some health professionals will not necessarily work for all. To help tailor our recommendations to maximise the likelihood of sustained behaviour change, we sought to understand what personas exist among health professionals.

### AI-driven persona generation tool: *PersonifAI*

We used BIT's artificial intelligence (AI) driven persona generation tool, *PersonifAI*, to generate hypothetical profiles of values and motivations (i.e., 'personas') that may be

<sup>40</sup> This excludes any health professionals in AFA system coordinator or NDIA YPIRAC planner roles, as we did not ask this survey question to these participants.

<sup>41</sup> Note this number is likely to be higher than the general population of health professionals, as the survey advertisement specifically called for participation from health professionals who make decisions, referrals, or recommendations that influence whether younger people enter or exit RAC.

relevant to health professionals who make decisions about housing and care support options for younger people with disabilities or high care support needs.

*PersonifAI* is a customised large language model, built on the GPT-4 architecture made by OpenAI, that has been refined to create distinct, evidence-based personas centred around a target behaviour specified by the user. *PersonifAI* has been constrained to draw only on scientific literature about behavioural economics, psychological motivation, cognitive biases, and user experience and service design principles to inform the personas it generates. If empirical data about the specified target behaviour is available, *PersonifAI* will also incorporate these data into the personas. Each persona includes comprehensive insights on values, motivators, behavioural barriers and enablers, cognitive biases, communication strategies, and intervention ideas.

For this research, *PersonifAI* was prompted to produce hypothetical personas that may be at play for *general practitioners (GPs) referring younger people with complex progressive disabilities to residential aged care*.<sup>42</sup> Four personas were produced by the AI model, which are summarised in the table below. When interpreting these personas, it is important to note that the majority of the training data that *PersonifAI* draws on to produce personas is not specific to the Australian context. The full output produced by *PersonifAI* is shown in [Appendix E](#).

Persona label	Description
Prevention-focused practitioner	Primarily values patient autonomy, preventative care, and long-term wellbeing. Is primarily motivated by positive patient outcomes and the desire to prevent premature institutionalisation.
Resource-seeking rationalist	Primarily values evidence-based practice, efficiency, and practical solutions. Is primarily motivated by data-driven results and streamlined processes.
Compassionate care advocate	Primarily values empathy, patient-centred care, and holistic approaches. Is primarily motivated by the emotional wellbeing of patients and the desire to provide compassionate care.
System-conforming traditionalist	Primarily values established practices, systemic stability, and professional norms. Is primarily motivated by adherence to standard procedures and minimising risk.

### Testing the relevance of personas for Australian health professionals

In the survey of health professionals and system administrators, we aimed to investigate which of the four hypothetical personas resonated most strongly with health professionals by assessing the prevalence of each persona among the health professionals in our survey sample. To this end, we asked respondents to rank a series of values and motivations, each corresponding to one of the four personas, in order of their importance or relevance when




<sup>42</sup> We chose to use the term “general practitioners” instead of “clinicians”, as we found that prompting *PersonifAI* with a more specific target group allowed it to produce personas with more concrete and interpretable values and motivations.

making decisions about RAC for younger people. The specific items in the survey used to evaluate the four personas are shown as Q15 to Q17 in [Appendix D](#).

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the Freedom of Information Act 1982  
by the Department of Health and Aged Care

## Findings

In this section of the report, we present the key findings from our research activities. The findings are summarised and indexed for quick reference below:

#	Category	Finding
<a href="#">1</a>	 Capability	Health professionals have limited knowledge of the upcoming legislative changes designed to support the YPIRAC targets
<a href="#">2</a>		Many health professionals and system administrators have difficulty identifying suitable alternatives to RAC
<a href="#">3</a>		Some health professionals and system administrators don't know how to support younger people to access suitable alternatives to RAC
<a href="#">4</a>	 Opportunity	Health professionals and system administrators are constrained by the short supply of suitable alternatives to RAC for younger people
<a href="#">5</a>		Health professionals are constrained by narrow funding eligibility criteria and small funding packages when supporting younger people to access RAC alternatives
<a href="#">6</a>		Health professionals are constrained by referral and application systems that are fragmented and burdensome
<a href="#">7</a>		Health professionals face time pressures that make it difficult for them to support younger people to identify and access suitable alternatives to RAC
<a href="#">8</a>	 Motivation	Most health professionals are driven by a motivation to provide compassionate care to younger people
<a href="#">9</a>		Some health professionals believe that RAC facilities will offer the best care when compared with alternatives
<a href="#">10</a>		Health professionals take into account the preferences of younger people and their families, who sometimes prefer RAC over other alternatives
<a href="#">11</a>		Some health professionals may refer younger people to RAC through their existing networks or out of habit
<a href="#">12</a>		Stakeholders support the rationale behind the YPIRAC targets, but are concerned about feasibility, sustainability, and unintended consequences

Each research finding is framed in the language of the *COM-B* model of behaviour change, which states that behaviours are influenced by internal **capability** (knowledge and skills) and **motivation** (attitudes and habits) factors, as well as external **opportunity** (structural and environmental) factors.<sup>43</sup> Specifically, each research finding is expressed as either a capability, motivation, or opportunity factor that influences a health professional or system

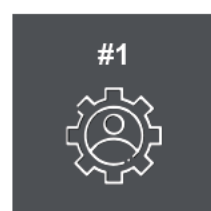
<sup>43</sup> Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science*, 6, Article 42. <https://doi.org/10.1186/1748-5908-6-42>

administrator's decision to recommend RAC versus alternative housing and care support options. As we highlight in the relevant sections, the various capability, motivation, and opportunity factors we describe in this section are often interdependent. Specifically, many of the capability and motivation barriers we heard about from stakeholder representatives, health professionals, and system administrators often appear to be exacerbated by the opportunity barriers they identified.

*Note: When describing key interview insights and quotes in this report, we focus on themes observed across the stakeholder representatives we spoke to and avoid attributing specific ideas to particular organisations except where such attribution provides crucial context. We have sought clearance from the relevant interviewees whenever such attributions are made.*

## Capability factors

According to the COM-B model of behaviour change, **capability** factors are a key source of influence on an individual's behaviour (see the [Opportunity factors](#) and [Motivation factors](#) sections for the other two sources). These capability factors lie internally within the individual and encompass the range of knowledge and skills that can enable or inhibit a target behaviour.<sup>44</sup> In this section, we report the key capability factors that influence a health professional or system administrator's decision to recommend RAC versus alternative housing and care support options.

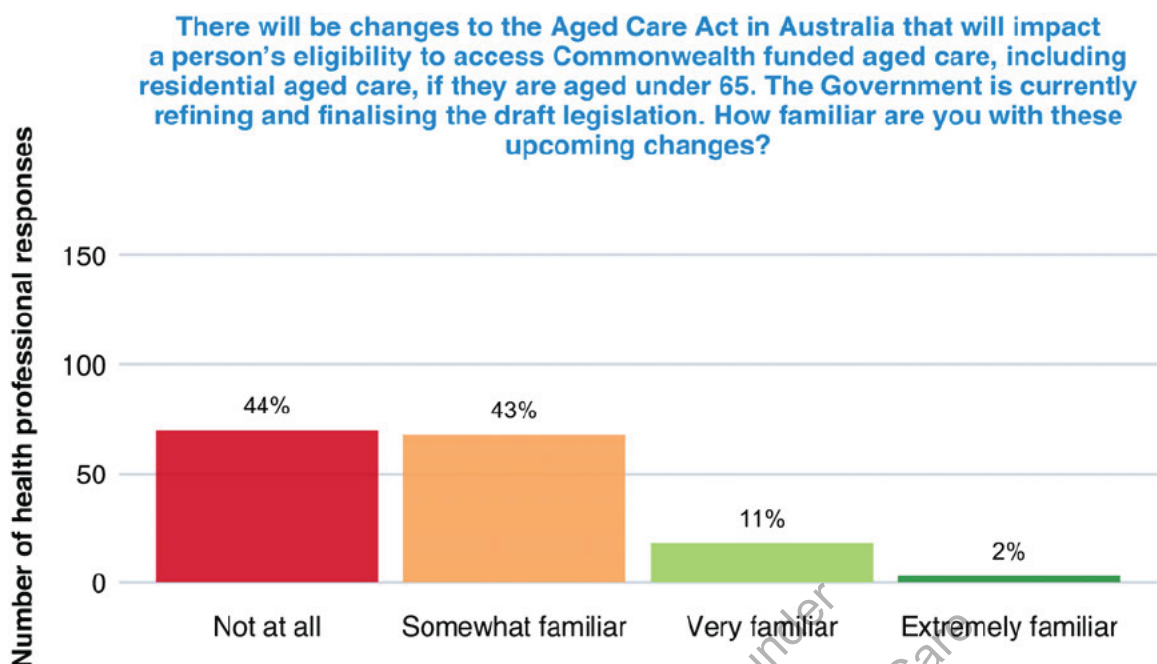


Health professionals have limited knowledge of the upcoming legislative changes designed to support the YPIRAC targets

The health professionals we surveyed reported low awareness of the upcoming legislative changes proposed in the exposure draft of the Aged Care Bill (see [Appendix A](#)). Specifically, the majority of health professionals in our survey sample indicated they were either 'not at all' (44%) or only 'somewhat' (43%) familiar with the revised RAC eligibility criteria. Consistent with this low self-reported familiarity, only 29% of health professionals in our survey sample correctly identified the revised eligibility criteria for accessing RAC (see [Appendix F](#)).

<sup>44</sup> Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science*, 6, Article 42. <https://doi.org/10.1186/1748-5908-6-42>





Self-reported familiarity with the revised RAC eligibility criteria was much higher among those respondents in our survey sample who work in a system administrator role, with only 15% of system administrators indicating they were 'not at all' familiar with the upcoming changes, compared to 54% of non system administrators. This is not surprising, given the core responsibility of system administrators is to work directly with younger people who are living in or at risk of entering RAC. The system administrators in our survey sample also correctly identified the revised eligibility criteria for accessing RAC at more than double the rate (51% correct) of non system administrators (24% correct).

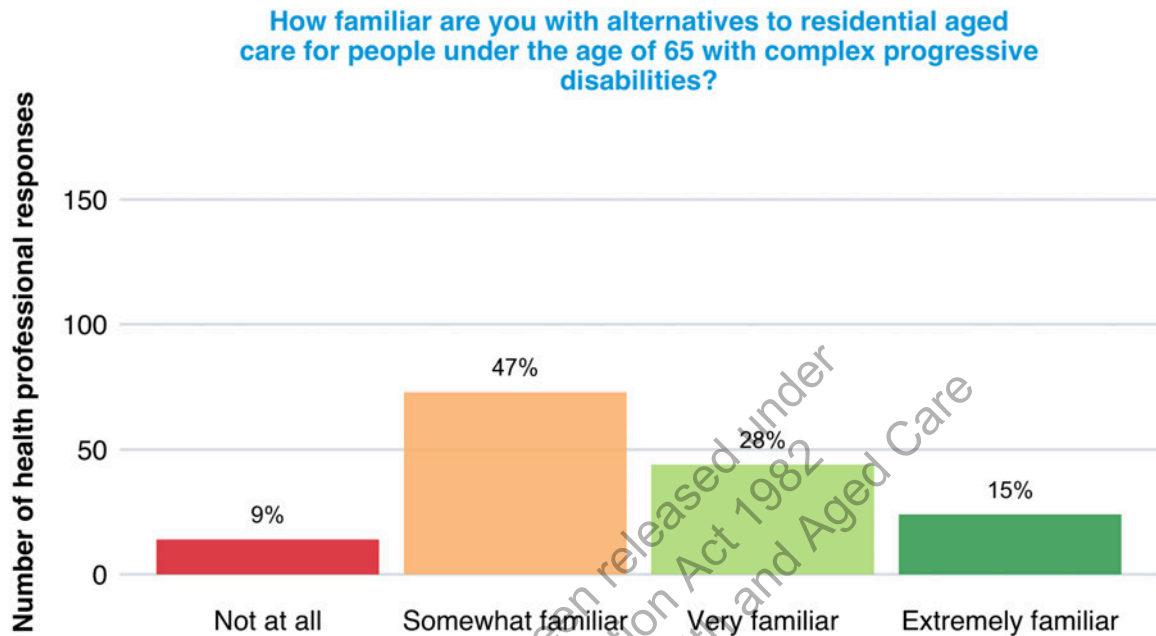


## Many health professionals and system administrators have difficulty identifying suitable alternatives to RAC

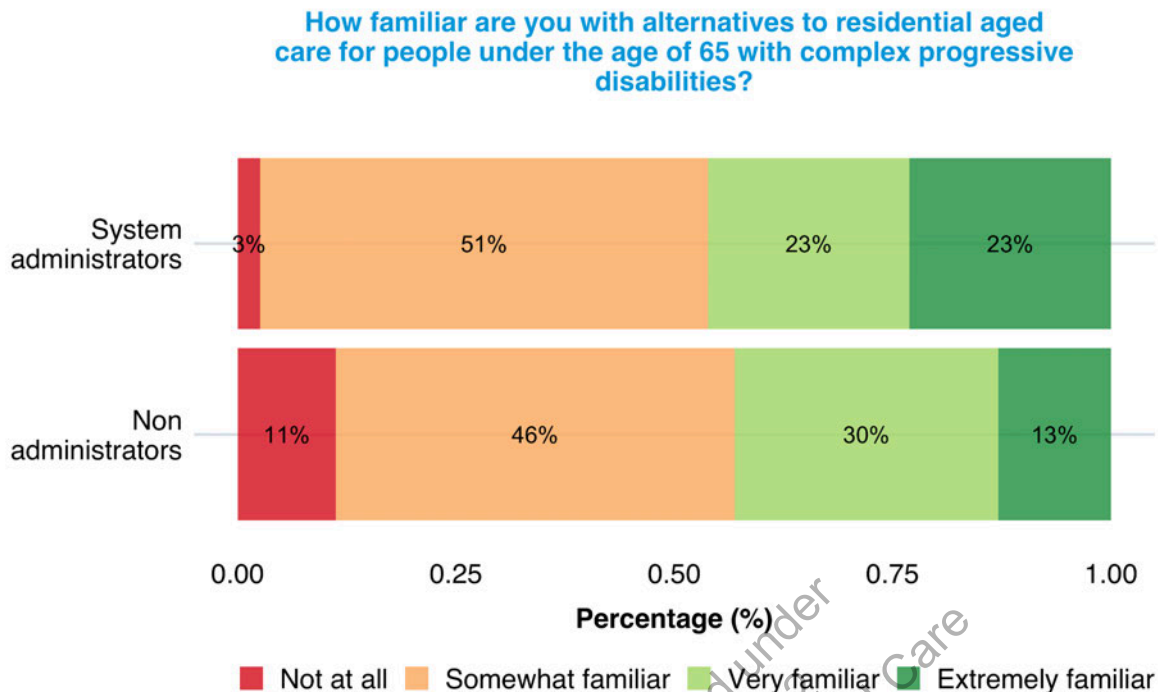
In order to support younger people to identify and access suitable alternatives to RAC, it is crucial that health professionals are equipped with an understanding of what these alternatives are. However, several stakeholder representatives we spoke to noted that some health professionals may lack sufficient knowledge of suitable alternatives to RAC when helping younger people explore housing and care support options. Consistent with this suggestion, we found less than half (43%) of the health professionals in our survey sample felt 'very' or 'extremely' familiar with alternatives to RAC for younger people. Interestingly, however, only 29% of health professionals felt that such lack of familiarity was a 'very' or 'extremely' relevant barrier to their decision making (see [Appendix F](#)). For those health professionals, the extent of this knowledge gap can nevertheless be significant. As one GP in our survey sample put it:

*“I have a complete void of knowledge in this area. We have had no training or education on this matter.”*

– GP from our survey sample



Unsurprisingly, self-reported familiarity with RAC alternatives was higher for the system administrators in our survey sample, with 23% reporting they are ‘extremely’ familiar with alternatives to RAC for younger people compared to 13% for non system administrators. That said, over half (51%) of the system administrators we surveyed reported they are only ‘somewhat’ familiar with alternatives to RAC for younger people, suggesting their knowledge may still be significantly limited.



