

Impact analysis: alternative models for allocating residential aged care places

FINAL REPORT

30 January 2020

Professor Michael Woods

Centre for Health Economics Research and Evaluation, University
of Technology Sydney

Grant Corderoy

Senior Partner, StewartBrown

Independent Impact Analysis

The independent Impact Analysis was led by Professor Michael Woods from the Centre for Health Economics Research and Evaluation at the University of Technology Sydney (UTS) and Mr Grant Corderoy, Senior Partner at aged care accounting and business advisory firm StewartBrown. The Australian Government Department of Health (the department) provided secretariat support.

StewartBrown and the department provided extensive data and undertook detailed data analysis.

Professor Woods, Mr Corderoy and the Secretariat would like to acknowledge and thank the many stakeholders and interested parties for their attendance at the consultation forums, their views and submissions in response to the consultation documents and their participation through other engagement activities. Your knowledge and feedback has contributed significantly to informing the development of the Final Report and is gratefully appreciated.

Table of contents

This report details the findings of an impact analysis undertaken into alternative models for allocating residential aged care places. Below is the table of contents for the report.

<i>Independent Impact Analysis</i>	<i>ii</i>
<i>Structure of the report</i>	<i>vii</i>
<i>Key points: Independent Impact Analysis</i>	<i>viii</i>
<i>Executive summary</i>	<i>ix</i>
Introduction	ix
The Aged Care Approvals Round and the state of the residential aged care sector	ix
The framework for designing and assessing the status quo and new allocation models	xi
Assessment of the current ACAR and management of residential places	xii
Development and assessment of alternative Model 1	xii
Development and assessment of alternative Model 2	xiii
Comparative evaluation of the alternative models	xiv
Transition to a more consumer-led residential aged care sector	xvi
Timing for the transition to assigning residential care places to eligible consumers	xvii
<i>Chapter 1: Introduction</i>	<i>18</i>
Project intent and scope	18
Objectives of the project	18
Matters that are out of scope	18
Royal Commission	19
Methodology	19
Consultation	19
Data	20
Desktop review	21
Limitations	22
Involvement of the Department of Health	22
<i>Chapter 2: The system under review</i>	<i>23</i>
Residential aged care	23
Accessing residential aged care - consumers' perspective	23
Provision of residential aged care - providers' perspective	23
Allocating new residential aged care places: Aged Care Approvals Round	24
Recent ACARs	32
Programs related to allocated residential aged care places	36
Service utilisation and provision	39
Future demand	45

Future growth and investment required _____	46
The reform landscape _____	51
<i>Chapter 3: A framework for designing and assessing models for allocating places in residential aged care_</i>	<i>53</i>
2018-19 Budget measure and key independent policy reports _____	53
Rationales for consumer choice, provider competition and government regulation in aged care _____	55
Guiding Principles set out in the Discussion Paper _____	57
Feedback on the five proposed principles _____	57
The five principles adopted for this Impact Analysis _____	59
<i>Chapter 4: Learning from other consumer driven market based human services sectors _____</i>	<i>60</i>
Increasing Choice in Home Care _____	60
National Disability Insurance Scheme _____	62
Formal childcare _____	63
Consumer driven and market based residential aged care in other countries _____	64
Conclusion _____	66
<i>Chapter 5: Assessment of the current ACAR and places management arrangements _____</i>	<i>67</i>
Criterion 1. Provide greater consumer choice and control in a competitive residential aged care market	67
Summary of conclusions: criterion 1 _____	73
Criterion 2. Drive outcomes for quality and safety in residential aged care that meet or exceed approved standards _____	74
Summary of conclusions: criterion 2 _____	75
Criterion 3. Facilitate timely and equitable access to residential aged care and respite services for those in need _____	75
Summary of conclusions: criterion 3 _____	83
Criterion 4. Facilitate a residential aged care sector that has continued growth and financial investment which responds to increasing consumer demand and changing preferences _____	83
Summary of conclusions: criterion 4 _____	88
Criterion 5. Have transparent and accountable processes _____	88
Summary of conclusions: criterion 5 _____	90
<i>Chapter 6: Model 1 assessment and refinement _____</i>	<i>91</i>
Overall stakeholder reaction to Model 1 _____	91
Criterion 1. Provide greater consumer choice and control in a competitive residential aged care market	92
Summary of conclusions: criterion 1 _____	96
Criterion 2. Drive outcomes for quality and safety in residential aged care that meet or exceed approved standards _____	96
Summary of conclusions: criterion 2 _____	97
Criterion 3. Facilitate timely and equitable access to residential aged care and respite services for those in need _____	97
Summary of conclusions: criterion 3 _____	98

Criterion 4. Facilitate a residential aged care sector that has continued growth and financial investment which responds to increasing consumer demand and changing preferences _____	99
Summary of conclusions: criterion 4 _____	101
Criterion 5. Have transparent and accountable processes _____	101
Summary of conclusions: criterion 5 _____	103
Revised Model 1 _____	104
Operation of the amended Model 1 from consumer and provider perspectives _____	105
<i>Chapter 7: Model 2 assessment and refinement</i> _____	107
Overall stakeholder reaction to Model 2 _____	107
Criterion 1. Provide greater consumer choice and control in a competitive residential aged care market _____	108
Summary of conclusions: criterion 1 _____	111
Criterion 2. Drive outcomes for quality and safety in residential aged care that meet or exceed approved standards _____	111
Summary of conclusions: criterion 2 _____	114
Criterion 3. Facilitate timely and equitable access to residential aged care and respite services for those in need _____	114
Summary of conclusions: criterion 3 _____	119
Criterion 4. Facilitate a residential aged care sector that has continued growth and financial investment which responds to increasing consumer demand and changing preferences _____	120
Summary of conclusions: criterion 4 _____	130
Criterion 5. Transparent and accountable processes _____	130
Summary of conclusions: criterion 5 _____	131
Revised Model 2 _____	132
Operation of the amended Model 2 from consumer and provider perspectives _____	132
<i>Chapter 8: Comparative evaluation of the alternative models</i> _____	133
Comparison of current arrangements, Model 1 and Model 2 _____	133
Comparative assessment against key principles _____	134
Complement reforms to residential aged care and aged care more broadly _____	138
Summary and recommended alternative model _____	138
<i>Chapter 9: Transition to a more consumer-led residential aged care sector</i> _____	140
1. Approved Provider status _____	140
2. Reform of the residential aged care funding model _____	142
3. Assessment of consumer eligibility for a subsidised residential aged care place _____	145
4. Additional services _____	146
5. Consumer and provider information _____	147
6. Delivery of residential respite care _____	149
Further considerations _____	151
Impact Analysis Proposals _____	153
Residential aged care under Model 2: a view of the future _____	155

<i>References</i>	<i>156</i>
<i>Index of figures</i>	<i>161</i>
<i>Index of tables</i>	<i>163</i>

Appendices

Appendices A to E, which are referred to in the chapters, are separately attached to this report, as follows:

Appendix A: Project inception note for informal discussions

Appendix B: Public discussion paper

Appendix C: Submissions to public discussion paper

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

Appendix E: StewartBrown's analysis of occupancy rates

Structure of the report

An outline of the chapters within this report is as follows.

Chapter 1: Introduction describes the intent, scope and methodology of the Impact Analysis

Chapter 2: The system under review describes residential aged care, Aged Care Approvals Round (ACAR) and places management, related programs, overview of service utilisation and provision, and the aged care reform landscape

Chapter 3: A framework for designing and assessing models for allocating places in residential aged care describes the development of key principles used to design and assess alternative allocation models

Chapter 4: Learning from other consumer driven market based human services sectors describes the experiences of choice and competition from home care reforms, disability and childcare sectors, and selected international residential aged care systems

Chapter 5: Assessment of the current arrangements assesses the current ACAR and places management model against the key principles

Chapter 6: Model 1 assessment and refinement considers Model 1 against the key principles, drawing on consultation feedback and available evidence. Improvements to the model in light of the assessment are outlined.

Chapter 7: Model 2 assessment and refinement considers Model 2 against the key principles, drawing on consultation feedback and available evidence. Improvements to the model in light of the assessment are outlined.

Chapter 8: Comparative evaluation of the alternative models presents a comparative evaluation of the performance of Model 1 and 2 as well as the current arrangements against the principles, and provides a recommendation for the model that best satisfies the principles.

Chapter 9: Transition to a more consumer-led residential aged care sector discusses the key steps and considerations relevant to moving to the recommended model.

Key points: Independent Impact Analysis

In the 2018-19 Budget the Australian Government announced its: ‘... in-principle support for the transition of residential places to the consumer, pending a detailed analysis of the impacts of such a model.’ This was in response to the *Legislated Review of Aged Care 2017* which recommended discontinuing the Aged Care Approvals Round (ACAR) for residential aged care and instead assigning places directly to consumers to support greater consumer choice. This independent Impact Analysis advises the Government on the implications of reforming the residential aged care places allocation model (benefits, risks, and complexities) and key implementation issues.

Residential aged care provides full-time clinical and personal care and support, other care services and accommodation. At 30 June 2019, there were 182,705 permanent (and 6,068 respite) residents in 2,717 aged care homes, operated by 873 approved providers. Over 60,000 consumers enter subsidised aged care homes per year.

The Government allocates a capped supply of subsidised residential aged care places to selected providers through the periodic competitive ACAR. Allocated places can also be transferred or acquired between providers. Consumers must find an aged care home with an available allocated place and be offered that place.

Current arrangements do not provide a consumer-driven market. Less-preferred homes may enjoy higher occupancy than they would in a more open market. Providers have little incentive to excel in the quality of their care or to compete on other services or accommodation. Providers have limited flexibility to increase the scale, location and diversity of their aged care homes in response to consumer preferences. The department does not monitor ‘priority of access’ conditions intended to encourage services for special needs groups or those in rural and remote areas.

Currently the supply of residential places exceeds demand (although not all supply meets consumer preferences and there are local variations in availability). Consumers generally enter an aged care home in around one month of being assessed as eligible for care. With the supply of home care packages increasing and the age-specific utilisation rate of residential care declining, demand is unlikely to exceed supply under current policy settings.

The Impact Analysis concludes that the alternative Model 1 provides only modest benefits for consumers (fewer unavailable places, improved monitoring of priority of access conditions, more focus on satisfaction and innovation) and providers (more transparent processes) but the flaws of allocations to providers and capped supply remain.

Model 2 removes the cap on supply of residential (and residential respite) care places. Places would be assigned directly to eligible consumers, who would exercise choice and would benefit from greater provider competition and diversity of providers, services and accommodation settings. Specialist and rural/remote providers would have more flexibility to meet consumer preferences, but ongoing viability remains their greatest concern.

Model 2 changes are consistent with ongoing reforms. Aged care services would be consumer driven, market based, proportionately regulated and equitably and sustainably subsidised. Regulation aims to protect consumer receipt of high quality and safe care and basic daily services and safety nets safeguard equitable access. Consumer choice and provider competition would focus on provider reputations for excellence in care as well as the provision of additional services and accommodation which met the diversity of preferences and affordability.

The Impact Analysis concludes that Model 2 best meets the key assessment principles and that the risks can be mitigated to an acceptable level with appropriate sequencing of related reforms. These reforms include: strengthening the approved provider assessment process; reforming residential aged care funding; better and more responsively assessing the current and foreseeable needs of eligible consumers; clarifying the scope of additional services; improving information and support; and creating viable residential respite care.

In the interests of policy certainty and forward planning, the Government should announce in 2020 that it confirms its decision to transition residential aged care places to eligible consumers and that places will be assigned to consumers from 1 July 2022. Practical market effects would not be significant before 2026 given the lead times required for new providers to enter the market and for all providers to establish new capacity.

Executive summary

Introduction

This Impact Analysis examines the impact of a transition of subsidised residential aged care places from being allocated to approved providers of residential aged care (providers) to being assigned to eligible aged care consumers. In particular, it addresses the exercise of choice by consumers in need of full-time professional care when they are seeking an aged care home that meets their needs and preferences and when they reassess whether this remains their home of choice.

The Impact Analysis has its genesis in the 2018-19 Australian Government Budget announcement that: 'In response to the *Legislated Review of Aged Care 2017* – the Tune Review, the Government provides in-principle support for the transition of residential places to the consumer, pending a detailed analysis of the impacts of such a model.' The transition would be from the current approach – which allocates subsidised residential aged care places to providers – to alternative arrangements that support greater consumer choice.

The Impact Analysis has been required to develop alternative models and advise on the benefits, risks and complexities of such a transition as well as key implementation considerations. The Impact Analysis was evidence-based, informed by:

- detailed analysis of data held by the Australian Government Department of Health (Department of Health), StewartBrown Sector Surveys and public sources
- extensive consultation with stakeholders across the aged care, health and finance sectors, and with state/territory governments
- a review of other relevant human services markets
- advice from subject matter experts in the Department of Health.

In parallel with this Impact Analysis, the Royal Commission into Aged Care Quality and Safety (established on 8 October 2018) was holding public hearings. An interim report was released by the Royal Commission on 31 October 2019 and has been noted in this Impact Analysis. The final Royal Commission report is due by 12 November 2020.

The Aged Care Approvals Round and the state of the residential aged care sector

Many older people reach a stage in their lives when they request an aged care assessment and are assessed as being eligible for subsidised residential aged care. While the majority prefer to receive care at home for as long as possible, over 60,000 aged care consumers enter an aged care home each year. This involves approaching one or more providers who hold allocated places to provide subsidised residential aged care. Providers obtain these allocated places either from the Australian Government (at no charge) through a periodic competitive Aged Care Approvals Round (ACAR), from another provider via a transfer of places or from acquisition of another provider. Consumers must be offered a place by a provider who has an available vacancy. Public subsidies and supplements for the care and accommodation of eligible consumers are paid directly to the providers.

The Australian Government undertakes three key processes when planning the allocation and distribution of new aged care places, as set out in the *Aged Care Act 1997* and the *Allocations Principles 2014*.

1. Determine the number of new places to be made available (as guided by an aged care provision ratio).
2. Target specific geographic locations, consumers from vulnerable cohorts (i.e. special needs groups), and particular priorities for service provision (i.e. key issues). These conditions can be attached to specific allocated places.

3. Allocate places to specific providers after a competitive selection process, assessed in accordance with criteria specified in the legislation.

The subsequent management of allocated places includes departmental oversight of providers as they develop their newly allocated (provisional) places to become operational in a timely manner, monitoring places that providers take offline (such as for refurbishment) and approving the movement of places to another aged care home operated by a provider or the transfer of places to another provider (in some cases at a secondary market price).

At 30 June 2019, there were 2,717 aged care homes operated by 873 providers delivering permanent residential aged care to 182,705 consumers. There were 258,934 allocated (operational, offline and provisional) residential aged care places on that date. During 2018-19, 242,612 consumers received permanent residential aged care at some time during the year and 65,523 people received residential respite care. In December 2019, the Minister for Aged Care announced an ACAR for 2020 which will offer an additional 10,000 residential aged care places.

There are several discernible trends in residential aged care. The age-specific utilisation rate of consumers is declining as is their average length of stay, while at the same time their average age is increasing as is the acuity of their care needs. Over half of all consumers in aged care homes have a diagnosis of dementia.

[Assessing the balance between supply and demand.](#)

The Impact Analysis undertook an analysis of the likely supply of subsidised residential aged care over the long term and trends in the likely demand for that care.

On the supply side, the key factor is the government's policy settings. The Impact Analysis has assumed the following:

- number of new subsidised places to be made available will be guided by the aged care provision ratio
- the sector (though not necessarily individual providers) will be sufficiently viable to attract investment and be able to offer those places to consumers.

A number of factors need to be taken into account in assessing demand:

- the departmental data on the mean (average) occupancy of operational places (which excludes places that are still only provisionally allocated (not yet operational) and those that are formally offline) is at 89.4 percent for 2018-19. This indicates that aggregate capacity is 10 percent above occupancy, noting that capacity varies by location
- StewartBrown's data for available places (which also excludes unavailable places in newly opened or refurbished aged care homes and other places that are unofficially offline) suggest that vacancy rates are around 5.5 percent over the 2018-19 period
- consumers who are seeking residential aged care and do not also have an option to receive home care typically enter in around one month's time (but not necessarily to a home of their preference or location)
- the age-specific use of residential aged care is declining. Its market share is also declining relative to home care, more so as greater numbers of home care packages are being released by the government.

In 2019, the Aged Care Financing Authority (ACFA) published a projection of the supply and demand for residential aged care through to 2039 which made the same supply assumptions as above. On the demand side, ACFA's projection assumed that the current ratio of residential aged care use to population growth would continue. On this basis, the ACFA analysis demonstrated that there would be an excess supply of places over demand over the full two decades of the projection period.

The Impact Analysis considers that demand is likely to be lower than what ACFA projected. Currently there is no overall unmet demand for residential aged care (although not all supply would meet the preferences of consumers and there are local variations in the demand/supply balance). Given other trends, such as the declining age-specific rates of residential aged care utilisation as home care expands, and assuming current supply-side policy settings remain, this lack of unmet demand is likely to continue for at least the next 20 years.

Further, should there be medical breakthroughs, such as in the prevention, delay of onset or treatment of dementia, there would be a further significant lowering of demand for residential aged care.

The framework for designing and assessing the status quo and new allocation models

The Impact Analysis developed a framework to guide the design and assessment of alternative models for allocating subsidised residential aged care places. The framework was guided by the 2018-19 Budget announcement of in-principle support for the transition of residential places to the consumer to enhance consumer choice. Other significant aged care policy documents were also reviewed, particularly the 2011 *Caring for Older Australians Inquiry Report*, the 2016 *Aged Care Roadmap* and the 2017 *Legislated Review*.

A set of draft principles was included in the July 2019 public Discussion Paper. Following feedback from open forums and submissions, five principles were adopted:

1. provide greater consumer choice and control in a competitive residential aged care market
2. drive outcomes for quality and safety in residential aged care that meet or exceed approved standards
3. facilitate timely and equitable access to residential aged care and respite services for those in need
4. facilitate a residential aged care sector that has continued growth and financial investment which responds to increasing consumer demand and changing preferences
5. have transparent and accountable processes.

These principles are consistent with the foundations of aged care reform already in place, which are that aged care services should be consumer driven, market based, equitably and sustainably subsidised and proportionately regulated.

Aged care brings together three concepts – consumer choice, provider competition and government involvement through regulation and safety nets – though in different ways in the delivery of care compared to the provision of additional services and accommodation.

- The receipt of high quality and safe care and basic daily services and the availability of safety nets to safeguard equitable access are fundamental consumer rights. The regulation of quality and safety aims to ensure that acceptable standards are being met at all times, by all providers, for all people in their care. Consumer choice and provider competition have a supplementary role where providers offer care that is demonstrably exemplary.
- The provision of additional services by some providers is an opportunity for consumers to continue to make choices according to their preferences and the affordability of those services. Providers can compete on quality and price, and regulation should ensure appropriate consumer protection for this vulnerable population.
- The provision of accommodation for those requiring full-time professional care is another opportunity for consumers to continue making choices about where they will live and what standard of accommodation they will live in, according to preferences and affordability, and for providers to compete. Regulation and safety nets focus on accommodation being of at least an acceptable standard, is accessible to all, and consumers are fully informed.

Assessment of the current ACAR and management of residential places

The Impact Analysis assessed the current arrangements against the above five principles. It found that ACAR is not providing a consumer-driven market offering real choice for consumers.

The supply-side capping of the number of subsidised residential aged care places under ACAR has likely meant that less-preferred homes enjoy higher occupancy than they would in a more open market and providers in general have little incentive to compete, to excel in the quality of their care, or to innovate in their services and accommodation.

The capping of places and the conduct of the ACAR also constrains the ability of providers to respond to consumer demand and changing preferences. They have limited flexibility to increase the scale, location and diversity of their market offerings. There is a bias toward existing providers as new entrants gain proportionately fewer places under ACAR.

The Impact Analysis was not able to assess whether providers are complying with the priority of access conditions (such as to special needs groups), which are attached to some allocated places through ACAR, as this is not monitored by the department. Locational targeting by the government to rural/remote regions is found to increase allocations to regional locations but making places available does not guarantee that there will be sufficient service provision – ongoing viability is the more significant issue in delivering services in these areas. Similarly, a provider's decision to offer places to supported (fully subsidised) residents is primarily driven by financial incentives rather than the attachment of priority access conditions to places.

The residential respite arrangements do not promote the ready availability of respite care. In particular, the respite funding arrangements for providers result in lower returns compared to permanent care and the respite allocation processes are cumbersome.

