Appendices: Impact Analysis – Alternative models for allocating residential aged care places

Appendix A: Project inception note for informal discussions

This projection inception note was provided to participants of the initial informal discussions, led by Professor Michael Woods and Grant Corderoy.

The discussions were held with a cross-section of attendees from an earlier scoping workshop undertaken by the department in September 2018, where participants were nominated by members of the Aged Care Sector Committee and the Aged Care Guild.

The departmental secretariat also attended.

Introduction

The Department of Health has commissioned an analysis of the potential impact of changes to the allocation of residential aged care places to provide greater consumer choice.

The Centre for Health Economics Research and Evaluation (CHERE) at the University of Technology Sydney is leading the Project Team with the support of the aged care accounting and business advisory firm StewartBrown, and staff from the Department.

This Project Inception Note is being made available to stakeholders who attended the Department's ACAR Impact Analysis policy workshop in Sydney in September last year. It provides a foundation for follow-up discussions with those stakeholders under Stage 1 of the Project (see below) as input into the development of a detailed Discussion Paper. This Note sets out the background to the impact analysis project, its proposed scope, approach, timeframes and contact details.

Background

The process for planning the allocation and distribution of new residential aged care places and capital grants is established under the *Aged Care Act 1997*. It is implemented through Aged Care Approval Rounds (ACAR) which enable new and existing approved providers to apply for new subsidised residential aged care places and capital grants in open competition.

In the 2018-19 Budget the Government announced in-principle support for the transition of residential aged care places to consumers through alternative arrangements that provide greater consumer choice. The Government's support is subject to a detailed analysis of the impacts of such an arrangement.

The Budget measure responds to recommendations in the Aged Care Legislated Review (Tune Review). The Tune Review made three recommendations in this area:

- Recommendation 3: Discontinue the ACAR for residential care places, instead assign places directly to consumers within the residential care cap, with changes to take effect two years after announcement.
- Recommendation 4: Announcement on ACAR discontinuation be accompanied by appropriate provisions to ensure continuing supply of residential care services in areas with limited choice and competition.
- Recommendation 8b: In discontinuing the ACAR for residential care, review how best to ensure adequate supply and equitable access to residential respite care.

Scope of the project

The scope of the project involves: the development of alternative allocation models that provide greater consumer choice; consultation with stakeholders; analysis of model impacts on affected stakeholders and related issues; and identification of appropriate implementation and transition arrangements. Specifically, the Project Team will:

1. Develop alternative model/s for allocating residential aged care places that provide greater consumer choice within a more consumer driven market in residential aged care while maintaining

or improving access to residential aged care, including in regional, rural and remote areas, thin markets and for vulnerable consumer cohorts and those requiring residential respite care. The Project Team will identify the key problems and strengths of the current arrangements and develop models that operate within the funding envelope and existing program scope and structure.
2. Comprehensively assess the potential impacts of the alternative allocation models for various stakeholder groups, including but not limited to issues such as: consumer choice and access; safe, high quality service delivery; financial viability and sustainability of the sector; sector growth and investment; market structure; and consumer and government funding. Flow-on effects and linkages with other programs, processes, work or reforms underway that are materially related to the allocation of residential aged care places will also be assessed.
3. Identify appropriate implementation and transition arrangements for the alternative model/s, including strategies to manage and mitigate risks and potential market disruptions.

Out-of-scope

Although the scope of the project is broad, all interested parties should note that there are various related matters that are out of scope.

1. Uncapping the supply of residential aged care places (i.e. caps will remain on the number people receiving residential aged care, but not on the number of beds that providers can offer).
2. Introducing individualised budgets (as per home care) into residential aged care. This relates to the funding model, which is not within the remit of this project.
3. Introducing a consumer directed care (CDC) model of service delivery (as per home care) into residential aged care. It is important not to conflate empowering consumer choice of a provider (and therefore the provider's care and services) with a fully developed CDC model where consumers exercise extensive direction over what care and services are delivered and how they are delivered.
4. Alternative allocation arrangements for flexible care places (this does not preclude consideration of the applicability of the alternative model/s to flexible care).

Key linkages to other reforms

Key linkages between reform in this area and other reforms underway or in the future will also be considered, including precursors for this reform, sequencing and how the reforms are coordinated and fit together. The Project Team will also be monitoring the progress of the Royal Commission into Aged Care Quality and Safety. In addition, evidence and lessons from prior reforms in aged care (e.g. February 2017 Increasing Choice reforms to home care) or other sectors (e.g. disability reforms) will be taken into account.

Key reform linkages to be considered
Residential aged care funding model reform
Resource Utilisation and Classification Study to determine the drivers of costs in residential aged care and to develop a resident classification system and funding model that reflects these drivers.
Streamlined consumer assessment reform
Development of a new framework for streamlined consumer assessments for all aged care services, to be delivered by a new national assessment workforce from 2020.
Reforms to manage prudential risk in residential aged care
• Compulsory retrospective levy on residential aged care providers where defaults exceed $3 million in any fiscal year • Stronger prudential standards applied to accommodation payments • Strengthening government's prudential regulatory capability to better protect the pool of accommodation payments and reduce the likelihood of claims on the Guarantee Scheme
Greater protections and transparency of quality reforms
• Enhanced public information on residential aged care provider quality • New Aged Care Quality and Safety Commission – including improved risk profiling
Review of Multi-Purpose Services Program
• Assessment of the appropriateness, effectiveness and efficiency of the MPS program
Review of Transition Care Program
• Assessment of the appropriateness, effectiveness and efficiency of the TCP
Aged Care Workforce Strategy
• Strategic actions to boost supply, address demand and improve productivity for the aged care workforce. Sector-led implementation of the Strategy.

Project Approach and Timeframes

The development of alternative allocation models, assessment of potential impacts of a change to current arrangements and the identification of implementation/transition arrangements will draw on detailed consultation and data analysis to be undertaken during the first half of 2019.

Stage 1: January to March

Targeted high level discussions will be undertaken in February with key stakeholders who attended the Department's ACAR Impact Analysis policy workshop in Sydney in September last year. To assist with these discussions some questions are listed below. They are not intended to be exhaustive, rather to help frame a conversation. The information gathered from this phase of consultation will test the topics which should be in scope and out of scope and inform development of a comprehensive Discussion Paper that will seek broadly-based feedback on alternative models.

An initial high level assessment of potential allocation models will be undertaken concurrently to ensure that the alternatives proposed in the Discussion Paper do not have immediately evident unintended consequences.

The Discussion Paper will have an intended release date of late March.

Stage 2: April

Consultations

In-depth discussions will be undertaken with all stakeholder groups during April. They will be based on the pre-released Discussion Paper that describes one or more alternative models in detail and outlines key questions and issues relating to potential impacts and implementation/transition arrangements.

This second round of consultations will include:

- Meetings with a broader range of individual stakeholders – either face-to-face in selected cities or by teleconference.
- Discussion forums and meetings in each state and territory – involving interested persons and organisations.

The benefits and risks of the potential alternative allocation models will also be quantified to the extent possible given the available data. Throughout the project, advice will be sought from appropriate experts as required to refine and test the feasibility of alternative models.

Final report: June

A final report will be presented to the Department by end June. It will present the final alternative models, impact analysis and associated implementation and transition arrangements.

Project Team

The Impact Analysis Project is being undertaken by a Project Team comprising:

Professor Mike Woods, Centre for Health Economics Research and Evaluation (CHERE), University of Technology Sydney. Mike will lead the Project Team. He will draw on his deep knowledge of aged care and the underlying principles supporting the reforms in undertaking model development, together with his experience in developing policy and operational options as part of policy research. Mike will draw on his own and CHERE's strong health economics expertise and his long term and close working relationship with many of the key stakeholders to lead the consultations.

Grant Corderoy, Senior Partner of StewartBrown. Grant will provide support across the scope of the project and take a lead role in the financial impact analysis. He will draw on his national network of peak bodies and aged care sector clients, as well as StewartBrown's financial and operational data and knowledge base to assist in developing feasible alternative models. StewartBrown has a strong professional relationship with the Department and other stakeholders involving skills transfer, specific targeted financial analysis and their participation in its regular national Finance Forums.

Departmental personnel will be an integral part of the Project Team. Individual staff will be allocated to the Project Team on an as-needed basis.

Contact details

A member of the Project Team will contact the stakeholders invited to participate in the Stage 1 consultations to arrange a time convenient to them. If you have any issues, please email the Team at: ACARImpactAnalysis@health.gov.au

Questions to help frame the discussion

Current context

Unpacking the issues with current arrangements

- What are the issue/s with the model for the allocation and management of places for residential aged care?
    - What is the evidence that these issues are problems that need to be resolved, and what are their key causes?
    - What are the consumer, provider, financier and government perspectives on these issues?
- Are these problems occurring at national level, or only for certain areas or consumer groups?

Identifying the strengths of current arrangements

- What works well under the current model – from the consumer, provider, financier and government perspectives, and what are the key elements of success?
- What should be retained or further strengthened?

Considerations for alternative arrangements

With regard to alternative model/s, what would success look like in each of the categories below?

- Consumer choice and access, including with respect to regional, rural and remote areas, thin markets, and for vulnerable consumer cohorts and those requiring residential respite care
- Improvements to the delivery of safe, high quality services
- Sector viability and sustainability
- Sector growth and investment
- Market structure
- Consumer and government funding

In developing a Discussion Paper that will need to speak to the diversity of consumers, providers and financiers of residential aged care, and relevant parts of the Government, are there any other specific issues which need to be addressed?

Flow-on effects and linkages with other programs, processes, work or reforms underway that are materially related to the allocation of residential aged care places will also be assessed.

Appendix B: Public discussion paper

Residential aged care: Proposed alternative models for allocating places

Discussion paper

July 2019

Contents

Purpose of this discussion paper

Introduction

As part of the 2018-19 Budget *More Choices for a Longer Life* package, in-principle support was provided for a proposal to move from the current approach of allocating residential aged care places, to providers through the Aged Care Approvals Round (ACAR), to alternative arrangements that support greater consumer choice. Prior to progressing to an alternative model, a detailed analysis of the potential impacts of such an arrangement on all stakeholders is to be completed.