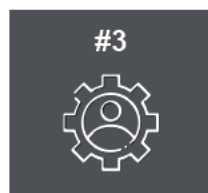
These relatively low levels of self-reported familiarity with suitable RAC alternatives among health professionals and system administrators likely stem from the fact that these alternatives simply do not exist or are in short supply (see [Finding #4: Health professionals and system administrators are constrained by the short supply of suitable alternatives to RAC for younger people](#)).

When asked to list the specific alternatives to RAC they were familiar with for younger people, the health professionals in our survey sample most frequently listed SIL (39%), followed by unspecified in-home care (34%) or NDIS (33%) alternatives (see [Appendix F](#)). While these three responses were the most common among the health professionals in our survey sample, they were nevertheless only listed by a minority. Moreover, while it is promising that the “NDIS” was listed by 1 in 3 health professionals as a viable alternative, it is worth noting that this response captures the funding *source* (i.e., NDIS) but not the specific housing or care support *option* for which this funding can be used (i.e., SIL, SDA, ILO), implying a potential knowledge gap. Indeed, SDA (22%) and especially ILO (2%) were listed relatively infrequently by the health professionals in our survey sample. It is also evident that housing and care support options that fall outside the scope of NDIS funding were not listed as often as those that can be supported by the NDIS, suggesting that knowledge gaps may be especially large when identifying RAC alternatives for younger people who cannot access NDIS funding. Again, this apparent knowledge gap may not actually be a knowledge gap at all, but rather symptomatic of the limited supply of RAC alternatives for younger people who are not eligible for the NDIS (see [Finding #4: Health professionals and system administrators are constrained by the short supply of suitable alternatives to RAC for younger people](#)).

During interviews, several stakeholder representatives advised that PHNs would be an effective channel for distributing information to health professionals to educate them about the YPIRAC initiative, the number of younger people living in RAC within their geographical



region, and what alternative housing and care support options are available to the younger people in their care. We also heard that HealthPathways, a clinical assessment and referral pathway tool, is often accessed by GPs to search for a particular pathway for their patients. It was suggested that educational materials designed to address knowledge gaps could be integrated with HealthPathways to maximise engagement from GPs. That said, we note that in our survey sample, HealthPathways was rated as 'not at all influential' to 65% of health professionals when making decisions about patients who have disabilities (see [Appendix E](#)). However, this is most likely because only 6% of our survey sample were GPs; indeed, 10% of our survey sample rated HealthPathways as 'extremely influential' or 'very influential'.



### Some health professionals and system administrators don't know how to support younger people to access suitable alternatives to RAC

Beyond gaps in their understanding of *what* alternatives to RAC exist for younger people, health professionals also have gaps in their understanding of *how* to access these alternatives. One stakeholder representative told us that some GPs "wouldn't even know where to start" if they identified a younger person at risk of entering RAC. This knowledge gap also extends to some social workers – whose role it is to connect patients or clients to relevant support services – with one social worker from our survey sample stating that "not having a clear picture of... the pathways to access these [alternatives]" is a significant challenge when supporting younger people to explore options beyond RAC. Further still, knowledge gaps also appear to exist among some RAC staff, with one stakeholder representative claiming there is "no knowledge within the aged care homes [about how] to facilitate a move-out." These knowledge gaps likely stem from the fact that health, disability, and aged care services are fragmented, making them difficult to navigate (see [Finding #6: Health professionals are constrained by referral and application systems that are fragmented and burdensome](#)).

***"Not one person has the capability to have the knowledge across all of those services systems and what's available to a person. States and territories have their own ways of doing things and their own eligibilities and pathways."***

– Representative of a stakeholder organisation

In particular, we heard that some health professionals have gaps in their understanding of the NDIS, what kinds of housing and care support alternatives it can fund, and how to coordinate supports from both the health system and disability system. A social worker from our survey sample commented that they feel uncertain about "the ways in which [the] NDIS can/is required to support people who can no longer be cared for at home by their primary carer." Moreover, stakeholder representatives shared that not all allied health professionals who work in RAC, or who work with younger people at risk of entering RAC, have the knowledge or skills to write functional capacity reports in the manner required to secure appropriate NDIS funding for their patients (see [Finding #6: Health professionals are constrained by](#)

*referral and application systems that are fragmented and burdensome*). This issue is heightened in regional and rural areas, where there is an undersupply of highly trained and experienced allied health professionals.

***“If you don’t get the right people writing the right reports, that can drastically impact a person’s NDIS plan, including their SDA as well, which is problematic”.***

– Representative of a stakeholder organisation

The above knowledge gaps are particularly concerning, given younger people and their families rely on skilled health professionals and system administrators to make them aware of their housing and care support options and to help them take steps to access the option deemed most suitable. Without such support, one stakeholder representative told us that exploring alternatives to RAC is “in the too-hard basket for families.” Across our stakeholder interviews, we heard that this is because:

- **Some younger people have significant cognitive impairments.** These impairments can reduce a younger person’s capacity to explore and weigh up housing and care support options.
- **Some younger people, particularly those living in RAC, lack access to phones and computers.** This makes it difficult or impossible for them to access the information needed to explore options on their own.
- **Some younger people don’t have family or other social supports to help them make decisions about their living situation.** One stakeholder representative told us there are “often people in [RAC] that don’t have a single relative... who is the advocate for this young person.”
- **Younger people who have been living in RAC for extended periods may experience diminished confidence and capacity to make decisions about their living arrangements.**

To provide younger people and their families with the guidance they need, stakeholder representatives advised us that AFA system coordinators, NDIS support coordinators, NDIS health liaison officers, NDIS accommodation officers, social workers, and occupational therapists often act as key enablers. However, we also heard that many of these staff are in short supply and that visiting staff who work outside RAC can have difficulty building long-term, trusting relationships with younger people who are already living in RAC. A representative of the s47E(d)

also advised that Aboriginal and Torres Strait Islander health worker and health practitioner roles serve as “cultural brokers” between Aboriginal and Torres Strait Islander people and other health professionals. This is because staff in these roles are trained to advocate for culturally appropriate options and support health professionals to communicate in culturally accessible ways.

## Opportunity factors

According to the COM-B model of behaviour change, **opportunity** factors are a second key source of influence on an individual's behaviour (see the [Capability factors](#) and [Motivation factors](#) sections for the other two sources). These opportunity factors lie externally to the individual and encompass the range of structures and processes in the social and physical environment that can enable or inhibit a target behaviour.<sup>45</sup> In this section, we report the key opportunity factors that influence a health professional or system administrator's decision to recommend RAC versus alternative housing and care support options.



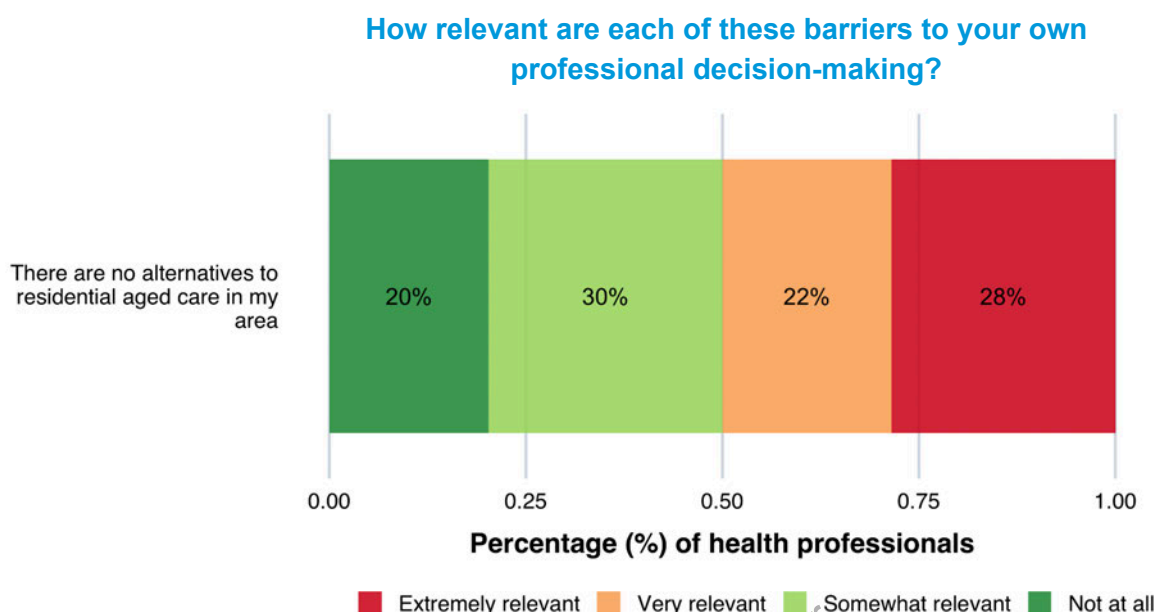
**#4** Health professionals and system administrators are constrained by the short supply of suitable alternatives to RAC for younger people

*"The whole problem is there's nowhere else for them to go."*

– Representative of a stakeholder organisation

Half the health professionals in our survey sample reported that the lack of alternatives to RAC in their area is an 'extremely' or 'very' relevant barrier to recommending more age-appropriate housing and care support options for younger people. This barrier was particularly common among those health professionals based in regional or rural areas (55% of whom selected 'extremely' or 'very' relevant). That said, the lack of RAC alternatives was also an issue for more than a third of the health professionals in our survey sample who were based in cities (40% of whom selected 'extremely' or 'very' relevant). This means health professionals may refer younger people to RAC simply because it is the only available option. As one stakeholder representative put it, Aboriginal and Torres Strait Islander people living in rural and remote areas "may meet all the [NDIS] criteria, but there's actually not the service out there."

<sup>45</sup> Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science*, 6, Article 42. <https://doi.org/10.1186/1748-5908-6-42>



Based on stakeholder interviews and free-text responses from the health professionals in our survey sample, we heard about several ways in which the supply of suitable alternatives to RAC can be insufficient:

- **Suitable alternatives to RAC are not available due to prohibitively long waiting lists.** We discuss this point in detail under [Finding #7](#) (*Health professionals face time pressures that make it difficult for them to support younger people to identify and access suitable alternatives to RAC*).
- **Suitable alternatives to RAC are located too far away from the younger person's family or social network, especially in regional and rural areas.** We discuss this point in detail under [Finding #10](#) (*Health professionals take into account the preferences of younger people and their families, who sometimes prefer RAC over other alternatives*).

*"I work in a rurally isolated large regional town... [There are] limited local residential options that are accessible without a long waiting list... [And at times] travel to other regional or metropolitan centres is more than 400 kilometres, making it a very difficult option for a younger person to remain connected to their community/family."*

– Occupational therapist from our survey sample

- **There are limited culturally appropriate housing and care support options for Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.**



- **Available alternatives to RAC are not suitable because they do not meet the younger person's support needs.** We discuss this point in detail under [Finding #9](#) (*Some health professionals believe that RAC facilities will offer the best care when compared with alternatives*).
- **Suitable alternatives to RAC are not available for younger people with high care support needs who are ineligible for NDIS funding.** We discuss this point in detail under [Finding #5](#) (*Health professionals are constrained by narrow funding eligibility criteria and small funding packages when supporting younger people to access RAC alternatives*).

*"The basic reality is there is no alternative for those with significant health impairments who are not eligible for the NDIS but need 24/7 nursing care."*

– Local Health District Disability Lead from our survey sample

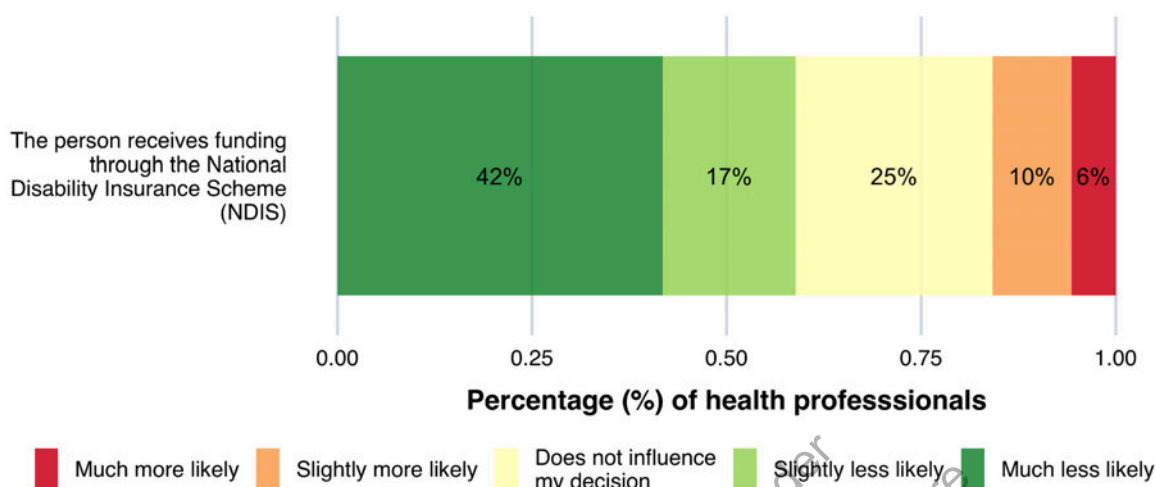
The above points highlight that the limited supply of RAC alternatives underpins many of the other issues identified by stakeholder representatives and health professionals throughout this report.



Health professionals are constrained by narrow funding eligibility criteria and small funding packages when supporting younger people to access RAC alternatives

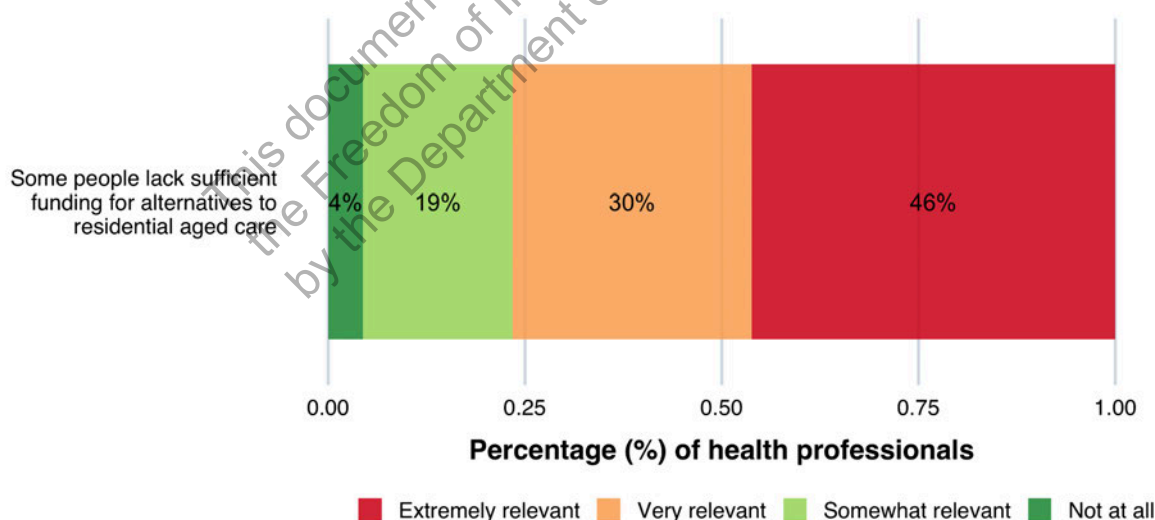
Where suitable housing and care support alternatives to RAC do exist, they typically come at a high cost. As a result, one stakeholder representative emphasised that "financial resources are a huge factor" in the decision making of health professionals. In principle, NDIS funding is available to cover the costs associated with accessing age-appropriate housing and care support alternatives for younger people living with disability. For example, stakeholder representatives told us that NDIS-funded SDA and SIL are common alternatives to RAC that can accommodate high care support needs. The availability of NDIS funding therefore plays a crucial role in health professionals' decision making, with 59% of health professionals in our survey sample indicating they would be 'much less' or 'slightly less' likely to refer a younger person to RAC if that person is NDIS funded. This was by far the most influential decision making factor among those we asked health professionals about in the survey (see [Appendix E](#)).