Some providers consider that owning allocated places within a constrained supply was good for attracting investment while others considered that the quality of the management, the business model and the reputation of the aged care home were more important considerations. Similarly, some for-profit providers considered that the bed licences they acquired on the secondary market, and the recording of fair value on their balance sheets, was important to supporting investment. Other for-profit providers and financiers were more focused on cash flow and operational viability. Bed licence values were not seen as a significant issue by not-for-profit providers.

Providers advised the Impact Analysis that their business planning and investment decisions were challenged by the uncertainty of the timing, scale and targeting of ACAR processes and opacity of outcomes. The lack of transparency and accountability for the administration of ACAR and the subsequent management of allocated places was frequently cited.

The Impact Analysis proposed two alternative models for the allocation of subsidised residential aged care models in its Discussion Paper. The first model retained the underpinning architecture of ACAR, while the second discontinued ACAR and assigned subsidised places directly to eligible consumers. The development and assessment of the two models are discussed below, followed by a comparative assessment of each with the other and with the status quo.

Development and assessment of alternative Model 1

Based on consideration of consultation feedback to the Discussion Paper, the Impact Analysis refined Model 1 to include the following changes to ACAR while preserving its basic structure.

Amend locational controls on the distribution of residential aged care places

Recognising that greater locational flexibility of allocated places within the capped ACAR framework could negatively impact on thin markets, Model 1 proposes strengthened conditions be placed on the movement of places by a provider to ensure that any special needs conditions can be fully satisfied and that places in remote, rural or regional areas remain in the same zone/s. To retain the integrity of ACAR, Model 1 also proposes that there be controls on the transfer of places between providers, including on the secondary market.

Reduce the number of non-operational residential aged care places

Model 1 proposes that providers should be required to notify the department why, when and for how long all places are offline and update the department on when those places are back online.

Improve the administration of the ACAR

Under Model 1, the ACAR would be undertaken on a regular and known basis, with greater pre-release consultation with stakeholders and more advanced notice to prepare an application.

There should be greater transparency about the selection criteria and consideration of innovative models of care and Consumer Experience Report performance during the competitive assessment. Publication of clear criteria and activity relating to the movement and transfer of places would aid market functioning.

Improve the allocated places management processes

Model 1 promotes increased availability of residential respite care by removing minimum and maximum respite care allocation rules, allowing providers to respond to demand for respite within their total allocation of residential aged care places (though a consumer limit of 63 days per annum would remain, along with the limitations of allocated places inherent under ACAR).

It is proposed that providers who have places with priority of access conditions should be followed-up more rigorously by the department and it should improve its data collection on special needs groups.

Impact analysis

Based on the available evidence and assessment of Model 1 against the five criteria, the Impact Analysis drew the following conclusions.

The stakeholder response to Model 1 could best be described as 'neutral to somewhat positive'. The Model was seen as offering incremental improvements to ACAR's operational flexibility and responsiveness and some providers valued its preservation of a level of certainty and stability.

Model 1 would improve equity of access by closely managing place mobility where thin market conditions applied, together with a more rigorous follow-up on priority of access conditions. There would be a small increase in operational places through the strengthened offline places reporting requirements as well as greater responsiveness to the demand for respite care.

Model 1 is unlikely to drive quality and safety improvements but the greater focus on innovative care models and inclusion of Consumer Experience Reports in ACAR assessments could support the growth of more innovative providers and those who recorded higher consumer satisfaction. There would likely be modest improvements in responsiveness, growth and transparency, but overall, providers considered that long term viability remained the key determinant of growth and investment in the residential aged care sector.

Development and assessment of alternative Model 2

As with Model 1, Model 2 was refined in the light of consultation feedback to the Discussion Paper. In essence, Model 2 discontinues the ACAR process and associated management of places, thus freeing up the supply-side of residential aged care and respite care to promote greater competition amongst approved providers. Permanent residential or respite care places would be assigned directly to consumers who were eligible for this type of care.

The Impact Analysis has concluded that, on the basis of current supply-side settings, demand will not exceed the aggregate supply of subsidised assignable places for at least the next 20 years. Accordingly, Model 2 does not propose the establishment of a prioritisation arrangement.

Consumers would be assessed for eligibility to receive subsidised residential aged care or residential respite care, with the assessment focussing on those people who had a current or foreseeable need for full-time professional care in an aged care home. There would be more timely short-form reassessments for those living at home if their circumstances changed and they became in need of full-time professional care. Eligible consumers would be directly assigned a subsidised place and could approach providers in their preferred

area, taking into consideration whether the quality and safety of care exceeded regulatory standards. Consumers could also exercise their choice of amenity, according to the price and quality of additional services and accommodation.

Providers would still be required to be approved, to operate accredited aged care homes and to meet all regulatory standards. They would be free to compete in any location, expand their service footprint, and offer additional services and accommodation according to their assessment of consumer demand and preferences.

Impact analysis

The stakeholder response to discontinuing ACAR under Model 2 was more polarising:

- supporters saw the potential benefits for both consumers and providers. They emphasised the importance of appropriately sequencing complementary reforms and the need for maintaining safeguards for vulnerable consumer groups and rural/remote regions.
- critics saw disruption, investment uncertainty and reduced occupancy. They were concerned about a possible prioritisation arrangement if demand exceeded funded assignable places. The Impact Analysis has concluded that such an arrangement will not be required under current policy settings.

Model 2, by assigning subsidised places for residential respite or permanent full-time professional care to consumers, would provide them with a greater ability to exercise choice as well as gain the benefits of greater competition between providers. Choice would be greater in areas of higher demand, but its impact will be gradual over medium term, with little disruption to existing providers in the early years of its implementation.

While greater competition would create incentives for providers to increase the quality and safety of their care, the need for strong regulatory oversight would remain and providers and the government would need to report performance more transparently to enable consumers to differentiate between providers.

Removing supply-side constraints would lead to an increase in the number and diversity of aged care homes, including the accommodation settings in which professional full-time care is delivered – particularly if supported by complementary changes to the legislative definition of ‘residential care’. The regulation of approved provider status would need to be sufficiently rigorous to reflect this change and the assessment of a consumer’s eligibility for full-time professional care would need to be prudently and precisely undertaken. Specialist and rural/remote providers would have more flexibility to meet consumer demand and preferences, but the Impact Analysis was regularly reminded that the more important reform for these providers was a change in funding to ensure their sustainable viability.

Under Model 2 the growth of individual providers and the level of financial investment is no longer dependent on winning places in the ACAR process but on providers’ business acumen, reputation, management quality and responsiveness to consumers. Government can assist the sector by increasing the transparency of its administration to supplement normal market intelligence and address funding reform to ensure sector level financial viability. Some providers are likely to experience poorer financial performance over the medium term and may exit the sector.

Comparative evaluation of the alternative models

The following table provides a comparative assessment of the two Models with the status quo and with each other. They are assessed against the five criteria developed for this Impact Analysis. The symbol ‘+’ indicates that the model improves on the status quo and ‘++’ indicates that the model is superior to both the status quo and the other model.

Key principle	Model 1	Model 2
Choice, competition	+: small increase in operational places by strengthened offline reporting	++: Consumers control place; availability of beds determined by market/demand; uncapped supply
Quality, safety	+: modest: consideration of consumer satisfaction in ACAR	+: Suitability checks (minimal gatekeeper role) removed; approved provider status check strengthened; increased competition to improve quality and safety (if regulatory oversight retained and consumers differentiate on quality and safety)
Timely, equitable access	+: small increase in operational places by strengthening offline reporting; follow-up of priority of access conditions and tighter controls on movement of places in thin markets; removal of minimum and maximum respite care allocations	++: removal of supply-side controls (including special needs, respite) Funding levels that recognise higher costs of service delivery in thin markets will be key (applies to Model 1 as well).
Growth, investment: in response to demand, preferences	++: small increase in operational places by strengthening reporting of offline places; expanded focus on innovation and certainty of ACAR timeframes and processes	++: removal of supply-side controls; increased competition and efficiency may encourage innovation; investment and financing decisions made on basis more aligned with other markets; may increase scrutiny of investment and reduce financial results of some aged care homes
Transparency, accountability	+: regular ACAR; more consultation in planning; more transparency of basis for allocations; published criteria and activity on places movement and transfers; restrictions on transfers of places; more active follow-up of priority of access; strengthened offline places monitoring/reporting	++: Ability to offer care based on business acumen; responsiveness to consumers and access to capital; government providing market information to support decision making of consumers and providers

The Impact Analysis assessed the complexities and risks of the two models.

- Model 1 has little operational risk but may achieve only minimal improvements. It may inhibit ongoing reform if it is represented by some providers as being sufficiently responsive to consumer demand and preferences.
- Model 2 presents greater complexities but these are not seen as over-riding the range of superior benefits identified above. The discontinuation of ACAR and the assignment of places directly to consumers will require greater reliance on other reforms and on complementary regulatory mechanisms. The Impact Analysis is of the view that fiscal risks are not likely for at least the next two decades, based on current policy settings.

The Impact Analysis considers that Model 2 would introduce changes to residential aged care which are consistent with the ongoing reforms, namely that aged care services should be consumer driven, market based, equitably and sustainably subsidised and proportionately regulated. The Impact Analysis concludes that Model 2 best achieves the key assessment principles and that the risks can be mitigated to an acceptable level with appropriate sequencing of related reforms.

Transition to a more consumer-led residential aged care sector

The Impact Analysis has identified a number of related reforms that would enhance the implementation of the Model 2 changes.

1. *Strengthening the approved provider assessment process, including by introducing reassessment requirements*
 - This should be a pre-requisite regulatory initiative given the significance of opening up supply-side innovation.
 - The assessment of approved provider applicants was transferred to the Aged Care Quality and Safety Commission on 1 January 2020. This provides an opportunity to ensure the regulatory mechanisms are robust, coordinated and complementary, and include regular reassessments.
 - The department is strengthening the prudential standards required of an aged care provider and will more closely monitor their financial management and governance on an ongoing basis. This should be in place prior to the commencement of Model 2.
2. *Introducing the reforms to residential aged care funding to replace the Aged Care Funding Instrument*
 - Model 2 should come into effect once parameters of the new funding model are more reliably known and precede the introduction of new funding arrangements. The market impact of Model 2 is not expected to be significant during the first four years of ACAR being discontinued.
3. *Reforming the assessment of consumer eligibility to better reflect current and foreseeable needs and be more responsive to assessing the changing needs of consumers*
 - Sufficient changes are needed to increase the precision of the assessment process to ensure that eligibility for full-time professional care is prudently and precisely assessed and for there to be a reasonable level of confidence in estimating the number of eligible consumers.
 - The tender process for the new assessment workforce is to be undertaken in 2020 and the new arrangements are expected to commence April 2021. Further changes to the assessment arrangements will be needed with the introduction of the new funding model.
 - The introduction of new assessment arrangements represents an opportunity to develop verifiable Key Performance Indicators for undertaking assessments based on current and foreseeable need and for timely and responsive short-form reassessments.
4. *Clarifying the scope of additional services*
 - Greater regulatory clarity around the scope and pricing of additional services is highly preferable when discontinuing ACAR and assigning places directly to consumers. This will facilitate a greater range of competitive offerings by providers.
5. *Improving information and support available to consumers and information available to providers and government*
 - There is a need for significant improvements in the range, quality, clarity and timeliness of information and supports (such as system navigators) to assist consumers in making choices, to signal demand for providers and to enable the government to monitor equity of access.
6. *Developing a residential respite care program which is attractive to both consumers and providers (as a business model in its own right).*
 - Model 2 provides for the separate assignment of residential respite places to eligible consumers and overcomes some of the cumbersome administrative process associated with the current respite care allocation. However, respite funding is substantially less than permanent residential care. Funding neutrality is an important objective.

The Impact Analysis also notes several other considerations to maximising the potential opportunities afforded under Model 2. This includes expanding the number of home care packages to reduce avoidable entry to residential aged care and re-thinking accommodation settings for full-time care. A revision of the legislated definition of residential aged care, which currently precludes such care from being provided in a person's private home, would facilitate the delivery of subsidised full-time professional care to eligible consumers in a more diverse range of accommodation settings – provided building code and accreditation requirements are met.

Detailed work to estimate the future demand for full-time professional care would assist the department and help inform the market.

Timing for the transition to assigning residential care places to eligible consumers

The Impact Analysis draws the following conclusions:

- the assignment of subsidised residential aged care places to eligible consumers should take place from 1 July 2022.
- in the interests of policy certainty, the government should announce its decision in 2020, giving stakeholders two years' notice and enabling the roll-out of consumer and provider education, as well as allowing business planning by providers, workforce and financiers, alongside the undertaking of related reforms by government.
- significant market impacts are not likely to be realised until 2026, and even then the changes will be gradual.

Chapter 1: Introduction

Project intent and scope

As part of the 2018-19 Budget measure, *More Choices for a Longer Life – healthy ageing and high quality care*, the Australian Government (the Government) provided:

‘in-principle support for the transition of residential places to the consumer, pending a detailed analysis of the impacts of such a model.’ (Australian Government Department of Health, 2018e).’ (p. 25)

This would involve a change from the current approach of allocating places to providers through the Aged Care Approvals Round (ACAR), to alternative arrangements that support greater consumer choice. The Government’s announcement was in response to recommendations in the *Legislated Review of Aged Care* (Legislated Review) to discontinue the ACAR for residential aged care and instead assign places directly to consumers (Tune, 2017).

The Impact Analysis, which is the subject of this report, is intended to advise Government on the potential implications of reforming the residential aged care places allocation model, including benefits, risks and complexities, as well as advise on key implementation and transition considerations.

Subject to Government decision, further work on a detailed operational model for the preferred allocation approach as well as implementation and transition arrangements, including necessary sequencing and cost implications, would be required.

Objectives of the project

The objectives of the Impact Analysis were to:

- develop alternative models for allocating residential aged care places that provide greater consumer choice
- comprehensively assess the potential impacts of the alternative allocation models for stakeholders, including flow-on effects with other programs that relate to an allocation of residential aged care places or ACAR more generally
- identify key implementation and transition considerations for the alternative models, including interdependencies with other reforms, appropriate sequencing, and strategies to maximise benefits and to manage or mitigate risks and disruptions.

As in any human services program that supports vulnerable people, potential changes aimed at improving the arrangements should avoid unintended consequences for the program’s consumers. This matter has been to the forefront of considerations during the Impact Analysis.

Matters that are out of scope

This Impact Analysis is focussed on the consequences of changing the allocation of residential aged care places. Various related matters are out of scope for detailed analysis. Nonetheless, several of them directly affect the sequencing and effectiveness of changes to the place allocation arrangements and are therefore discussed at several points in the report. The related issues include:

- fiscal sustainability of government expenditure on subsidised residential aged care
- residential aged care funding reform (a separate project is underway to trial a proposed new funding model – the Australian National Aged Care Classification; AN-ACC)
- appropriateness of a consumer directed care model of service delivery in residential aged care, including individualised budgets (as per home care)
- alternative allocation arrangements for flexible aged care places.

Royal Commission

A Royal Commission into Aged Care Quality and Safety (Royal Commission) was established on 8 October 2018. Its final report is due by 12 November 2020. The interim report¹ was released on 31 October 2019 while this Impact Analysis was being undertaken.

The issues being considered by the Royal Commission are relevant to the objectives of the reforms to residential aged care and to careful consideration of how and in what circumstances market mechanisms and regulation can best support an aged care system that offers consumers greater choice and control. Where germane, this report draws on evidence from the material the Royal Commission has released.

Methodology

The Impact Analysis has had regard to the quantitative and qualitative evidence relevant to assessing the potential benefits, risks and complexities of the current places allocation arrangements for subsidised residential aged care and the options for alternative models. Specifically, the Impact Analysis drew on an evidence base informed by:

- feedback from consultation with stakeholders across the aged care, health and finance sectors, and from state/territory and local governments
- extensive data analysis, largely undertaken by StewartBrown
- a desktop review of other similar consumer demand driven human services programs.

Consultation

In preparing this report, the Impact Analysis actively sought input from stakeholders through informal and formal consultation activities:

Informal discussions (13 – 28 February 2019)

- Shortly after finalising the scope of the project, a 'Project Inception Paper' was released to a cross-section of interested parties that included representatives from a consumer peak body, providers and their peak bodies, the finance sector and independent experts (see [Appendix A](#)). The paper set out the objectives, scope and approach of the Impact Analysis and key questions to facilitate discussion regarding the strengths and issues with the current system and considerations for alternative models.
- The Impact Analysis held informal discussions with the representatives on an individual basis to seek their views on the matters outlined in the paper. These discussions informed the development of a public discussion paper.

Public discussion paper (1 July – 13 September 2019)

- The Impact Analysis released online a public discussion paper (see [Appendix B](#)) outlining two proposed alternative allocation models and key issues relating to design, potential impacts and implementation/transition arrangements to seek feedback from stakeholders. Suggestions for other alternative models were also welcomed.
- A total of 59 written submissions were received (see [Appendix C](#) for the list of stakeholders who made a submission).

¹ Royal Commission into Aged Care Quality and Safety, October 2019, Interim Report: Neglect

Public consultation forums (12 August – 6 September 2019)

- During the submission period for the discussion paper, face-to-face consultation forums (3-hour sessions) were held in each Australian capital city to provide an opportunity for stakeholders to hear about the models, provide their views, discuss potential implications, and ask questions.
- The forums were supplemented by two teleconferences (1.5 hour sessions) with non-metropolitan stakeholders and others who were unable to attend a forum.
- Additional bilateral meetings were held with some targeted stakeholders to discuss particular issues or perspectives.
- A total of 244 stakeholders attended the forums and teleconferences (see [Appendix D](#) for lists of attendees).

Data

Sources

Sources of data for the Impact Analysis included:

- Departmental unpublished and published data concerning the operation of the residential aged care program, including the ACAR and allocated places management arrangements, its providers and consumers, and data for other relevant aged care programs. This data was collected from departmental information systems and records.
- Detailed financial and supporting data from StewartBrown's Aged Care Financial Performance Survey (quarterly) of around 1,100 aged care homes and around 35,000 home care packages across Australia.
- Publicly available data, including from:
 - National Aged Care Data Clearinghouse, managed by the Australian Institute of Health and Welfare (accessed through the GEN Aged Care Data website)
 - Report on Government Services, prepared by the Productivity Commission
 - Australian Bureau of Statistics.

Occupancy rate

When conducting analysis relating to residential aged care, the measurement of occupancy in aged care homes is an important metric. The occupancy rate is the total number of days that all people spent in a type of aged care over a year, divided by the total number of places that were available in that type of care over the year (Australian Institute of Health and Welfare, 2017). In the residential aged care context, occupancy is measured as the number of days that an available residential aged care place is occupied by a consumer (based on a subsidy claimed by the provider), divided by a denominator which records the number of days the residential aged care place was available to be occupied (i.e. operational places²). Put simply, occupancy represents the percentage of time an available bed in an aged care home is occupied by a consumer.

Occupancy rates include permanent and respite consumers but excludes residential aged care places under the flexible aged care programs.

² Operational place refers to a residential aged care place that was allocated to a provider and has been made available for a person to receive care. It needs to be noted that the number of operational places may be over-counted since these are based on administrative data and some places which are considered operational may not actually be available to be occupied.

This Impact Analysis has considered different metrics when assessing the occupancy rates:

- *Average occupancy* – is the mean, and for this Impact Analysis, the denominator is the total number of operational places in the departmental data set less the number of offline places³ reported to the department. The denominator has not been further reduced to account for operational places which are not available for occupancy such as where there is a progressive commissioning (ramping up) of new or significantly refurbished homes as well as offline places which have not been officially made known to the department. Average occupancy is a measure of *capacity* or potential for availability within the residential aged care sector.
- *Median occupancy* – is the mid-point occupancy level of all aged care homes and provides a guide as to the range of occupancy levels based on the average occupancy measure. Median occupancy may be also used as a measure for *choice* in many geographic locations.
- *Average available occupancy* – is the measure used by StewartBrown for their data set (comprising 40.5 per cent of all aged care homes), which makes allowance for the staging of new and significantly refurbished homes and offline places not reported to the department. This is a useful basis for assessing its converse – the level of *vacancy* of places that providers are currently offering to potential consumers.

Whilst there are differences between each of the above measures of occupancy at the sector level, and as reported by StewartBrown and the department, the occupancy trends are relevant and each measure confirms that the number of residential aged care places either currently available or soon to become available is greater than current demand. Further discussion on StewartBrown's analysis of occupancy rates is included at [Appendix E](#).

When occupancy is reported at the consolidated sector level in this Impact Analysis, the average (mean) and median occupancy rate in relation to departmental data is used, and for StewartBrown data the average available occupancy rate is used.

When considering occupancy at the aged care home level, it is reported at an aggregated region level to avoid any identification of individual aged care homes.