The Budget Fact Sheet can be viewed on the Department of Health website.

The Centre for Health Economics Research and Evaluation (CHERE) at the University of Technology Sydney, in collaboration with aged care accounting and business advisory firm StewartBrown and the Department of Health, is undertaking this impact analysis of alternative arrangements for allocating residential aged care places that encourage a more consumer demand driven market.

Why we are consulting

This discussion paper sets out two proposed alternative models for allocating residential aged care places and offers initial commentary on possible impacts and implementation and transition arrangements. This paper seeks your feedback on:

- whether the two proposed models are the most appropriate for the purposes of analysis, and whether other model variants should be considered;
- the potential impacts of the models (such as the benefits, costs, and risks) and interdependencies with other programs or reforms in aged care – using the matters raised in this paper as a guide only; and
- significant implementation and transition considerations.

Moving to an alternative model for allocating residential aged care places would be a structural reform of the aged care sector, with potentially wide reaching implications for consumers[1] and providers. There may also be flow-on effects to other programs related to an allocation of residential aged care places or ACAR more generally (such as respite care and capital grants) as well as interdependencies with other reforms. Any unintended consequences will also need to be considered.

Your input will be important to ensure a comprehensive understanding of these impacts.

No decisions have been made about any changes to the ACAR, implementation or transition arrangements at this time, including timing of any possible changes.

How to have your say

We want to hear from all interested stakeholders. There are two ways to have your say:

1. **Online Consultation Hub**
   Respond online through the Consultation Hub by **13 September 2019**; and/or
2. **Discussion forum**
   Express an interest in attending a discussion forum in your capital city. Stakeholders in non-metropolitan areas can express an interest in participating in teleconference discussions.

[1]In this discussion paper, the term 'consumer' means the recipients of aged care services, and where appropriate, their families and carers.

Context and scope of impact analysis

Moving to a consumer demand driven market

Australians are living longer and the ageing population is growing. As a result, there will be an increasing demand for subsidised aged care services. There is also a growing preference among senior Australians to remain living in their home and community for as long as possible and a desire for greater flexibility, choice and innovation in aged care services.

Successive reforms to the aged care system over the last decade have responded to these trends by placing greater choice and control in the hands of consumers. Key changes have included:

- assigning a Home Care Package to the consumer, through a national prioritisation process, rather than allocating the packages to providers through the ACAR. Consumers with a package select their preferred provider to which the government subsidy is paid, enabling consumers' greater choice in deciding who provides their home care services;
- requiring Home Care Package providers to deliver care on a consumer directed care (CDC) basis, giving consumers greater say on how funds are spent (through the use of an individualised budget);
- enabling consumers of residential aged care to purchase additional amenities ('additional services'), such as greater choice of entertainment and lifestyle options; and
- providing choice for consumers of residential aged care about how they pay for their accommodation costs (via a fully Refundable Accommodation Deposit (RAD), a Daily Accommodation Payment (DAP), or a combination of both).

Recommendations for reform

The measure announced in the 2018-19 Budget responds to recommendations in the Legislated Review of Aged Care 2017 (Tune Review) for changes to be made to the process for allocating residential aged care places, so that it is responsive to consumer need. The Tune Review made three recommendations in this area:

- Recommendation 3: Discontinue the ACAR for residential aged care places, instead assign places directly to consumers within the residential aged care cap, with changes to take effect two years after announcement;
- Recommendation 4: Announcement on ACAR discontinuation be accompanied by appropriate provisions to ensure continuing supply of residential aged care services in areas with limited choice and competition; and
- Recommendation 8b: In discontinuing the ACAR for residential aged care, review how best to ensure adequate supply and equitable access to residential respite care.

Ceasing the ACAR for residential aged care as part of the move towards a more consumer demand driven market has also been recommended in the Aged Care Sector Committee's *Aged Care Roadmap*, the National Aged Care Alliance's *Blueprint for Aged Care Reform* and the Productivity Commission's 2011 *Caring for Older Australians Inquiry Report*.

Key linkages to other reforms

The impact analysis will consider key linkages with other reforms underway, including lessons from prior reforms in aged care (e.g. February 2017 Increasing Choice reforms to home care), and progress of the Royal Commission into Aged Care Quality and Safety.

Key reform linkages to be considered
Residential aged care funding model reform
• Resource Utilisation and Classification Study (RUCS) to determine the drivers of costs in residential aged care and to develop a resident classification system and funding model that reflects these drivers. • A consultation paper has recently been released on a proposal for a new residential aged care funding tool and system.
Streamlined consumer assessment reform
• Development of a new framework for streamlined consumer assessments for all aged care services, to be delivered by a new national assessment workforce from 2020.
Reforms to manage prudential risk in residential aged care
• Compulsory retrospective levy on residential aged care providers where defaults exceed $3 million in any fiscal year • Strengthening government's prudential regulatory capability to better protect the pool of accommodation payments and reduce likelihood of claims on Guarantee Scheme • A consultation paper was recently released for comment on proposals for changes to strengthen the prudential standards applying to residential aged care.
Greater protections and transparency of quality reforms
• Enhanced public information on residential aged care provider quality • New Aged Care Quality and Safety Commission.
Review of Multi-Purpose Services Program
• Assessment of the appropriateness, effectiveness and efficiency of the MPS program.
Aged Care Workforce Strategy
• Strategic actions to boost supply, address demand and improve productivity for the aged care workforce. Sector-led implementation of the Aged Care Workforce Strategy.
Report on respite care
• The Aged Care Financing Authority completed a report (October 2018) on the increasing use of respite care and the appropriateness of the current arrangements, including funding structures, for providers and consumers.

Out of scope

There are various related matters out of scope for the purpose of this impact analysis:

- Removing fiscal constraints on government expenditure for subsidised residential aged care;
- Introducing individualised budgets (as per home care) into residential aged care;
- Residential aged care funding reform (refer to RUCS);
- Introducing a consumer directed care model of service delivery (as per home care) into residential aged care. This impact analysis is focussed on the allocation of residential aged care places;
    - This does not preclude consumers from negotiating additional services with providers or preferring to choose a particular provider which offers the care and services to best meet their needs.
- Proposing alternative allocation arrangements for flexible aged care places.
    - This does not preclude consideration of the applicability of the alternative model/s to flexible care, including short-term restorative care (STRC places are allocated through the ACAR).

Current arrangements

Residential aged care operates under the *Aged Care Act 1997* (the Act) to provide 24-hour support and accommodation to senior people who can no longer remain living at home. This can include support with day-to-day tasks, personal care, clinical care, and other care services. Government subsidised residential aged care must be provided through a government allocated place – these places are currently allocated to approved providers[2].

Snapshot of residential aged care[3]

Who provided residential aged care (as at 30 June 2018)?

- There were 2,695 aged care homes operated by 886 approved providers with a total of 246,536 allocated[4] residential aged care places.
    - Around 13 per cent of allocated places were yet to be constructed or opened ('provisionally allocated')[5] (construction takes an average of 4.3 years[6]). Around nine per cent of these provisionally allocated places have been allocated for 6 years or more.
    - Around 3 per cent of allocated places were previously operational but currently offline (temporarily unavailable for consumers), often due to renovations or rebuilding of the aged care home.
    - There were 207,142 operational[7] places (the remaining 84 per cent of allocated places). StewartBrown, through their quarterly financial performance survey, reports an occupancy rate[8] of 94.3 per cent[9].
- Not-for-profit providers (comprising religious, charitable and community-based providers) held 55.3 per cent of the operational residential aged care places, for-profit providers held 40.6 per cent, and government providers held 4.2 per cent.

Who received residential aged care (in 2017-18)?

- 241,723 permanent residents in aged care homes at some time during the year.
- On 30 June 2018, there were 180,923 people receiving residential aged care.
- Average age (on entry) was 82.0 years for men, 84.5 years for women.
- Average length of stay for people who left permanent residential aged care in 2017-18 was 34.6 months (38.8 months for consumers with dementia and 30.4 months for consumers without dementia). Preliminary analysis of length of stay, to date, of residents who were admitted during the last five years suggests falling lengths of stay.
- Average annual government subsidy per resident was $65,588.

[2] To provide subsidised services under the Act, providers must first be approved by the department.
[3] Department of Health, 2017–18 Report on the Operation of the *Aged Care Act 1997*; Stocktake of Australian Government Subsidised Aged Care Places as at 30 June 2018; Aged care data warehouse
[4] Allocated places include operational places, offline places, and provisionally allocated places.
[5] Residential aged care places are initially allocated for four years, with the possibility to extend. After six years, if places are not operational, further extensions are only granted in exceptional circumstances.
[6] Legislated Review of Aged Care 2017, page 52
[7] Operational place is an allocated place that has become available for a consumer to receive care.
[8] The Department reports an average occupancy rate of 90.3 per cent in 2017-18, with occupancy measured as the number of days places are occupied by a consumer (based on subsidy claimed), divided by the number of operational place days.
[9] Based on data from participants in StewartBrown's Aged Care Financial Performance Survey (June 2018). There are methodological differences between occupancy calculations reported by StewartBrown and the Department: StewartBrown's data is based on a subset of the residential care sector and removes from the denominator operational places they have recorded as not being available for consumers to occupy due to refurbishment or other operational reasons.

Aged Care Approvals Round

The Aged Care Approvals Round (ACAR) is a competitive application process enabling prospective and existing approved providers to apply for new residential aged care places (including specifying whether residential respite care will also be delivered), short-term restorative care places, and financial assistance in the form of capital grants. Under the Act, new aged care places are made available for allocation in each state and territory having regard to the aged care provision ratio[10], population projections, and the level of current service provision. The Act also governs the way places are managed after they have been allocated. This includes timeframes for making allocated places operational, variations to conditions of allocation[11], and how places can be transferred, relinquished or revoked.