**To what extent does each of these factors make it more or less likely that you will refer a younger person to residential aged care?**



While NDIS funding plays a crucial role in the decision making of health professionals, 76% of those in our survey sample indicated that the lack of sufficient funding for alternatives to RAC is a 'very' or 'extremely' relevant barrier to them being able to support younger people to access more age-appropriate housing and care support options.

**How relevant are each of these barriers to your own professional decision-making?**



Based on stakeholder interviews and free-text responses from the health professionals in our survey sample, we heard there are three main types of funding constraints:

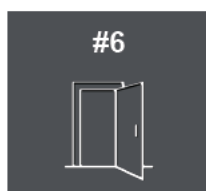
- **Some younger people are ineligible for NDIS funding because their high care support needs arise from medical conditions, rather than disability.** The NDIS ineligible medical conditions most commonly discussed by stakeholder

representatives were 1) life-limiting conditions requiring palliative or end-of-life care (e.g., cancer), 2) progressive chronic health conditions (e.g., heart failure and chronic obstructive pulmonary disease), and 3) certain mental health conditions (e.g., schizophrenia and substance use disorders, depending on the extent of long-term functional impairment). We heard that the housing and care support options for individuals with these types of conditions are largely limited to state-funded programs, for example the Safe and Supported at Home program in New South Wales and the Home and Community Care Program for Younger People in Victoria.<sup>46</sup> However, such programs are limited by eligibility criteria and level of service provision. A representative from <sup>s47E(d)</sup> noted they have had some success in approaching jurisdictions and asking them to extend their eligibility criteria for specific younger people with high care support needs who are NDIS-ineligible.

*“When you start to develop systems that are only for NDIS participants... or you’ve got another program that only will deal with people who have a particular condition, you don’t allow the flexibility or opportunity to have a broader system that takes on people that never fit into a box very well.”*

– Representative of a stakeholder organisation

- **Younger people who are NDIS-eligible do not always get sufficient funding packages.** Allied health professionals and system administrators told us that even when detailed evidence is provided to the NDIS about a younger person’s needs, there are many cases where the NDIS does not approve the level of funding required to meet those needs. Moreover, we heard that NDIS plans that fund access to SDA or SIL are of significantly higher monetary value than NDIS plans that fund access to RAC.
- **Some younger people living with disability are not eligible for NDIS funding.** Because NDIS funding is only available to Australian citizens, permanent residents, or Protected Special Category Visa holders, younger people living with disability who do not fall into these categories are unable to access RAC alternatives that are funded by the scheme.



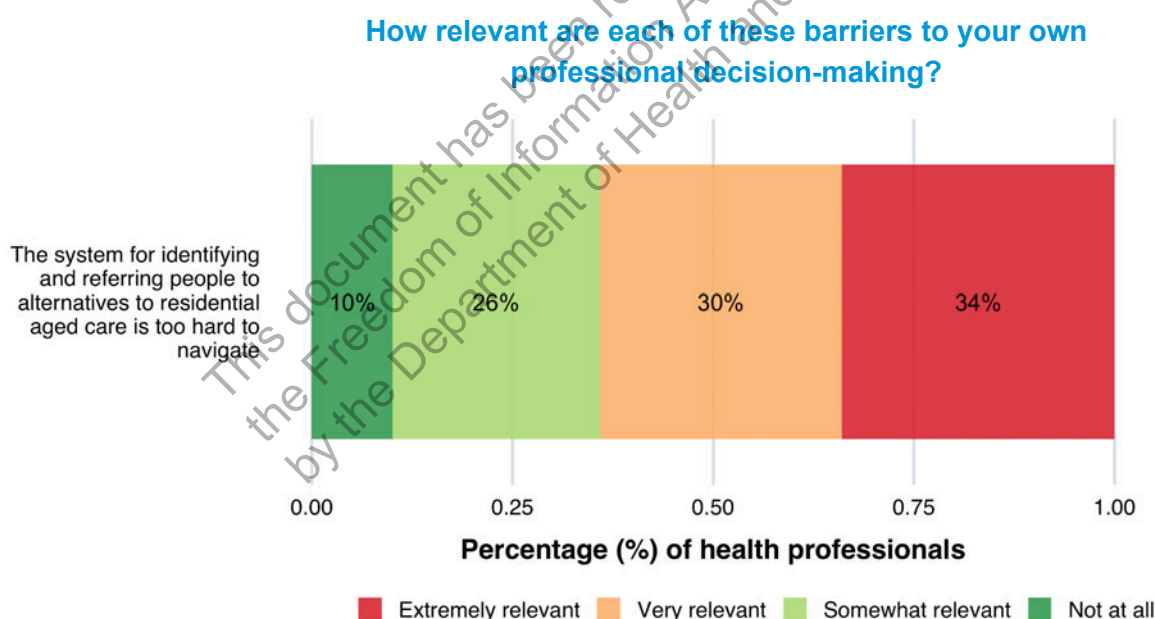
Health professionals are constrained by referral and application systems that are fragmented and burdensome

<sup>46</sup> NSW Health. (2021). [Safe and supported at home \(SASH\)](#); Victoria State Government. (2023). [Home and community care program for younger people](#).

***“The complexity of the ecosystem is really exhausting for healthcare professionals”.***

– Representative of a stakeholder organisation

Health professionals and system administrators supporting younger people with disabilities or high care support needs are often required to work within a complex system of health, disability, and aged care services that are difficult to navigate. Tellingly, one stakeholder representative – who had their own lived experience of supporting a family member with a disability, combined with expertise in applying for and coordinating disability supports for their clients – told us they choose to “pay out of pocket” for their family member’s disability supports “because [they] couldn’t bear to go through an [NDIS] application.” Indeed, 64% of health professionals in our survey sample cited the complexity of the system as an ‘extremely’ or ‘very’ relevant barrier impeding their decision making. As a result, some health professionals lack the requisite knowledge or skills to identify suitable alternatives to RAC or to navigate the referral pathways and application systems involved in supporting younger people to access these alternatives (see [Finding #2: Many health professionals and system administrators have difficulty identifying suitable alternatives to RAC](#); [Finding #3: Some health professionals and system administrators don’t know how to support younger people to access suitable alternatives to RAC](#)).



When providing evidence to qualify a younger person for NDIS funding, an allied health professional (typically an occupational therapist) needs to prepare a report that describes the younger person’s functional capacity in relation to strict criteria, using very specific language. During interviews, stakeholder representatives told us that there are many cases where providing comprehensive and detailed evidence during this process is not sufficient to obtain the necessary funding. One stakeholder representative also highlighted that it is often difficult to articulate and justify in writing just how much support is required for a given individual; a task that sounds quick and straightforward on paper may actually be far more laborious for a



support worker to implement. For example, the same stakeholder representative described a participant who, owing to their history, will not allow a support worker to move her until they have had a long conversation to build trust.

*“The burden of reporting that I have to do to prove to the NDIS what [my client] needs in the community is very very laborious... I train occupational therapists in how to do this and... if I’m not getting reports past the NDIS when I do them meticulously well... what do we do?”.*

– Representative of a stakeholder organisation

Moreover, stakeholder representatives highlighted the siloing of services delivered under the health and disability systems as a significant impediment to supporting younger people to access suitable alternatives to RAC. Such lack of coordination between health and disability systems leads to uncertainty about which government service or agency is responsible for managing younger peoples’ ongoing housing and care support needs, increasing the risk of these younger people falling through the cracks. In particular, health professionals and system administrators told us they face confusion when supporting younger people who don’t fall under the jurisdiction of core services and agencies. In our survey sample, one nurse commented that “the current referral pathway for anyone under the age of 65 is very confusing – especially if they need support services in the home and their NDIS application has been rejected.”

*“There are a lot of people who don’t perceive the NDIS as an appropriate pathway, that the primary issue that’s being addressed is their health needs... And the NDIS is not very good at actually coordinating disability support and health support within the same framework.”*

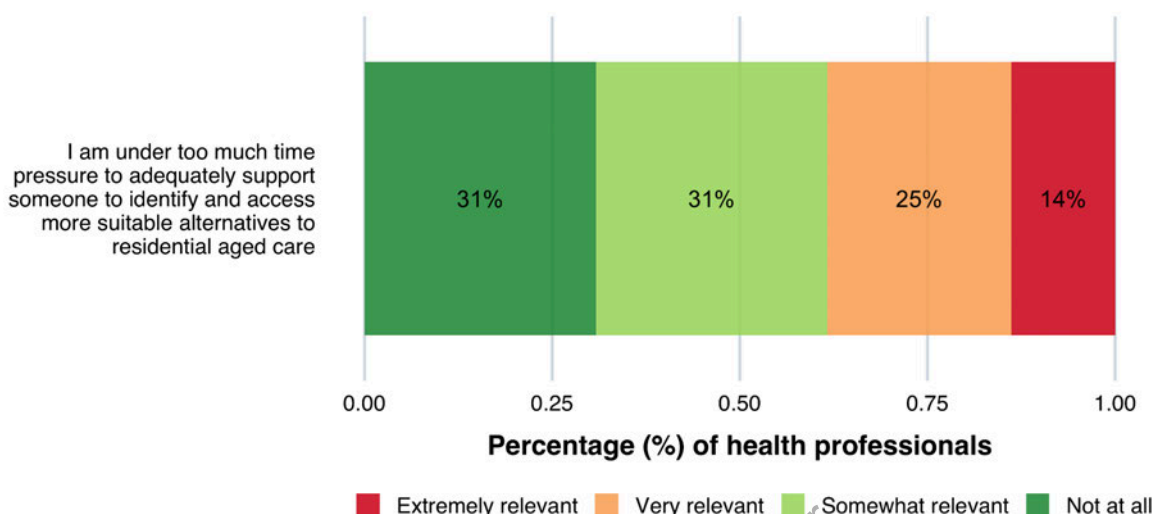
– Representative of a stakeholder organisation



**Health professionals face time pressures that make it difficult for them to support younger people to identify and access suitable alternatives to RAC**

Supporting younger people to explore and access housing and care support options is time intensive. Roughly 1 in 3 health professionals in our survey sample cited time pressures as an ‘extremely’ or ‘very’ relevant barrier to supporting younger people to identify and access suitable alternatives to RAC. Stakeholder representatives told us that skilled system administrators can help to alleviate some of the time pressures that health professionals face, but there are not always enough such staff.

### How relevant are each of these barriers to your own professional decision-making?



For GPs, several stakeholder representatives noted that the capacity to engage in case management of a younger person is primarily constrained by Medicare Benefits Schedule (MBS) item numbers. Without an item number to bill for a particular activity, GPs are highly unlikely to have capacity to undertake this activity during their workday. As one stakeholder representative commented, “if the case management takes quite a bit of time, [GPs] need to be able to bill it in that way.” None of the stakeholder representatives we spoke to were able to say with certainty whether there is an MBS item number for time spent exploring and discussing housing and care support options with younger people. One stakeholder representative mentioned an item number that can be used to bill time spent on “chronic disease management and team care arrangements,” but when asked about item numbers for time spent exploring alternatives to RAC for younger people they said, “to have those conversations, and at length... I definitely don’t think the MBS item numbers would cover those.” Another stakeholder representative recalled an MBS item number for time spent visiting clients who have moved into RAC to discuss their support needs and options. This stakeholder representative was not sure if this item number still exists, but they were in support of incentivising GPs to use their time in this way.

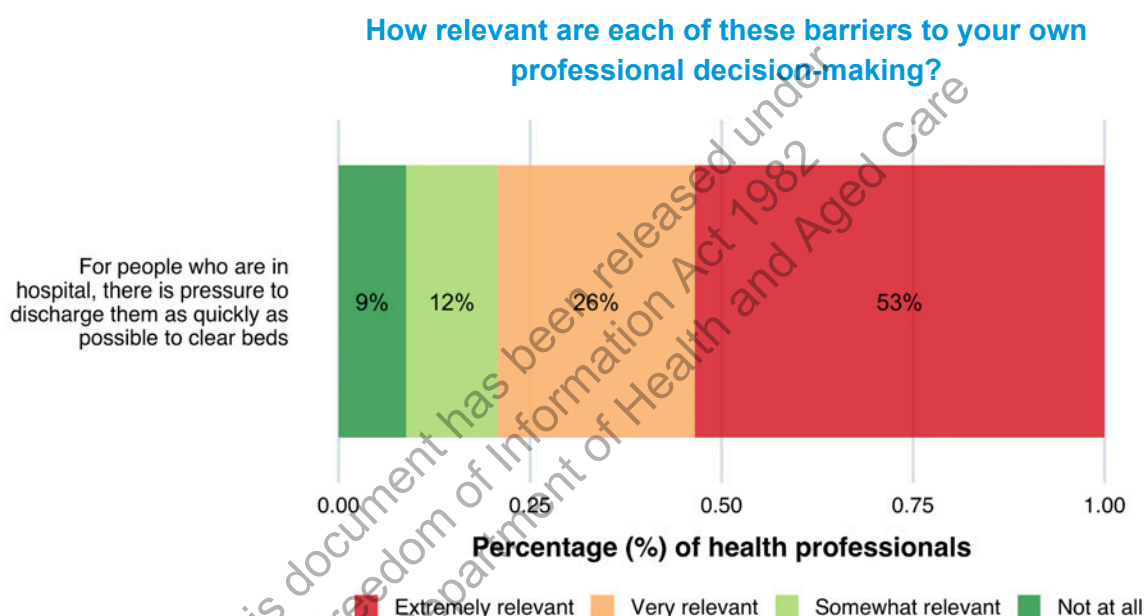
***“If I am to advocate and investigate options for a patient, it would have to be in my own (unpaid) time.”***

– GP from our survey sample

For allied health professionals, time pressures are largely felt when preparing reports to submit as evidence for NDIS applications on behalf of the younger people in their care (see [Finding #6: Health professionals are constrained by referral and application systems that are fragmented and burdensome](#)). Stakeholder representatives told us these allied health professionals have high caseloads due to workforce shortages and are also motivated to progress applications quickly to find housing and care support solutions for their clients in a

timely manner. As a result, they don't always have time to produce reports of the quality needed to secure high-value NDIS plans that fund home and living supports. We also heard these time pressures are exacerbated in rural areas because occupational therapists are extremely limited in these contexts and visiting professionals cannot provide sufficient support because they cannot bill for their travel time.

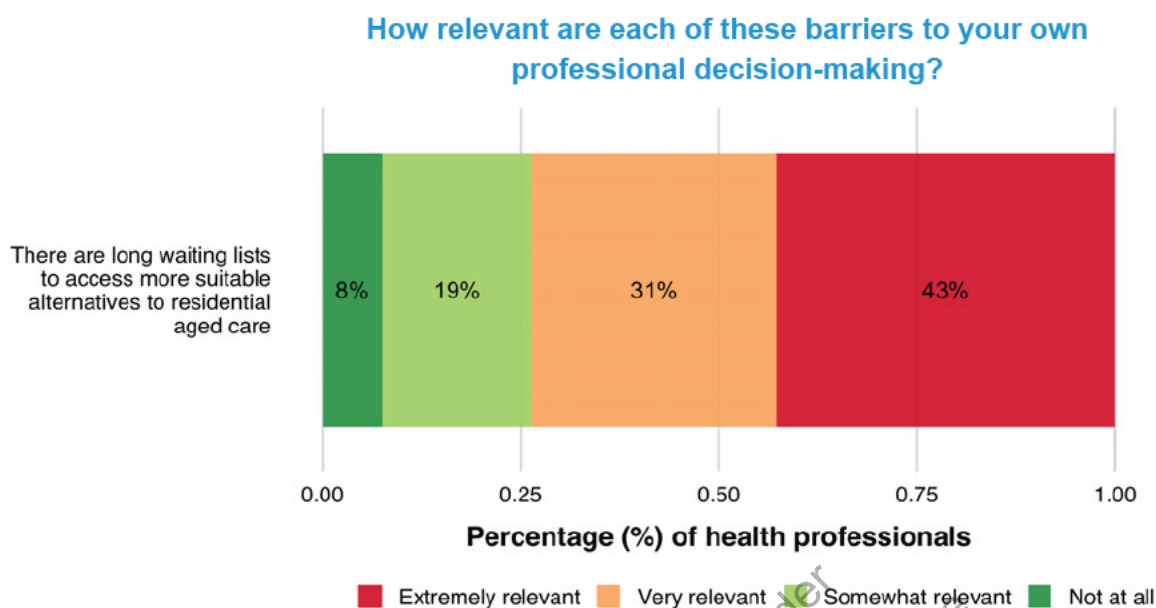
For staff working in hospitals, pressure to clear hospital beds severely limits the time available for health professionals to support younger people to explore suitable RAC alternatives. Indeed, 79% of health professionals in our survey sample indicated that the pressure to discharge people in hospital as quickly as possible to clear beds was an 'extremely' or 'very' relevant barrier to their professional decision making when considering alternatives to RAC for younger people. This barrier was rated higher than any of the other barriers we asked about in the survey (see [Appendix F](#)).