Time periods

Most of the data used in this report covers the financial year 2017-18, for comparability and consistency across metrics. Where longitudinal trends are analysed, data from earlier financial years are also used.

Comprehensive data from the latest complete financial year 2018-19 was not available when detailed analysis was undertaken. However, for some metrics where 2018-19 data became available at the time of finalising this report, they have been included.

Desktop review

The Impact Analysis also researched other consumer demand-driven human services programs as well as subsidised residential aged care arrangements in other countries. The programs included:

- reforms to home care, where home care packages are assigned to consumers rather than providers
- the National Disability Insurance Scheme
- formal child care services – specifically, centre-based day care
- international approaches to subsidised residential aged care – specifically, New Zealand, United Kingdom and Japan.

³ Unused places that have been operational in the past but are not currently providing care and the provider is not receiving government subsidies in respect of those places.

Limitations

- There were some limitations in the data accessed for this analysis, particularly relating to consumer-level data. Comments have been made throughout this report as appropriate.
- All practical efforts⁴ were made to encourage maximum public participation in the public consultations. However, the reach was limited to those stakeholders who were aware, interested and available to contribute. Further, aged care providers (including their peak bodies) were the largest group of stakeholders represented during the consultations, followed by other stakeholder categories including health sector and workforce representatives (including their peak bodies), financial sector representatives, state and local government representatives, and consumer and carer representatives (including their peak bodies). As such, the Impact Analysis does not purport that the information received is exhaustively representative of all stakeholders' views.
- The environment during which the Impact Analysis, including its consultations, was conducted should also be noted. Specifically, the Royal Commission into Aged Care Quality and Safety was in progress throughout the duration of the Impact Analysis. While careful planning of the Impact Analysis consultations was taken to minimise overlap with Royal Commission hearings, discussions were occurring at a time when the sector was under significant scrutiny. This may have limited the capacity of some stakeholders to engage with the Impact Analysis consultation and/or led to topical issues that were being canvassed at hearings being more 'front of mind' or commonly raised during consultations than would otherwise be the case.

Involvement of the Department of Health

The secretariat of the Impact Analysis were departmental staff who supported Professor Michael Woods and Grant Corderoy.

Departmental subject matter experts on the operation of the aged care programs, including the ACAR and places management, provided ready access to information systems and records and were available for consultation on technical and program matters.

The department had an opportunity to review the report and provided comments ahead of its finalisation.

⁴The discussion paper and forums were promoted via the department's standard aged care bulk email alerts to the sector, and via key sector advisory bodies and peak groups

Chapter 2: The system under review

Residential aged care

Residential aged care provides full-time clinical and personal care and support (including day-to-day services and additional services), other care services and accommodation for consumers of aged care services who can no longer remain living at home. The residential aged care program operates under the *Aged Care Act 1997* (the Act) and the Australian Government provides a range of subsidies to those who have been assessed as eligible.

Subsidised residential aged care can be offered on a permanent or respite basis. Permanent care means a person moves into an aged care home on an ongoing basis and it becomes the place where they normally live. Respite care is short-term care for a person so that either their carer or the person being cared for can have a break from their usual care arrangements.

Government-subsidised residential aged care must be provided through ‘places’ that are allocated to aged care providers through a periodic process called the Aged Care Approvals Round (ACAR) which is described below. Care and accommodation subsidies (and supplements) are paid directly to the aged care home, in respect of an eligible consumer occupying a place.

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 – the entry point to access subsidised aged care services – and have their care needs assessed by an Aged Care Assessment Team (ACAT) as being eligible for subsidised residential aged care
2. find an aged care home, operated by an approved provider, with an available allocated place and be offered that place. The consumer and aged care home then enter into a contract to formalise the offer and acceptance. If there are no available places at a consumer’s preferred aged care home, they can ask to be placed on a wait list managed by the aged care home.

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 (higher level of amenities or services beyond the minimum requirements) will pay fees for those services as negotiated with the provider.

Provision of residential aged care - providers’ perspective

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

1. be an approved provider⁵ of residential aged care
2. have an accredited⁶ aged care home⁷
3. hold an allocation of residential aged care places.

⁵ To become an approved provider, an applicant must be a corporation and meet certain threshold requirements to demonstrate suitability to provide the aged care.

⁶ In order to be eligible for a government subsidy, aged care homes must be accredited by the Aged Care Quality and Safety Commission, which involves assessment against the Aged Care Quality Standards via site audits. The Certificate of Accreditation is time-limited, after which the service must apply for re-accreditation.

⁷ Under the *Aged Care Act 1997* (the Act) (subsection 41-3(2)), ‘residential care’ does not include care provided in the person’s private home (nor can it be provided in a hospital/psychiatric facility; or a facility that primarily provides care to people who are not frail and aged).

In order to receive a subsidy (and relevant supplements) for consumers in their care, the provider must have an eligible consumer occupying one of the allocated available places. No subsidies or supplements are paid for vacant places under the residential aged care program⁸.

An allocation of places can be obtained from successful application through the ACAR or by negotiating a transfer of places from another approved provider, subject to departmental approval.

Allocating new residential aged care places: Aged Care Approvals Round

The ACAR is a competitive written application process enabling prospective and existing approved providers to apply for new subsidised residential aged care places, short-term restorative care places, and financial assistance in the form of capital grants.

A key policy objective for the Government in its allocation planning process is to ensure that residential aged care places are allocated in a way that best meets the identified needs of the community⁹.

The process for planning the allocation and distribution of new aged care places is set out in the Act and the Allocations Principles 2014. The process has three key elements:

4. determining the number of new places to be made available
5. targeting of specific geographic locations, consumers from vulnerable cohorts (i.e. special needs groups)¹⁰, and particular priorities for service provision (i.e. key issues)
6. allocating those places to specific providers after a competitive selection process, assessed in accordance with criteria specified in the legislation.

These three parts of the process are discussed in turn.

Determining the number of places available in the ACAR

The Australian Government manages the supply of aged care places and its Budget expenditure on subsidising those places by specifying a national target provision ratio of subsidised aged care places for every 1,000 people aged 70 years and over (termed the 'aged care provision ratio'). The current target is set at 125 places by 2021-22 – comprising 78 residential aged care places, 45 home care places and 2 restorative care places (transition care and short-term restorative care) (Tune, 2017). The target ratio is intended as an estimate of consumer demand.

The number of new aged care places made available for allocation in each state and territory is calculated to meet the target aged care provision ratio for each jurisdiction, and is also influenced by:

- Government funding available in the forward estimates (budget projections for the three years beyond the current fiscal year). Since 1 July 2018, the previously separate budget items for home care and residential aged care programs have been combined. This was intended to enable greater flexibility to respond to changes in demand for home care packages and residential aged care, in response to consumer preferences (Commonwealth of Australia, 2018)
- demographic projections
- current levels of service provision (i.e. operational places, occupancy levels)

⁸ Different subsidy payment arrangements apply for residential aged care places under the flexible aged care programs

⁹ See the Act, Section 12-2.

¹⁰ The special needs groups under Section 11-3 of 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.

- newly allocated places from previous ACARs that are not yet operational (i.e. provisionally allocated places). Any offline places are not included in calculating¹¹ the progress towards meeting the target provision ratio, and so do not affect the number of places released in the ACAR.

Since the 2016-17 ACAR, new places have been made available at the state and territory level rather than within each of the 73 Aged Care Planning Regions¹² or grouping of Aged Care Planning Regions as was the case in previous ACARs. This approach is consistent with advice provided in the Aged Care Sector Committee's Aged Care Roadmap, which recommended minimal regional restrictions on the distribution of aged care places (Aged Care Sector Committee, 2016).

The Minister for Aged Care and Senior Australians, informed by advice from the department, formally determines the number of places by care type which are to be available for allocation in each state and territory through a Ministerial Determination.

Mechanisms for targeting specific priorities

The ACAR process includes certain mechanisms that seek to shape service provision, through:

- giving priority to assessing applications for, and allocating places to, suitable aged care homes that propose to target particular identified needs in the community
- stipulating conditions specific to an allocation of places.

Targeting identified community needs through the ACAR

Community needs include the availability of services in particular geographic areas (such as regional, rural and remote areas), to consumers from vulnerable cohorts (e.g. legislatively defined special needs groups), and to address key issues, which commonly include dementia care and respite care. Other key issue groups may also be identified as part of the ACAR sector consultations or by applicants themselves in their applications¹³.

The department publishes an 'Essential Guide' for each ACAR, which provides guidance on the ACAR application and assessment process. In the last ACAR, the Essential Guide stated:

'In the 2018-19 ACAR, the department will give priority to assessing and allocating places to suitable applications for residential care places to services located in regional, rural and remote areas. While this is priority for the 2018-19 ACAR, residential care places will remain available for allocation nationally, including metropolitan areas.' (Australian Government Department of Health, 2018b) (p. 11).

The degree to which applications are sought in particular areas and/or for needs groups/key issues are conveyed through a category of prioritisation, from Category 1 (highest priority) down to Category 6 (lowest priority) in each Statistical Area Level 3 (SA3)¹⁴, which are more granular geographic areas than Aged Care Planning Regions. Categories 1 to 3 were assigned to SA3s where either all or the majority of the population are based in regional, rural or remote locations. Categories 4 to 6 were assigned to SA3s where either all or the majority of the population are based in metropolitan locations. Suitable applications in the higher categories are considered and allocated places before applications in lower priority categories (Australian Government Department of Health, 2018b).

¹¹ The department models the number of places it needs to release through an ACAR on the basis of how many operational and provisionally allocated places there are at a national level in the first instance, and then within each state and territory. Offline places are not included in this modelling, and so have no impact on the number of places released.

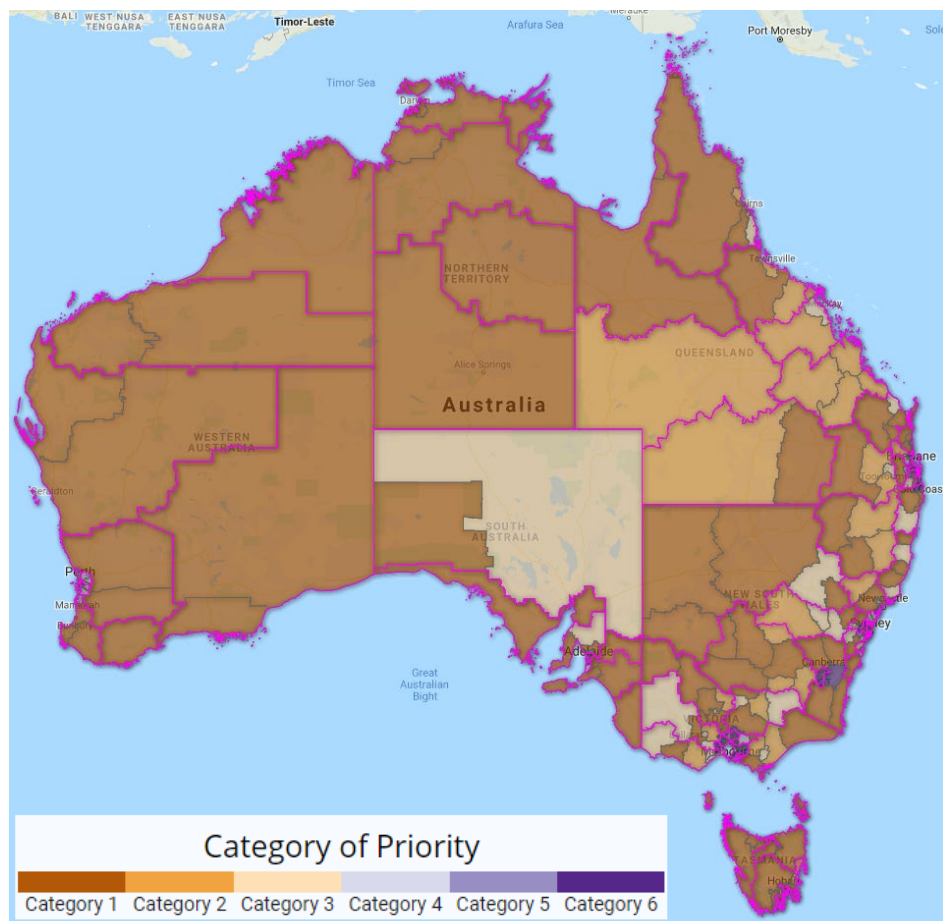
¹² Aged care services in Australia are funded and delivered in regions called Aged Care Planning Regions.

¹³ Examples of other Key Issue groups that were allocated places in the 2018-19 ACAR include: couples, palliative, bariatric and mental health care.

¹⁴ Statistical Area Level 3 (SA3s) form part of the Australian Statistical Geography Standard framework of statistical areas. SA3s offer more granularity than Aged Care Planning Regions. There are over 300 SA3s nationally compared to only 73 Aged Care Planning Regions. SA3 geography was first introduced in 2016-17 ACAR. Aged Care Planning Regions are constructed of groupings of SA2s, which are a smaller geography than SA3.

When the ACAR is advertised, an interactive map (figure 2.1) is published to help prospective applicants understand the priorities and targeting focus within each SA3 of a state and territory. To complement the interactive map, a snapshot of graphs and tables is also published to help applicants inform their understanding of aged care needs in each SA3. These snapshots provide an overview of aged care service provision, population projections and special needs group data.

Figure 2.1 Map of 2018-19 ACAR Categories of Priority across Australia



Note: Categories of Priority are shaded accordingly for each SA3, denoted by grey boundaries. Aged Care Planning Regions are denoted by purple boundaries.

Source: Department of Health, previously published on 2018-19 ACAR webpage

Conditions of allocation

Targeting of particular priorities in the ACAR is supplemented by specific conditions of allocation that may be attached to residential aged care places, based on the provider's proposed service provision targeting in their application.

For example, if an applicant for a residential aged care place in an ACAR indicates that it wishes to provide priority of access for consumers from one or more special needs groups or key issue groups, and is subsequently allocated a place, the place may have a "priority of access" condition of allocation imposed on it for the relevant group. In recent ACARs, around 23 per cent of places have been allocated which have specified priority of access for one or more special needs groups and around 31 per cent of places have been made in respect of key issue groups, the majority of which have a focus on dementia care.

A priority of access condition of allocation requires the approved provider to give priority of access to a special needs group or other key issue group targeted in the application in filling the place. However, the approved provider may allow a person from outside the targeted group to fill the place: the condition imposed on the place is to give priority of access rather than to guarantee that it will only be used by a person from a particular group. These places are not quarantined from use if special needs/key issue consumers are not occupying them. The department has not historically monitored whether a place is being

used by a person from a group where a “priority of access” condition exists. It has committed to doing so in the near future (Smith, 2019b).

ACAR applications, assessment and allocation

Application information

Current and prospective approved providers¹⁵ seeking new aged care places through the ACAR are required to complete a written application form and provide requested documentation. As noted earlier in this chapter, the department publishes an ‘Essential Guide’ for each ACAR, which provides guidance on the ACAR application and assessment process.

Applicants are asked to provide detailed information in their written application, including:

- applicant details and their organisation’s financial information (Statements of Financial Position, Profit and Loss and Cash Flows)
- description of their proposal for service, including where the aged care home is located, what they plan to do with the places, how they will provide care, who will benefit and how, and when the places will be operational – including details of any proposed capital works and the quantity and quality of accommodation
- demonstration of their understanding of the need for residential aged care places in the local community, including provision of data to substantiate their claims
- description of any targeting and tailoring of care to special needs groups or key issues (e.g. residential respite, dementia), including suitability of their experience/expertise and building
- provision of a Certificate of Occupancy or details about the status of land acquisition and zoning, financing arrangements for capital works – including milestones/ timeframes and associated risks – supported by evidence (e.g. approved or submitted development application).

Competitive assessment

All ACAR decisions, including the allocation of places, are made by the department based on the results of a competitive assessment process, the criteria for which are prescribed in aged care legislation¹⁶. The department assesses each applicant’s responses to the ACAR application form questions and also leverages information ascertained through other processes.

There are two broad stages of the assessment process undertaken by the department.

- Assessment, undertaken by state and territory offices (state offices), of individual applications to determine rating scores and undertake an initial ranking between applications, and prioritisation against the department’s objectives in the ACAR.
- Moderation and analysis conducted by the national office in partnership with state offices, taking account of all available information.

The initial assessment of applications is undertaken by rating their suitability against the relevant criteria, using a three-point-scale rating system (‘does not meet’, ‘meets’, ‘exceeds’). Information considered in the rating process includes not only the content of the application, but also information from other sources available to the department, particularly applicants’ compliance record where they are an existing aged care provider and evidence of their financial viability:

¹⁵ Applicants do not need to be an ‘Approved Provider’ at the time they submit their ACAR application(s), however no decision can be made with respect to any ACAR application until Approved Provider status is determined.

¹⁶ See Allocation Principles 2014, Sections 28-31

'A history of non-compliance, or an active Notice of Non-Compliance, does not preclude a provider from being allocated places, but is a factor considered in moderation. Places are not allocated to any approved provider with an active sanction.' (Smith, 2019a) (Paragraph 44).

The process produces an overall rating score that is used as the starting point of the ranking process. The state office then considers the overall rating score against targeted priorities and may adjust the ranking of applications based on how these priorities will be addressed.

For example, in the 2018-19 ACAR priority was given to applications in regional, rural and remote locations where additional residential aged care services were needed. In total, there were six categories of prioritisation for each geographical area, ranging from Category 1 (highest priority) down to Category 6 (lowest priority). Applications that would address Category 1 needs were given priority.

Provision of services to people from special needs groups and key issue groups were also a targeted priority in all locations with certain localities having a particular focus on certain groups. This can be relevant in considering competing applications to provide care in the same location, by looking at whether any of the applications are more likely to meet that identified need. For example, where provision of services to meet the needs of people from Aboriginal and Torres Strait Islander backgrounds is a focus.

From this initial assessment process, the state offices produce draft recommendations proposing which applications should be approved. These are then discussed in a moderation process involving both the national office and the state office staff, referred to as the Recommendation Review Panel (RRP). This allows both a national standardised approach to getting the best outcome from the ACAR, as well as risk management across the process. The RRP considers information available nationally as well as information from the moderation of applications across regions, and comparison of applications across the full ACAR process. This can result in adjustments to rankings and recommendations.

Examples of factors that national moderation by the RRP can address include:

- whether the proposed allocations will increase diversity of choice for current and future care recipients, and their carers and families¹⁷
- whether an applicant has made multiple separate applications for places in many locations across the country and is recommended for allocation in a large number of instances. The national moderation process allows consideration of the capacity of that applicant to successfully operationalise all places in a timely manner
- analysis of the total pool of recommendations across the country which may show that services supporting a special needs group are under-represented among the pool of proposed recommended applications. The RRP can review similarly ranked applications and see if there are alternative proposals that would better support those special needs
- an applicant may be issued a Notice of Non-Compliance for one of their existing services while assessment is underway. The RRP can take this into account in reviewing performance of competing applications.

The RRP Chair formally advises the departmental delegate of the outcome of the application assessment process and requests the delegate to exercise delegation to formally allocate places to recommended applicants (Smith, 2019a).

Allocation

Allocations of places can only be made to organisations that are approved providers under the Act. While an ACAR application can be submitted at the same time as an application to become an approved provider, the applicant cannot be allocated places (or a grant) until they are approved as an approved provider.

¹⁷ See *Allocation Principles 2014*, Section 29

Approved Provider criteria

When assessing an applicant's suitability to become an approved provider, the department considers the applicant's:

- experience in providing aged care or other relevant forms of care
- demonstrated understanding of its responsibilities as a provider of the type of care for which approval is sought
- systems it has, or proposes to have, in place to meet those responsibilities
- record of financial management and the methods used, or proposed, to ensure sound financial management
- if the provider has been a provider of aged care, its conduct as a provider and compliance with its responsibilities as a provider and obligations arising from the receipt of any payments from the Commonwealth for providing that aged care.

Applicants must provide documentation to support their application. This includes, for example, national police checks for key personnel, recent financial statements, business plans and organisational charts.

Provisionally allocated places

Places are allocated to successful applicants in respect of a specified location (service) nominated in their application. The places are allocated on a provisional basis (provisionally allocated places) until such time as they are able to be operationalised and utilised by a consumer. It takes on average 4.3 years for providers to acquire land, obtain planning approval and construct and commission an aged care home¹⁸.