The application process for residential aged care places and capital grants is highly competitive. In the latest 2018-19 ACAR[12], there were applications for 37,802 new residential aged care places, in respect of the 13,500 places being made available. Just over 30 per cent of total places sought were in rural, regional and remote areas (these areas were prioritised in the ACAR). Around 65 per cent of the places allocated were for the development of new aged care homes and around 35 per cent were to expand, rebuild or upgrade existing aged care homes, and expand homes that were yet to be developed. Providers also sought over $394 million in capital grant funding (80 per cent of the funding sought was for rural, regional and remote areas), in respect of $60 million available.

Accessing residential aged care - consumers' perspective

Under current arrangements, in order to receive subsidised residential aged care, a person must:

1. be registered with My Aged Care and be assessed by an Aged Care Assessment Team (ACAT) as being eligible for subsidised residential aged care; and
2. find an approved provider with an available government allocated place in their aged care home and be offered that place.

Consumers can be asked to pay a basic daily fee to cover day-to-day living costs (up to 85 per cent of the single person rate of the basic age pension) and are expected to contribute to their care and accommodation costs if they can afford to (based on income and assets assessments). Consumers who choose extra or additional services will pay fees for extra or additional services as negotiated with the provider.

Provision of residential aged care - providers' perspective

Under current arrangements, in order to deliver subsidised residential aged care and receive a subsidy, an organisation must:

1. be an approved provider of residential aged care;
2. hold an allocation of residential aged care places (in an accredited[13] aged care home); and
3. have an eligible consumer occupying an available place.

---

[10] The Australian Government manages the supply of aged care places and expenditure by specifying a national target provision ratio of subsidised aged care places for every 1,000 people aged 70 years and over.
[11] The Act stipulates mandatory conditions of allocation and provides for other conditions specific to each allocation of places to be specified based on the provider's ACAR application.
[12] 2018-19 Aged Care Approvals Round Results
[13] All aged care homes receiving government subsidies need to meet quality standards known as accreditation standards.

Subsidies and supplements for care and accommodation are paid to the provider in respect of an eligible consumer, taking into account the consumer's contributions. No subsidies or supplements are paid for a vacant place. Care funding is based on the consumer's assessed needs (currently determined by applying the Aged Care Funding Instrument (ACFI) – noting that longer-term care funding reform is being considered).

Programs related to the allocation of residential aged care places

Residential respite care

Residential respite provides subsidised short-term care in aged care homes, with the primary purpose of giving a carer or the person being cared for a break from their usual care arrangements. Residential respite may be used on a planned or emergency basis.

To receive subsidised residential respite care, a person must have been approved for respite care (high or low level of care) by an ACAT. Residential respite care consumers are entitled to 63 days of subsidised respite care in a financial year. In 2017-18, 61,993 people received residential respite care. On average, each recipient received 1.3 episodes of residential respite care during 2017-18, and their average length of stay per episode was 25.6 days[14]. Residential respite is most commonly accessed in weekly units, with a fortnight the most common length of stay[15].

Unlike permanent residential aged care, respite consumers do not make any accommodation or care contributions but can be asked to pay the basic daily fee to cover day-to-day living costs (up to 85 per cent of the single person rate of the basic age pension).

Approved providers do not have a separate allocation of residential respite places, rather, a portion of each permanent allocation of residential aged care places can be used for the provision of respite care, known as a respite care allocation. All approved providers are able to provide respite care if they have the capacity to do so, even if places are not allocated with respite care being a condition of allocation. To receive the respite care subsidies and supplements, an approved provider must have a respite care allocation recorded on the Department of Human Services provider payment system. A provider cannot claim respite subsidies and supplements if their respite care allocation is exhausted.

In 2017-18, there were 2,522 aged care homes (around 94 per cent of all aged care homes) that provided residential respite care[16].

Any changes to the allocation of residential aged care places will require consideration of how residential respite care is offered by providers and accessed by consumers in the future.

Extra Service Status

Some aged care homes have Extra Service Status for the whole facility, or a distinct part of the facility. This involves the provision of a higher than specified standard of accommodation, range and quality of food, and non-care services such as recreational and personal interest activities. Approved providers with Extra Service Status are able to charge an extra service fee[17] for residents occupying an extra service place.

---

[14] Department of Health, 2017–18 Report on the Operation of the *Aged Care Act 1997*
[15] Aged Care Financing Authority, October 2018, Report on Respite for Aged Care Recipients
[16] Department of Health, 2017–18 Report on the Operation of the *Aged Care Act 1997*
[17] An extra service subsidy reduction applies to residents in care prior to 1 July 2014.

Since 2014, there has been a significant decrease (approximately 30 per cent) in the total number of places with Extra Service Status from 17,390 in 2014 to 11,884 in 2017[18]. As at 30 June 2018, there were 233 aged care homes with Extra Service Status (around 9 per cent of all aged care homes)[19].

The recent trend towards offering additional services has reduced the need and incentive for providers to retain Extra Service Status. No Extra Service Status approvals round has been conducted since 2012, and there are currently no plans to conduct a round in the future.

Any changes to the allocation of residential aged care places will need to consider the future of Extra Service Status.

Capital grants

Providers can apply for financial assistance in the form of capital grants through the ACAR in conjunction with an application for new residential aged care places, or as a stand-alone grant application (to receive a capital grant, a provider must hold an allocation of residential aged care places at the service for which the grant is sought). Capital grants are provided for the construction or upgrade of buildings:

- in regional, rural and remote areas of Australia; and/or
- which specifically focus on the provision of residential aged care to people from Special Needs Groups or consumers who are eligible for government support toward the cost of their accommodation, including in major cities; and/or
- in a location where there is a demonstrated need for additional residential aged care services.

Capital grants are only available to organisations that cannot afford to fund the proposed capital works without a grant from the government.

Any changes to the allocation of residential aged care places will require a review of the allocation and administrative provisions for capital grants.

Younger people in residential aged care

Younger people with high-level care needs may be living in an aged care home if they have been unable to access alternative housing and care. A younger person is generally considered to be under the age of 65, or 50 for Aboriginal and Torres Strait Islander people. There is no age restriction limiting the delivery of subsidised aged care services under the Act.

Currently, the ACAT assessor is responsible for determining whether or not a younger person is eligible to receive aged care services under the Act. The aged care legislation requires that, to be eligible, there are no other care facilities or care services more appropriate to meet the person's needs (see *Approval of Care Recipients Principles 2014* section 6). As of 30 June 2018, there were 6,045 people aged under 65 years living in an aged care home[20].

[18] Aged Care Financing Authority, July 2018, Sixth Report on the Funding and Financing of the Aged Care Sector
[19] Department of Health, Extra service status (ESS) service list: 30 June 2018 – GEN aged care data
[20] Productivity Commission, Report on Government Services 2019: Services for people with disability, Table 15A.52

Younger people accessing aged care services may be eligible for supports through the National Disability Insurance Scheme (NDIS) as it rolls out across Australia through to 1 July 2020. Younger people who are already in aged care can continue to receive aged care and may become eligible for additional supports through the NDIS.

On 22 March 2019, the Department of Social Services (which has policy responsibility for the NDIS) announced a national action plan to reduce the number of younger people living in aged care homes[21].

The changes under either proposed model would extend to younger people in residential aged care in respect of whom aged care subsidies and supplements are payable.

Any changes to the allocation of residential aged care places will need to consider younger people who need high-level care.

[21] The plan is available at www.dss.gov.au/disability-and-carers/programmes-services/for-people-with-disability/younger-people-with-disability-in-residential-aged-care-initiative

The case for change

Issues with current allocation process

Some stakeholders have identified issues with the current allocation process for residential aged care, including the ACAR being:

- perceived as a 'lucky dip', with some stakeholders feeling the outcomes from ACAR are not transparent and do not always reflect how 'bed ready' providers are to start delivering care;
- used by some providers who apply to 'crowd out' local competition or to 'sell' their places to others which circumvents the planning and rationale underpinning the release of places; and
- disadvantageous to smaller providers who may not have appropriate resources to apply due to the requirement for lengthy written submissions (providers often engage consultants to prepare their applications).

Allocation of places to the provider does not support a consumer driven market

There have also been suggestions from some stakeholders that allocating residential aged care places to the provider does not support a consumer driven market, as:

- underperforming providers are still able to fill vacant beds, as supply is constrained (via allocation of places) and consumers have limited choice (can only choose among providers with allocated places that are available);
- there is minimal pressure for existing providers to innovate or be responsive to consumer needs or preferences in their service or accommodation offerings. For example, the independent Aged Care Financing Authority (ACFA) has noted that 'around 18 per cent of residents are in rooms that could be considered 'ward style rooms' which are shared and have a common shared bathroom'[22] – which are generally not in line with consumer preferences;
- providers cannot easily build or expand into other areas, due to locational controls on allocations and transfers and difficulty obtaining new places; and
- many allocated places are not operational and therefore unavailable to consumers.

[22] Aged Care Financing Authority, July 2018, Sixth Report on the Funding and Financing of the Aged Care Sector

Key matters to consider if reforming allocation arrangements

Differences between residential aged care and home care

In moving towards a more consumer demand driven market in residential aged care, there are some fundamental differences from the home care environment that need to be considered in designing alternative allocation arrangements. These include:

- complexity of care needs – consumers of residential aged care are often more frail and may have more complex care needs;
- financial complexity – more complex to organise personal finances to fund accommodation costs (where required to pay) in residential aged care;
- higher barriers to enter the market – residential aged care providers require significant capital investment and infrastructure;
- workforce flexibility and skills mix – the acuity of care needs of older people residing permanently in residential aged care coupled with the staffing levels and skills mix required to operate residential aged care may mean there is less flexibility for quick adjustments to be made to workforce capacity in response to possibly more dynamic consumer demand patterns (including periods of vacancies);
- market agility to respond to changes in demand – due to the infrastructure required in the delivery of residential aged care, providers would generally not be able to quickly respond to consumer need without advance notice. There is also limited short-term flexibility for providers to adjust overhead costs (such as labour, administration, support and everyday living costs) associated with running an aged care home; and
- differences in demand – the home care sector is rapidly expanding to meet growing demand, which in the immediate term may reduce the number of senior Australians seeking residential aged care. However, it is expected that over time, demand for residential aged care will rise as a result of the ageing population.