A factor compounding the impact of pressures to clear hospital beds may be the long waiting lists for suitable RAC alternatives. Seventy-four percent of health professionals in our survey sample identified long wait times as an 'extremely' or 'very' relevant barrier they face when considering RAC alternatives for younger people, with one health professional suggesting that younger people may have to wait up to a year in hospital before they are able to access a more viable housing or care support alternative. As a result, one health professional in our survey sample expressed concern that the eligibility restrictions for RAC proposed under the new Aged Care Act may have the unintended consequence of leaving younger people "waiting endlessly in hospital taking up an acute bed."

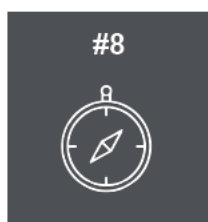
***"In an acute hospital setting... yes there [is] pressure for beds, but also very limited appropriate options for discharge."***

— Social worker from our survey sample



## Motivation factors

According to the *COM-B* model of behaviour change, **motivation** factors are a third key source of influence on an individual's behaviour (see the [Capability factors](#) and [Opportunity factors](#) sections for the other two sources). These motivation factors lie internally within the individual and encompass the range of attitudes and habits that can enable or inhibit a target behaviour.<sup>47</sup> In this section, we report the key motivation factors that influence a health professional or system administrator's decision to recommend RAC versus alternative housing and care support options.



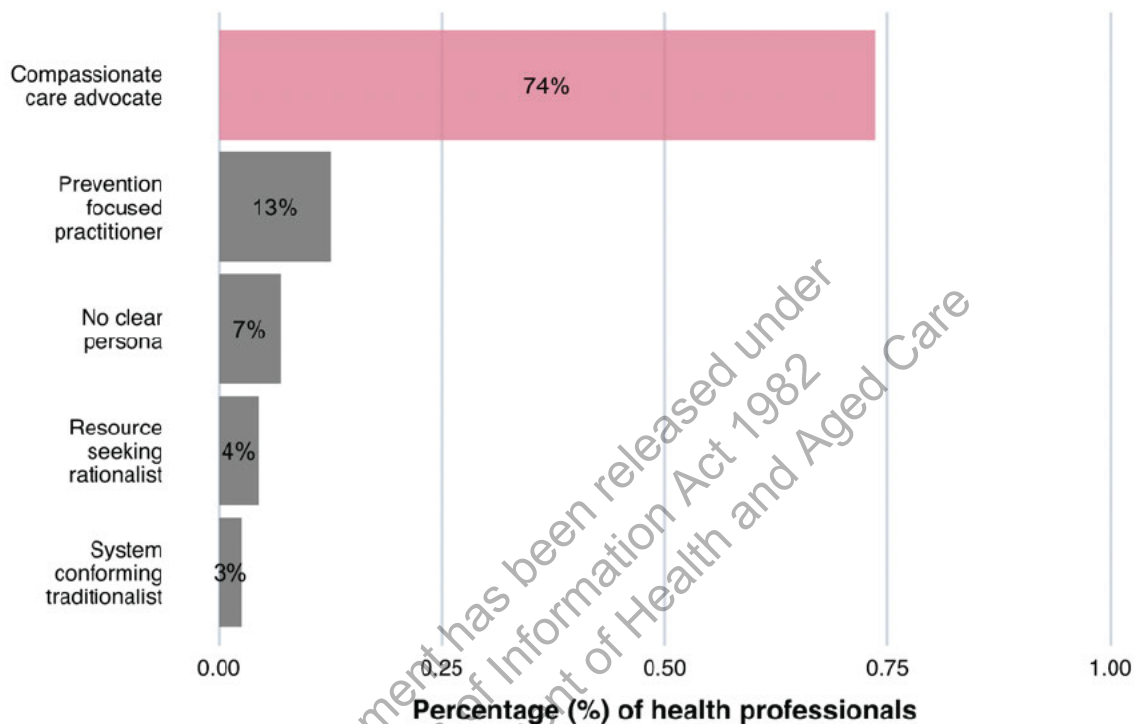
Most health professionals are driven by a motivation to provide compassionate care to younger people

As part of the survey, we looked at which of the four hypothetical personas generated by *PersonifAI* (see [Methodology](#) section) best fit each health professional in our survey sample. Health professionals were categorised as fitting into the persona they ranked the highest across questions assessing their values and motivations (see *AI-derived values, motivations, and enablers* in [Appendix D](#) for relevant survey questions).

We found that 3 in 4 health professionals in our survey sample fit into the **compassionate care advocate** persona, with the next most common being the prevention-focused

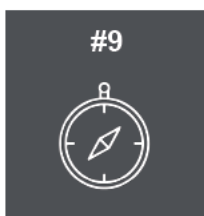
<sup>47</sup> Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science*, 6, Article 42. <https://doi.org/10.1186/1748-5908-6-42>

practitioner persona. These findings suggest that the vast majority of health professionals in our survey sample approach RAC referral or recommendation decisions for younger people with the goal of prioritising their emotional wellbeing through providing empathetic, patient-centred care. These concerns tend to take precedence over other considerations around preventive care and long-term outcomes (prevention focussed persona), evidence-based practice and practical solutions (resource seeking persona), and established processes and professional norms (system conforming persona).



*“People in this industry do it because we want to help people and get the best for people.”*

– Representative of a stakeholder organisation



**Some health professionals believe that RAC facilities will offer the best care when compared with alternatives**

Health professionals want to help younger people find the housing or living support options that will best meet their physical and psychological needs. In the words of one stakeholder representative, a health professional’s goal is “to get the right outcome for the person”, consistent with our finding that the majority of health professionals fit the persona of a compassionate care advocate (see [Finding #8: Most health professionals are driven by a](#)

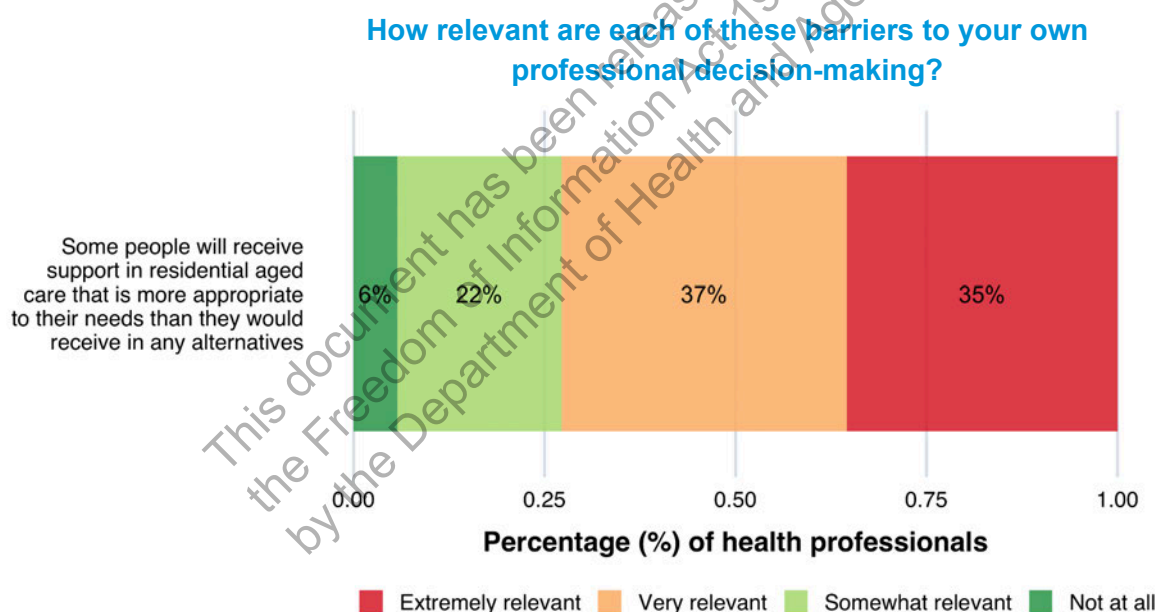


*motivation to provide compassionate care to younger people*). In some cases, health professionals will arrive at the conclusion that getting the right outcome means referring a younger person to RAC. This conclusion is underpinned by the belief that the younger person's needs will be better served in RAC than any other available alternative. This is a decision that the health professional and their team do not make lightly. As one stakeholder representative put it:

***“The decision to put a young person into residential aged care is... something that you don't really want to do and it involves huge angst amongst the care team... It might be the best of a really shocking list of alternatives.”***

– Representative of a stakeholder organisation

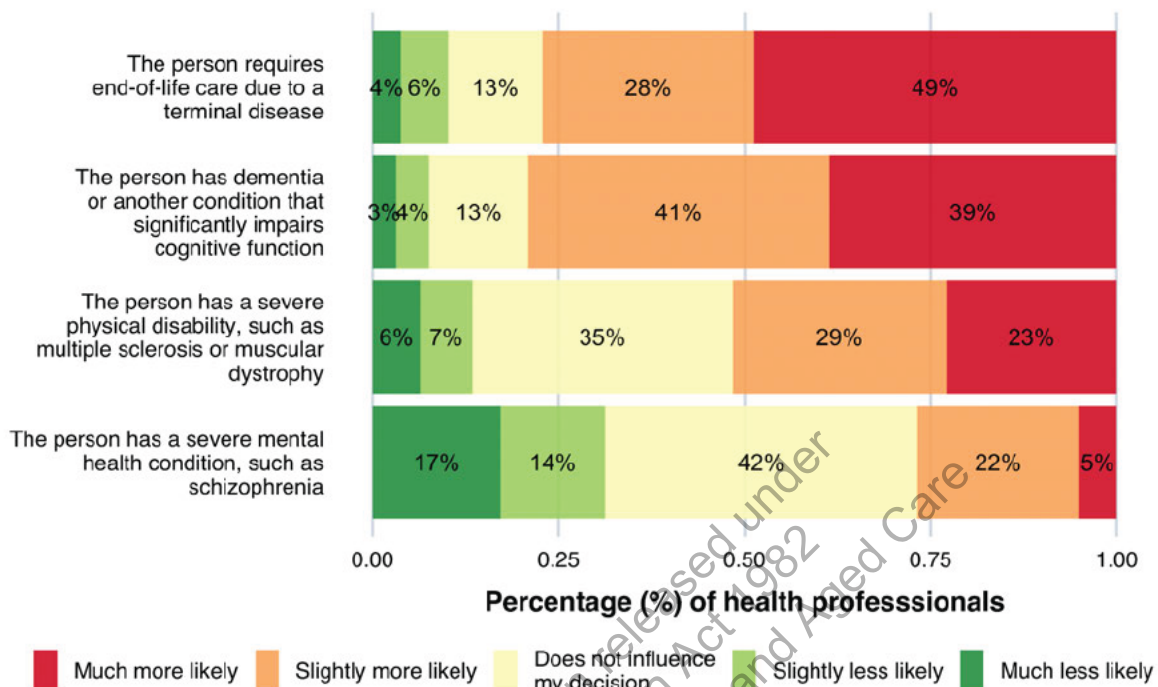
For close to 3 in 4 health professionals in our survey sample, the belief that RAC will offer the best support for at least some younger people in their care was rated as an ‘extremely’ or ‘very’ relevant barrier to them recommending other alternatives. Stakeholder representatives told us they often have concerns about whether RAC alternatives will be able to provide round-the-clock care from skilled staff and access to necessary equipment.



When asked which factors would make them ‘much more likely’ to refer a younger person to RAC, the health professionals we surveyed identified end-of-life care (due to a terminal disease) and dementia (or other significant cognitive impairment) as the top two most influential factors, selected by 49% and 39% of the sample respectively. In contrast, severe physical disabilities or mental health conditions were rated by health professionals as comparatively less likely to culminate in a referral to RAC (see [Appendix F](#)). This collection of findings is likely explained by the fact that RAC alternatives are, according to stakeholder representatives, less equipped to manage younger onset dementia and palliative care needs.



**To what extent does each of these factors make it more or less likely that you will refer a younger person to residential aged care?**



Health professionals take into account the preferences of younger people and their families, who sometimes prefer RAC over other alternatives

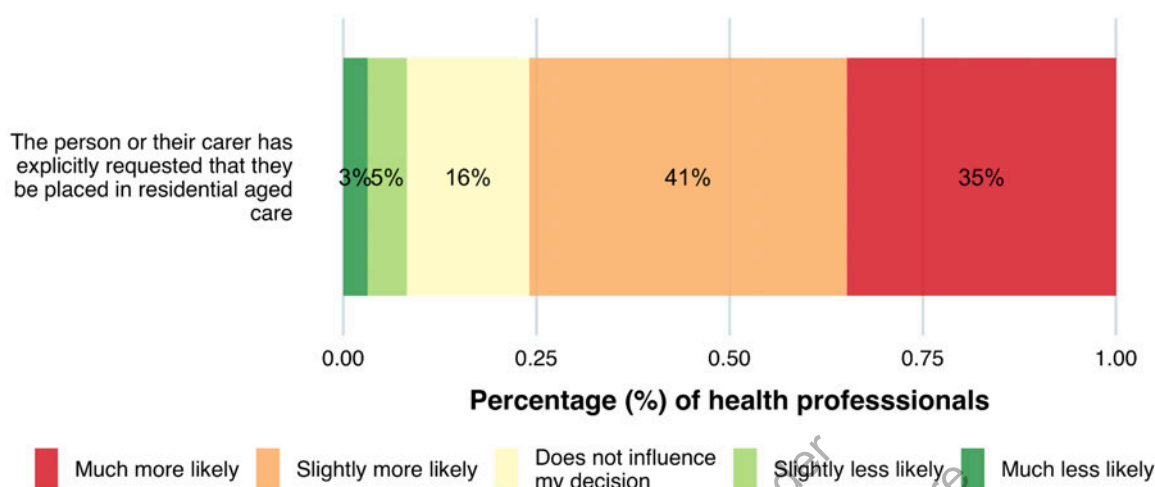
Whether a younger person is already living in RAC, or considering entering RAC for the first time, for some younger people and their families RAC is the preferred option over other housing and care support alternatives. Health professionals take the preferences of these younger people and their families seriously.

***"65 is not a magic number, and individual circumstances and preferences should be taken into account."***

— Occupational therapist from our survey sample

When asked which factors would make them 'much more likely' to refer a younger person to RAC, the health professionals we surveyed identified an explicit request for placement in RAC by the younger person or their family as among the top three most influential factors in their decision making (see [Appendix F](#)).