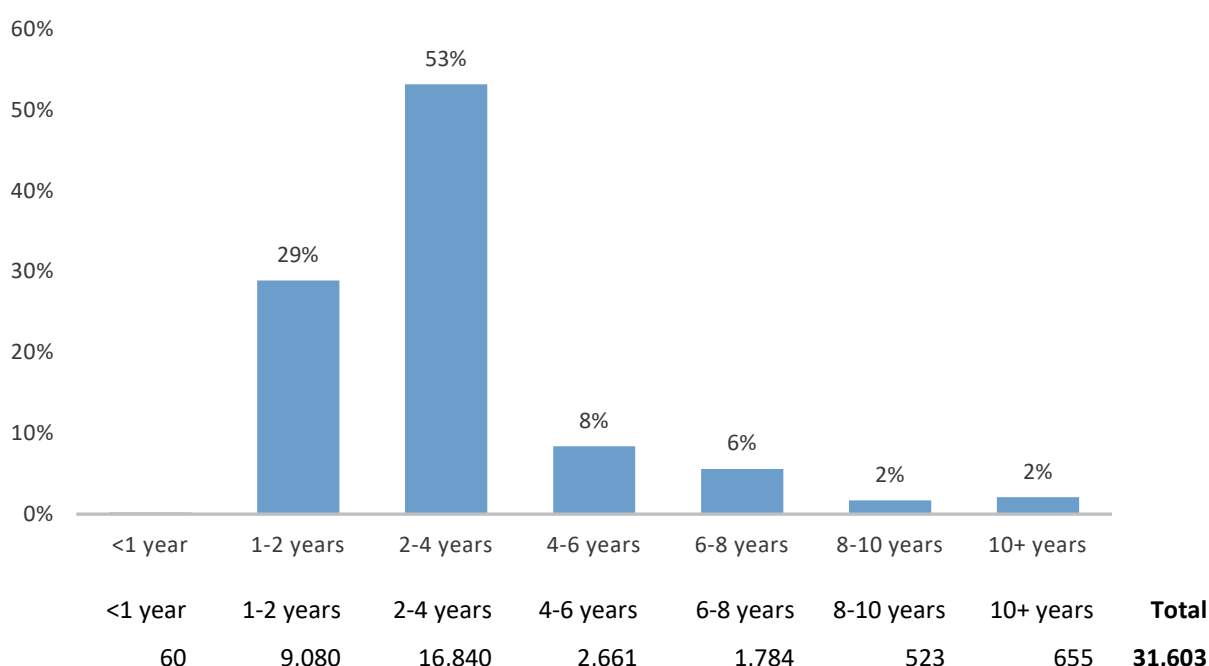
Provisionally allocated places can include those forming part of an aged care home that is yet to be built or is currently undergoing construction.

Approved providers who receive provisionally allocated places are given an initial period of four years to make the places operational (it is a condition of allocation that annual progress reports must be submitted to the department), with two possible 12-month extensions available on application to the department. Extensions beyond six years are only available where the approved provider can demonstrate exceptional circumstances. After six years the provisionally allocated places can be revoked and returned to the department if an extension has not been approved. Departmental data shows that no provisionally allocated places were revoked in 2018-19, but there were around 350 places revoked in 2017-18 due to the timeframes not being met and exceptional circumstances not being demonstrated.

The distribution of provisionally allocated residential aged care places by years since allocation (as at 30 June 2018) is shown below (figure 2.2).

¹⁸ See Aged Care Amendment (Movement of Provisionally Allocated Places) Bill 2019, Second Reading Speech – 13 February 2019, House of Representatives Bills

Figure 2.2 Distribution of provisionally allocated residential aged care places by years since allocation, proportion and number, 30 June 2018



Source: Analysis based on unpublished data from Department of Health

Management of allocated places – variations to conditions of allocation

Conditions of allocation can be varied through a formal written application to, and approval by, the department. Typically, providers seek to vary the conditions relating to:

- location (i.e. temporary or permanent movement of the places to another aged care home)
- changes to the aged care home, including name and administrative identifiers
- an increase or decrease in the number of days during which residential respite is to be delivered.

Operational, offline and provisionally allocated places can be moved to any location within the state or territory that the place/s were originally allocated, if the provider can demonstrate to the department that: such movement would be in the interests of consumers; there is a clear need for places in the new region; and the move is not detrimental to the original region. Places cannot be relocated to a different state or territory. In 2018-19, over 1,100 residential aged care places (operational, offline and provisional) were relocated to a different Aged Care Planning Region, representing less than half of one per cent of the total pool of allocated residential aged care places as at 30 June 2019.

Despite having made certain commitments in the ACAR application, some providers can have difficulties locating suitable land and navigating local government planning processes. In such circumstances, operationalising places in the original Aged Care Planning Regions to which they were allocated may not be feasible for them. The Act did not previously permit movement of a provisionally allocated place to another Aged Care Planning Region. However, the Aged Care Amendment (Movement of Provisionally Allocated Places) Bill 2019 was passed in September 2019¹⁹ to allow the Secretary of the department (or delegates) to permit approved providers to move provisionally allocated places between Aged Care Planning Regions within a state or territory where a provider can demonstrate that the movement is in the interests of consumers and there is a clear need for places in the new region.

¹⁹ The Aged Care Amendment (Movement of Provisionally Allocated Places) Bill 2019 received Royal Assent on 20 September 2019

Management of allocated places – surrendering, revocation or transfers

Once an aged care provider has been allocated an aged care place, it remains with that provider permanently, unless:

- the place is surrendered by the approved provider
- the place is revoked by the department
- the provider transfers the place to another approved provider

Departmental data indicates that in 2018-19 (and similarly in 2017-18), over 600 provisionally allocated places were surrendered, representing around 2 per cent of total provisionally allocated places as at 30 June 2019. This was typically because the provider could not, or no longer wished to, progress with the project (e.g. renovations or builds).

Places are not often revoked. There were no places revoked by the department in 2018-19. However, in 2017-18, around 300 operational or offline places were revoked due to revocation of approved provider status as a result of non-compliance and (as previously mentioned above) an additional 350 provisionally allocated places were revoked for not meeting timeframes. Together this represented less than half of one per cent of the total pool of allocated residential aged care places as at 30 June 2019. Where places are surrendered or revoked, the department does not reallocate these places outside of an ACAR but defers re-allocation until the next ACAR is undertaken.

Operational, offline and provisionally allocated places can be transferred to another approved provider within the state or territory through submission of a Notice to Transfer Aged Care Places form to the department, rather than a formal application process. The department may veto the transfer notice under particular circumstances (Australian Government Department of Health, 2016b). The department considers whether the transfer:

- would meet the objectives of the planning process (i.e. best meet the identified needs of the community, particularly any special needs groups)
- would still meet the needs of consumers currently being provided with care through those places
- would be to a suitable provider, considering such matters as their standard of care and accommodation and their conduct as a provider
- supports the financial viability of both the transferor and transferee aged care home.

Where the location of an allocation of places changes (including to a different region within the state or territory) as part of a transfer, there are in effect two decisions being made: (1) a transfer of responsibility for those places from one provider to another provider; and (2) a variation to the conditions of allocation to change the location of the places.

Departmental data indicates that in 2018-19, nearly 11,000 allocated residential aged care places were transferred to another provider, representing around 4 per cent of total allocated places as at 30 June 2019. Around 9,000 were operational places (4 per cent of operational places), less than 1,500 were provisional (4 per cent of provisional places), and over 400 were offline places (5 per cent of offline places).

Recent ACARs

The ACAR has been run five times in the last eight years, during which over 53,000 new places have been allocated. This section describes the outcomes of recent ACARs.

Timings

The timing of ACAR has varied over recent years, as indicated below in relation to the last five ACARs (table 2.1).

Table 2.1 Opening, closing and results announcement dates of last five ACARs

ACAR	Opening date	Closing date	Results announced
2018-19	2 July 2018	10 August 2018	5 March 2019
2016-17	19 September 2016	28 October 2016	26 May 2017
2015	15 August 2015	25 September 2015	18 March 2016
2014	24 May 2014	4 July 2014	4 December 2014
2012-13	10 November 2012	21 December 2012	05 July 2013

Source: Compiled based on published Department of Health ACAR information

At the time of finalising this report, a 2020 ACAR was announced, offering 10,000 residential aged care places, 750 short-term restorative care places and up to \$60 million in capital grants (Senator the Hon Richard Colbeck, Minister for Aged Care and Senior Australians, 2019). The opening date for applications will be in March 2020, with a closing date in May 2020.

Results

The application process for residential aged care places and capital grants is highly competitive, as shown below (table 2.2). The number of places and grants sought consistently exceed the places and grants available. The Impact Analysis notes that this may in part be in response to the capping of total places under ACAR and consequent over-bidding in the face of uncertainty. There would be little expectation by providers who lodge large numbers of applications that they would be successful for all of the places they sought.

Table 2.2 Residential aged care places and capital grants available, sought and allocated in last five ACARs

ACAR	Places available	Places sought	Places allocated	Ratio of places available to places sought	Capital grants sought	Capital grants allocated
2018-19	13,500	37,802	13,500	1: 2.8	\$394m+	\$60m
2016-17	10,000	45,053	9,911	1: 4.5	\$415m+	\$64m
2015	10,940	38,859	10,940	1: 3.6	\$444m+	\$67m
2014	9,330	19,169	11,196*	1: 2.1	\$456m+	\$103m
2012-13	8,341	11,078	7,775	1: 1.3	\$315m+	\$51m

Note: *Competition for new residential aged care places was much stronger in the 2014 ACAR than in previous rounds. An additional 1,866 residential aged care places were created through a variation to the original Ministerial Determination.

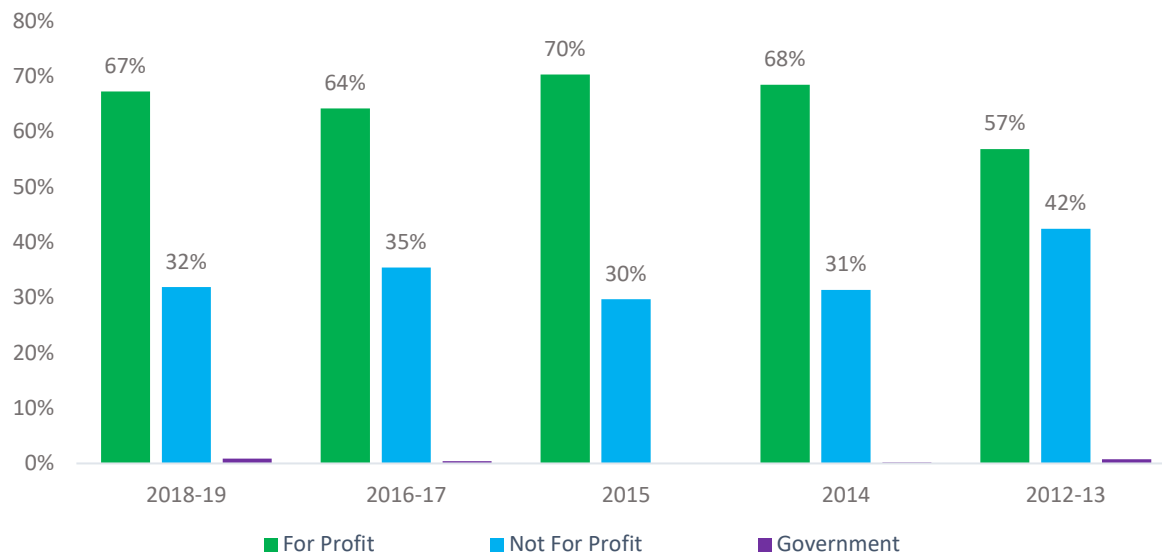
Source: Department of Health, compiled based on published and unpublished information

Key trends in the allocation of residential aged care places over recent years have included:

- significant bidding by providers to a level which exceeds, at the national level, the known number of places being made available under the ACAR
- consistent undersubscription in smaller states/territories (e.g. Northern Territory, Australian Capital Territory, Tasmania)

- more than half of the allocated places being for the development of new aged care homes (with the remaining allocated to expand, rebuild/upgrade existing aged care homes)
- for-profit providers consistently being allocated a greater share of the allocated places, compared to other ownership types (figure 2.3).

Figure 2.3 Share of total allocated residential aged care places by organisation type, last five ACARs



Source: Analysis based on published Department of Health ACAR results

2018-19 ACAR – Overview of places sought

In the last completed 2018-19 ACAR, 571 applications were received, seeking a total of 37,802 new residential aged care places, in respect of the 13,500 places being made available (Australian Government Department of Health, 2019a). On average, 66 new places were sought per application.

Some of the other key features of the results of the last round are set out as follows.

Development of new or existing aged care homes

- Most places sought (around 73 per cent) were to develop new aged care homes. An average of 108 places were sought per application relating to new aged care homes.
- Just over a quarter of places sought (around 27 per cent) were to expand existing aged care homes, rebuilding/upgrading of older homes or expanding homes yet to be developed. On average, 33 new places were sought per application relating to existing aged care homes.

Organisation type

- The majority of places (68 per cent) were sought by for-profit providers, mostly to develop new aged care homes.
- Around a third of places (31 per cent) were sought by not-for-profit providers, with a balance across existing and new aged care homes.
- Government providers only sought 1 per cent of the available places, mostly to expand existing aged care homes.

Priority categories

- In the 2018-19 ACAR, the department set a high priority on applications proposing to deliver services in regional, rural and remote areas that had low levels of care available relative to the target provision ratio and had unmet needs²⁰ in residential aged care.
- Around 27 per cent of places were sought in the highest priority category while almost 30 per cent of places sought were in the lowest priority category.
- Providers tended to apply for lower priority categories, with around 67 per cent of places sought in priority categories 4-6 (predominantly metropolitan areas). This trend did not significantly differ between for-profit or not-for-profit ownership types. The majority of the 1 per cent of places sought by government providers was for priority category 1 areas.
- There was a 42 per cent increase in the number of regional, rural and remote places sought (11,949) compared to 2016-17 ACAR (8,402). It should be noted that the large majority of these places were sought in regional areas, rather than rural or remote areas. Further, when considered relative to the 36 per cent increase in the total number of places made available in 2018-19 ACAR (13,500) compared to 2016-17 (9,911), it is a marginal increase.

Prioritisation and organisation type

- Among for-profit applicants, between 2016-17 ACAR and 2018-19 ACAR there was:
 - a decline in both the applications (-37 per cent, 345 down to 219) and places (-40 per cent, 29,712 down to 17,744) sought for major cities
 - an increase in applications and places sought in non-metropolitan areas, specifically:
 - inner regional: 20 per cent increase in applications (from 64 to 77) and 43 per cent increase in places (from 5,177 to 7,378)
 - outer regional: 50 per cent increase in applications (from 6 to 9) and 249 per cent increase in places (from 186 to 650)
 - there were no changes in the number of applications or places sought in remote and very remote areas, which remained close to nil.
- Among not-for-profit applicants (including government providers), between 2016-17 ACAR and 2018-19 ACAR there was:
 - an increase in applications (4 per cent, from 121 to 126) and places (20 per cent, from 6,705 to 8,039) in major cities
 - an increase in applications in non-metropolitan areas, specifically:
 - inner regional: 56 per cent increase in applications (from 64 to 100) and 36 per cent increase in places (from 2,301 to 3,124)
 - outer regional: 3 per cent increase in applications (from 32 to 33) and 8 per cent increase in places (from 606 to 656)
 - there was only a negligible increase in the very small number of applications and places sought in remote and very remote areas

²⁰ Based on submissions made by stakeholders during consultation undertaken as part of ACAR planning and data maintained by the department

2018-19 ACAR – Overview of places allocated

Table 2.3 shows the relationship between the priority levels set for the 2018-19 ACAR and the outcomes of the process. Overall, applications seeking places in high priority categories were more likely to be allocated places.

In the 2018-19 ACAR, a total of 13,500 residential aged care places were allocated. While 61 per cent of places were allocated to major cities (8,224), there was a significant 94 per cent increase in the number of places allocated (5,276) to regional, rural and remote areas (largely to regional areas) compared to 2016-17 ACAR (2,719). These non-metropolitan allocations of places were as follows:

- Inner regional: 4,750 (36 per cent of total allocated places)
- Outer regional: 499 (4 per cent of total allocated places)
- Remote: 27 (0.2 per cent)
- Very remote: Nil

As such, it appears the prioritisation had a bigger percentage impact on the number of places allocated in non-metropolitan areas, rather than on the earlier discussed applications and places sought in these areas.

Table 2.3 2018-19 ACAR applications and residential aged care places sought and allocated by priority category

Priority category	No. of applications	No. of residential care places sought	No. of successful applications	No. of residential care places allocated	Success rate of applications	Success rate of places sought
Cat. 1 - RRR	159	9,948	97	4,522	61%	45%
Cat. 2 - RRR	24	625	17	456	71%	73%
Cat. 3 - RRR	44	1,951	22	702	50%	36%
Cat. 4 - Metropolitan	115	9,485	61	4,442	53%	47%
Cat. 5 - Metropolitan	59	4,812	25	1,772	42%	37%
Cat. 6 - Metropolitan	170	10,981	34	1,606	20%	15%

Note: RRR: Regional, rural, remote

Source: Compiled based on published and unpublished information from Department of Health

Conditions of allocation specifying priority of access

Of the 13,500 residential aged care places allocated in the 2018-19 ACAR, 2,968 (22 per cent) were allocated with conditions of allocation specifying priority of access to special needs groups and 4,849 (36 per cent) were allocated in respect of key issue groups, the majority of which focused on dementia care.

Allocated places for new aged care homes versus existing aged care homes

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.

Allocated places to new versus existing provider applicants

In the 2018-19 ACAR, new and prospective approved provider applicants sought 2,473 (7 per cent) of the total places with the remaining 35,329 places (93 per cent) sought by existing approved providers. Only 308 places (2 per cent) were allocated to new approved providers compared to 13,192 places (98 per cent) being allocated to existing approved providers.

Allocated places to providers with a strong compliance record

In the 2018-19 ACAR, the majority (76 per cent) of residential aged care places were allocated to providers with no compliance or sanctions action taken upon them within the last three years (or ever). A further

20 per cent of places were allocated to providers who had some history of compliance action taken upon them (subsequently remedied), with only 2 per cent of places allocated to providers with an active Notice of Non Compliance. The remaining 2 per cent of places were allocated to new providers who did not have a compliance record.

Programs related to allocated residential aged care places

There are several programs that currently interact with the allocation of residential aged care places. These programs include residential respite care and capital grants that supports the development of residential aged care in economically non-viable circumstances.

Other programs relevant to considerations to changes to the place allocation mechanism include Extra Service Status and Additional Services programs.

The short-term restorative care program is a form of flexible aged care for which places are also allocated to providers via the ACAR, However, as outlined in chapter 1, flexible aged care places are out of scope for this Impact Analysis.

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, and is provided to a consumer at a high or low level (depending on the ACAT's assessment and approval).

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. If the allocation system is altered in a way that means providers no longer have allocated places, then the respite care allocation mechanism will need to be modified as well.

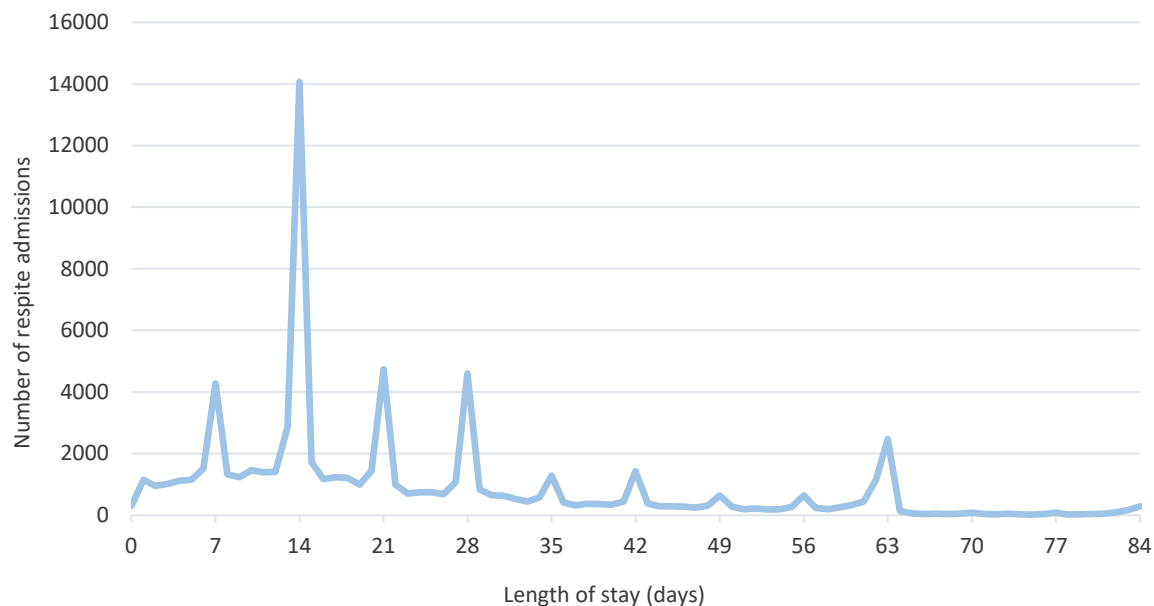
All approved providers are able to provide respite care if they have the capacity to do so, even if places are not allocated with respite care being a condition of allocation. In 2018-19, there were 2,579 aged care homes (around 95 per cent of all aged care homes) that provided residential respite care (Australian Government Department of Health, 2019b).