Increased financial pressure in the sector

ACFA[23,24] has observed the residential aged care sector is facing increased financial pressure, driven by:

- revenue not keeping pace with the growth in expenditure (in particular, rising staff costs). There appears to be a growing number of smaller providers, particularly in regional and remote areas, that are currently facing significant financial stress;
- changes to ACFI and pausing of indexation in 2017-18;
- declining occupancy rates for operational places, contributed to by the underlying desire of many senior people to be accommodated in their home i.e. be that their original home, retirement village, independent living/assisted living unit and the increasing number of Home Care Packages being released.

[23] Aged Care Financing Authority, July 2018, Sixth Report on the Funding and Financing of the Aged Care Sector
[24] Aged Care Financing Authority, September 2018, Update on funding and financing issues in the residential aged care industry

- shifting consumer preferences from RADs to DAPs and RAD/DAP combinations to pay for accommodation. The extent to which this is an issue varied depending on the provider's business model (some providers are more reliant on RADs).

Aged care places may have a financial value

Residential aged care places as an intangible asset

Allocated residential aged care places are currently recorded on the balance sheets of some providers as an 'intangible asset' (an asset that is not physical in nature).

- Not-for-profit (NFP) providers have the option of recording allocated residential aged care places obtained via the ACAR as an intangible asset at a "fair value" assessment. While the majority of NFP providers have removed allocated places from being disclosed as an intangible asset, there are still a reasonable number of NFP providers who retain allocated places as an intangible asset.
- For-profit providers can only record allocated residential aged care places as an intangible asset at cost or fair value via acquisition.

Intangible assets (including allocated residential aged care places) must be tested for impairment every year. The impairment testing methodology for goodwill and allocated residential aged care places may differ.

Allocated residential aged care places, when disclosed as an intangible asset, are assessed as having an indefinite useful life as they are issued for an unlimited period and therefore not amortised. Should the allocation via ACAR change, the "indefinite useful life" assessment will need to be reviewed and potentially residential aged care places will be removed from being an intangible asset.

Consideration of residential aged care places by investors/financiers

Financiers generally discount or eliminate the value of allocated residential aged care places as an asset when assessing investment risk. However, investors may currently attribute a value to allocated residential aged care places as they may offer ongoing operational certainty.

It is understood that the current allocation and regulation of residential aged care places does provide operation certainty for providers (and investors/financiers) and minimises risk of increased competition from new entrants into their particular geographic area. In this context it can be considered that allocated residential aged care places have some value (but not necessarily to be recorded as an intangible asset).

Promoting equitable access to aged care

Targeting of need is undertaken through the current allocation arrangements, in order to encourage service provision in particular geographic areas (such as rural, remote and regional areas), to consumers from vulnerable cohorts (e.g. Special Needs Groups[25]), and to address pressure points (such as residential respite care, dementia care). Assessment and allocation of places in the ACAR give priority to applications that address identified needs in the aged care community. This is supplemented by specific conditions of allocation that can be attached to residential aged care places (such as priority of access

[25] The Special Needs Groups under the Act are: people from Aboriginal and Torres Strait Islander communities; people from culturally and linguistically diverse backgrounds; veterans; people who live in rural or remote areas; people who are financially or socially disadvantaged; people who are homeless or at risk of becoming homeless; people who are care-leavers; parents separated from their children by forced adoption or removal; and lesbian, gay, bisexual, transgender and intersex people.

to Special Needs Groups) – subsidy deductions can be applied to an aged care home that fails to meet the conditions specified in their allocation of places.

However, while these mechanisms enable and incentivise provider behaviour, achieving an equitable spread of places is ultimately dependent on providers making commercial decisions to apply for places through ACAR rounds.

Regulatory framework that supports a market

It will also be important to consider what supporting changes to other aspects of the regulatory framework might be required to open up the market to more competition. For example, the boundaries between what is currently considered 'home care' and 'residential aged care' could be reviewed and reconsidered to open up the scope for more innovative care delivery and accommodation offerings. Such changes would need to be balanced with regulatory controls in other aspects of the system, such approved provider status and regulation of quality and safety as well as prudential risk.

Any changes to the allocation of residential aged care places will also need to consider any unintended consequences, including for businesses, access to care, as well as any supporting changes that may be required.

Current arrangements: Questions for discussion

- What works well under the current residential aged care allocation and places management model for consumers and/or providers?
- Are there other issue/s with the current model for the allocation and management of places for residential aged care that have not been covered in this paper? If so:
    - Are these problems occurring at national level, or only in certain areas (e.g. rural, regional and remote areas) or for particular consumer groups?
    - What evidence supports your view that these are significant issues which need to be addressed?

Proposed options for alternative allocation models

Design principles

An appropriate alternative model for allocating residential aged care places must be able to achieve what is important to the community. It is proposed that the following design criteria must underpin the alternative models that are considered.

The model must:

- provide opportunities for a more consumer driven market in residential aged care;
- maintain or improve access to residential aged care and respite services, including in regional, rural and remote areas, thin markets and for vulnerable consumer cohorts;
- facilitate an adaptable and viable residential aged care sector, with continued growth and financial investment;
- be financially sustainable for consumers, providers and government; and
- complement future reforms to residential aged care and aged care more broadly.

Design principles: Questions for discussion

- Are the proposed design principles appropriate?
- Are there any other principles that you consider should be included?

This discussion paper sets out two proposed alternative models for allocating residential aged care places and offers initial commentary on possible impacts and implementation and transition arrangements.

The two potential alternative allocation models to support a more consumer demand driven market in residential aged care which are explored in this discussion paper are:

- Model 1: Improve the ACAR and places management; and
- Model 2: Assign residential aged care places to consumers

Model 1. Improve the ACAR and places management

Description of the model

This reform option retains the ACAR and places management framework, but investigates options to:

- reduce locational controls on the distribution of residential aged care places; and/or
- reduce the number of non-operational residential aged care places to maximise the availability of places to consumers; and/or
- improve the administration of ACAR and places management processes.

Reduce locational controls on the distribution of residential aged care places

Since the 2016-17 ACAR, new places have been allocated at the state and territory level rather than within each Aged Care Planning Region[26] (ACPR) or grouping of ACPRs. This approach has given providers greater flexibility and a more strategic focus to apply for, as well as transfer, places based on their service projections and identified need, often at an organisational level, rather than at a service outlet level within a designated ACPR.

Further options to reduce locational controls may include:

- extending the state and territory level approach to all residential aged care places, regardless of when they were allocated; and
- allowing the transfer of residential aged care places between providers to occur at a state and territory level, regardless of when they were allocated.

An element of locational targeting or control could be enacted as required to encourage services to invest in thin markets or in ACPRs that are significantly below the aged care provision ratio.

Reduce the number of non-operational residential aged care places

Changes could be made to require and/or encourage providers to make allocated residential aged care places available to consumers more quickly, such as:

- strengthening the monitoring of offline places and require providers to bring their offline places back online within a required timeframe. The department could reclaim and reallocate these places where providers have not complied with these requirements.

Improve the administration of ACAR and places management processes

Improvements to the administration of ACAR and places management process could also be considered, such as:

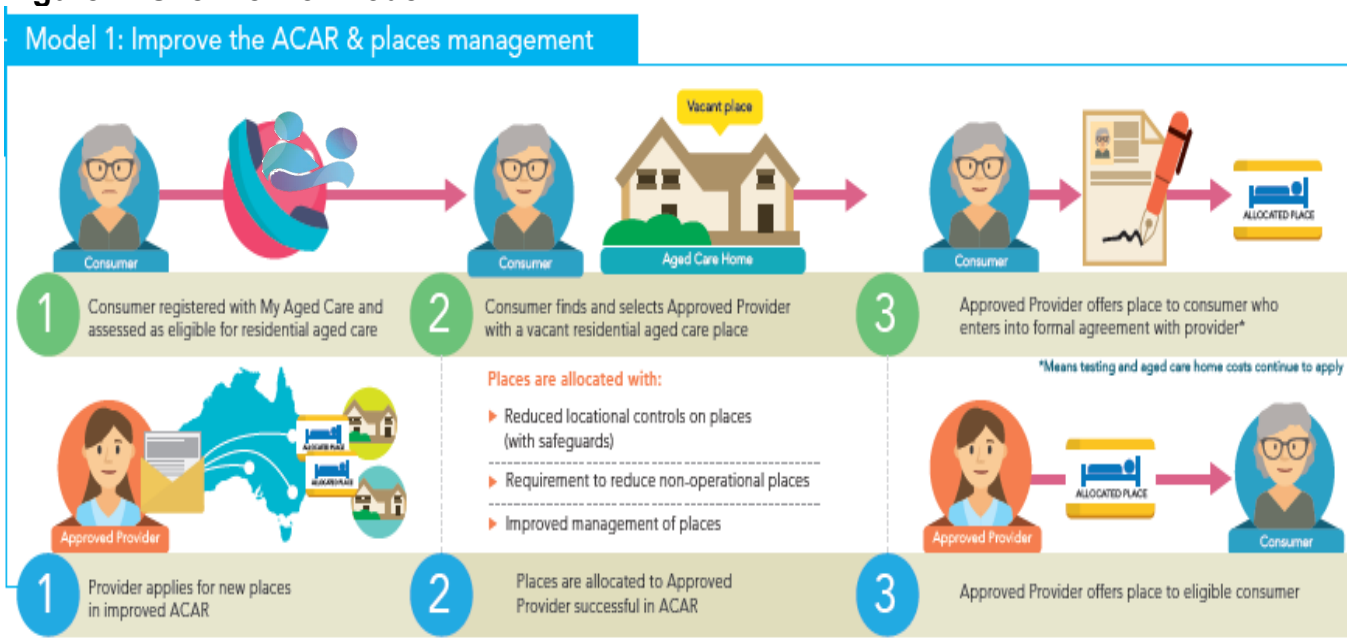
- introducing the ability for providers to ‘top up’ residential aged care places to address consumer demand, outside of the ACAR;
- simplifying the administrative process for providers to use a residential aged care place to deliver residential respite care, including requirements relating to managing a residential respite allocation and the incentive supplement[27];

[26] Aged care services in Australia are funded and delivered in regions called Aged Care Planning Regions (ACPR). There are 73 ACPRs across Australia.
[27] An additional amount is available for eligible providers if they use an average of 70 per cent or more of their respite care allocation during the 12 months up to and including the month providing respite care.