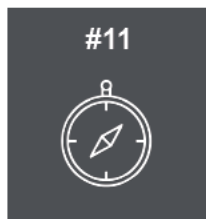
**To what extent does each of these factors make it more or less likely that you will refer a younger person to residential aged care?**



During interviews, stakeholder representatives identified a range of reasons why some younger people and their family members prefer RAC over alternative housing and care support options:

- **Living in RAC may allow the younger person to live closer to their family**, if they have family members living in the same RAC facility, or any alternative housing and care support options are located further away from where their family lives (see [Finding #4: Health professionals and system administrators are constrained by the short supply of suitable alternatives to RAC for younger people](#)).
- **Some younger people and their families believe RAC will provide better resources to support their care support needs**; a belief that is sometimes shared by health professionals (see [Finding #9: Some health professionals believe that RAC facilities will offer the best care when compared with alternatives](#)).
- **Some younger people and their families are not aware there are viable alternatives to RAC**. When they are made aware of these alternatives, they often “fear the unknown” until they can see what these housing and care support options have to offer.
- **Some younger people who are already living in RAC feel comfortable there** and moving them out would risk disrupting their sense of stability and community.
- **Some younger people and their families believe RAC will be less socially isolating** than other housing and care support options that involve living alone.

- **Some younger people and their families believe RAC will provide more privacy and independence** than other housing and care support options that involve living in shared accommodation.



Some health professionals may refer younger people to RAC through their existing networks or out of habit

Beyond reflective motivation factors that involve carefully weighing up a younger person's needs and preferences, the decision to refer a younger person to RAC can also be influenced by more automatic motivation factors such as habits and routines. For example, stakeholder representatives told us that:

- **Some health professionals have existing knowledge of and relationships with RAC facilities.** Referring younger people to a specific RAC facility is a common procedure for these health professionals. One stakeholder representative described this as “a slipstreaming process for people, often from a hospital, into a known residential aged care setting”. Such slipstreaming in hospital settings may be exacerbated by the significant pressure for hospital staff to clear beds (see [Finding #7: Health professionals face time pressures that make it difficult for them to support younger people to identify and access suitable alternatives to RAC](#)).
- **Some health professionals may overlook options for disability-specific housing and care support options because they work within the health sector.** As one stakeholder representative put it, some health professionals “view disability through a more medical model and [may say] that nursing care is what’s needed because of [their] health conditions”.
- **Some health professionals associate dementia with RAC.** As dementia is far more prevalent in older people than in younger people, staff who are specially trained to manage dementia are far more likely to be found in RAC settings. When presented with a younger person with dementia, health professionals like gerontologists and neurologists may therefore habitually make the same referral to RAC they would make for a person aged over 65 with dementia.

*“If you’ve got dementia, you’re often involved with a clinician or may be in a hospital that has practices of referring people to aged care... that’s the path that most older people go. So if someone is a bit out of the box and they’re younger, it’s the diagnosis or the circumstances that will trigger a decision... you end up down the path that other people with dementia tread.”*

– Representative of the s47E(d)

#12



Stakeholders support the rationale behind the YPIRAC targets, but are concerned about feasibility, sustainability, and unintended consequences

When asked how they feel about the YPIRAC targets, stakeholder representatives expressed their endorsement of the underlying rationale that younger people should not be living in RAC. As one stakeholder representative put it:

*“Absolutely it is not the right environment for a young person to be living in residential aged care... [These facilities] are particularly tailored to the care of older people... So I can only support those targets wholeheartedly.”*

– Representative of a stakeholder organisation

One stakeholder representative also suggested the YPIRAC targets have played a key role in driving down the number of younger people entering RAC (see [Appendix B](#) for statistical trends). That said, another stakeholder representative was sceptical of this view, as they called into question the validity of the publicly available data that is used to evaluate how the nation is tracking in relation to the targets. They felt the published figures were misleading because repeat entries are only counted as one entry and a large proportion of exits are due to dying, ageing out, or being diverted into another equally unappealing facility or program.

Despite largely positive sentiments toward the rationale behind the YPIRAC targets, stakeholder representatives expressed concern about the feasibility of achieving them. As one stakeholder representative commented, “targets are important, but they need to be achievable and accompanied by support for all parties involved.” Along similar lines, another stakeholder representative commented that “I think they have set the target, before they have set the answer,” implying that the targets focus on *what* needs to be achieved without providing any guidance about *how* to achieve it. Specifically, we heard that the 2025 target seems unrealistic given:

- **There are a lack of suitable housing and care support alternatives to RAC available to younger people** (see [Finding #4](#): *Health professionals and system administrators are constrained by the short supply of suitable alternatives to RAC for younger people*).
- **Some younger people living in RAC do not have a goal to move** (see [Finding #10](#): *Health professionals take into account the preferences of younger people and their families, who sometimes prefer RAC over other alternatives*).



- **There are competing time demands on RAC staff who are busy meeting other legislative and regulatory requirements**, such as mandatory Quality Indicators.<sup>48</sup>

*“At the moment we don’t have the scaffolding... that’s the worry about these targets.”*

– Representative of a stakeholder organisation

One stakeholder representative also noted the importance of continuing to drive the YPIRAC issue once the 1 January 2025 deadline passes. They argued in favour of “another 10 year strategy” to ensure younger people don’t simply return to RAC once the issue is no longer a Government priority.

Beyond feasibility and sustainability considerations, some stakeholder representatives raised concerns about unintended consequences of the YPRIAC targets. For example, a representative from s47E(d) highlighted the risk of people with younger onset dementia getting stuck in hospital due to being blocked from entering RAC and having no other suitable alternative accommodation options available to meet their care support needs. Moreover, there was concern among some stakeholder representatives that the upcoming legislative exemptions for people aged 50 to 64 who are either Aboriginal and Torres Strait Islander persons or persons experiencing homelessness will “institutionalise a right of entry into residential aged care” for these cohorts. These stakeholder representatives were concerned that such a “right of entry” sends the message that it is preferable for people in these cohorts to end up in RAC. Such a message would place these younger people at risk of being referred to or left behind in RAC even when there are other more suitable options available, simply because these alternatives are never explored. In contrast to these views, a representative from the s47E(d) felt that using age 50 (rather than 65) as the benchmark for Aboriginal and Torres Strait Islander peoples seemed appropriate in that it goes some way to acknowledging the health and life expectancy disparities faced by this cohort.

<sup>48</sup> The Quality Indicators are explained here: Australian Government Department of Health and Aged Care. (2024). [National aged care mandatory quality indicator program \(QI program\)](#).

## Recommendations

In this section of the report, we present the key recommendations emerging from our research findings. These recommendations are summarised and indexed for quick reference below:

#	Recommendation
<b>A</b>	Co-design a consolidated decision tool that will help health professionals identify suitable RAC alternatives for younger people
<b>B</b>	Empower staff in system navigation, coordination, and liaison roles with the resources they need to be experts in traversing the health, disability, and aged care systems
<b>C</b>	Train health professionals to identify trigger points for early intervention, to help younger people plan for their future housing and support needs before it's too late
<b>D</b>	Educate GPs and allied health professionals about how to claim for time spent exploring suitable alternatives to RAC with younger people
<b>E</b>	Provide clear guidance to stakeholders about how they can best support the YPIRAC targets now and beyond the 1 January 2025 deadline

In line with DoHAC's plan to develop and disseminate training and education materials for health professionals and system administrators, we have focussed our recommendations on potential **training and education opportunities and channels** to support health professionals and system administrators to make the most age-appropriate housing and care support decisions and recommendations for younger people. Each recommendation is accompanied by implementation guidance, which we have infused with insights from behavioural science where appropriate.

### Recommendation A

Co-design a consolidated decision tool that will help health professionals identify suitable RAC alternatives for younger people

**This recommendation addresses the finding that** many health professionals lack sufficient knowledge of suitable alternatives to RAC for younger people. This is in part driven by the lack of supply of such alternatives. Where suitable alternatives are available, they are distributed across different government programs and jurisdictions throughout Australia. Fragmentation in the naming conventions, eligibility criteria, and funding pathways across these alternatives to RAC means that identifying and comparing suitable options for younger people can be extremely challenging for health professionals.

**This recommendation aims to address these challenges by** providing health professionals with a decision tool for exploring the housing and care support options available to younger people. This decision tool would provide health professionals with a



consolidated inventory of all housing and care support options available to younger people in Australia, guide them to narrow down the most suitable options for a given younger person in their care, and present next steps for assisting the younger person to access these options.

**This recommendation would involve** designing a decision tool with the following functionality requirements:

- A database that sits at the ‘backend’.** This database would comprise a consolidated inventory of all housing and care support options available to younger people in Australia with disability or high care support needs. The database would include specialised housing options as well as options for accessing support at home. It would encompass all such options available across different jurisdictions and government programs, and cover both the health and disability systems. Providers would be regularly prompted to provide updates about the current eligibility criteria, availability, and estimated wait times for the facilities they provide. Any such updates would be automatically fed into the database, allowing it to be dynamically updated with the most current information.
- A user-interface that sits at the ‘frontend’.** Because the database sits at the backend of the decision tool, health professionals would not interact directly with the database itself. Rather, they would interact with it indirectly via a user-friendly interface that would enable the health professional to easily search the contents of the database to identify the most suitable housing and care support options for a given younger person in their care. The user-interface would comprise a series of screens that request inputs from the health professional, such as the younger person’s postcode, care support needs, and how far away they would be willing to live from their current location. Based on these inputs, the health professional would be shown a shortlist of the housing and care support options within the specified geographical radius that would meet the younger person’s needs. Each item in the shortlist would include the name of the program through which the option is funded, what care supports are on offer, current availability and wait times, eligibility criteria for access, how many people would be sharing the accommodation, and which areas of the home would be shared versus private. From there, the health professional could click a given option to read a list of next steps for assisting the younger person to access this option (e.g., providing the name and referral details of a skilled system navigator who can work directly with the younger person; see [Recommendation B](#)).

**When implementing this recommendation, DoHAC should:**



How

#### Conduct an audit of RAC alternatives for younger people

- Ensure the audit includes RAC alternatives administered by state and federal government programs across the health and disability systems.* This will enable DoHAC to build a consolidated database of the available housing and care support options for younger people.
- Use the audit to identify key service and funding gaps across different regions.* Identifying gaps in the supply of RAC alternatives will enable DoHAC to plan ways

to better resource underserved regions, promoting equity of access to RAC alternatives.

#### **Co-design the decision tool with stakeholders and health professionals**

- *Ensure co-design includes a diverse range of voices.* Co-design will ensure the decision tool is fit for purpose, thereby increasing user buy-in. Include representatives from different health professional cohorts (GPs, nurses, allied health professionals, medical specialists), members of the YPIRAC Stakeholder Reference Group, and representatives of state and federal government departments and agencies across the health, disability, and aged care.
- *Recruit health professionals who embody the compassionate care advocate persona.* This cohort will be best placed to ensure the decision tool produces information that will aid health professionals in incorporating patient preferences into the decision process.

#### **Collaborate with stakeholders to promote the decision tool across multiple channels**

- *Embed the decision tool in existing practice tools used by health professionals.* Integration with familiar tools, such as HealthPathways for GPs, will enhance adoption by leveraging existing habits and reducing the cognitive load of learning a new system.
- *Leverage the messenger effect by promoting the decision tool through trusted organisations across the health, disability, and aged care systems.* This could include PHNs, peak professional bodies, and state and federal government departments.
- *Highlight the benefits of the decision tool for improving patient care outcomes.* Such tailoring of promotion materials will directly appeal to the values and motivations of the compassionate care advocate persona.

## **Recommendation B**

Empower staff in system navigation, coordination, and liaison roles with the resources they need to be experts in traversing the health, disability, and aged care systems

**This recommendation addresses the finding that** health professionals have difficulty supporting younger people and their families to navigate the referral and application pathways required to access the most suitable housing and care support options and funding. These navigation challenges arise because health professionals who provide care to younger people often do not operate across health, disability, and aged care systems, but instead operate within a single system. In contrast, roles such as AFA system coordinators, NDIS support coordinators, NDIS health liaison officers, NDIS accommodation officers, and social workers can provide the necessary system navigation support, but there is often not enough such staff.


**This recommendation aims to address these challenges by** ensuring health professionals are supported by a well resourced workforce of system navigators, coordinators, and liaisons who have specialised expertise in supporting younger people to

identify and access alternatives to RAC. Specifically, this recommendation aims to empower these system navigators, coordinators, and liaisons by ensuring their workforce is appropriately staffed to meet demand, and equipped with any training and educational materials they need to navigate the complexities of the health and disability systems.

**This recommendation would involve** assessing the current availability and distribution of staff in system navigation, coordination, and liaison roles, filling any workforce gaps, and designing and delivering training and educational materials to help them provide effective system navigation support to younger people living in or at risk of entering RAC. Topics the training and educational materials should focus on include:

- **Effectively navigating the landscape of funding and service options across the health, disability, and aged care systems at both a federal and state level.** This could be supported by the decision tool recommended under [Recommendation A](#).
- **Funding and service options for younger people with dementia or palliative care needs.**
- **Working with hospital staff to identify funding and service options for younger people at the point of hospital discharge.**
- **Working with Aboriginal and Torres Strait Islander health workers and health practitioners to explore culturally appropriate funding and service options for Aboriginal and Torres Strait Islander peoples.**
- **Building trusted relationships with younger people who are already living in RAC who may be wary of visiting professionals.**

**When implementing this recommendation, DoHAC should:**

 How	<p><b>Make the training and educational materials appealing</b></p> <ul style="list-style-type: none"> <li>• <i>Co-design the materials with experienced system navigators, coordinators, and liaisons.</i> This will ensure the training and educational materials are tailored to real-world challenges, thereby enhancing engagement and ensuring these resources are impactful.</li> <li>• <i>Use patient-centred language.</i> Training that emphasises opportunities and strategies for maximising patient autonomy and empathy is likely to resonate well with the compassionate care persona.</li> <li>• <i>Recognise system navigators, coordinators, and liaisons who complete training modules and apply new skills.</i> These staff are likely to be intrinsically motivated to engage in professional development, which can be further reinforced through formal praise and recognition for achieving professional development milestones.</li> </ul>
	<p><b>Review the size and distribution of the workforce of system navigators, coordinators, and liaisons</b></p>



- *Assess the current number and caseloads of system navigators, coordinators, and liaisons.* Ensure they align with best-practice standards for manageable workloads. This assessment will help identify gaps and areas needing additional resources or funding.
- *Assess the geographic distribution of system navigators, coordinators, and liaisons.* Ensure adequate staffing in rural and regional areas by addressing any geographic disparities to ensure all younger people, regardless of location, have access to appropriate support.
- *Consider how a specialist navigator role could be used to support younger people at risk of entering RAC.* The new 'navigator' roles recommended by the NDIS review panel following the 2023 NDIS review<sup>49</sup> present an opportunity to provide younger people with additional dedicated support for accessing funding and services to meet their housing and care support needs. To this end, DoHAC could advocate for the remit of 'navigators' to include providing specialised support for younger people to access suitable RAC alternatives. DoHAC should consider ways this navigator role could fill current gaps or shortages in service delivery for younger people.

## Recommendation C

Train health professionals to identify trigger points for early intervention, to help younger people plan for their future housing and support needs before it's too late

**This recommendation addresses the finding that** health professionals have limited ability to explore a wide range of RAC alternatives when under pressure to make referrals or recommendations for a younger person in urgent need of complex or specialised care. Under these circumstances, health professionals may be more likely to default to referring younger people to RAC out of habit, or may even be forced to rule out otherwise suitable RAC alternatives due to long waiting lists.

**This recommendation aims to address these challenges by** training health professionals to identify timely opportunities for early intervention to support younger people and their families to engage in effective early planning around their future housing and care support needs. Engaging in early planning will give younger people time to explore a wider range of RAC alternatives and mitigate the risk of younger people entering RAC due to waiting until they need immediate complex or specialised care.