To incentivise providers to use their respite care allocation, an additional supplement amount (respite incentive supplement) in respect of high level respite care is available for 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.

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 with the possibility of extensions of up to 21 days at a time if needed.

In 2018-19, 65,523 people received residential respite care and, on 30 June 2019, there were 6,068 people receiving residential respite care (Australian Government Department of Health, 2019b). On average, each recipient received 1.3 episodes of residential respite care during 2018-19, and their average length of stay per episode was 25.8 days (Australian Government Department of Health, 2019b). Residential respite is most commonly accessed in weekly units, with a fortnight the most common length of stay (figure 2.4).

Figure 2.4 Frequency of length of residential respite care stay, 2017-18



Source: Aged Care Financing Authority, July 2019, Seventh report on the Funding and Financing of the Aged Care Industry

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).

Capital grants

Providers (excluding state or territory governments or their authorities²¹) 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 one or more of the following circumstances:

- the buildings are in regional, rural and remote areas of Australia
- they 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
- they are 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. The standard grant agreement requires the grantee to continue to provide care at that aged care home for a period of up to 20 years.

In the 2018-19 ACAR, the large majority of grants were allocated to priority categories 1-3 (regional, rural, and remote areas) (table 2.4). Only one grant was allocated to a lower category (category 4), to a remote provider specialising in providing care to a particular special needs group (but was based in a SA3 that contained a combination of metropolitan and non-metropolitan areas).

²¹ Approved Providers which are state or territory governments, or authorities of state or territory governments, are not eligible to receive a capital grant

Table 2.4 2018-19 ACAR capital grants applications, amounts sought and allocated, by priority category

Priority category	No. of capital grant applications	Capital grant amount sought	No. of successful applications	Capital grant allocated	Success rate	Proportion allocated of amount sought
Cat. 1 - RRR	55	\$203,878,305	20	\$42,996,328	36%	21%
Cat. 2 - RRR	16	\$72,666,729	3	\$3,240,000	19%	4%
Cat. 3 - RRR	13	\$37,481,698	4	\$12,565,081	31%	34%
Cat. 4 - Metropolitan	5	\$36,517,029	1	\$1,182,280	20%	3%
Cat. 5 - Metropolitan	3	\$25,046,667	-	\$0	0%	0%
Cat. 6 - Metropolitan	3	\$18,000,000	-	\$0	0%	0%

Note: RRR: Regional, rural, remote

Source: Compiled based on published and unpublished information from Department of Health

Extra Service Status and Additional Services

Extra service status (ESS) 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. Some aged care homes have ESS for the whole aged care home, or a distinct part of the home.

ESS was awarded to approved providers on a competitive basis, either as part of the ACAR or as a standalone ESS approvals round. No ESS approvals round has been conducted since 2012, and there are currently no plans to conduct a round in the future. ESS does not attach to an aged care place but attaches instead to an aged care home (or to a distinct part of the home). As such, ESS is only relevant to reviewing the mechanism that allocates places insofar that it offers a point of market differentiation for providers who have this status.

Approved providers with ESS are able to charge an extra service fee for consumers occupying a place located in an aged care home, or part of the home, where the ESS applies – irrespective of the consumption of such services. Prior to 2014²², one of the main motivations for providers to seek Extra Service places was that providers were permitted to charge an accommodation bond (lump sum refundable deposit) for all consumers of ESS aged care homes, whereas in non-ESS aged care homes an accommodation bond could only be charged for low care residents.

Since 2014, there has been a significant decrease (approximately 30 per cent) in the total number of places with ESS from 17,390 in 2014 to 12,148 in 2018 (Aged Care Financing Authority, 2019).

As at 30 June 2018, there were 233 aged care homes with Extra Service Status (around 9 per cent of all aged care homes) (Australian Government Department of Health, 2018d).

Consumers of residential aged care can also choose to purchase additional amenities ('additional services'), which exceed the minimum care and service requirements – provided the consumer can make use of or benefit from those services. Examples of these services include subscription or internet entertainment services, hairdressing and alcoholic beverages with meals. These may be offered individually or as part of a bundle of services. However, there is currently uncertainty relating to the criteria for classification of a service as an 'additional service' compared to those provided to all consumers.

²² Since 2014, consumers (both in extra service and non-extra service aged care homes) have more choice about how they wish to pay for their accommodation costs. See 'Reform Landscape' section later in this chapter.

The department has advised that some providers have indefinitely suspended their ESS, while others have permanently relinquished their ESS. This is commonly due to:

- the greater flexibility now available in offering higher accommodation standards and charging prices which reflect those standards
- the intention to offer similar services on an 'additional service' basis, which can be tailored to individuals and charged per service or as a bundled fee
- reduced consumer demand for Extra Service offerings, including dissatisfaction about having to pay Extra Service fees
- a desire to reduce administration or changed business priorities
- a desire for greater flexibility to intake supported residents

However, given the uncertainty regarding additional services, some providers have indicated that they will retain the ESS of some of their aged care homes for the foreseeable future.

Service utilisation and provision

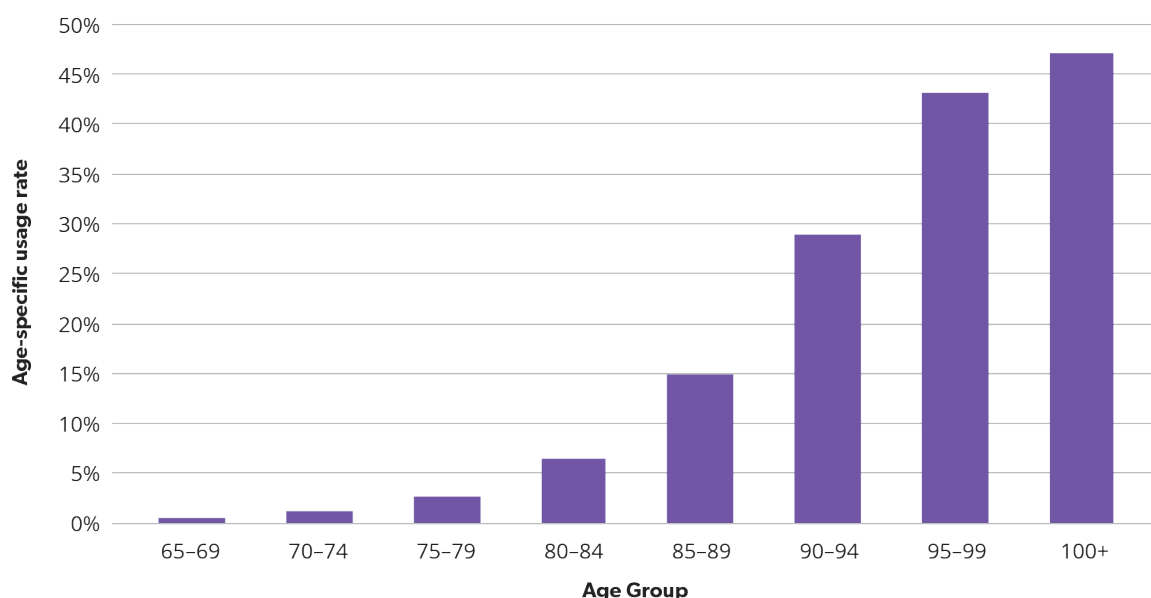
People in residential aged care

Age-specific utilisation

In 2018-19, 242,612 people received permanent residential aged care at some time during the year, and as at 30 June 2019 there were 182,705 people receiving permanent residential aged care (Australian Government Department of Health, 2019b). There were 60,657 first admissions into permanent residential aged care in 2018-19.

As age increases, the age-specific usage rates for residential aged care increases (figure 2.5).

Figure 2.5 Age-specific usage rates of residential aged care, 30 June 2019



Source: Department of Health, November 2019, 2018-19 Report on the Operation of the Aged Care Act 1997

Over the last few years, a slight decline in age-specific usage rates of residential aged care can be observed, including among the most prevalent (combined) age category of 85+ years (table 2.5). This suggests declining utilisation of residential aged care.

Table 2.5 Age-specific usage rates of residential aged care per 1,000 people, 30 June 2015 to 30 June 2018

Age	30 June 2015	30 June 2016	30 June 2017	30 June 2018
under 65	0.3	0.3	0.3	0.3
65–69	5.5	5.5	5.4	5.5
70–74	12.0	11.8	11.8	11.8
75–79	27.6	27.3	27.1	26.4
80–84	67.7	65.7	64.6	63.4
85+	215.4	213.9	211.4	208.8

Source: Compiled based on Productivity Commission Report on Government Services 2016, 2017, 2018 and 2019

People appear to be entering an aged care home at increasingly older ages. The average age on admission to permanent residential aged care was 84.6 years for women and 82.3 years for men in 2018-19 (Australian Government Department of Health, 2019b), up from 81 years for women 80.3 years for men in 2017-18 (Australian Government Department of Health, 2018a) and 80.5 years and 79.6 years respectively in 2016-17 (Australian Government Department of Health, 2017a).

Younger people in residential aged care

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 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 needs²³.

A younger person is generally considered to be under the age of 65, or 50 for Aboriginal and Torres Strait Islander people. As of 30 June 2019, there were 5,606 people aged under 65 years living in an aged care home (Australian Government Department of Health, 2019b).

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 (Australian Government Department of Social Services, 2019b). The Royal Commission into Aged Care Quality and Safety has called for priority action to reduce the number of younger people in residential aged care. In response to the Interim Report of the Royal Commission, the Australian Government announced on 25 November 2019 that it would strengthen the initial targets in the national action plan and would support further initiatives to help younger people to move to more appropriate accommodation and support. In the meantime, aged care subsidies and supplements remain payable in respect of younger people in residential aged care.

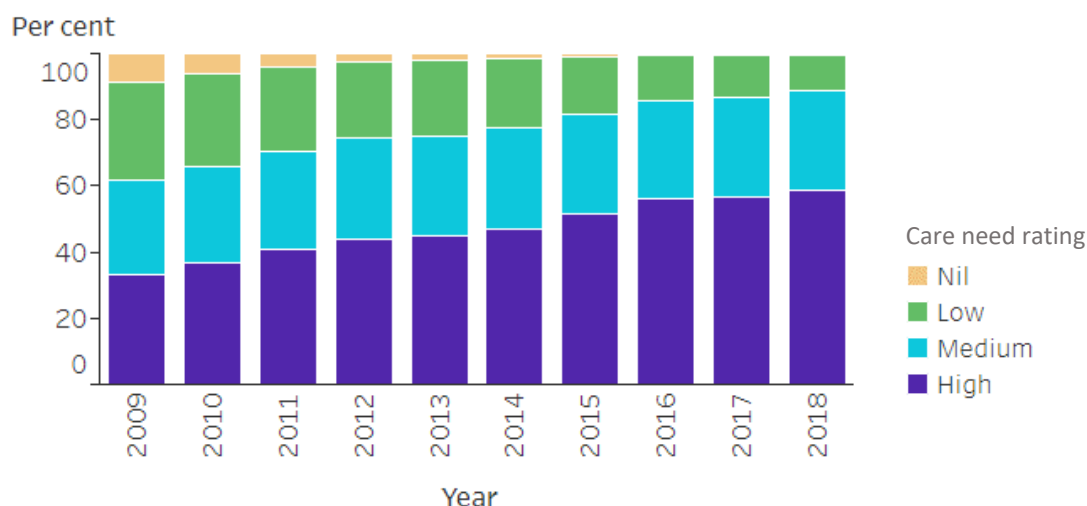
Acuity of need

An analysis of the Aged Care Funding Instrument (ACFI)²⁴ 'activities of daily living' care domain show that the proportion of people with a high care need has progressively increased over the last decade (figure 2.6).

²³ See *Approval of Care Recipients Principles 2014*, Section 6

²⁴ The Aged Care Funding Instrument (ACFI) assesses the relative care needs of residents and is the mechanism for allocating government subsidy to aged care providers for delivering care to residents. ACFI has three funding categories or domains: Activities of Daily Living, Behaviour, and Complex Health Care. Funding in each of these domains is provided at the following levels: High, Medium, Low and Nil.

Figure 2.6 Care need ratings for activities of daily living of people in residential aged care, 30 June 2009 to 30 June 2018



Source: Australian Institute of Health and Welfare, GEN Aged Care Data

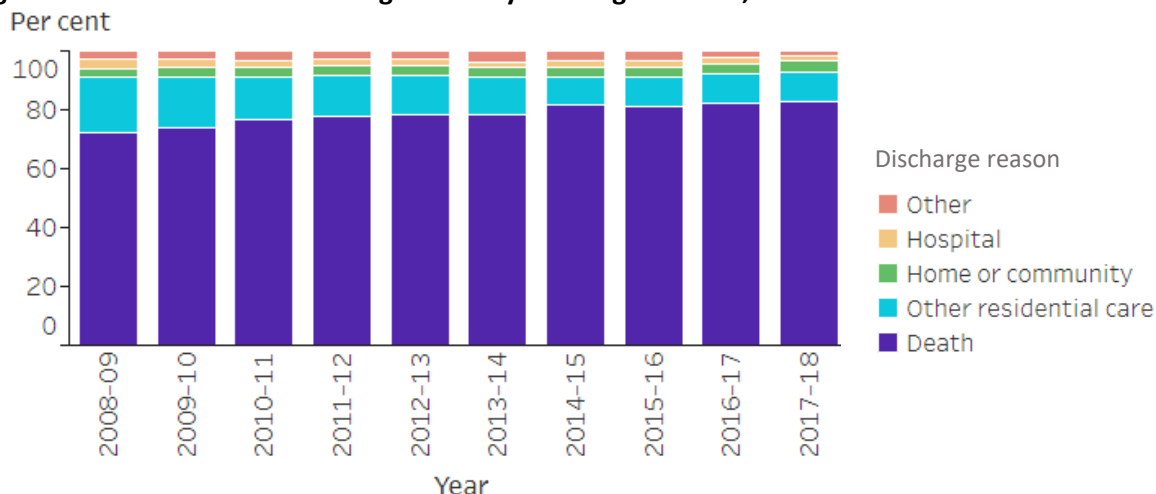
Further, at 30 June 2019, just over half (51.4 per cent) of all permanent residential aged care consumers had a diagnosis of dementia (Australian Government Department of Health, 2019b), up from 50.2 per cent as at 30 June 2018 (Australian Government Department of Health, 2018a), and 50 per cent as at 30 June 2017 (Australian Government Department of Health, 2017a) and 30 June 2016 (Australian Government Department of Health, 2016a).

Length of stay

In 2018-19, the average length of stay for permanent residential aged care was around 2 years and 8 months (Australian Government Department of Health, 2019b). In general, length of stay was longer for residents living with dementia – closer to 3.2 years (Australian Government Department of Health, 2017-18). Analysis undertaken by the Aged Care Financing Authority (ACFA) suggests there is a gradual decline in average length of time between first admission into permanent residential aged care and final discharge (Aged Care Financing Authority, 2019).

The most increasingly common reason for leaving permanent care was death (83 per cent in 2017-18 compared to 72 per cent in 2008-09), and this group had the longest average length of stay at just over 2 years and 8 months (Australian Institute of Health and Welfare, 2017-18). The proportion of residents who moved to another aged care home decreased by a similar share over the same time (from 19 per cent to 10 per cent) (figure 2.7).

Figure 2.7 Exits from residential aged care by discharge reasons, 2008-09 to 2017-18



Source: Australian Institute of Health and Welfare, GEN Aged Care Data

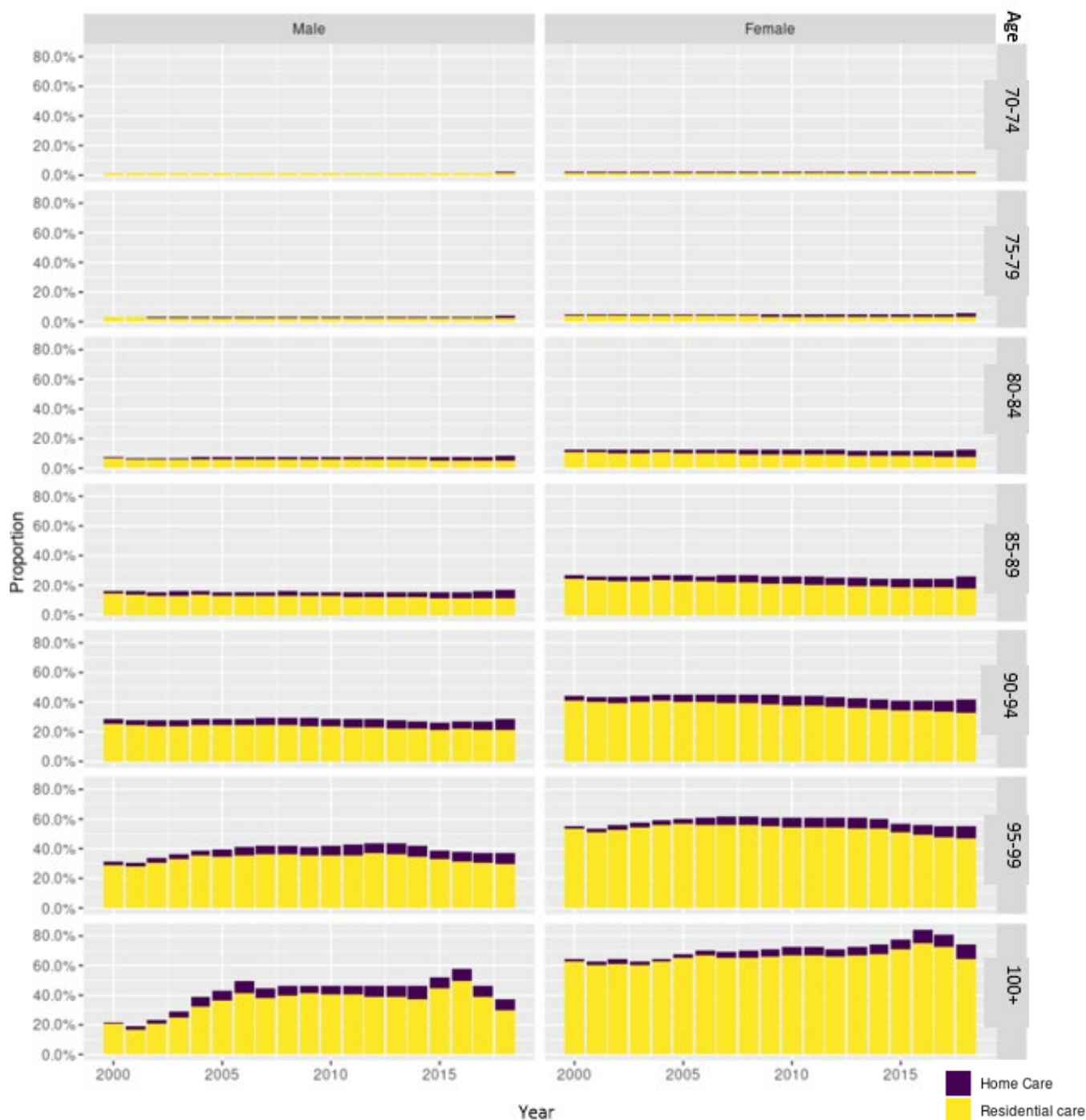
Taken together, it appears that people may be delaying their entry into an aged care home for as long as possible, preferring instead to remain in the community.

Substitution of residential aged care and home care

There are indications that home care is substituting for residential aged care. As the amount of home care available has expanded, there has been a clear reduction in the age-specific use of residential aged care.

Analysis below (figure 2.8) demonstrates that the proportion of people in each age group (age-specific use) who are receiving a type of aged care has remained stable over a long period of time. However, as home care packages have increased significantly as a share of these two care types there has been a clear reduction in the age-specific use of residential aged care.