- further streamlining the ACAR application process by exploring opportunities to improve data/information linkages with other processes or systems; and
- enhanced transparency in processes relating to the ACAR.

An overview of Model 1 from the consumer and provider perspectives is at Figure 1.

Figure 1. Overview of Model 1



Exploring the potential impacts

Benefits

Consumers' perspective	Providers' perspective
• May be better able to access care where and when they need it, as providers can distribute/obtain places more flexibly • Greater competition in some areas may drive improvements in service or accommodation offerings • Broader range of local providers to choose from in some areas • May be easier to access residential respite care (as administrative process becomes easier for providers)	• Ability to manage their places more strategically across a wider area and be more agile to respond to changes in consumer demand • Easier for providers to expand and innovate • Retaining the certainty of the ACAR may underpin future growth and investment in the aged care sector • A more efficient ACAR application process may encourage smaller providers to apply • Streamlining of administrative processes would allow providers to direct their time and resources to service delivery

Risks

Consumers' perspective	Providers' perspective
• May be more difficult to find a place in rural, regional and remote areas if there is an outflow of existing places to metropolitan areas where costs may be lower • May be a disruption to service or reduction in available aged care places if some providers exit the market in an unplanned manner (due to increased competition pressures)	• Some providers with less popular homes may experience increased vacancies as other providers with more popular consumer offerings expand. This may lead to some providers exiting the market in an unplanned manner.

Implementation and transition considerations

Although this model is not considered to be a structural change for the sector, the changes would benefit from a gradual roll-out to allow time for transition and adaptation in the sector.

The implementation timeframe would also need to allow for:

- Legislative amendments to the Act and relevant subordinate legislation; and
- Administrative changes to ICT systems.

Model 1. Improve the ACAR and places management: Questions for discussion

Overall model

What are your views on the suggested improvements proposed under this model?

Key design considerations

- How can this model ensure/encourage adequate supply of and equitable access to residential aged care and residential respite care (aside from increasing funding or revising the funding model), including:
    - in rural, regional and remote areas and other thin markets?
    - for consumers from vulnerable cohorts (such as Special Needs Groups, consumers with dementia)?
- Are there variations to this model which should be included in the impact analysis?
- What other key changes could be made to the existing ACAR and/or places management arrangements to encourage a more consumer driven and competitive residential aged care sector?

Exploring the potential impacts

- In overview, what would be the potential impact of this model (consider benefits, costs and risks) on you or the stakeholder group or organisation you represent?
- What do you think might be the impact on the residential aged care sector overall?
- If this model were to be implemented, what are the potential impacts on, linkages or interdependencies with, other programs or reforms in aged care that might impact you or the stakeholder group or organisation you represent?

Implementation and transition considerations

- How could implementation of this model maximise the benefits and minimise risks/disruptions?
    - What steps/sequencing and timeframes would be appropriate to facilitate a smooth transition?
    - What specific supports or enablers would be required to ensure the changes are understood by all stakeholders and successfully implemented?

Model 2. Assign residential aged care places to consumers

Description of the model

This reform option proposes ceasing the allocation of residential aged care places to an approved provider, and instead assigning a 'place' to a consumer. Consumers with an assigned residential aged care place would be able to receive subsidised residential aged care from any approved provider with an available bed in their aged care home (and is able to deliver the required care and services).

Approved providers would no longer need to obtain places through the ACAR or through transfer from other providers in order to deliver residential aged care. Payment of the residential aged care subsidy would no longer be linked to the provider holding an allocated place occupied by a consumer, but rather be contingent upon a consumer with an assigned place accessing a bed in the provider's aged care home.

From the consumers' perspective

In order to receive subsidised residential aged care under this model, a person must:

1. be registered with My Aged Care and assessed as being eligible for subsidised residential aged care;
2. be included in a queue by way of a prioritisation framework;
3. be assigned a residential aged care place; and
4. find an approved provider of their choice with a vacancy and be offered that vacancy.

Key design considerations (consumers)

Creation of a queue

Pressure points with the home care prioritisation system

In home care, there is a national prioritisation system used to assign packages. The establishment of a national system has enabled the centralisation of information, thus providing greater visibility of overall demand levels for the first time, and packages to be assigned more equitably, not based on location. However, it is not without some significant pressure points. As the supply of packages is capped in line with available budget and demand for home care continues to increase, at any given time there are consumers waiting for access to a home care package.

Unmet demand and actual wait times for residential aged care are unknown

There is limited visibility of actual demand and wait times for residential aged care. In 2017-18, there were 119,638 people approved as being eligible for residential aged care compared with only 61,997 first admissions to residential aged care that same year[28]. That is, the number of people approved for residential aged care does not necessarily reflect the number of people who are currently actively seeking to enter an aged care home. For example, at 31 December 2018, 96,000 people waiting for a home care package at their approved level also had an approval for residential aged care[29].

[28] Department of Health, Aged Care Data Warehouse – 2018 Aged care data snapshot
[29] Department of Health, March 2019, Home Care Packages Program – Data Report 2nd Quarter 2018-19: 1 October – 31 December 2018

As a proxy for wait times[30] for residential aged care, in 2017-18 the median elapsed time between a consumer's ACAT approval and entering an aged care home was 121 days, with around 64 per cent entering an aged care home within nine months[31]. However, this is an over-estimate of actual wait times as it includes any period between the date of ACAT approval and the date at which a consumer was actively seeking a place in an aged care home.

Further, as noted earlier, the current occupancy rates and trend suggests that, should a consumer with an assigned place be seeking a vacant bed, there would be vacancies in most regions. However, there are locational variations in occupancy rates as well as variations in the price, quality and appropriateness to consumer need.

As noted earlier, this impact analysis includes the assumption that the current fiscal constraints on government expenditure for subsidised residential aged care will be retained. As such, the total number of residential aged care places would continue to be capped. Therefore, if the number of people requiring residential aged care exceeds the number of places available, a queue would be required to manage access.

Prioritisation within the queue

Prioritisation to determine a person's position in the queue

This model proposes that a prioritisation framework be established to determine a person's position on the queue. Newly available and additional places would be released throughout the year and assigned to the person at the top of the queue.

Factors to consider in prioritisation

A consistent basis for prioritising eligible consumers would be needed to ensure equitable access. In home care, prioritisation is based on two factors: the date of a consumer's approval for home care and their priority for service (medium or high) as determined by the ACAT. Given the high acuity of care needs among consumers eligible for residential aged care, a more granulated approach to prioritisation may well be required.

A potential prioritisation framework for residential aged care may need to consider a range of factors, for example:

- date of approval for residential aged care;
- date of actively seeking residential aged care;
- urgency of need, with possibly several tiers of urgency (i.e. not limited to medium and high). This may also include consideration of whether the person is transitioning between service systems (such as acute care and disability services); and
- other factor/s, possibly drawing on information beyond that collected during the comprehensive assessment.

Validity period of the assigned place

Set timeframe to enter a formal agreement for an aged care home

Once assigned a residential aged care place, the consumer would be able to contact their preferred approved provider to request entry to their aged care home. In line with home

[30] The time between an ACAT approval and a person's access to an aged care service can be influenced by a range of factors, including: availability of places and services, the individual's preference to remain at home, personal circumstances, decision to reject an offer of a place etc.
[31] Department of Health, Aged Care Data Warehouse – 2018 Aged care data snapshot

care arrangements, it is proposed that the consumer be given a set number of days (with an option for an extension of another set number of days) to select a provider and enter into a formal agreement for an aged care home. After that has occurred, the place would remain assigned to the consumer until they no longer require residential aged care.

Withdrawal of place if timeframe exceeded

To maximise the availability of places to other consumers waiting on the queue, it is proposed the place be withdrawn and returned to the pool if a formal agreement with an approved provider is not entered into within the set timeframe. However, where a place is withdrawn, it is proposed the consumer would be able to re-join the queue and be re-assigned a place if required.

An issue to consider is, if time waited is counted from the date of original approval, how to discourage people from joining the queue, turning down the assigned place (or allowing it to be withdrawn) so they can re-join towards the top of the queue in the future.

Request for entry into preferred aged care home

Once a consumer has selected their preferred aged care home, a request for entry would be made. The preferred approved provider would have the option to accept, reject or, where there are no vacancies, add the consumer to the aged care home's waitlist.

In line with current arrangements, it is proposed that relevant information about the consumer's specific care needs and the consumer's eligibility for government assistance with their accommodation costs be made available to the provider to assist them in determining if they can meet those needs and advise the consumer of any applicable accommodation payments. Once a provider has accepted the consumer's request, they can commence negotiations and enter into formal agreement for services (as per current arrangements).

Consideration needs to be given to how best to ensure equitable access to appropriate care for all consumers and dissuade 'cherry picking' of consumers when the provider is actioning the request for entry, such as giving preference to consumers with a greater capacity to pay.

Changing providers or exiting

If a consumer later chooses to move to another aged care home, their assigned place would follow them to the next aged care home. They would need to notify their existing provider and re-activate the process associated with requesting entry to an aged care home.

Where a consumer permanently exits residential aged care, their assigned place would be returned to the pool. The returned place would be re-assigned to the next consumer on the queue.

From the providers' perspective

In order to deliver and be paid for delivering subsidised residential aged care under this proposed model, an organisation must:

1. be an approved provider of residential aged care (with an accredited aged care home); and
2. have accepted an eligible consumer with an assigned residential aged care place.

Key design considerations (providers)

Supporting sector sustainability in a competitive market

Approved providers' existing operational residential aged care places would cease to have regulatory relevance. In like manner, the concepts of provisionally allocated places and offline places would also cease to have regulatory significance. There would be no inherent value in owning a 'bed licence'. The only two requirements to deliver subsidised care to eligible consumers with assigned places would be having approved provider status (for residential aged care) and having an accredited aged care home.