**This recommendation would involve** developing training and educational materials that help health professionals identify when and how to effectively support younger people to plan in advance for their future housing and care support needs. Younger people are likely to have contact with health professionals before their condition progresses to the point of needing highly supervised or specialised care. For example, younger people may have contact with GPs when they first develop symptoms of a long-term degenerative condition, or with occupational therapists when assessing what accessibility modifications should be made to

<sup>49</sup> Independent Review into the National Disability Insurance Scheme. (2023). [Finding your way around with help from a navigator.](#)

their existing home. Health professionals involved at these early points of contact with younger people should be provided with training on key signs, symptoms, or milestones that signal an opportunity for early intervention (e.g., when symptoms of a degenerative condition are first identified). These health professionals should also be trained in how to approach the topic of future housing and care needs in a constructive and compassionate manner once a trigger point is identified. Through early intervention, health professionals could support younger people by:

- **Helping younger people develop clear and concrete plans for how they will meet their future housing and care support needs.**
- **Connecting them to appropriate services such as system navigators, coordinators, and liaisons (see [Recommendation B](#)).**

**When implementing this recommendation, DoHAC should:**



How

#### **Work with PHNs and peak professional bodies to co-design and disseminate early intervention training and educational materials**

- *Map pathways to RAC for younger people with different disabilities and medical conditions.* Use journey mapping to highlight points of contact with health professionals, and identify key moments of change that could be opportunities for early intervention. Prioritise long-term degenerative conditions and other conditions where early planning can significantly impact outcomes.
- *Tell health professionals what the trigger points are, and provide concrete steps they can take to engage in early intervention when a trigger is identified.* Include tailored directions for specific disabilities and medical conditions, outlining key moments of change chronologically based on the journey map for the condition.
- *Incorporate discussion prompts and motivational interviewing techniques that help health professionals initiate empathetic conversations with younger people about future housing and care support needs.* Tailoring discussion prompts and motivational interviewing techniques in this way may appeal to health professionals who resonate with the compassionate care persona.
- *Disseminate training and educational materials through PHNs and peak professional bodies.* This will leverage the messenger effect, whereby information from trusted sources is more likely to be accepted by the audience.

#### **Reduce friction costs by embedding early intervention resources into existing workflows**

- *Include prompts in existing clinical resources to remind or notify health professionals of potential trigger points.* For example, prompts could be embedded in assessment tools for relevant health conditions, or in the online referral form or GP e-referral for My Aged Care (see [Background: My Aged Care referral options for health professionals](#)).
- *Integrate early intervention educational materials into HealthPathways or equivalent care planning systems.* Such integration will make it easier for health professionals to access guidance around what to do next once they encounter a trigger.



## Recommendation D


Educate GPs and allied health professionals about how to claim for time spent exploring suitable alternatives to RAC with younger people

**This recommendation addresses the finding that** health professionals can perceive exploring suitable RAC alternatives with younger people as non-billable work, leading to the perception that they do not have the capacity to provide this type of support during work hours.

**This recommendation aims to address these challenges by** ensuring GPs and allied health professionals are aware of MBS item numbers that can be used to bill for time spent exploring suitable RAC alternatives with younger people. Ensuring these health professionals are aware that exploring suitable RAC alternatives is a billable Medicare service will help reduce perceived time barriers for providing this type of support to younger people.

**This recommendation would involve** educating GPs and allied health professionals about which MBS items are relevant when supporting younger people to explore housing and care support options, detailing the specific activities these items cover, and providing common use cases for these items. Where appropriate, new MBS items should be introduced to address gaps and ensure comprehensive support for special populations that are overrepresented among younger people in RAC.

**When implementing this recommendation, DoHAC should:**

 How	<b>Conduct an audit of existing MBS items</b> <ul style="list-style-type: none"> <li>• <i>Leverage the principle of co-design.</i> Consult with GPs and allied health professionals who have experience working with younger people to identify which MBS items they currently use, and any gaps that make it difficult to bill their time.</li> <li>• <i>Explore the possibility of introducing new MBS items where necessary to address gaps.</i> DoHAC could especially focus on addressing gaps involved in working with vulnerable cohorts such as Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse individuals, and people in rural and regional areas.</li> </ul>
	<b>Develop a comprehensive summary resource of MBS items</b> <ul style="list-style-type: none"> <li>• <i>Create a clear and concise document for GPs and allied health professionals that details all MBS items relevant to case management for younger people living in or at risk of entering RAC.</i> This resource should include the types of activities each item covers and provide common use cases. By offering clear examples, health professionals can easily understand how to apply these item numbers in their practice.</li> <li>• <i>Apply the behavioural principles of salience and simplicity.</i> Ensure the comprehensive summary resource is visually appealing and easy to navigate.</li> </ul>
	<b>Disseminate the summary resource through trusted organisations and systems</b>

- *Capitalise on the messenger effect by distributing the resource through PHNs and peak professional bodies.* Information from trusted sources is more likely to be accepted, maximising uptake of the resource.
- *Work with PHNs to integrate the resource into HealthPathways.* This will capitalise on the existing habits of GPs, who already engage with HealthPathways regularly.

## Recommendation E

Provide clear guidance to stakeholders about how they can best support the YPIRAC targets now and beyond the 1 January 2025 deadline

**This recommendation addresses the finding that** despite consistent endorsement of the rationale behind the YPIRAC initiative, stakeholders felt uncertain about how the YPIRAC targets would be achieved given the various barriers at play, and concerned about what will happen beyond the 1 January 2025 deadline.

**This recommendation aims to address these challenges by** implementing a clearer communication approach that allows stakeholders to be more active participants in meeting the YPIRAC targets.

**This recommendation would involve** developing and disseminating clear and solution-focused guidance to stakeholders on DoHAC's strategy for meeting the YPIRAC targets by 1 January 2025. This guidance would focus on concrete actions stakeholders can take to support health professionals to overcome the capability, opportunity, and motivation barriers identified in this report. The guidance should also explain how DoHAC is mitigating the risk of any unintended consequences of the YPIRAC targets and upcoming Aged Care Act, and how the department plans to continue with the YPIRAC initiative after the 1 January 2025 deadline.

**When implementing this recommendation, DoHAC should:**



How

### Increase understanding of, and buy-in for, DoHAC's YPIRAC strategy

- *Highlight success stories.* Showcasing successful case studies of, and testimonials from, younger people who have been successfully transitioned into age-appropriate housing should resonate with the compassionate care advocate persona.
- *Tailor messaging to different stakeholder groups.* People are more likely to engage with messages that are personalised to their needs. Guidance should therefore be tailored to help stakeholders overcome the specific capability, opportunity, and motivation barriers that are most relevant to their organisation.
- *Encourage stakeholders to make public commitments.* Public commitments act as commitment devices, which are behavioural strategies to lock oneself into following through with a plan. Public commitments further increase accountability and follow-through, since people are more likely to act consistently with their commitments when these are made in a public setting.

**Continue DoHAC's policy of transparency around the YPIRAC targets**

- *Create regular feedback loops with stakeholders.* Host interactive workshops and focus groups where stakeholders can voice concerns and contribute ideas for the YPIRAC GEN Aged Care dashboard. This co-design approach will help foster a sense of ownership over the initiative's goals and outcomes.

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the Freedom of Information Act 1982  
by the Department of Health and Aged Care

## Conclusion

In this project, we identified a series of capability, motivation, and opportunity factors that influence health professionals and system administrators who make decisions about whether younger people enter or exit RAC. The capability and motivation factors we identified in this project are amenable to intervention through training and education initiatives. Hence, these factors formed the basis of our Recommendations. However, we emphasise that the opportunity factors we identified in this project loomed large for many stakeholders we spoke to. Addressing these opportunity factors will require deeper structural reforms beyond training and education initiatives. Key structural reforms would include addressing the:

- **Short supply of suitable alternatives to RAC for younger people** (see [Finding #4](#)).
- **Narrow eligibility criteria, small funding packages, and stringent reporting standards when seeking funding for RAC alternatives** (see [Findings #5](#) and [#6](#)).
- **Undersupply of hospital beds, which pressures hospital staff to discharge patients to RAC when waiting lists for alternatives are too long** (see [Finding #7](#)).

Without addressing these opportunity barriers, the provision of training and education materials alone is unlikely to result in the achievement of the YPIRAC targets.

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## Appendix A: Aged Care legislation

In Australia, the **Aged Care Act 1997** is the primary law under which government funded aged care currently operates.<sup>50</sup> Based on Recommendation 1 of the Royal Commission into Aged Care Quality and Safety final report,<sup>51</sup> the Australian Government has committed to replacing this legislation – as well as the *Aged Care (Transitional Provisions) Act 1997* and *Aged Care Quality and Safety Commission Act 2018* – with a **new Aged Care Act**.<sup>52</sup> An exposure draft of the Aged Care Bill was published in December 2023 (and last updated in March 2024) following extensive public consultation. While initially planned for commencement on 1 July 2024, subject to parliamentary processes the Australian Government has agreed to defer the commencement date of the new Aged Care Act to 1 July 2025.

Under the current aged care legislation, the **Approval of Care Recipients Principles 2014** states that:<sup>53</sup>

A person is eligible to receive residential care only if:

(a) the person is assessed as:

- (i) having a condition of frailty or disability requiring continuing personal care; and
- (ii) being incapable of living in the community without support; and

**(b) for a person who is not an aged person—there are no other care facilities or care services more appropriate to meet the person's needs.**

For younger people aged under 65, Aboriginal and Torres Strait Islander people aged under 50, and people who are experiencing homelessness or at risk of becoming homeless who are aged under 50, the *Approval of Care Recipients Principles 2014* additionally states that:

(2) The application must be accompanied by one of the following:

- (a) an Exploration of Home & Living Supports for NDIS Participants Form completed for the person by the National Disability Insurance Agency;
- (b) a Summary Report: Younger People at Risk of Entering Residential Aged Care completed for the person by Ability First Australia.

(3) However, the documentation mentioned in subsection (2) is not required if the application is:

- (a) in relation to the provision of respite care; and
- (b) made on the basis that the person urgently needed the care when it started and it was not practicable to apply for approval beforehand.

<sup>50</sup> Australian Government Department of Health and Aged Care. (1997). [Aged Care Act 1997](#); Australian Government Department of Health and Aged. (2024). [Aged care laws in Australia](#).

<sup>51</sup> Royal Commission into Aged Care Quality and Safety. (2021). [Final report: Care, dignity and respect](#).

<sup>52</sup> Australian Government Department of Health and Aged. (2024). [About the new Aged Care Act](#).

<sup>53</sup> Australian Government Department of Health and Aged Care. (2014). [Approval of care recipients principles 2014](#).



This means under the current legislation, younger people are eligible for RAC if there are no other care facilities or care services that are more appropriate to meet the person's needs, as assessed by an ACAT delegate and evidenced by an *Exploration of Home and Living Supports* form (for NDIS participants) or *AFA Summary Report: Younger People at Risk of Entering Residential Aged Care* (for non-NDIS participants). In short, aged care services are currently used as a last resort for younger people.<sup>54</sup>

Under the new legislation, younger people aged under 65 will be ineligible for access to Commonwealth funded aged care (i.e., aged care services funded through My Aged Care, including RAC), with exceptions made for people aged 50 to 64 who are either Aboriginal and Torres Strait Islander persons or persons experiencing homelessness.<sup>55</sup> Younger people with disabilities or high care support needs will instead be supported to seek more age-appropriate alternatives. Those younger people who are already living in RAC will be able to exercise their choice to remain in RAC if they should prefer.

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the Freedom of Information Act 1982  
by the Department of Health and Aged Care

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<sup>54</sup> Australian Government Department of Health and Aged Care. (2023). [Principles and guidelines for a younger person's access to Commonwealth funded aged care services](#).

<sup>55</sup> Australian Government Department of Health and Aged Care. (2023). [Who will be able to access aged care under the draft new Aged Care Act](#).

## Appendix B: GEN Aged Care Data on YPIRAC targets

Data in this section were summarised from the Australian Institute of Health and Welfare GEN Aged Care Data on younger people in RAC.<sup>56</sup> The below table shows the number of younger people in RAC across 2019-2023 and the number of younger people who entered or exited RAC in each of these years.

Year	Entered*	Exited**	% Exited due to...				Total in RAC at 31 Dec****	
			Return to family or home	Death	Hospital	Other***	Excluding First Nations people aged 50-64	First Nations people aged 50-64
2019	1,635	1,121	11.69%	78.23%	4.64%	5.44%	4,903	367
2020	987	1,004	17.83%	71.12%	2.99%	8.07%	3,953	377
2021	658	773	15.39%	71.93%	2.98%	9.70%	3,085	345
2022	387	742	17.65%	64.29%	2.43%	15.63%	2,131	291
2023	293	538	18.77%	61.52%	1.86%	17.84%	1,470	246

\*Number of first admissions for people under the age of 65 to permanent RAC (including Aboriginal and Torres Strait Islander people aged 50-64).

\*\*Number of exits of people under the age of 65 from permanent RAC (including Aboriginal and Torres Strait Islander people aged 50-64; does not include transfers between facilities). YPIRAC who 'age out' of the cohort are not counted as 'exits'.

\*\*\*The Australia institute of Health and Welfare does not have visibility of what precisely 'Other' includes.

\*\*\*\*Number of people under the age of 65 living in permanent RAC at 31 December.

<sup>56</sup> Australian Institute of Health and Welfare. (2023, December). [GEN Aged care data: Younger people in residential aged care.](#)

# Appendix C: Interviews with stakeholder representatives

## Using this interview guide

This guide is for a semi-structured interview. Interviewers do not need to ask every question and are free to adapt the probes to capture the unique experiences and expertise of each stakeholder representative.

Interviewers are to:

- Read any *context-setting text in italics*
- Ask **key questions in bold**
- Use the probes listed in bullet points as needed, or generate new probes

Research question Do not ask these	Interview question Ask the participant these
<b>[NA]</b>  <b>Warm up</b>	<b>To get us warmed up, tell me a bit about your organisation?</b> <ul style="list-style-type: none"> <li>• How would you describe the purpose of the organisation?</li> <li>• How many members are there?</li> <li>• Where are they located?</li> </ul>
<b>[RQ3]</b>  <b>What influence do stakeholders have over younger people's housing or care support decisions, and over the health professionals who support these younger people?</b>	<i>During this interview, I will use the term 'younger people' to refer to people under the age of 65.</i>  <b>How does your organisation influence younger people's entry into residential aged care?</b>

**[RQ1]**

**What do stakeholders know, and how do they feel, about the YPIRAC targets and corresponding legislative changes?**

*As you may know, following the Royal Commission into Aged Care Quality and Safety final report, the Australian Government committed to a number of targets regarding Younger People in Residential Aged Care.*

**Can you share your understanding of these targets?**

*If needed, clarify the targets:*

*No one <65 entering RAC from 1 Jan 2022.*

*No one <45 living in RAC from 1 Jan 2022.*

*No one <65 living in RAC from 1 Jan 2025.*

*For Aboriginal and Torres Strait Islander people, and people experiencing homelessness, the threshold is age 50.*

**What do you think about these targets?**

- Do you think they're realistic?
- Do you foresee any challenges?

**[RQ2]**

**What types of health professionals do younger people interact with when making housing or care support decisions?**

*When being assessed for entry into Residential Aged Care, we understand that people pass through a common pathway via My Aged Care. Along this pathway, they come into contact with various health professionals.*

**Who are some of those health professionals?**

- Where in the pathway is that contact taking place?

**In that pathway, where does your organisation come in?**

**Which steps in the pathway do you think are the best targets for intervention in preventing younger people from entering residential aged care?**

- Why?
- Which health professionals are involved in this step?

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[RQ4]

**What capability, motivation, and opportunity factors are contributing to younger people entering or remaining in residential aged care?**

*Now let's focus on the factors that contribute to younger people entering residential aged care for the first time.*

**What are the most common reasons that younger people enter residential aged care?**

- What are the common circumstances of younger people who enter residential aged care?
- Why do you think some health professionals recommend residential aged care to younger people?

**In an ideal world, what would health professionals do when confronted with a younger person considering entering residential aged care?**

- What barriers are currently preventing health professionals from performing these behaviours?

**What alternatives to residential aged care are you aware of for younger people?**

- To what extent do you think health professionals are aware of these alternatives?
- What barriers prevent health professionals from referring younger people to these alternatives?

*We're now going to focus briefly on younger people who are already living in residential aged care.*

**In an ideal world, what would health professionals do when confronted with a younger person already living in residential aged care?**

- What barriers are currently preventing health professionals from performing these behaviours?