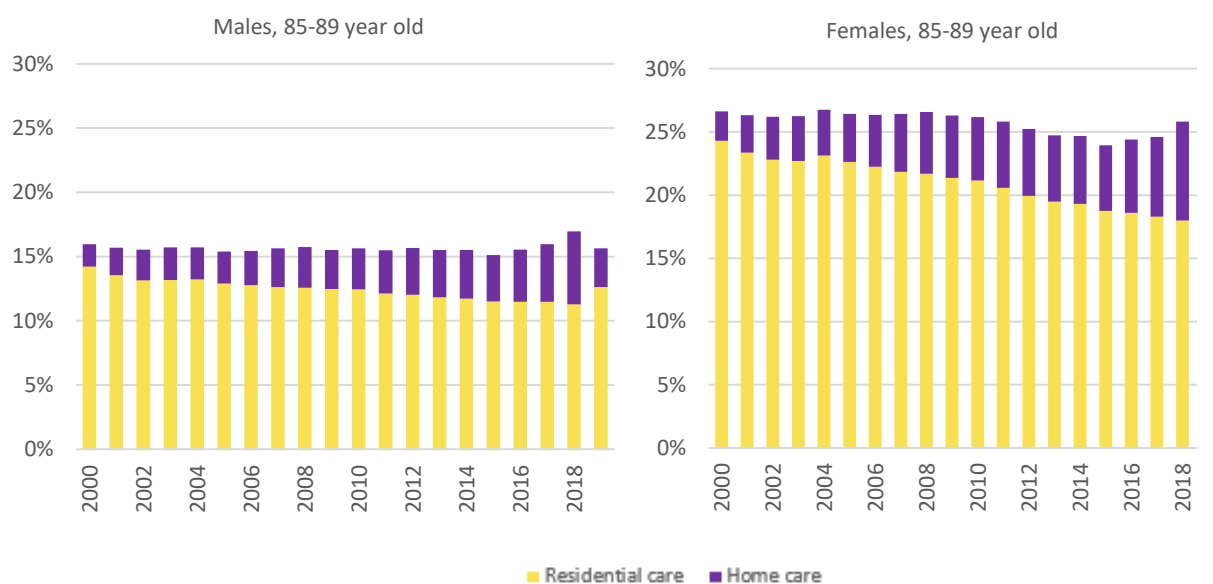
Figure 2.8 Age-specific utilisation of residential aged care and home care, 2000 to 2018



Source: Adapted from Aged Care Financing Authority, July 2019, Seventh report on the Funding and Financing of the Aged Care Industry

Among the 85-89 year olds and older age groups, the decline in rates of residential aged care utilisation compared to increased utilisation rates of home care over the decade to 2018 is clearly observable. Figure 2.9 presents an enlarged view of the residential aged care and home care utilisation rates presented in figure 2.8, as it relates males and females aged 85-89 years.

Figure 2.9 Utilisation of residential aged care and home care for 85-89 year olds, 2000 to 2018



Source: Aged Care Financing Authority, July 2019, Seventh report on the Funding and Financing of the Aged Care Industry

Service providers and places

Across Australia on 30 June 2019, there were 873 approved providers delivering residential aged care through 2,717 aged care homes (Australian Government Department of Health, 2019b) – with a total of 258,934 allocated residential aged care places (Australian Government Department of Health, 2019g). Over the years, there has been an ongoing, gradual consolidation of residential aged care providers, with the number falling from 972 in 2015-16 to 886 in 2017-18 (Aged Care Financing Authority, 2019).

Allocated places include operational places, offline places and provisionally allocated places. At 30 June 2019 (Australian Government Department of Health, 2019g):

- around 14 per cent of allocated places (36,905) were yet to be constructed or opened (hence their status as 'provisionally allocated').
- at least 3 per cent of allocated places (8,655) were previously operational but currently reported to the department as offline (temporarily unavailable for consumers)
- around 82 per cent of allocated places (213,397) were operational places (available to consumers).

It is noted that a further 10,000 residential aged care places will be allocated in the 2020 ACAR.

The median occupancy rate for aged care homes was 94.3 per cent and average occupancy was 89.4 per cent through 2018-19 (Australian Government Department of Health, 2019b). Similarly, StewartBrown, through their aged care financial performance survey, reports an average occupancy rate of 94.45 per cent as at 30 June 2019 (StewartBrown, 2019a) with a decline to 93.9 per cent in the September 2019 quarter (StewartBrown, 2019b). The issues relating to the various methods of reporting on occupancy were discussed in chapter 1 and in greater detail in [Appendix E](#).

Places and aged care homes by organisation type

On 30 June 2019, more than half (55 per cent) of operational residential aged care places were held by not-for-profit organisations (comprising religious, charitable and community-based providers), with for-profit organisations accounting for almost 41 per cent, and the remaining 4 per cent managed by governments (table 2.6).

The majority of residential aged care providers (63 per cent) operate only one aged care home, accounting for 20 per cent of aged care homes and operational residential aged care places in the sector. Conversely, a small minority (2 per cent) of providers operate 20 or more aged care homes, accounting for 31 per cent of aged care homes and 33 per cent of operational residential aged care places in the sector.

Table 2.6 Number of providers, aged care homes, and places in residential aged care, by organisation type, location and portfolio scale, 2018-19

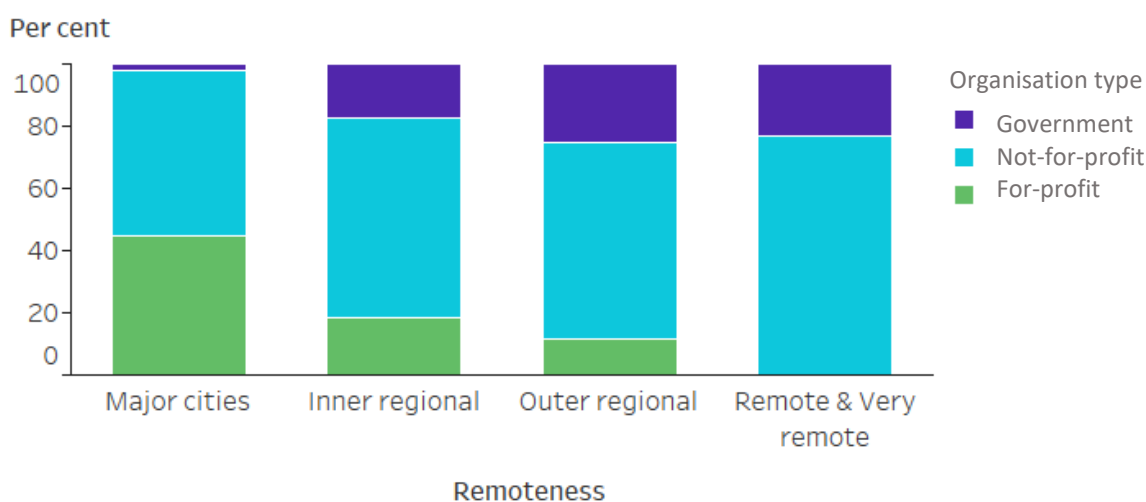
	Total sector 2018-19	Organisation type			Location						Portfolio scale			
		Not-for-profit	For-profit	Government	Major Cities of Australia	Inner Regional Australia	Outer Regional Australia	Remote Australia	Very Remote Australia	Mixed remoteness	Single aged care home	2 to 6 aged care homes	7 to 19 aged care homes	20 or more aged care homes
Providers	869	488	288	93	441	202	109	11	1	105	547	241	59	22
Aged care homes	2,718	1,558	922	238	1,697	656	320	33	12	n.a	547	673	652	846
Operational places	213,397	117,500	87,425	8,472	150,014	45,617	16,433	1,048	285	n.a	42,179	47,635	53,419	70,164

Source: Compiled based on published Aged Care Service List 30 June 2018 from GEN Aged Care Data

Remoteness and scale by ownership

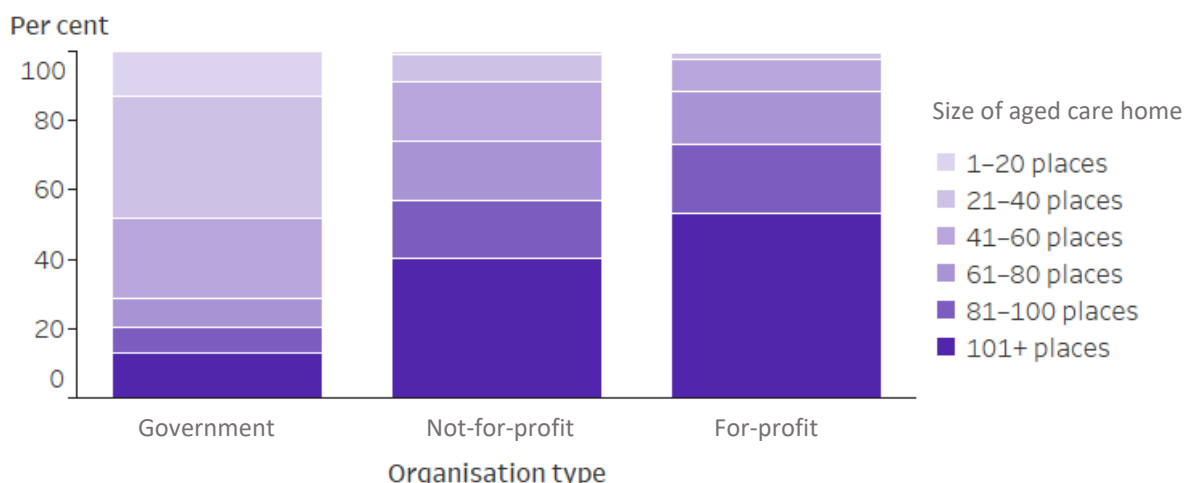
Generally, aged care homes run by for-profit providers are larger and are concentrated in major cities while not-for-profit providers manage a significant proportion of the aged care homes in all regions of Australia (figures 2.10 and 2.11). There are no for-profit aged care homes in remote and very remote regions of Australia (as at 30 June 2018).

Figure 2.10 Aged care homes by organisation type and remoteness, 30 June 2018



Source: Australian Institute of Health and Welfare, GEN Aged Care Data

Figure 2.11 Size of aged care home by organisation type, 30 June 2018



Source: Australian Institute of Health and Welfare, GEN Aged Care Data

Future demand

The Australian population is growing and ageing. At 30 June 2019, 16 per cent of Australia's population were aged 65 years and over (4.0 million people) and 2.0 per cent were aged 85 years and over (509,000 people). By 2029, it is estimated that 18 per cent of the population will be aged 65 years and over (5.3 million people) and 2.3 per cent (688,000 people) will be 85 years and over (Australian Government Department of Health, 2019b).

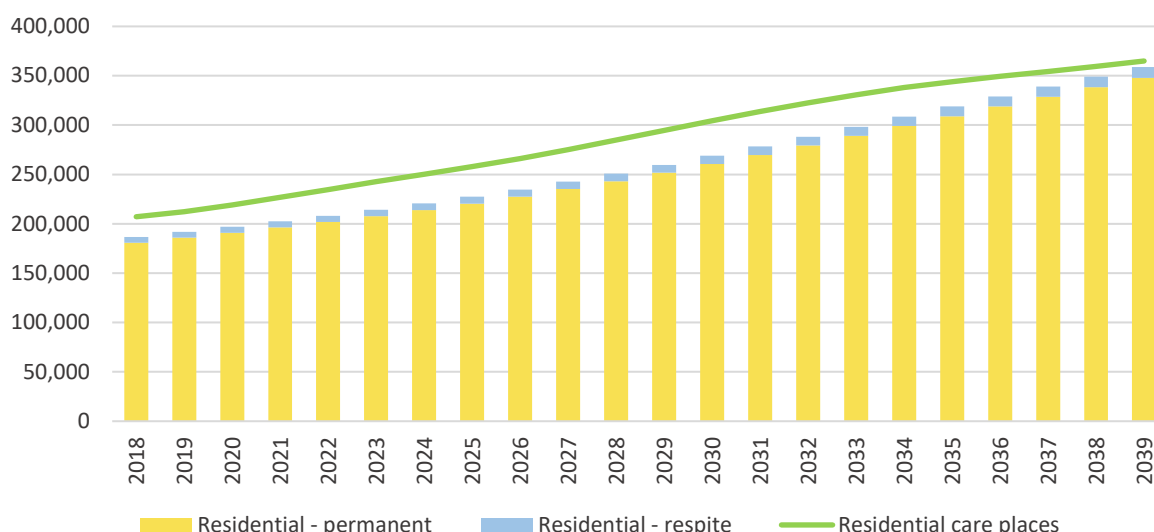
ACFA has undertaken analysis to project demand for residential aged care over the next 20 years (Aged Care Financing Authority, 2019). Figure 2.12 projects the current age-specific usage rates of residential aged care proportional to growth in the population (using Australian Bureau of Statistics single-year age and sex population projections).

It is evident from the graph that, if the growth in the number of residential aged care places grows in line with the current target provision ratio (green line) and is not impacted by any other factors, there would be an excess supply of residential aged care (including residential respite) over the next two decades.

As the 'baby boomers'²⁵ enter their 80s in the late 2020s and the 2030s, their demand could start to put pressure on the sector and its ability to ensure there is adequate supply of residential aged care (including residential respite). However, ACFA's projection does not take into account the declining age-specific usage rates of residential aged care noted earlier, nor do they allow for any significant changes in underlying drivers such as the incidence of, and treatment for, dementia. For example, should there be medical breakthroughs, such as in the prevention, delay of onset or treatment of dementia, there would be a further significant lowering of demand for residential aged care. The Impact Analysis considers that future demand for residential aged care is likely to be lower than ACFA's projections.

²⁵ The 'Baby Boomer' generation are those people born between 1946 and 1966 during the post-war economic boom.

Figure 2.12 Projected demand for and supply of residential aged care and respite places, 2018 to 2039



Source: Aged Care Financing Authority, July 2019, Seventh report on the Funding and Financing of the Aged Care Industry

These projections, taken together with the current aggregate 5-10 per cent vacant capacity in aged care homes, indicate that currently there is no overall unmet demand for residential aged care (although not all supply would meet the preferences of consumers and there are local variations in the demand/supply balance). Given other trends such as the declining age-specific rates of residential aged care utilisation as home care expands, and assuming current policy settings remain and that the sector will be sufficiently viable to attract investment to grow capacity in line with the target provision ratio, this excess of supply over demand is likely to continue for at least the next 20 years.

Future growth and investment required

An ageing population will require the sector to secure substantial future investment to underpin the expansion of capacity in line with the target provision ratio.

Capital for residential aged care is financed from a range of sources, including: internal funding; related party loans (particularly by the for profit providers); equity investments; loans from financial institutions; interest free loans from consumers in the form of refundable accommodation deposits and capital investment support from government (e.g. capital grants and accommodation supplements).

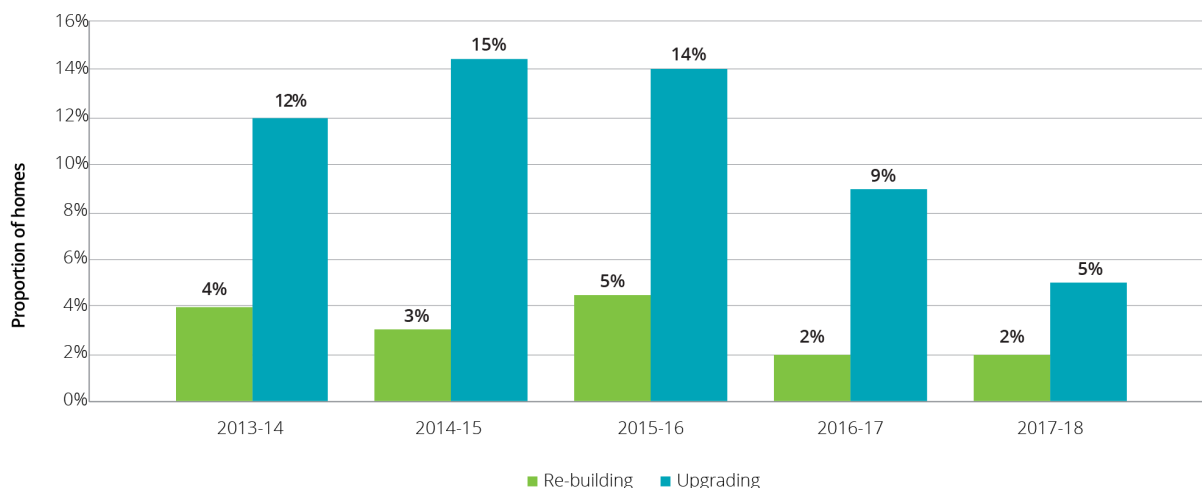
To the extent that the current aged care planning ratio is a valid indicator of demand, ACFA has estimated that the residential aged care sector would need to build more than 88,000 places over the next decade in order to meet that ratio (Aged Care Financing Authority, 2019). At the same time, ACFA estimates the sector would need to rebuild or refurbish a quarter of the current stock of aged care homes covering around 54,000 places. The estimated investment requirement of the sector over the next decade would be in the order of \$55 billion.

Declining investment trend

Currently, investment in the residential aged care sector has slowed. The ACFA 2019 annual report canvassed the declining investment intentions in the residential aged care sector (figure 2.13). It observed:

‘...following on from the decline reported in last year’s report, in 2017-18, there was a further significant decline in providers reporting they were planning to rebuild or upgrade their facilities. In 2015-16 the proportion of facilities planning to rebuild or upgrade were 5 per cent and 14 per cent respectively. In 2017-18, following two years of declining intentions, only 2 per cent of facilities are reporting they are planning rebuilding works and 5 per cent planning to upgrade.’ (Aged Care Financing Authority, 2019) (p. 103)

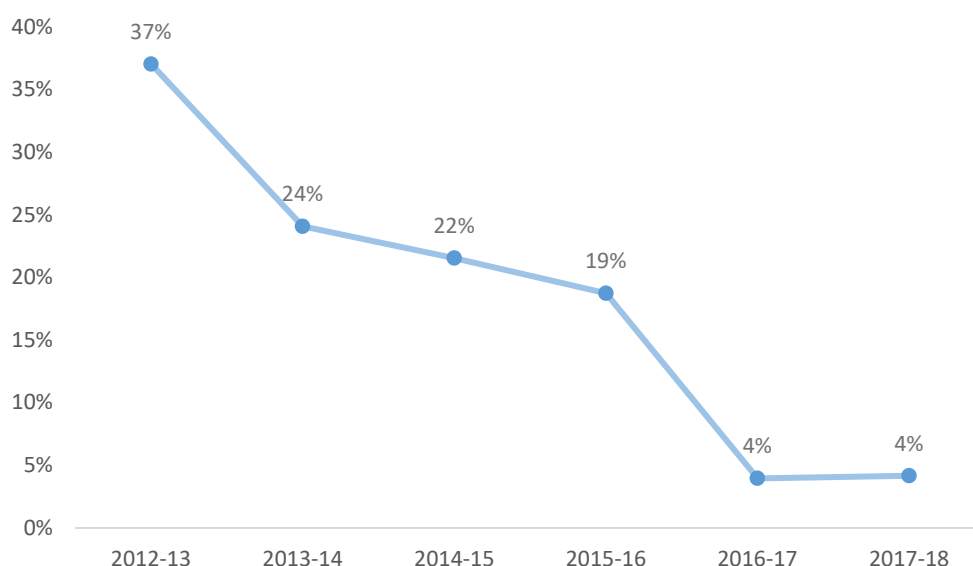
Figure 2.13 Proportion of aged care homes planning to either upgrade or rebuild, 2013-14 to 2017-18



Source: Aged Care Financing Authority, July 2019, Seventh report on the Funding and Financing of the Aged Care Industry

The department's Aged Care Financial Report data has also tracked a trend of declining rate of growth in building activity in the sector (figure 2.14).

Figure 2.14 Rate of year-on-year growth in residential aged care building activity, 2012-13 to 2017-18



Source: Analysis based on unpublished data from Department of Health

Overall, investment into the sector through shareholder capital injection, external finance or use of existing capital reserves has decreased. As referred to later this may be, in part, due to more of the homes having now been refurbished and become eligible for the higher accommodation supplement. Analysis by StewartBrown shows that the contraction in investment is often the result of declining financial performance, coupled with the increased cost of maintaining or refurbishing existing aged care homes and of building new aged care homes.