In order to support their ongoing sustainability, existing approved providers may need to consider one or more of the following matters:

- those who have disclosed some or all of their residential aged care places as an intangible asset on the balance sheet on the basis of them having an indefinite useful life will have to consider impairment, writing off the value or amalgamating with purchased goodwill;
- some providers may need to review their business, service and workforce models to remove any assumptions or settings linked to their current ACAR allocation of residential aged care places; and
- in general, providers would need to review their models to better position their service and/or accommodation offerings to remain competitive and attractive to consumers. This may also involve increased market research and marketing/advertising activities. Greater efficiencies, while maintaining safety and quality standards, may need to be identified in order to offset any associated costs of these activities.

Financing sector growth

The ability of a number of providers to obtain capital financing, which supports their construction of new aged care homes and the refurbishment of existing homes, is integral to the continued growth of the sector.

If the current aged care planning ratio remains a valid indicator of demand, then ACFA[32] has estimated that the residential aged care sector will need to build an additional 88,110 places over the next decade in order to meet that ratio (78 operational residential aged care places per 1,000 people aged 70 and over by 2021-22). The estimated investment requirement of the sector over the next decade would be in the order of $54 billion.

Capital for residential aged care providers is financed from equity investments; loans from financial institutions; interest free loans from residents in the form of RADs; capital investment support from government (e.g. capital grants); and retained earnings.

[32] Aged Care Financing Authority, July 2018, Sixth report on the Funding and Financing of the Aged Care Sector

Under this proposed model:

- for providers seeking to obtain capital or external borrowing, they would no longer be able to use an allocation of residential aged care places to provide assurances of future revenue streams to financiers/investors or lenders; and
- when assessing investment risk of providers' proposals for capital/borrowing, financiers/investors and lenders may no longer have visibility of the provider's possible revenue stream, or of future distribution of residential aged care places through the ACAR-related information sources.

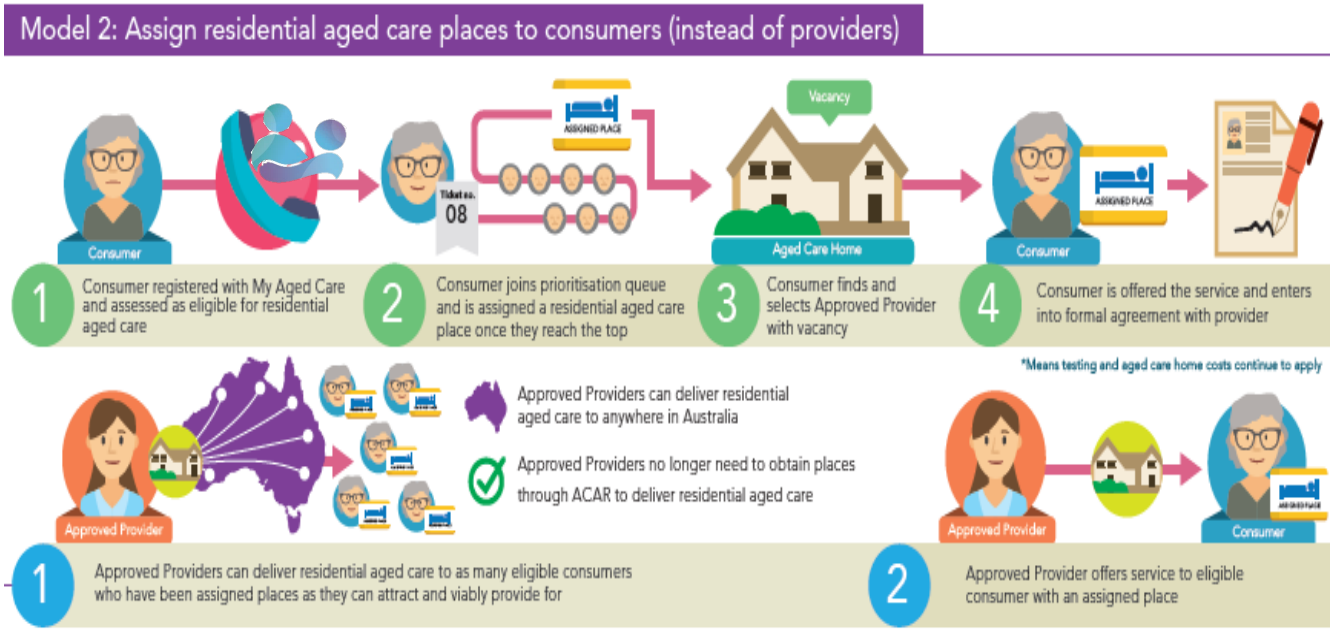
Encouraging service provision in thin markets

If the ability to target need through the ACAR and conditions of allocation is removed, consideration needs to be given to service provision and equitable access to care in thin markets. That is, areas with a small number of providers and consumers (such as rural, remote and regional areas or locations that have relatively larger numbers of older persons from Special Needs Groups).

It is recognised that this issue may be addressed through funding levers (e.g. capital grants, viability supplements, 'reverse auctions' where providers bid for the prices at which they are willing to deliver their services, or broader funding model reform) or other targeted programs such as the Multi-Purpose Services Program. However, it is also worth exploring other non-funding related mechanisms to encourage and support service provision in thin markets, for example the attachment of relevant conditions to approved provider status.

An overview of Model 2 from the consumer and provider perspectives is at Figure 2.

Figure 2. Overview of Model 2



Exploring the potential impacts

Benefits

Consumers' perspective	Providers' perspective
• Greater responsiveness from providers to consumers' needs and preferences • Improved, more diverse and innovative service and accommodation offerings as providers seek to differentiate themselves • Wider range of price points, from competitive pricing to specialised or premium services to cater for those who want more and can pay for more • As an assigned place would be 'owned' by the consumer, they may feel more in control and empowered to negotiate better offerings with providers or to 'vote with their feet' if not satisfied with the provider	• Approved providers able to deliver residential aged care to as many eligible consumers, in as many parts of Australia, as they can attract and viably provide for • Small, niche providers could grow and specialise • New providers could more quickly enter the market (subject to becoming an approved provider), including potential opportunities for providers of private assisted living facilities

Risks

Consumers' perspective	Providers' perspective
• Possible delays in accessing care due to prioritisation queue • May be disruption to service if an uncompetitive provider exits in an unplanned manner • Priority of access for consumers from Special Needs Groups no longer applies (unless it is tied to approved provider status, or other mechanism) • Consumers in rural, regional and remote areas, in thin markets or in other areas that do not attract providers who have more popular consumer offerings may not reap benefits of competitive market or may face challenges finding local providers • Additional burden and complexity, such as administrative processes associated with prioritisation, obtaining a place and researching/accessing information to be able to exercise choice • Consumers may think they have same degree of CDC/choice in residential aged care as they do for home care – residential aged care could remain unattractive	• Competition could lead to more variable vacancies for some providers (with overhead costs remaining largely fixed) • Increased costs of running an aged care home (e.g. market research, advertising, product innovation/differentiation) and the reduction of any excess profits, but competitive pressures may lead to reductions in management costs • Some providers may have large portfolios requiring redevelopment or a new rebuild to remain competitive • It may be more difficult or expensive to access capital for some providers, as investment risk may be higher • Balance sheet or cash flow shock from removal of allocated places • May be more difficult to recruit or retain suitable workforce, as there may be more providers and variable vacancy rates

Directly affected aged care programs

Residential respite care

As residential respite allocations would no longer apply, for example through conditions of allocation, if allocated residential aged care places cease an alternative distribution approach to enable continued availability of respite would be required.

As choice of residential aged care provider becomes more explicit, consumers may increasingly adopt a 'try before you buy' approach with respite before entering permanent residential aged care. ACFA has observed this trend is already happening, with an increasing proportion of respite consumers transferring directly into permanent care following a respite stay (an increase of 55 per cent from 2013-14 to 2017-18)[33].

The approach to distributing residential respite care places would need to allow expenditure to be controlled, support timely and equitable access to both residential aged care and respite care, encourage approved providers to offer respite but not encourage the use of respite for purposes other than to provide the carer or consumer a break.

Extra service places

Consideration is required as to the future of extra service places if providers' allocation of residential aged care places no longer exist – as well as the relationship between extra service and additional services.

Additional Services

In light of the trend towards offering additional services, further work would also be required to clarify the scope of additional services, particularly in the move to a more market based system where service and product differentiation is key. It is noted that this would be further to separate work underway to clarify current additional services arrangements.

Capital grants

It is expected that capital grants would continue to be distributed to providers on a competitive basis. The allocation and administrative provisions for grants would need to be reviewed to ensure it best supports the operation of the proposed model and its objectives.

Implementation and transition considerations

Given the complexity and structural changes associated with the proposed model, implementation would require long lead times and it would be important that all stakeholders are fully consulted and involved in implementation and transition planning. Moving towards a more consumer driven and market based system will challenge traditional models of business, workforce and service delivery to be increasingly responsive and flexible to the needs and preferences of consumers.

Realistic transition arrangements and timeframes would be critical to avoid significant disruption to consumers and providers. Some stakeholders have suggested that an advance notice period between two to four years would be required. Consumers would need time to understand the new arrangements. Providers would need to: decide whether to stay or leave the market; prepare for and respond to the new arrangements – including operationalising currently allocated places (or undertake building work); and reconfigure

[33] Aged Care Financing Authority, October 2018, Report on Respite for Aged Care Recipients

business and financial structures. The finance sector would need to review and adjust their lending and investment practices.

Appropriate sequencing with related reforms that provide the foundation for this model to operate effectively will be an important consideration. This includes decisions on the new streamlined assessment model and workforce and potential future reform of the funding model for residential aged care (including independent assessment of funding for individual consumers according to need).

System enablers would also need to be in place, including:

- potentially strengthened suitability criteria for becoming an approved provider of residential aged care to protect consumers and sector stability. This is because removing the ACAR would place a greater onus on the approved provider arrangements to regulate new providers wishing to enter the market. Changes may also be required to introduce the potential attachment of a wider range of conditions to approved provider status;
- ensuring that the regulatory framework does not constrain innovation and prevent market differentiation in service and accommodation settings. This would also require clarification of Additional Service standards and approval processes; and
- information and supports to assist consumers in comparing providers and exercising informed choice.