**In your experience, what are the reasons that younger people choose to remain in residential aged care?**

- What barriers are they likely to face when making a decision about leaving?

[RQ3 cont.]

**What influence do stakeholders have over younger people's housing or care support decisions and over the health professionals who support these younger people?**

Finally, let's discuss any opportunities that exist to support health professionals in recommending age-appropriate alternatives to residential aged care.

**How could health professionals better support younger people and their families to make age-appropriate decisions about residential aged care?**

**What do you think would best support health professionals to make age-appropriate referrals for younger people at risk of entering residential aged care?**



[NA]

Wrap up and close

*We are almost at time now.*

**Before I end the interview, is there anything further you would like to add?**

**What questions do you have for us?**

*Thank you again for taking the time to speak with us today.*

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## Appendix D: Survey of health professionals and system administrators

### Welcome and consent

Thank you for taking part in our survey about younger people in residential aged care.

Please read the below, then click the "Next Page" button to continue to the survey.

[Click here for a downloadable copy of this information](#)

### What does participation in this research involve?

We are surveying Australian health professionals to understand factors that influence their decision to refer younger people aged under 65 into residential aged care or other more suitable alternatives.

This survey will take no more than 15mins.

### What is the purpose of this research?

This research is funded by the Australian Government Department of Health and Aged Care (DoHAC), and is being carried out by The Behavioural Insights Team.

This research will inform future training and communication materials developed by DoHAC for health professionals. These materials will support the national target of no people under the age of 65 living in residential aged care by 1 January 2025.

### How will my data be used?

Your responses will be completely anonymous.

Aggregated survey findings will be presented to DoHAC in the form of a research report. This report will be shared internally within DoHAC, and with the Younger People in Residential Aged Care (YPIRAC) Joint Agency Taskforce and Stakeholder Reference Group.

### Do I have to take part in this research?

You don't have to do this survey if you don't want to. You may also skip any questions or close the survey at any time.

Once you have completed and submitted the survey, you will not be able to withdraw your responses.

[Click here for a downloadable copy of this information](#)

## Screenener questions

### Age and Consent

1. I am over 18 and consent to participate in this research

- Yes (click the 'Next Page' button below)
- No (close this tab)

2. Do you currently work as a health professional in Australia, or have you done so in the last 12 months?<sup>57</sup>

- Yes
- No

3. In your role as a health professional, do you or could you make decisions, referrals, or recommendations that influence whether people aged under 65 enter or exit residential aged care?<sup>58</sup>

- Yes
- No

### Knowledge, attitudes and practices

4. Since 1 January 2022, how many times have you been involved in decisions about home and living support options for people under the age of 65 with complex progressive disabilities?<sup>59</sup>

- None
- Once or twice
- 3 to 5 times
- 5 to 10 times
- More than 10 times

5. Since 1 January 2022, how many times have you decided to refer a person under the age of 65 with complex progressive disabilities to residential aged care?<sup>60</sup>

- None
- Once or twice
- 3 to 5 times

<sup>57</sup> Respondents who were members of NDIA or AFA were presented with the following alternative wording for this question: "Do you currently work in Australia as a health professional, AFA System Coordinator, or NDIA Planner, or have you done so in the last 12 months?"

<sup>58</sup> Respondents who were members of NDIA or AFA were presented with the following alternative wording for this question: "In your role, do you or could you make recommendations that influence whether people aged under 65 enter or exit residential aged care?"

<sup>59</sup> Respondents who were members of NDIA or AFA were presented with the following alternative wording for this question: "Since 1 January 2022, how many times have you been involved in exploring alternative accommodation options for people under the age of 65?"

<sup>60</sup> Respondents who were members of NDIA or AFA were not asked this question.

- 5 to 10 times
- More than 10 times

6. To what extent are the following resources influential in your own professional decision-making about people who have complex progressive disabilities, regardless of their age?<sup>61</sup>

(0 = Not at all, 1 = Somewhat influential, 2 = Very influential, 3 = Extremely influential)

- Guidelines published by the Department of Health and Aged Care (DoHAC)
- Guidelines published by the National Disability Insurance Agency (NDIA)
- Guidance published on the My Aged Care (MAC) website
- Guidance from your Primary Health Network (PHN) or Local Health District (LHD)
- Guidance from the HealthPathways information portal
- Bulletins or newsletters issued by a peak professional body, such as the Royal Australian College of General Practitioners (RACGP) or the Australian College of Nursing (ACN)
- Reports by allied health professionals (e.g. functional capacity reports)
- Clinical notes about the patient

Please list any other influential resources, if any, that are missing from this list:

*[Free text]*

7. How familiar are you with alternatives to residential aged care for people under the age of 65 with complex progressive disabilities?<sup>62</sup>

0 = Not at all

1 = Somewhat familiar

2 = Very familiar

3 = Extremely familiar

8. In the textboxes below, please list the types of alternatives to residential aged care you are familiar with for people under the age of 65 who have complex progressive disabilities.<sup>63</sup>

Please list the alternatives in order of familiarity, starting with the one you are most familiar with in the first textbox.

<sup>61</sup> Respondents who were members of NDIA or AFA were presented with the following alternative wording for this question: "To what extent are the following resources influential in your own professional decision-making about people who have disabilities, regardless of their age?"

<sup>62</sup> Respondents who were members of NDIA or AFA were presented with the following alternative wording for this question: "How familiar are you with alternatives to residential aged care for people under the age of 65 with disabilities?"

<sup>63</sup> Respondents who were members of NDIA or AFA were presented with the following alternative wording for this question: "In the textboxes below, please list the types of alternatives to residential aged care you are familiar with for people under the age of 65 who have disabilities. Please list the alternatives in order of familiarity, starting with the one you are most familiar with in the first textbox."

- [\[Alternative 1\]](#)
- [\[Alternative 2\]](#)
- [\[Alternative 3\]](#)
- [\[Alternative 4\]](#)
- [\[Alternative 5\]](#)

9. There will be changes to the Aged Care Act in Australia that will impact a person's eligibility to access Commonwealth funded aged care, including residential aged care, if they are aged under 65. The Government is currently refining and finalising the draft legislation. How familiar are you with these upcoming changes?

0 = Not at all

1 = Somewhat familiar

2 = Very familiar

3 = Extremely familiar

10. Which of the below best reflects your understanding of who will be able to access Commonwealth funded residential aged care under the new Aged Care Act?

- No person under the age of 65 will be allowed to enter residential aged care under any circumstances
- No person under the age of 65 will be allowed to enter residential aged care unless they have specific care needs that can only be met through residential aged care
- No person under the age of 65 will be allowed to enter residential aged care unless they are an Aboriginal or Torres Strait Islander person aged 50 or over, or a homeless person aged 50 or over
- Not sure

11. Below is a list of potential barriers you might face when considering alternatives to residential aged care for people under the age of 65 with complex progressive disabilities. How relevant are each of these barriers to your own professional decision-making?<sup>64</sup>

*(0 = Not at all, 1 = Somewhat relevant, 2 = Very relevant, 3 = Extremely relevant)*

- There are no alternatives to residential aged care in my area
- There are long waiting lists to access more suitable alternatives to residential aged care
- I don't know what alternatives to residential aged care would be suitable
- The system for identifying and referring people to alternatives to residential aged care is too hard to navigate

<sup>64</sup> Respondents who were members of NDIA or AFA were presented with the following alternative wording for this question: "Below is a list of potential barriers you might face when considering alternatives to residential aged care for people under the age of 65 with disabilities. How relevant are each of these barriers to your own professional decision-making?"



- For people who are in hospital, there is pressure to discharge them as quickly as possible to clear beds
- Some people lack sufficient funding for alternatives to residential aged care
- Some people will receive support in residential aged care that is more appropriate to their needs than they would receive in any alternatives
- I am under too much time pressure to adequately support someone to identify and access more suitable alternatives to residential aged care

12. In the space below, please write down any other barriers that are relevant to you, if not covered above.

*[Free text]*

13. Below is a list of factors that you might take into account when making decisions about home and living support options for people under the age of 65 with complex progressive disabilities. To what extent does each factor make it more or less likely that you will refer them to residential aged care?<sup>65</sup>

*(1 = Much less likely, 2 = Slightly less likely, 3 = Does not influence my decision, 4 = Slightly more likely, 5 = Much more likely)*

- The person has a severe physical disability, such as multiple sclerosis or muscular dystrophy
- The person has dementia or another condition that significantly impairs cognitive function
- The person has a severe mental health condition, such as schizophrenia
- The person is of Aboriginal and/or Torres Strait Islander descent
- The person is homeless or at risk of homelessness
- The person requires end-of-life care due to a terminal disease
- The person receives funding through the National Disability Insurance Scheme (NDIS)
- The person or their carer has explicitly requested that they be placed in residential aged care
- The person's partner or carer is no longer able to provide the necessary supports in their home
- The person has had positive experiences in previous placements in residential care (e.g. respite care)

14. In the space below, please write down any other factors that are relevant to you, if not covered above.

*[Free text]*

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<sup>65</sup> Respondents who were members of NDIA or AFA were presented with the following alternative wording for this question: "Below is a list of factors that you might take into account when making decisions about home and living support options for people under the age of 65 with disabilities. To what extent does each factor make it more or less likely that you will refer them to residential aged care?"

## AI-derived values, motivations, and enablers

15. The following are a list of values that health professionals might prioritise when making professional decisions.

Which of these values would you prioritise most when making a professional decision around residential aged care for people under the age of 65 with complex progressive disabilities?<sup>66</sup>

Please rank each value from 1 (highest priority) to 8 (lowest priority)

- Patient autonomy
- Preventative care
- Evidence-based practice
- Practical solutions
- Holistic care approach
- Patient-centred care
- Professional norms
- Established practices

16. The following are a list of motivations that might guide health professionals' decisions.

Which of these motivations would be most relevant to your own professional decisions around residential aged care for people under the age of 65 with complex progressive disabilities?<sup>67</sup>

Please rank each motivation from 1 (most relevant) to 8 (least relevant)

- Adherence to standard procedures
- Minimising risk
- Emotional wellbeing of patients
- Providing compassionate care to patients
- Data-driven decision making
- Streamlined referral processes
- Positive patient outcomes
- Avoiding premature institutionalisation

17. The following are a list of factors that might support health professionals to make certain decisions.

<sup>66</sup> Respondents who were members of NDIA or AFA were presented with the following alternative wording for this question: "The following are a list of values that health professionals might prioritise when making professional decisions. Which of these values would you prioritise most when making a professional decision around residential aged care for people under the age of 65 with disabilities?"

<sup>67</sup> Respondents who were members of NDIA or AFA were presented with the following alternative wording for this question: "The following are a list of motivations that might guide health professionals' decisions. Which of these motivations would be most relevant to your own professional decisions around residential aged care for people under the age of 65 with disabilities?"

Which of these factors would be most helpful in terms of making it easier for you to make decisions, referrals, or recommendations to residential aged care alternatives for people under the age of 65 with complex progressive disabilities?<sup>68</sup>

Please rank each factor from 1 (most helpful) to 8 (least helpful)

- Access to resources about alternatives to residential aged care
- Positive feedback about residential aged care alternatives from patients and families
- Clear and streamlined referral processes for residential aged care alternatives
- Accessible research and case studies on the effectiveness of residential aged care alternatives
- Availability of strong support groups for patients or their families
- Adequate training in handling emotional aspects of care decisions
- Endorsement of residential aged care alternatives by professional bodies
- Policy changes that set up residential aged care alternatives for success

## Demographics

18. Which of the following best describes your role as a health professional?

- General practitioner
- Nurse
- Medical specialist
- Allied health professional
- Other (please specify):

If you selected "Medical specialist" or "Allied health professional", please specify what type:

*[Free text]*

19. Are you currently in any of the below roles?

- Member of Aged Care Assessment Team (ACAT)
- Ability First Australia (AFA) System Coordinator
- National Disability Insurance Agency (NDIA) YPIRAC Planner
- None of the above

20. In which type of area do you primarily work as a health professional?

- City
- Regional
- Remote

<sup>68</sup> Respondents who were members of NDIA or AFA were presented with the following alternative wording for this question: "The following are a list of factors that might support health professionals to make certain decisions. Which of these factors would be most helpful in terms of making it easier for you to make decisions, referrals, or recommendations to residential aged care alternatives for people under the age of 65 with disabilities?"

## Appendix E: Output of personas from PersonifAI

**E You**

We'd like to encourage general practitioners (GPs) to avoid referring young people with complex progressive disabilities to residential aged care. What personas might be in play for this target behaviour?



**PersonifAI**

To encourage general practitioners (GPs) to avoid referring young people with complex progressive disabilities to residential aged care, we'll develop four distinct personas. Each will be based on different values, motivators, barriers, enablers, cognitive biases, communication strategies, and intervention ideas related to this target behavior.

### 1. The Prevention-Focused Practitioner

1. **I value...** Patient autonomy, preventive care, and long-term wellbeing.
2. **I am motivated by...** Positive patient outcomes and the desire to prevent premature institutionalization.
3. **Things that might make it hard for me to do the target behavior:**
  - Lack of knowledge about alternatives to residential care.
  - Time constraints in exploring and coordinating complex care paths.
  - Perceived pressure from family or specialists to choose residential care.
4. **Things that might make it easy for me to do the target behavior:**
  - Access to a network of community care resources.
  - Training in progressive disability management.
  - Positive feedback from patients and families.
5. **The cognitive biases that might be at play for me:**
  - Default bias (tendency to choose the default or easy option).
  - Optimism bias (believing that patient outcomes will be better in non-residential care).
  - Confirmation bias (seeking information that supports non-residential care options).
6. **Communication strategies that are likely to resonate with me:**
  - Stories of successful community-based care.
  - Clear, concise information about alternative care resources.
  - Recognition of my efforts in patient-centered care.
7. **Some ideas for interventions that are likely to work for me:**
  - Workshops on progressive disability management.
  - A directory or app listing local community care resources.
  - Peer recognition programs for patient-centered care.

## 2. The Resource-Seeking Rationalist

1. **I value...** Evidence-based practice, efficiency, and practical solutions.
2. **I am motivated by...** Data-driven results and streamlined processes.
3. **Things that might make it hard for me to do the target behavior:**
  - Insufficient data on the effectiveness of alternatives.
  - Lack of clear protocols or guidelines.
  - Time-consuming process to arrange complex care solutions.
4. **Things that might make it easy for me to do the target behavior:**
  - Accessible research and case studies on non-residential care effectiveness.
  - Clear guidelines and streamlined referral processes.
  - Time-saving tools for care coordination.
5. **The cognitive biases that might be at play for me:**
  - Anchoring bias (relying heavily on the first piece of information encountered).
  - Bandwagon effect (following trends in GP practices).
  - Status quo bias (preferring current norms and practices).
6. **Communication strategies that are likely to resonate with me:**
  - Fact-based information and statistics.
  - Efficient and practical tool demonstrations.
  - Best practice guidelines and protocols.
7. **Some ideas for interventions that are likely to work for me:**
  - Database of research on non-residential care outcomes.
  - Training in efficient care coordination and referral systems.
  - Decision-support tools integrated into practice management software.



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### 3. The Compassionate Care Advocate

1. **I value...** Empathy, patient-centered care, and holistic approaches.
2. **I am motivated by...** The emotional wellbeing of patients and the desire to provide compassionate care.
3. **Things that might make it hard for me to do the target behavior:**
  - Emotional appeals from families for residential care.
  - Perceived lack of support for home-based or community care.
  - Overwhelming case complexity.
4. **Things that might make it easy for me to do the target behavior:**
  - Strong support networks for patients and families.
  - Success stories of home or community-based care.
  - Adequate training in handling emotional aspects of care decisions.
5. **The cognitive biases that might be at play for me:**
  - Empathy gap (difficulty in understanding what others are going through).
  - Affect heuristic (making decisions based on emotions).
  - Availability heuristic (basing decisions on memorable or recent cases).
6. **Communication strategies that are likely to resonate with me:**
  - Emotional and personal success stories.
  - Educational materials focusing on patient quality of life.
  - Supportive and empathetic dialogue with colleagues and experts.
7. **Some ideas for interventions that are likely to work for me:**
  - Support groups or forums for GPs focusing on holistic care.
  - Training in emotional intelligence and patient-family communication.
  - Resources highlighting the benefits of non-residential care.