ACFA's examination of the sector also indicated that many providers were planning to shift their investment focus to private retirement living rather than subsidised residential aged care:

'... A large number of providers, both for-profit and not-for-profit, said their immediate plans would be directed to retirement living rather than residential care. Factors cited in influencing this decision included: the considerable policy and regulatory uncertainty in the aged care sector; the desirability of diversifying income streams given the volatility in residential aged care; and the advantages of

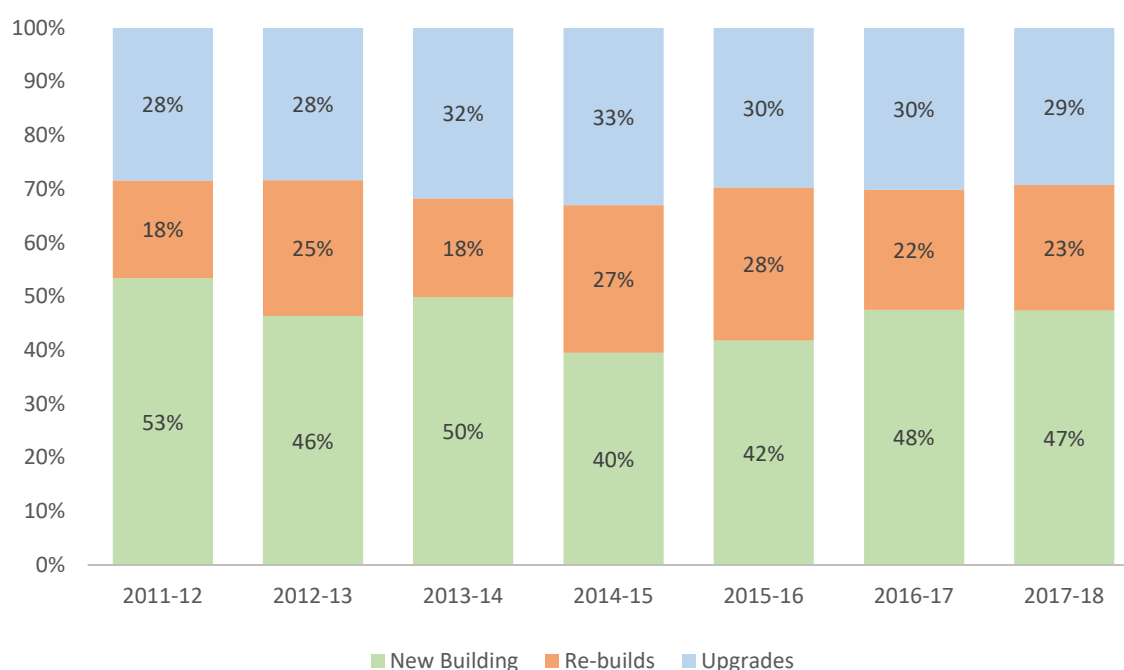
establishing an integrated aged care operation that involved retirement living, home care and residential aged care.’ (Aged Care Financing Authority, 2019) (p. 122)

Building stock

Based on analysis undertaken by ACFA, the predominant room configuration for aged care homes is a single-bed room with an ensuite (Aged Care Financing Authority, 2019). ACFA estimates that in 2017-18, around 80 per cent (77 per cent in 2016-17) of rooms are single-bed rooms with an ensuite and around 3 per cent (5 per cent in 2016-17) are shared rooms with an ensuite. However, around 14 per cent of residents are still in rooms that could be considered ‘ward style’ which are shared and have a common shared bathroom (18 per cent in 2016-17). That is, there is still scope for improvement in the building stock to meet the contemporary expectations of consumers.

Of the building work that has been undertaken each year, around half has been to construct new building stock (figure 2.15). The proportion of work relating to new builds, re-builds and upgrades has remained relatively stable over the years.

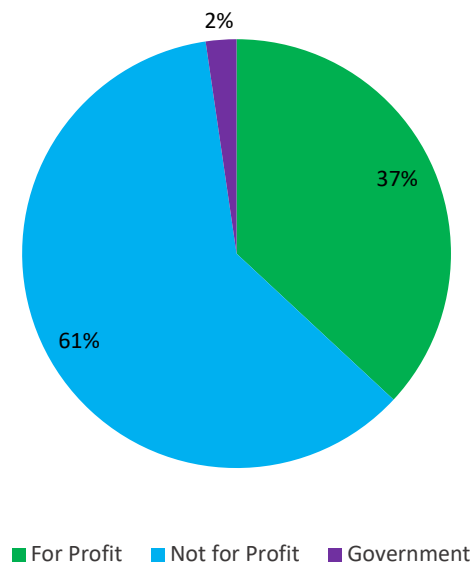
Figure 2.15 Residential aged care building work undertaken by activity, 2011-12 to 2017-18



Source: Analysis based on unpublished data from Department of Health

In 2017-18, the completion of, or construction work on, new buildings was dominated by the not-for-profit sector (figure 2.16), despite the for-profit sector being a large recipient of places through recent ACARs (see chapter 2).

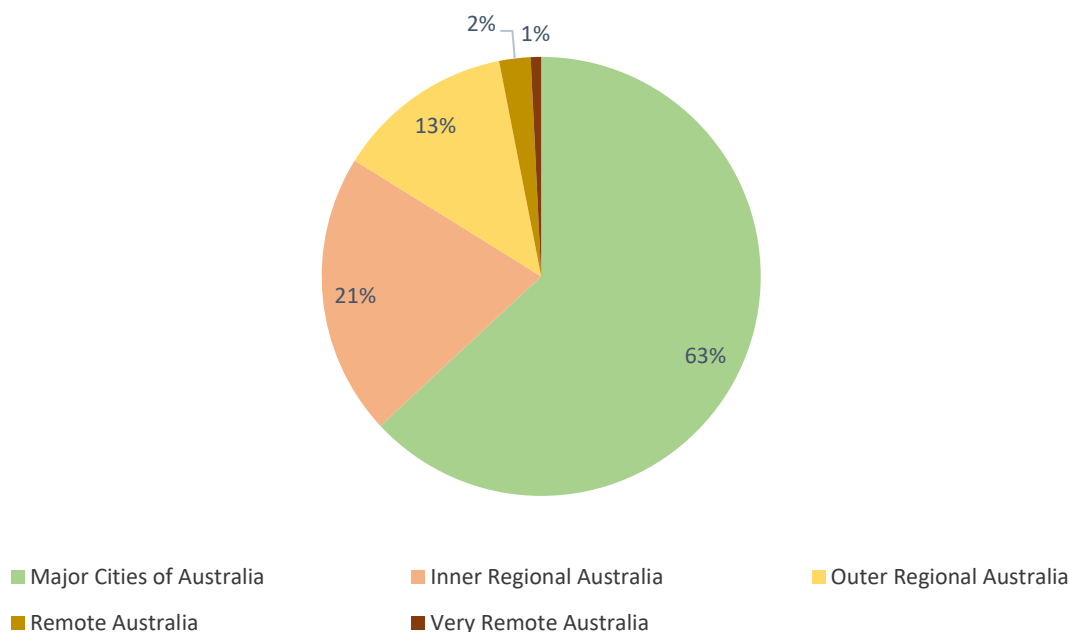
Figure 2.16 Distribution of new residential aged care buildings by organisation type, 2017-18



Source: Analysis based on unpublished data from Department of Health

In 2017-18, the majority of new builds were in the major cities, with very few in remote or very remote areas (figure 2.17) – noting the relative population numbers in the various locations. When the data is examined over a longer time frame, the results are similar with very little activity in outer regional, remote or very remote locations.

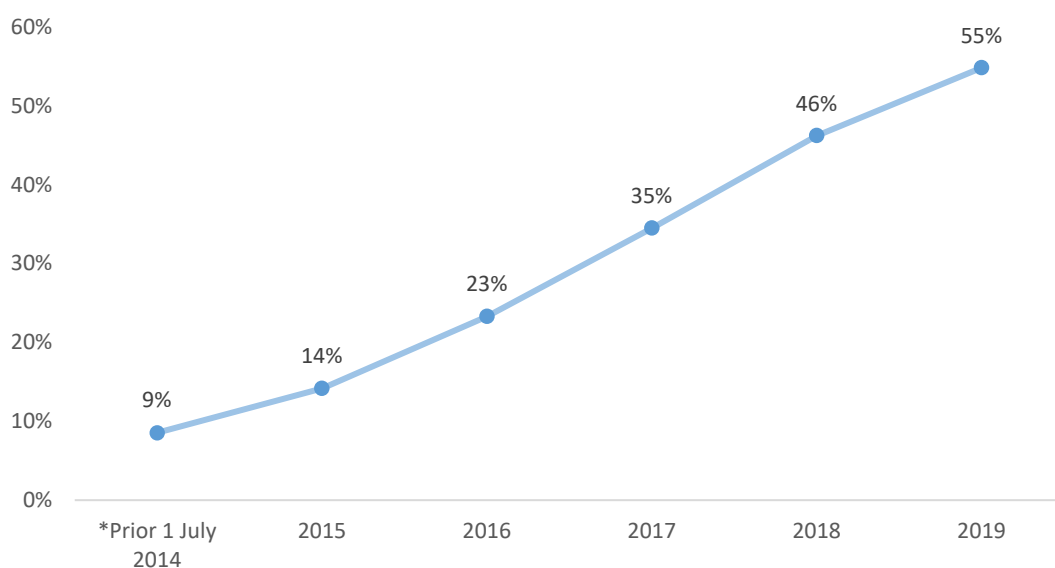
Figure 2.17 Distribution of new residential aged care buildings by remoteness, 2017-18



Source: Analysis based on unpublished data from Department of Health

The ability of the higher accommodation supplement to drive future investment in building stock may also be reducing, as over half of aged care homes (55 per cent, as at late May 2019) have been determined by the department as eligible to receive the higher supplement (figure 2.18). Whether or not the remaining 45 per cent of existing aged care homes invest in refurbishment will be dependent on the future returns on investment, alongside other factors such as financial viability and access to capital.

Figure 2.18 Proportion of aged care homes with approval for higher accommodation supplement, 2014 to 2019

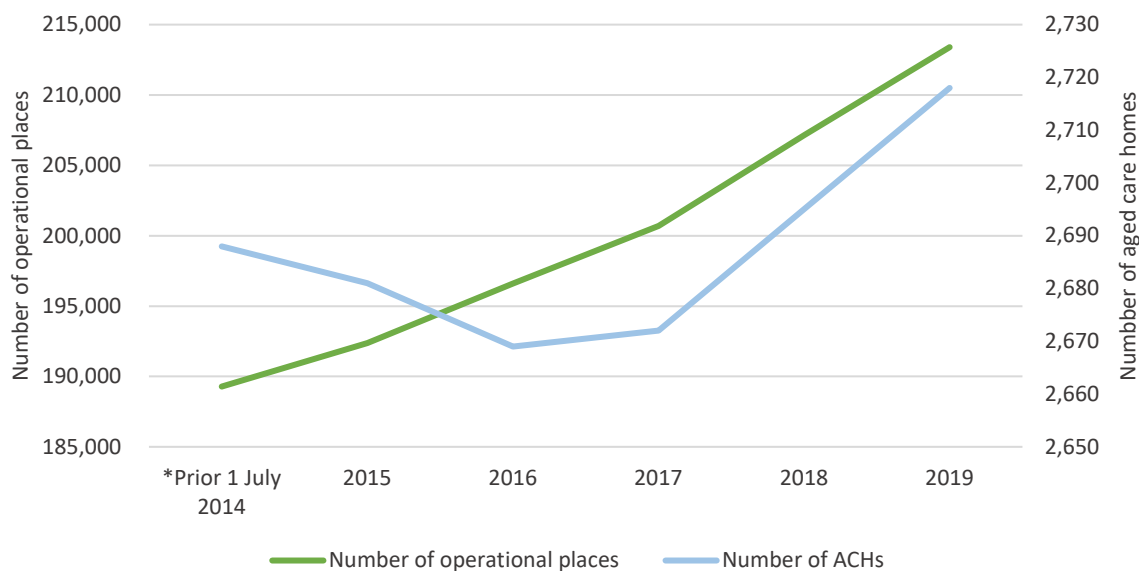


Note: 2019 only contains data for part of the year

Source: Analysis based on unpublished data from Department of Health

It appears there may have been a trend towards consolidation of aged care homes and homes increasing in size in the period 2014 to 2017 (figure 2.19). This means that smaller aged care homes may have been replaced by larger homes, or extended to become larger homes. Since 2017, however, the number of aged care homes have grown along with operational places. Given the declining number of providers, this means the aged care home portfolio size of some providers in the sector has been increasing.

Figure 2.19 Number of aged care homes and operational residential aged care places, 2014 to 2019



Source: Analysis based on unpublished data from Department of Health

The reform landscape

Changes have been made to the aged care system progressively over the last decade as part of a broadly agreed program of medium term reform. An overview of key relevant changes to-date, and those underway, is provided below.

Information and access

- The My Aged Care website and contact centre was launched in 2013 as a centralised system to provide consumers with information about aged care and services.
- In 2015, a new assessment process, central client records and electronic referral capabilities were introduced. The development of a new framework for streamlined consumer assessments for all aged care services, to be delivered by a new national assessment workforce, is underway. New aged care assessment arrangements will provide streamlined consumer assessment for access to aged care services from April 2021.
- From July 2020, aged care homes will have their performance ratings against the Aged Care Quality Standards published on My Aged Care, together with a tool to enable people to compare providers. Simplified, plain English accreditation reports for aged care homes will be published with the existing consumer experience reports.
- Four trials of face-to-face services to help people navigate the system commenced in October 2018 and are funded until June 2020. The trials are being independently evaluated to inform future policy design.

Choice and control in home care

- Since 2015, home care package service providers have been required to deliver care on a consumer directed care basis.
- In 2017, the method of allocating home care packages changed and a national prioritisation process was introduced (Increasing Choice in Home Care reforms). Packages are now assigned to consumers rather than allocated to service providers via the ACAR.
- By 2022-23, around 158,000 total home care packages will be available (including around 77,000 high level packages).
- From 1 July 2019, all home care providers have been required to publish their pricing information in a standardised pricing schedule on My Aged Care. The schedule provides information on the common services and costs under a home care package, to better support people to understand and compare home care pricing information.

Accommodation payments in residential aged care

- In 2014, the approach to residential aged care accommodation payments changed from an upfront bond for certain forms of residential aged care to a choice of: a lump sum refundable accommodation deposit (RAD); a rental style daily accommodation payment (DAP); or a combination of both. A maximum accommodation payment amount was also set (with providers required to apply for accommodation pricing which exceeds that maximum). Providers are required to publish their maximum accommodation prices.
- The Government has previously announced a commitment to improve the management of prudential risk relating to refundable accommodation deposits in residential aged care, including through the introduction of a compulsory levy on providers where refunds under the Accommodation Payment

Guarantee Scheme²⁶ exceed \$3 million in any financial year (Commonwealth of Australia, 2018). Work is also underway to review the prudential framework for refundable deposits.

Quality and safety reforms

- On 1 January 2019, the independent Aged Care Quality and Safety Commission was established. The Commission now oversees the accreditation, complaints handling and monitoring of Australian Government funded aged care services. The Commission follows a risk profiling approach to identify risks to consumers. Unannounced reaccreditation audits have been introduced.
- On 1 July 2019, the new consumer focused Aged Care Quality Standards came into force, intended to focus on quality outcomes for consumers rather than provider processes. The eight standards are:
 1. Consumer dignity and choice
 2. Ongoing assessment and planning with consumers
 3. Personal care and clinical care
 4. Services and supports for daily living
 5. Organisation's service environment
 6. Feedback and complaints
 7. Human resources
 8. Organisational governance
- From 1 January 2020, the responsibility for determining whether to approve an applicant to become an approved provider transitioned to the Aged Care Quality and Safety Commission.

Supporting sector sustainability and capacity

- A new residential aged care funding mechanism is being developed. Trials of the proposed new funding model – the Australian National Aged Care Classification (AN-ACC) – are underway and will run until mid-2020.
- A further study on the fixed costs of providing care in residential aged care in regional and rural Australia was completed in October 2019.
- A sector-led Aged Care Workforce Industry Council was established in 2019 'to lead implementation of an Aged Care Workforce Strategy, including planning for the future growth of the workforce' (Beauchamp, 2019).

Any changes to the places allocation model will occur in the context of these many reforms, some of them already introduced and others underway or planned. Appropriate coordination and sequencing will be important, which is discussed in the final chapter.

The Interim Report of the Royal Commission has raised significant issues around residential aged care, and its final report is likely to have some effect on future reform directions for aged care.

²⁶ Under the Accommodation Payment Guarantee Scheme, if a provider becomes insolvent and defaults on its obligation to refund a RAD, the Guarantee Scheme enables the Government to pay residents an amount equal to each RAD balance. The Guarantee Scheme is triggered if the provider has been placed into bankruptcy or liquidation and there is at least one outstanding RAD.

Chapter 3: A framework for designing and assessing models for allocating places in residential aged care

The Impact Analysis has developed a framework to guide the design and assessment of alternative models for allocating residential aged care places. The principles within the framework were informed by key government statements and independent reports, which have set the course for policy reform, and were subsequently refined during the stakeholder consultations.

This chapter is set out as follows:

- summary of underlying principles included in the 2018-19 Budget measure and other significant aged care policy documents
- commentary on the roles of choice, competition and regulation
- the five principles included in the Discussion Paper
- feedback from stakeholder consultations on the principles
- final set of five principles adopted for this Impact Analysis

This first section explains the rationale for the development of the five principles put forward in the Discussion Paper.

2018-19 Budget measure and key independent policy reports

2018-19 Budget measure

The Government announced in the 2018-19 Health Portfolio Budget Statement:

‘In response to the Legislated Review of Aged Care 2017 – the Tune Review, the Government provides in-principle support for the transition of residential places to the consumer, pending a detailed analysis of the impacts of such a model.’ (Australian Government Department of Health, 2018e) (p. 25)

The associated 2018-19 Budget Fact Sheet stated the Government’s

‘...in-principle support [for] the proposal to transition the allocation of residential aged care places through the ACAR to alternative arrangements that provide real choice for older Australians, [pending] an impact analysis...to understand the effect of such changes...to ensure [the government] has a sound understanding of the implications and risks before making a final decision...’ (Australian Government Department of Health, 2018c)

As a minimum, the primary principle to be applied to this Impact Analysis is that there be real choice for aged care consumers, and that choice should be an improvement to what current arrangements allow. As a result, one of the models to be analysed should provide for the transition of residential aged care places to the consumer.

Legislated Review of Aged Care 2017 (Legislated Review)

The Budget measure was announced in response to the recommendations of the Legislated Review which made specific recommendations about the discontinuation of ACAR for residential aged care (Tune, 2017):

- 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.

The core premises for these Legislated Review's recommendations were to shift the focus to consumers in order to make the market more responsive to their needs and preferences, while also recognising the importance of servicing areas where the market does not function adequately and to ensure access to respite care.

Ceasing the ACAR for residential aged care as part of the move towards a more consumer driven and market based arrangement has also been recommended in various other key policy reform documents.

[Aged Care Roadmap 2016](#)

The Aged Care Sector Committee, comprising the sector's key leaders, developed its 2016 *Aged Care Roadmap*. The Roadmap:

'sets out the path to a system where people are valued and respected, including their rights to choice, dignity, safety...and quality of life... have access to competent, affordable and timely care and support services through a consumer driven, market based, sustainable aged care system' (Aged Care Sector Committee, 2016) (p. 3).

The Roadmap identifies areas for further action to respond to future challenges and transform aged care in nine key domains:

1. Consumers, their families and carers are proactive in preparing for their future care needs and are empowered to do so
2. A single government operated assessment process that is independent and free, and includes assessment of eligibility, care needs, means and maximum funding level
3. Regardless of cultural or linguistic background, sexuality, life circumstance or location, consumers can access the care and support that they need
4. The community is dementia aware and dementia care is integrated as core business throughout the aged care system
5. A single aged care and support system that is market based and consumer driven, with access based on assessed need
6. A single provider registration scheme that recognises organisations registered or accredited in similar systems, and that has a staged approach to registration depending on the scope of practice of the providers
7. Sustainable aged care sector financing arrangements where the market determines price, those that can contribute to their care do, and government acts as the 'safety net' and contributes when there is insufficient market response
8. A well-led, well-trained workforce that is adept at adjusting care to meet the needs of older Australians
9. Greater consumer choice drives quality and innovation, responsive providers and increased competition, supported by an agile and proportionate regulatory framework

[Caring for Older Australians 2011](#)

As a precursor to the Roadmap, the Productivity Commission's 2011 Report *Caring for Older Australians* developed detailed reform recommendations for re-designing Australia's aged care system to meet future challenges, including the removal of regulatory restrictions on aged care places to open up supply (Productivity Commission, 2011).

The Report proposed eight aims for the aged care system as a guide to future policy change:

1. promote the independence and wellness of older Australians and their continuing contribution to society
2. ensure that all older Australians needing care and support have access to person-centred services that can change as their needs change
3. be consumer-directed, allowing older Australians to have choice and control over their lives and to die well
4. treat older Australians receiving care and support with dignity and respect
5. be easy to navigate, with older Australians knowing what care and support is available and how to access those services
6. assist informal carers to perform their caring role
7. be affordable for those requiring care and for society more generally
8. provide incentives to ensure the efficient use of resources devoted to caring for older Australians and broadly equitable contributions between generations.