Timing of implementation should allow the sector to adjust and settle from recent reforms and take into account the outcomes of the Royal Commission.

Implementation timeframes would also need to allow for significant legislative amendments to the Act and relevant subordinate legislation and significant changes to ICT systems, including My Aged Care and the Department of Human Services provider payment systems as well as the Aged Care Quality and Safety Commission (which will have responsibility for the approved provider approval process from 1 January 2020).

Model 2. Assign residential care places to consumers: Questions for discussion

Overall model

Overall, what are your views on this proposed model?

Key design considerations (consumers)

Creation and design of a prioritisation queue

- What are your views on the establishment of a queue to access subsidised residential aged care, if the demand from eligible persons exceeds the available places?
- What are your views on using date of approval and urgency of need as factors in determining a person's priority (noting these are the factors used in home care)?
- What other factors should also be included in the criteria for prioritising a person in the residential aged care queue?

Validity period of the assigned place

- What are your views on the validity period of the assigned place for residential aged care?
- Where a place is withdrawn, how can we balance the need to allow consumers to re-join the queue while also avoiding creation of perverse incentives for people to join the queue without intention of taking up a place at that time?

Request for entry into preferred aged care home

- What additional information or supports would consumers need to assist them in selecting a preferred aged care home?
- What would need to be in place to ensure equitable access to appropriate services i.e. in particular for consumers with limited capacity to pay, consumers from Special Needs Groups and those with dementia?

Key design considerations (providers)

Supporting sector sustainability in a competitive market

As an existing approved provider:

- Would you consider changing your business, service or workforce model if these reforms proceeded? If so, how?
- How would you ensure your aged care home/s remain competitive and attractive to consumers?

As a provider of private residential aged care (not government subsidised) or a provider of other accommodation that is primarily addressing the needs of senior people:

- Would you consider applying to become an approved provider under the Act to offer subsidised care if these reforms proceeded?

What features in the model, or the broader system, would be required to support providers to operate sustainably in a competitive market? For example, how could innovation and differentiation in service and accommodation offerings be facilitated?

Financing sector growth

- For those providers who are dependent on capital financing, what role does the ACAR system play in supporting their ability to obtain that financing?
- What might be required to ensure the residential aged care sector remains an attractive investment for financiers and lenders?

Encouraging service provision in thin markets

- How can adequate availability of residential aged care services be supported (aside from increasing funding or revising the funding model):
    a) in rural, regional and remote areas and other thin markets?
    b) for consumers from vulnerable cohorts (such as Special Needs Groups, consumers with dementia)?
- Is it possible to attach conditions to being an approved provider, and could these conditions be specific to locations or particular consumer groups?

Exploring the potential impacts

- What would be the overall potential impact of this model (consider benefits, costs, and risks) on you or the organisation or stakeholder group you represent?
- What do you think might be the impact on the residential aged care sector overall?
- If this model were to be implemented, what are the potential impacts on, linkages or interdependencies with, other programs or reforms in aged care that might impact you or the stakeholder group or organisation you represent?

Residential respite care

How could residential respite care places be distributed, and to whom, if residential aged care places no longer exist?

Extra service places

What are your views on how to manage extra service status under this model?

Capital grants

How might the allocation, eligibility criteria and/or administrative provisions (e.g. terms of repayment) for capital grants allocated through the ACAR need to change to best support the needs and objectives of a more market based model?

Implementation and transition considerations

- How could implementation of this model maximise the benefits and minimise risks/disruptions?
    - What steps/sequencing and timeframes would be appropriate to facilitate a smooth transition?
    - What specific supports or enablers would be required to ensure the changes are understood by all stakeholders and successfully implemented?

General question

Aside from the two proposed models, how else could we encourage greater consumer choice and a more consumer driven market in residential aged care?

Next steps

All persons and organisations with an interest in this issue are encouraged to submit their views. This discussion paper provides a guide to the more significant matters under consideration. Where possible, participants are encouraged to support their views with evidence.

Online Consultation Hub

If you are interested in responding to this discussion paper, please submit your views via the online Consultation Hub.

The closing date for responding to this discussion paper is **Friday 13 September 2019.**

Responses will be published on the Department's website to enable maximum transparency.

Discussion Forums

In addition, you can express your interest to participate in a discussion forum in your capital city or teleconference discussions in non-metropolitan areas. The discussions forums are intended to be held in August/September 2019, during the consultation period for the discussion paper. Please register your expression of interest to attend a discussion forum via Eventbrite by **Monday 15 July 2019.**

All expressions of interest will be considered to ensure that a broad range of stakeholders have an opportunity to contribute and address the key questions and issues relating to the potential impact of possible reforms and to the implementation/transition arrangements.

Please note that places are limited and submitting an expression of interest does not guarantee an invitation to the discussion forums or other forms of consultation. However, your views are important. Your response to this discussion paper, along with responses of others, will help to inform decisions on potential future reform.

Appendix C: Submissions to public discussion paper

Sub. #	Response #	Name	Stakeholder category
1	5541269	Anonymous	Carer or other consumer representative
2	921728131	Anonymous	Approved provider of home care
3	155625814	Lifecare	Approved provider of residential aged care, flexible aged care and home care; Provider of private aged care or seniors accommodation
4	503567890	Anonymous	Aged care worker
5		Anonymous	Approved provider of residential aged care
6	180895718	Taralga Retirement Village	Approved provider of residential aged care
7	210697936	Dr Khalil Sukkar	Aged care worker
8	303551146	Anonymous	Aged Care Assessment Team/Service
9	753075591	Anonymous	Approved provider of residential aged care
10	491835993	The Forrest Centre	Health professional
11	315965042	Menarock Aged Care Services	Approved provider of residential aged care
12	738240528	Anonymous	Approved provider of residential aged care
13	341518852	Palliative Care Australia	Peak body - Health
14	64759286	Anonymous	Approved provider of residential aged care
15	622597412	Anonymous	Other
16	278349190	Anonymous	Local council
17		Anonymous	Health professional
18	567236686	Anonymous	Other
19	136651904	Anonymous	Approved provider of residential aged care
20	1002370303	Eldercare	Approved provider of residential aged care and home care
21	710594650	Estia Health	Approved provider of residential aged care
22	274627660	Brisbane South PHN	Primary Health Network
23	736455536	Carers Australia	Peak body - Consumers/Carers
24	683865349	Anonymous	Approved provider of residential aged care, flexible aged care and home care
25	795189794	Catholic Health Australia	Peak body - Aged care providers
26	675410189	Bupa Villages and Aged Care Australia	Approved provider of residential aged care
27	524940597	Anonymous	Approved provider of residential aged care and home care
28	685534363	Dementia Australia	Peak body - Consumers/Carers
29	288005833	Anonymous	Other
30	314840631	Aged Rights Advocacy Service	Consumer advocacy organisation

Sub. #	Response #	Name	Stakeholder category
31	74595046	Australian Projections Pty Ltd	Other
32	399878072	City of Kalamunda Aged Care Advisory Committee	Local council
33	92035667	Carers NSW	Peak body - Consumers/Carers
34	876465424	COTA Australia	Peak body - Consumers/Carers
35	388568119	Advantaged Care	Approved provider of residential aged care
36	1024688987	Ryman Healthcare	Approved provider of residential aged care and home care; Provider of private aged care or seniors accommodation
37	219365230	Anonymous	Approved provider of residential aged care
38		Anonymous	Peak body - Aged care providers
39		Anonymous	Approved provider of residential aged care, flexible aged care and home care
40	948467645	WA Department of Health	State and territory government
41	382399848	Anonymous	Primary Health Network
42		Anonymous	Approved provider of residential aged care and home care; Provider of private aged care or seniors accommodation
43	31536210	Quality Aged Care Action Group	Peak body - Consumers/Carers
44	653803197	Leading Age Services Australia	Peak body - Aged care providers
45	852113340	ANZ	Finance sector
46		Anonymous	Approved provider of residential aged care
47	1014580548	Anonymous	Approved provider of residential aged care
48	953188499	Victorian Healthcare Association	Peak body - Health
49	493146728	Australian Nursing and Midwifery Federation	Peak body - Health
50		Anonymous	Approved provider of residential aged care
51	641423766	Resthaven	Approved provider of residential aged care
52	728432197	Aged & Community Services Australia	Peak body - Aged care providers
53		Anonymous	State and territory government
54	850533137	Salvation Army Aged Care	Approved provider of residential aged care
55		Anonymous	State and territory government
56	850533137	Wintringham	Approved provider of residential aged care and home care; Provider of private aged care or seniors accommodation
57	850533137	AMA	Peak body - Health
58		Anonymous	Peak body - Aged care providers
59	736645707	Uniting NSW.ACT	Approved provider of residential aged care and home care

	Denotes respondent did not provide consent to publish
	Denotes respondent provided consent for anonymous publishing

Written submissions, where consent provided to publish, are available on the department's website: consultations.health.gov.au/aged-care-policy-and-regulation/alternative-allocation-models-residential-care/

Appendix D: Attendees of consultation forums, teleconferences and bilateral meetings

- Face-to-face forums in each capital city facilitated by Professor Michael Woods and Grant Corderoy (3-hour sessions) – morning and afternoon sessions held in major capital cities where sufficient levels of interest.
- Two teleconferences (1.5 hour) with non-metropolitan stakeholders and other stakeholders unable to attend a forum.
- Supplementary bilateral meetings (up to one-hour) were held with some stakeholders who were interested and available, which included individuals who did not attend a forum.

There was an expression of interest process to seek attendees for the forums and teleconferences, promoted through the department's standard aged care bulk email alerts, and via key sector advisory bodies and peak groups. All stakeholders who expressed interest in attending were invited.

The departmental secretariat and departmental representatives from each state and territory office also attended respective consultation forums.