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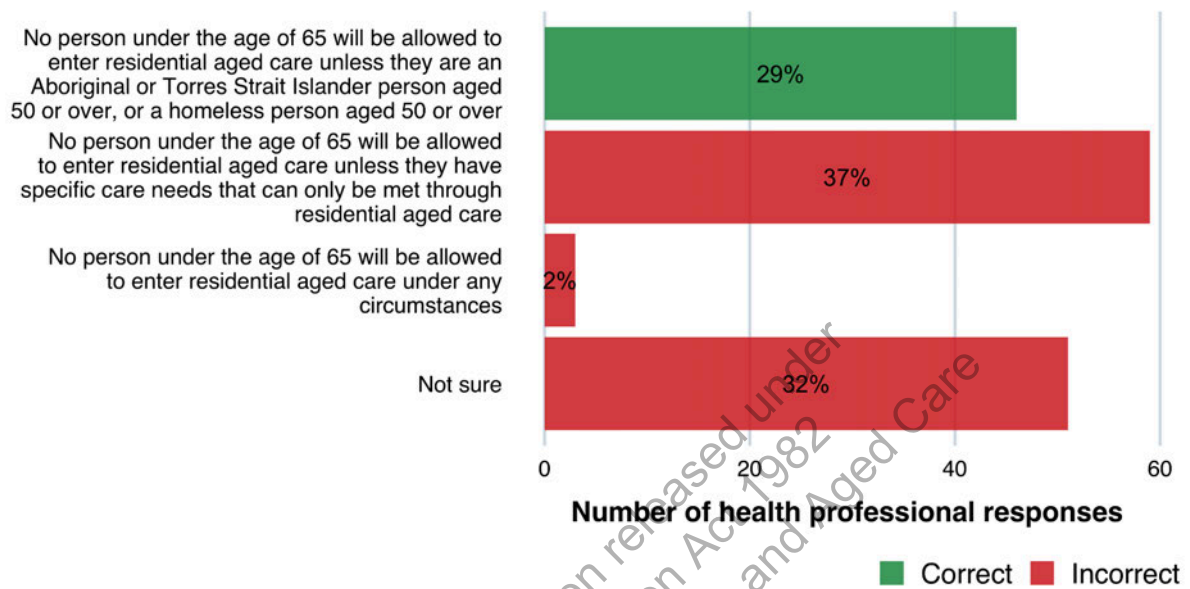
#### 4. The System-Conforming Traditionalist

1. **I value...** Established practices, systemic stability, and professional norms.
2. **I am motivated by...** Adherence to standard procedures and minimizing risk.
3. **Things that might make it hard for me to ↓ he target behavior:**
  - Institutional norms favoring residential care.
  - Lack of institutional support for alternative pathways.
  - Risk aversion and fear of negative outcomes.
4. **Things that might make it easy for me to do the target behavior:**
  - Policy changes favoring non-residential care.
  - Endorsement from professional bodies or leaders.
  - Evidence of risk mitigation in alternative care settings.
5. **The cognitive biases that might be at play for me:**
  - Authority bias (being influenced by the opinion of an authority figure).
  - Conformity bias (aligning with the opinions or behaviors of a group).
  - Loss aversion (preferring to avoid losses rather than acquiring equivalent gains).
6. **Communication strategies that are likely to resonate with me:**
  - Official guidelines and policy updates.
  - Endorsements from respected authorities or professional organizations.
  - Risk analysis comparing residential and non-residential care.
7. **Some ideas for interventions that are likely to work for me:**
  - Policy briefings and updates from health authorities.
  - Training sessions endorsed by professional medical bodies.
  - Risk management tools for non-residential care pathways.

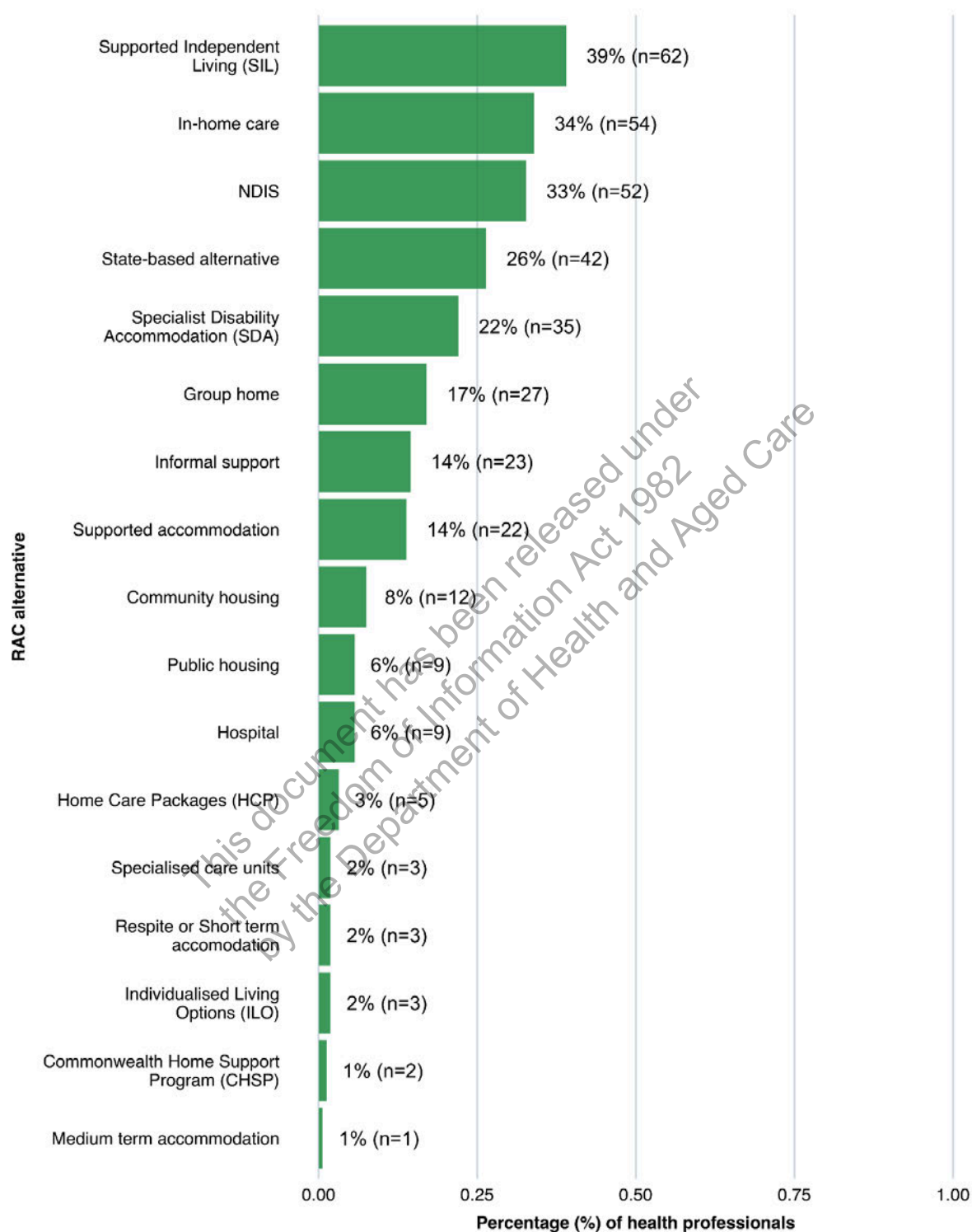
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## Appendix F: Key survey charts

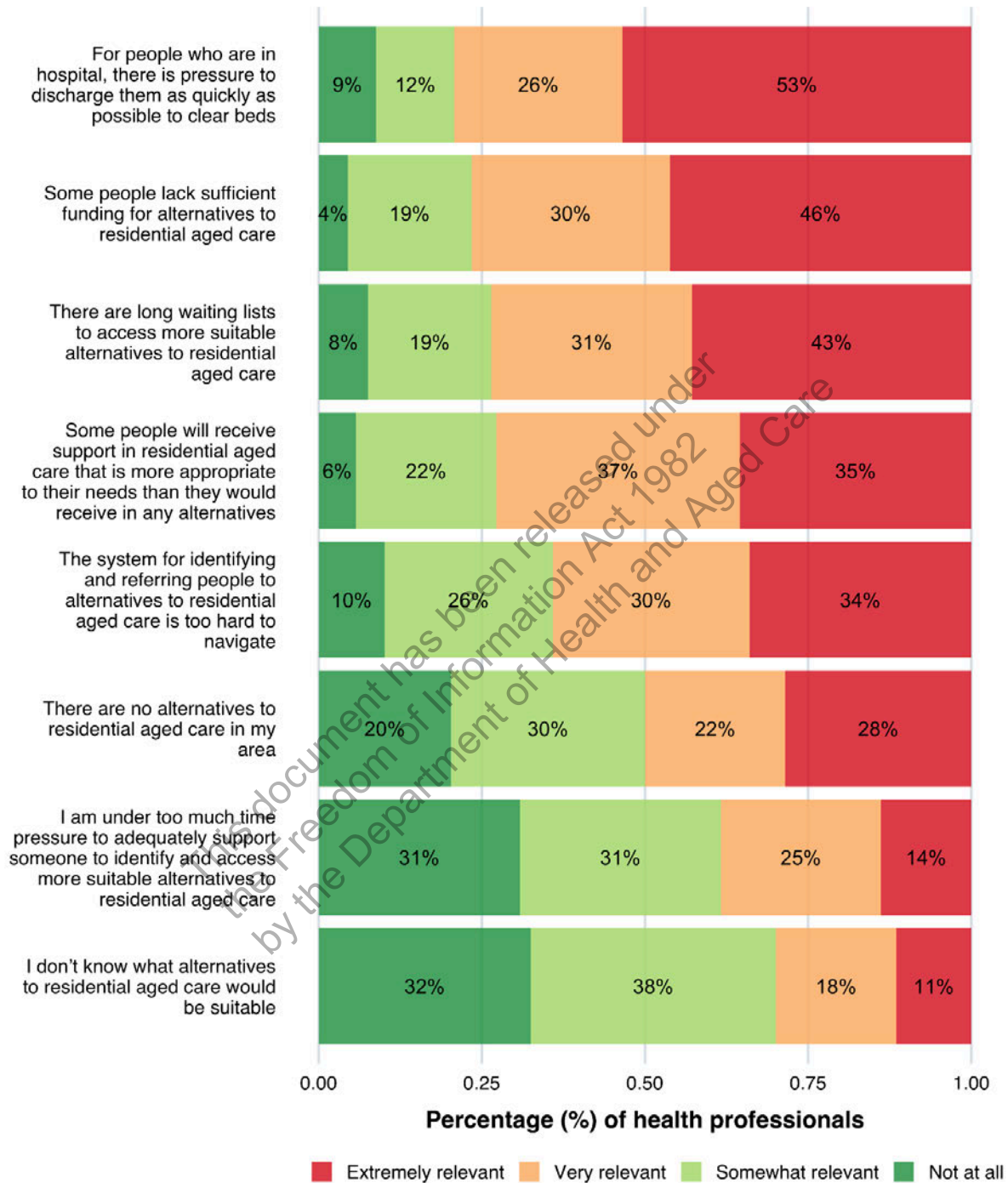
Which of the below best reflects your understanding of who will be able to access Commonwealth funded residential aged care under the new Aged Care Act?



In the text boxes below, please list the types of alternatives to residential aged care you are familiar with for people under the age of 65 who have complex progressive disabilities.

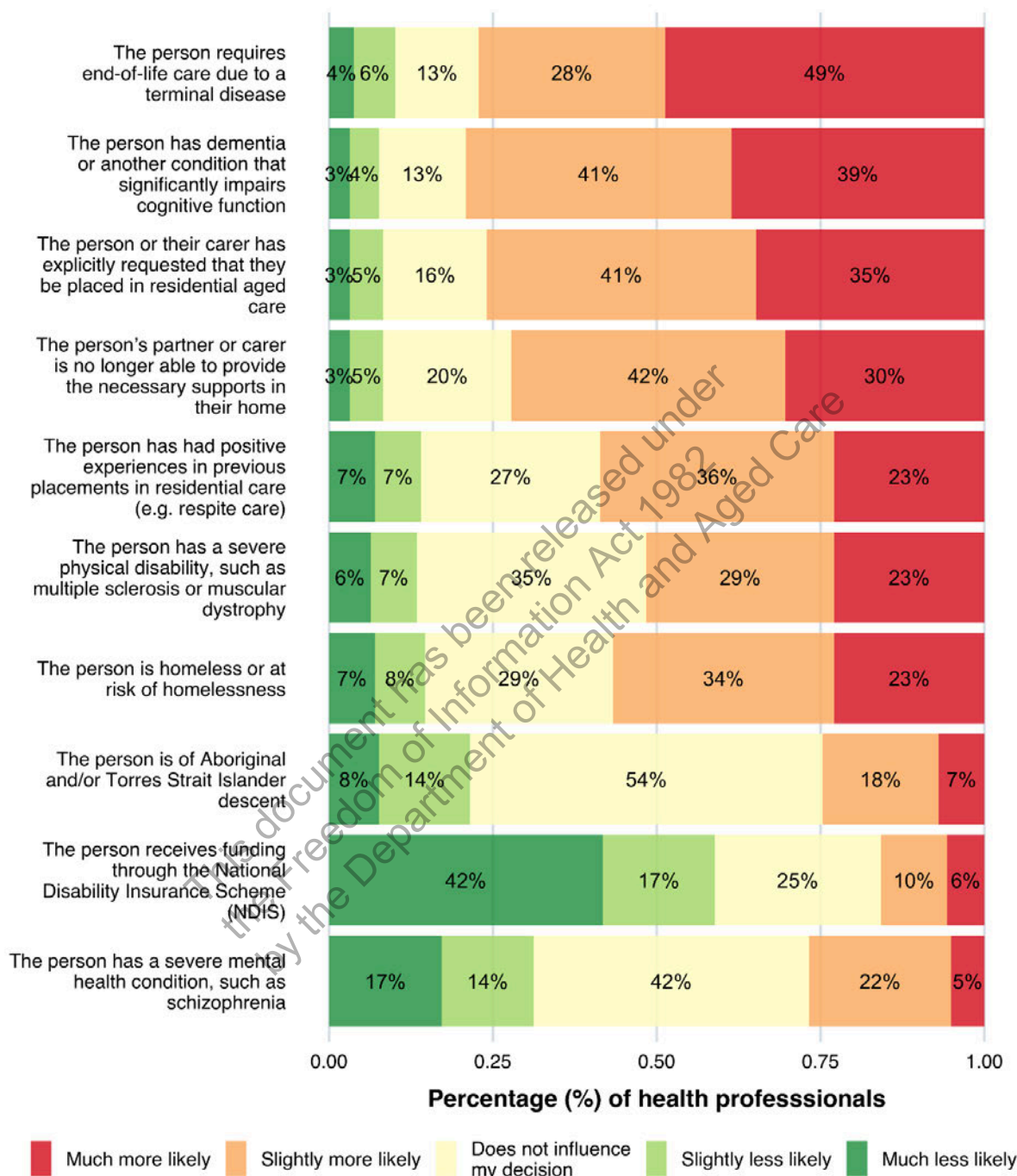


Below is a list of potential barriers you might face when considering alternatives to residential aged care for people under the age of 65 with complex progressive disabilities. How relevant are each of these barriers to your own professional decision-making?





Below is a list of factors that you might take into account when making decisions about home and living support options for people under the age of 65 with complex progressive disabilities. To what extent does each factor make it more or less likely that you will refer them to residential aged care?



**To what extent are the following resources influential in your own professional decision-making about people who have complex progressive disabilities, regardless of their age?**