Perth consultation forums (morning and afternoon sessions held): 12 August 2019

Amana Living
Baptistcare WA
Bethanie Group
Braemar Presbyterian Care
Brightwater Care Group
Catholic Homes
Commonwealth Bank of Australia
Coolibah Care
Dale Cottages Inc.
Global Care Group Inc
Melville Cares
Mt La Verna Retirement Village
Myvista
Oryx Communities
Panetta McGrath
Southern Cross Care (WA) Inc
SwanCare
WA Department of Health
WA Local Government Association
WA Primary Health Alliance

Canberra consultation forum (morning session held): 14 August 2019

Aged & Community Services Australia
Aged Care Guild
Australian Institute of Health and Welfare
Australian Projections Pty Ltd
Baptist Care Australia
Bolton Clarke
Carers Australia
COTA Australia
Goodwin Aged Care Services
HammondCare
Harbison
Leading Age Services Australia
St Andrews Village
Villaggio Sant' Antonio

Sydney consultation forums (morning and afternoon sessions held): 20 August 2019

Anglicare Sydney
Ansell Strategic
Bankstown City Aged Care
BaptistCare NSW & ACT
Bupa Villages and Aged Care
Carers NSW
CASS
Catholic Health Australia
Catholic Healthcare
Christadelphian Aged Care
Christian Brethren Community Services
Churches of Christ in Qld
CommBank Health
Dementia Australia
Fresh Hope Care
Greengate
Illawarra Diggers Aged and Community Care
IRT
Leigh Place Aged Care
Lutheran Aged Care Albury
Mark Moran Group
Ministry of Health
Moran Family
Multicultural Communities Council of Ill (MCCI)
National LGBTI Health Alliance
Ngambaga Bindarry Girrwaa Community Aboriginal Services Corporation
NSWNMA
Peninsula villages ltd
Presbyterian Aged Care NSW & ACT
ProActive Chartered Accountants
Quality Aged Care Action Group
RFBI
Royal Freemasons' Benevolent Institution
Southern Cross Care
St Sergius Aged Care
Tallwoods Corner Aged Care
The Salvation Army Aged Care
Twilight Aged Care
Uniting
UPA Sydney North District

Adelaide consultation forum (morning session held only): 26 August 2019

ACH Group
AnglicareSA
Ardrossan Community Hospital Inc.
Catalyst Foundation including Seniors Information Service
Clayton Church Homes
Eldercare
Fullarton Lutheran Homes
Global centre for modern ageing
Helping Hand Aged Care
Kalyra Communities - James Brown Memorial Trust
Life Care
Matthew Flinders Care Services
Multicultural Aged Care Inc
Regional Local Health Networks SA
Regis Aged Care Pty Ltd
Resthaven Incorporated
SA Health
Saint Hilarion Aged Care Inc.
Southern Cross Care
StewartBrown
Uniting Communities
Yorke and Northern Local Health Network

Melbourne consultation forums (morning and afternoon sessions held): 28 August 2019

AdventCare
Alan David Lodge - Barwon Health
ANZ Health
APM
Australian College of Nursing
Australian Nursing & Midwifery Federation
Baptcare
Beata Homecare
Blue Cross Community Care Services Group
Carers Victoria
Cavalry Health Care
Colliers
Continence Foundation of Australia
COTA Australia
Doutta Galla Aged Services
Eastern Health
ECCV
Emerald Terrace
Estia Health
Homestyle Aged Care
Japara
Jewish Care (Victoria) Inc.
Knowles Group (Arcare)
Knuppel Enterprises Pty Ltd
Luson
Luson Health
Martin Luther Homes
Menarock LIFE
Mercy Health
Monash City Council
Regis Aged Care
Royal Freemasons
Ryman Healthcare Limited
Samkay Health
Shepparton Retirement Villages
The Bays Aged Care
The Ideal consultancy
Unitingagewell
Vic Department of Health and Human Services
Victorian Healthcare Association
Villa Maria Catholic Homes
Wickro Pty Ltd T/as Homestyle Aged Care Services

Tasmania consultation forum (morning session held only): 30 August 2019

Glenview Community Services
May Shaw Health Centre Inc
Older Persons Mental Health Service South - Tasmanian Health Service
Princes Court Homes
Royal Hospital Hobart
Tasmanian Department of Health
Southern Cross Care

Brisbane consultation forums (morning and afternoon sessions held): 4 September 2019

Aboriginal and Torres Strait Islander Community Health Service Brisbane
Alzheimer's Association of Qld
Anglicare
Apollo Care
Australian Unity
Benevolent Living
Blue Care
Brisbane North PHN
Brisbane South PHN
Eldercare inc
Gold Coast Health
Good Shepherd Lodge Ltd
IRT
James Underwood & Associates
Knight Frank Health and Aged Care QLD
Leading Age Services Australia
Metro South ACAT
New Direction Care
Office of the Public Advocate
Ozcare
Palm Lake Care
Queensland Health
Queensland Nurses and Midwives Union
Rockpool Residential Aged Care
St Vincent's Care Services Ltd
TriCare
Uniting Care Queensland
Vacenti

Darwin consultation forum (morning session held only): 6 September 2019

Australia Regional & Remote Community Services
COTA NT
Northern Territory State Government Department of Health
Northern Territory State Government Aged Care Assessment Team
Pearl Supported Care (Southern Cross SA &NT)
Regis
Top End Health Services Aged Care

Teleconferences (two sessions held): 21 August 2019

Adventist
Baptcare
Centre for continuing education
Masonic Care Tasmania
Orana Gardens
Respect Aged Care
Summerset
Uniting
Uniting NSW/ACT
WACHS

Bilateral meetings

- Aged Care Rights Advocacy Service
- Aged and Community Services Australia
- Australian Nursing and Midwifery Federation
- Carers SA
- Multicultural Communities Council of SA
- New South Wales State Government Department of Health
- Quality Aged Care Action Group
- Remote Accord Leadership Group
- Victorian State Government Department of Health

Appendix E: StewartBrown's analysis of occupancy rates

As noted in chapter 1, there are various measures of occupancy that need to be considered when assessing the vacancy levels and demand utilisation.

StewartBrown's occupancy data is based on detailed information provided by their survey participants, which allows the removal from the denominator of any operational places they have recorded as not being available for consumers to occupy (e.g. due to a ramp-up period for new or refurbished aged care homes until they reach a 'normalised' operating level, or other operational reasons that might result in a bed not actually being available to a consumer on a given day).

In this respect, StewartBrown's measure of occupancy is strictly calculated on beds that are actually available for a care recipient to occupy at any point in time. This may be deemed to be a measure of the actual bed vacancy rate.

The department's data is based on operational place days as recorded in departmental administrative systems. This data does not necessarily reflect when an aged care home's bed is not actually available to be occupied on a given day/s (in cases where the provider has not reported the place's unavailability to the department) and in some instances whereby the provider has not utilised all approved places and also has not advised the department of this occurrence.

The department's data is a measure of overall capacity should all approved places become operational following refurbishment or unfilled places are later utilised.

StewartBrown undertook extensive analysis to reconcile the apparent discrepancy in the residential sector occupancy rates. Their analysis indicated that the mean (average) occupancy rate calculated using departmental data was influenced by a small proportion of places with very low occupancy, due to their being in the process of 'ramping up' following new building construction or major refurbishments.

Providers have estimated that the 'ramping up' period for a newly constructed home is between 18 to 24 months, and slightly smaller time frame for a major refurbished home.

A variance of around 1 per cent in the occupancy rate between the department's data and StewartBrown' data of the same aged care homes was identified (see table below).

Aged care home occupancy rates, 5-year trend

	FY15	FY16	FY17	FY18	FY19
StewartBrown	94.8%	95.1%	95.5%	94.8%	94.5%
DoH	94.7%	94.5%	94.4%	93.7%	93.5%
Variance	*0.1%*	*0.6%*	*1.0%*	*1.1%*	*1.1%*

Note: Analysis was undertaken on aged care homes for which a full five years' of occupancy data was available in both the department and StewartBrown's datasets

Source: Department of Health and StewartBrown

Financial Year 2017-18 Occupancy Analysis

A further detailed analysis was performed using the department's occupancy data for FY18 and with an aggregate comparison to the StewartBrown occupancy percentages. A summary is included in the below table:

Aggregate comparison of department's 2017-18 occupancy rates to StewartBrown's occupancy rates

Bands %	Occupancy %		No. Homes	Cumulative %	StewartBrown Average %
	Mean (Average)	Median			
95% >	97.4%	97.6%	1,313	48.7%	
85% >	94.9%	95.9%	2,241	83.1%	
80% >	94.1%	95.6%	2,378	88.1%	
75% >	93.5%	95.4%	2,473	91.7%	
70% >	92.9%	95.2%	2,541	94.2%	
70% <	53.1%	57.2%	157	5.8%	
Total places (beds)			**2,698**		**1,002**
Total occupancy %	**90.3%**	**94.7%**			**94.3%**

Source: Department of Health and StewartBrown

By way of explanation, all aged care homes with an occupancy of 95 per cent and higher as per the department data represented 1,313 homes (48.7 per cent of the data set) and had an *average* occupancy of 97.4 per cent for this cohort and a *median* occupancy of 97.6 per cent.

Similarly, for aged care homes with an occupancy of 80 per cent and higher represented 2,378 homes (88.1 per cent of the data set) and this total cohort had an *average* occupancy of 94.1 per cent and a *median* occupancy of 95.6 per cent.

The 157 homes with an occupancy of 70 per cent or less were by majority new builds or homes undergoing major refurbishment. These accounted for 5.8 per cent of the data set and had an *average* occupancy of 53.1 per cent using the department's calculation (no allowance for 'ramping up') and can distort the overall *average* occupancy.

Using the *median* occupancy over the total aged care homes (2,698) the occupancy percentage was 94.7 per cent which is similar to the StewartBrown mean (average) occupancy of 94.3 per cent which is calculated by excluding places (beds) not available to be filled by care recipients.

Accordingly, the ACAR Impact Analysis considered that calculating the *median* occupancy rate when using departmental data at the consolidated sector level provides a figure that is representative of the occupancy rate for over 90 per cent of residential aged care places, and is comparable to mean occupancy as reported by StewartBrown in its quarterly reports.