Both documents outline aims and actions for an aged care system which meets the needs and preferences of consumers. There are references to a system where consumers have choice and control and providers respond. The benefits seen from adopting a market-based approach in these documents are balanced with recognition that the government needs to provide safety nets and ensure that care and support is person centred and people are treated with dignity and respect. There are cautionary notes in the reports that the regulatory regime needs to be proportionate in its response to the limitations of the market's incentives and ensure social equity.

The efficient use of resources, sustainability and affordability are also attributes of future aged care delivery that are touched on in the guiding reports. These concepts have relevance to government (and taxpayers), providers, and consumers, who are all active participants in the system.

The Impact Analysis considers that all reform initiatives – including any changes to the places allocation model – should be complementary to other reforms recently undertaken, underway or proposed under the broadly agreed reform pathway.

Rationales for consumer choice, provider competition and government regulation in aged care

The importance of personal choice and control is being increasingly recognised in the design of social service programs. This has produced a broad range of research literature in welfare and healthcare sectors on the benefits of involving people more actively in their own care and support. Responsibility, participation and choice are seen as key policy framings of active participation in society (Newman & Tonkens, 2011). This is a counter to the experience of many people, captured in evidence to the Royal Commission, who report their loss of dignity and control when entering the aged care 'system'.

In healthcare sector there is progressive realisation that informing, educating and involving patients improves their outcomes. As underlined by Coulter and Ellins (2007):

'all strategies to strengthen patient engagement should aim to improve health literacy.' (Coulter & Ellins, 2007) (p. 27)

This is equally true for consumer engagement to be effective in aged care.

For consumers to make choices about their care and support, they must of necessity be presented with, and informed about, a diversity of providers and the services they offer. Further, consumer welfare is enhanced if the various providers have incentives to offer the highest quality at the lowest cost, and these incentives are best nurtured by competition.

These two concepts – choice and competition – were identified as being complementary in work by Le Grand (2007) which pulled together both evidence and theory to argue that:

‘in most situations, services whose delivery systems incorporate substantial elements of choice and competition have the best prospects of delivering a good local service. Properly designed, such systems will deliver services that are of a higher quality, more responsive and more efficient than ones that rely primarily upon trust, command-and-control or voice.’ (Le Grand, 2007) (p. 2)

The Productivity Commission, when addressing these issues in its 2017 Report on *Introducing Competition and Informed User Choice into Human Services* concluded that informed choice can improve outcomes for users because it:

- ‘empowers people to have greater control over their lives
- enables people to make decisions that best meet their needs and preferences
- generates incentives for providers to be more responsive to users’ needs and drives innovation and efficiencies in service delivery.’ (Overview, p. 5)

The Productivity Commission concluded that:

‘Competition (as an adjunct to user choice) delivers strong incentives for providers to be more focused on people who use services. Efforts by a provider to attract users can include improving the quality of the service they offer, reducing the price that they charge or tailoring their services to better meet the needs of the people they serve — all of which are beneficial to service users.’ (Productivity Commission, 2017a) (Overview, p. 6)

The Productivity Commission’s report also drew attention to the importance of sound government stewardship in the delivery of human services and noted the role of regulation in that stewardship. Australia is a mixed economy, where market forces are regulated through government intervention, and as such it recognises that market forces, by themselves, will not meet all of societies’ necessities and values.

Government intervention is required where there is market failure, a need to protect the vulnerable and improve societal equity. In this respect the Aged Care Sector Committee’s 2016 Aged Care Roadmap vision for the future included, in part, that:

‘Government will have a more proportionate regulatory framework that gives providers freedom to be innovative, whilst ensuring a safety net for consumers.’ (Aged Care Sector Committee, 2016) (p. 3)

The Australian Government Guide to Regulation (the Guide) sets out the important roles that governments play in the economy. It advises that:

‘there can be good arguments for government intervention, to improve efficiency or equity or both.’ (Department of the Prime Minister and Cabinet, 2014) (p. 17)

It cites the example of delivering services in rural and remote areas, though these arguments refer equally to most aged care services and to the availability of safety nets for those in need.

The Guide also advises on the correction of information asymmetry:

‘Regulatory intervention may be an option to impose the obligation to disclose or certify relevant information.’ (p. 18)

Its relevance to aged care includes that providers may have significantly more information than consumers, who are reliant on providers to deliver high quality and safe care, as well as to offer services and accommodation that meet their preferences at a fair price. As noted earlier, informed and engaged consumers can motivate providers to achieve better outcomes.

In aged care, the three market concepts – choice, competition and regulation – operate differently in the delivery of care compared to the provision of additional services and accommodation.

- The receipt of high quality and safe care and basic daily services, and the availability of safety nets to safeguard equitable access, are fundamental consumer rights. The regulation of quality and safety aims to ensure that acceptable standards are being met at all times, by all providers, for all people in

their care. Consumer choice and provider competition have a supplementary role where providers deliver care that is demonstrably exemplary.

- The provision of additional services by some providers is an opportunity for consumers to continue to make choices according to their preferences and the affordability of those additional services. Providers can compete on quality and price, and regulation should ensure appropriate consumer protection for this vulnerable population.
- The provision of accommodation for those requiring full-time care is another opportunity for consumers to continue making choices about where they will live and what standard of accommodation they will live in, according to their preferences and affordability, and for providers to compete. Regulation and safety nets focus on accommodation being of at least an acceptable standard, is accessible to all, and consumers are fully informed.

Guiding Principles set out in the Discussion Paper

Guided by the above considerations, the Impact Analysis included five principles in its public Discussion Paper. Responses were sought from interested parties, through either participation at forums or via written submissions.

The draft principles were:

1. provide opportunities for a more consumer driven market in residential aged care;
2. 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;
3. facilitate an adaptable and viable residential aged care sector, with continued growth and financial investment;
4. be financially sustainable for consumers, providers and government; and
5. complement future reforms to residential aged care and aged care more broadly.

Feedback on the five proposed principles

A clear majority of stakeholders during consultations (including at forums and in submissions) expressed agreement that the overall set of proposed principles were appropriate for guiding reform in this area.

Aged and Community Services Australia (ACSA) in its submission wrote:

‘We consider the design principles outlined in the discussion paper to be appropriate. The intent to provide for a more ‘consumer driven market’ is consistent with the intent of the Roadmap...’ (sub. 52, p. 6)

Carers Australia also agreed, commenting that the proposed principles:

‘are in keeping with the maxim that should guide all (or nearly all) well-intentioned interventions in the provision of essential services: first do no harm... We do want changes that will give consumers greater power, choice and control.’ (sub. 23, Q. 9)

Dementia Australia similarly gave their support, writing:

‘Dementia Australia supports the proposed design principles, given that they focus on a more consumer driven market, intend to improve access to residential aged care services and aim to facilitate an adaptable and viable residential aged care sector.’ (sub. 28, Q. 9)

COTA Australia also provided its agreement with the principles, offered suggestions to strengthen some, and noted the direction:

‘is consistent with the recommendations of the Productivity Commission, the Aged Care Roadmap and other policy positions - and we believe will underpin the sector transformation for which we have been advocating.’ (sub. 34, Q. 9)

Some stakeholders noted tension points between some of the principles.

Brisbane South Primary Health Network wrote:

‘there is some tension between the design criteria [regarding] a more consumer driven market and the criteria [regarding] maintaining or improving access to [residential aged care] and respite services in regional, rural and remote areas and for vulnerable cohorts. In reality a more consumer driven market may only be feasible in metropolitan areas.’ (sub. 22, Q. 9)

Other participants at the forums remarked that providing greater choice for consumers while also maintaining financial sustainability for consumers, providers and taxpayers may not be compatible, given their fiscal interests might not always necessarily align. Further, in several of the forums, there were comments made that ‘trade-offs’ would be needed and prioritisation of the relative importance of each principle would be required.

These comments are testament to the complexity and importance of a comprehensive assessment of impacts on stakeholders, to ascertain costs and benefits over the short and longer term.

Specific suggestions or recurring comments about the proposed principles made during the forums and submissions include:

- Use of the terms ‘opportunities’ in the first principle and ‘maintain’ in the second principle were considered by some to be setting very low performance thresholds.

COTA Australia wrote:

‘strengthen the first principle as ‘provide opportunities’ is a minimal response - we believe there must be a consumer driven market, not just opportunities for that to occur.’ (sub. 34, Q. 9)

This was echoed in comments made during some of the forums that the reference to ‘opportunities’ should be removed.

An anonymous service provider submission similarly suggested the first principle:

‘should be rewritten to explicitly mention ‘increased consumer choice’. (sub. 46, p. 4)

Further, Wintringham noted that:

‘any proposed change must do more than maintain access...’ (sub. 56, p. 7)

Similar suggestions were raised at several forums about the use of ‘maintain’ with relation to access, where issue was taken with the perceived inadequacy of the term.

- Inclusion of an explicit principle to be clear that the model must drive improvements in quality and safety.

Dementia Australia suggested that:

‘the provision of quality care should be included – and clearly articulated – in the design principles.’ (sub. 28, Q. 10)

Several forum attendees also sought the inclusion of an additional principle that clearly calls out the need to encourage quality of care and safety beyond just minimum standards.

- Inclusion of an additional principle highlighting the importance of transparency and accountability in any alternative model.

Eldercare suggested:

‘a principle relating to transparency of assessment and decision making should be included – this is to ensure that the process is free from conflicts of interest or political involvement’ (sub. 20, Q. 10).

The importance of transparency and accountability (alongside efficiency) of administrative processes was also raised by stakeholders across several forums.

The five principles adopted for this Impact Analysis

Following consultation and further analysis, the draft principles were revised. The final principles adopted for this Impact Analysis are as follows, with comments on their revision below:

1. Provide greater consumer choice and control in a competitive residential aged care market.

The importance of improving consumer choice and control, alongside market based competition, is more explicit in this revision, and previous reference to ‘opportunities’ has been removed to strengthen the focus on the end destination for this reform.

2. Drive outcomes for quality and safety in residential aged care that meet or exceed approved standards.

This is a more explicit principle which was drafted in response to stakeholder suggestions for the concepts of improved quality and safety to stand on their own, with strong regulatory standards, additional to the concept of a consumer driven market.

3. Facilitate timely and equitable access to residential aged care and respite services for those in need.

This principle now specifies what is required in terms of access to care, in response to suggestions that the performance threshold for access needs to move beyond maintaining the status quo. As the impact on access for all consumers will be considered, it has been simplified to omit references to particular consumer cohorts but retain acknowledgement of further government intervention being required where the market fails to deliver services to those in need.

4. Facilitate a residential aged care sector that has continued growth and financial investment which responds to increasing consumer demand and changing preferences.

This principle has clarified its focus on the ability of the sector to respond to increasing levels of demand for care and the changing nature of consumer needs and preferences. It removes a redundant reference to viability as the concept is covered by facilitating growth and investment.

5. Have transparent and accountable processes.

This is a new principle added in response to stakeholder suggestions to underscore the need for transparency and accountability in processes and systems.

The original proposed principle relating to financial sustainability was not retained as a separate principle, because it is implicit in other principles. However, the Impact Analysis recognises the importance of sustainability. A change from the allocation of subsidised places to providers, to the assignment of subsidised places to consumers, removes an important government fiscal gatekeeper. The government’s residential aged care financial expenditures are directly proportional to the number of places (beds) that eligible consumers can access. Financial sustainability is a system-wide consideration as it is also affected by other policy levers. This issue is discussed further in chapter 9.

These principles are consistent with the foundations of aged care reform already in place which are that aged care services should be consumer driven, market based, equitably and sustainably subsidised and proportionately regulated.

Alignment of the models with the broadly agreed aged care reform pathway is considered in chapter 8 where a comparative evaluation of the status quo and Models 1 and 2 is undertaken. The Royal Commission’s final report, due in November 2020, is also likely to have an impact on some features of aged care in the future.

This framework of principles has been used to assess the benefits and opportunities for improving the current allocation arrangements and guide the development of alternative models. Each of the alternative models has been assessed against these principles to identify their benefits, risks and complexities.

Chapter 4: Learning from other consumer driven market based human services sectors

Consumer driven and market based approaches to delivering human services are the basis for the delivery of care in other sectors and countries, with varying degrees of government intervention. Examining the experiences of those sectors affords a valuable source of policy learning. In this chapter, overviews of relevant features of the *Increasing Choice in Home Care* reforms, the disability and childcare sectors, as well as international examples of residential aged care are outlined. Specific lessons are also discussed in subsequent chapters.

Increasing Choice in Home Care

The Increasing Choice reforms to home care were implemented on 27 February 2017. These reforms sought to address: the limited choice of providers for consumers; a lack of consistent and equitable allocation of home care packages; and the regulatory burden for providers who wished to enter (or remain in) the home care sector. The Increasing Choice reforms implemented three main changes to address these issues:

- assignment of home care packages directly to consumers, rather than providers via the ACAR
- introduction of a national prioritisation system to manage access
- implementation of a streamlined approvals process for providers wishing to deliver home care

Underpinning this reform was the intention to drive greater consumer focus, quality and innovation in the delivery of care, through the creation of competition within a more market based environment.

National Prioritisation System

Prior to the reforms, the department assigned a set number of subsidised home care packages to providers, through the ACAR. Consumers who had been assessed as eligible for a package by an ACAT had to find a provider in their area which had a package available, and often had to wait for a package to become vacant.

As the Government would continue to limit the number of packages that were available, the reforms required the establishment of a new process to prioritise access to home care—the National Prioritisation System (NPS). The NPS takes into account two factors: a consumer's priority for a home care package and the date they were approved for home care. There are currently two priority streams in the NPS —medium and high—and people are allocated to a stream and a package level based on their ACAT assessment. The high stream is reserved for those at 'immediate risk' to their safety or imminent risk of admission to residential aged care. Carer stress is a factor that can influence a consumer's priority of access to the support provided by a package.

The initial NPS was constructed by including all people who had been assessed between 1 July 2016 and 26 February 2017 as being eligible for a subsidised package by an ACAT but were not, at that time, in receipt of any package or in receipt of the level of package they had been assessed as requiring.

People with approvals prior to 1 July 2016 were sent a letter advising them that they would be added to the NPS if they made contact with the My Aged Care Contact Centre.

On an ongoing basis, the scale of the NPS is dependent on a range of factors, including:

- the number of subsidised packages being made available, limited by a fiscal cap;
- the demand for home care services (particularly at the higher package levels);
- whether the ACAT assessments reflect current and foreseeable requirements or some prospective need; and
- the ability of families to access the non-subsidised market of services to help support their elderly family members.

The length of, and waiting times on, the NPS has been a contentious issue since the reforms were introduced as it gave transparency to the significant number of eligible people who had not been able to access their assessed package of care under the previous system. As of 30 June 2019, there had been evidence of a decline in the number of people on the waitlist, down to 119,524 people (Australian Government Department of Health, 2019e).

Since 2017 there has also been an increase in the elapsed time between ACAT approval and receipt of a home care package (Royal Commission into Aged Care Quality and Safety, 2019). This increase was inevitable as the NPS commenced with around 80,000 people with approvals prior to 27 February 2019 whose wait time was not previously being accounted for in published data. Working through this backlog resulted in longer wait times. Data held by the department indicates the median elapsed wait time between approval and assignment of the highest level home care package (level 4) in 2018-19 was 34 months.

It should also be noted that the level of unspent funding by those who have been allocated a package has been growing annually - it was in excess of \$750 million at 30 September 2019 (StewartBrown, 2019b). Reasons for this growth may include an innate conservatism to save for greater needs later, or consumers determining that their ongoing needs are less than their care needs as assessed by the ACAT.

Consumer choice and competition

Ongoing evaluation by the department has suggested that the reforms have made the overall home care system more consumer-centric and market-based. Consumer research undertaken by the department has indicated that among home care consumers who were surveyed, 66 per cent reported having entered a home care agreement with their preferred provider (AMR, 2019). Further data held by the department shows that around five per cent of people in a home care package, have taken the opportunity to change providers.

The home care market has grown with the number of home care providers nearly doubled since 2017 (Australian Government Department of Health, 2019e). This is because providers no longer have to compete for Home Care Packages through the ACAR —under which a large number of applications were received from providers to deliver a limited number of packages. Although the packages are now being assigned directly to consumers and can choose their provider, providers must still become an ‘approved provider’ before they can advertise and accept clients.

Effects of competition on prices are also emerging, as suggested by the declining trend in average maximum published exit fee amounts since the commencement of the reforms: \$225 as at 30 June 2019; representing a reduction of 19.6 per cent from \$280 as at 30 June 2017 (Australian Government Department of Health, 2019e). The proportion of providers who indicate they are not charging any exit fee amounts has also increased over that same period, from 36 per cent as at 30 June 2017 to around 41.6 per cent as at 30 June 2019 (Australian Government Department of Health, 2019e).

The capacity of the home care sector to grow rapidly to meet demand without risking quality has been questioned during the Royal Commission, including instances raised regarding home care provider negligence in delivering care (Royal Commission into Aged Care Quality and Safety, 2019).

Other key issues that have emerged during departmental monitoring and evaluation of the home care packages, apart from the wait times, have included:

- limitations on consumers’ abilities to exercise choice and control – due to inadequate comparable information on provider pricing in a centralised location (AMR, 2019). As noted in chapter 2, all home care providers are now required to publish their pricing information in a standardised pricing schedule on My Aged Care.
- lower growth of providers in non-metropolitan areas compared to metropolitan areas (Australian Government Department of Health, 2019e)
- providers experiencing a significant decline in financial performance – likely due to the increased number of competitors and price competition – which has squeezed profit margins (Aged Care Financing Authority, 2019).

In response, the department has undertaken a range of targeted actions (such as requiring all home care providers to publish pricing information in a standardised schedule on the My Aged Care website).

In relation to the wait times, the centralisation of information through the NPS has given the government and the community greater visibility of overall demand for subsidised home care (to the extent it is accurately reflected by ACAT assessments), and the urgency of that demand. Information on wait times is available to consumers through My Aged Care, and published in quarterly reports released by the department.

Greater transparency enables reforms to all parts of the system as well as better planning for, and management of, actual demand for subsidised care. The Royal Commission has also used the prioritisation system data to identify the current number of home care packages relative to number of consumers waiting as an issue, leading it to signal the need for urgent action on this in its interim report (Royal Commission into Aged Care Quality and Safety, 2019).

The Government has announced a number of measures to increase the number of home care packages, with a particular focus on higher level packages, including the re-profiling of packages so they are released sooner than originally planned. In addition, the creation in the 2018-19 Budget of a single budget item for subsidised home care packages and residential aged care places provides more flexibility to direct available funds to areas of greatest need (Aged Care Financing Authority, 2019).

Notably, the home care reforms have underscored the need to ensure that:

- appropriately tailored supports and accurate information (such as the 'Find a Provider' tool through My Aged Care) are available for consumers, so they can exercise informed choice and access care. Sufficient education on what interim subsidised services are available to people waiting for care, as well as the range of services available in the open market to people of all ages who need or want some help to assist them to live at home, would also be beneficial
- ACAT assessments reflect actual need for care rather than prospective need
- there are robust approved provider, quality, compliance and financial regulations and monitoring mechanisms

National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) was a major, complex national social reform designed to give people with permanent and significant disability choice and control of the support and care they receive (Productivity Commission, 2017b). The creation of the NDIS was a shift away from the previous block-funded welfare model of support to a consumer directed fee-for-service market-based approach.

Under the NDIS, eligible consumers (or their nominated carers) are able to manage their own support plans and make choices for disability-related services, supports, therapies and interventions that are received from NDIS registered service providers.

The NDIS became operational on 1 July 2013 with the commencement of trial sites. From 1 July 2016 transition to the full scheme commenced, with a progressive rollout nationally on a geographical or age basis. On 1 January 2019, the NDIS progressed to a second tranche, being offered to remaining groups across Victoria, Tasmania, and Queensland. Rollout to Western Australia is expected to be completed by mid-2020. When fully implemented approximately 460,000 people are expected to be supported by the NDIS (Joint Standing Committee on the National Disability Insurance Scheme, 2019).

An independent evaluation of the NDIS was conducted by the National Institute of Labour Studies at Flinders University, South Australia, which had monitored the roll-out of the NDIS since the Scheme's start in July 2013. The evaluation was completed in February 2018. It considered the impact of the NDIS trial in South Australia, Tasmania, New South Wales, Victoria, the Australian Capital Territory and the Barkly region in the Northern Territory. It found that most aspects of the NDIS are working well for the majority of the people that it touches, including providing improved levels of support, and satisfaction with choice and control of

what supports are received and where these are obtained (National Institute of Labour Studies - Flinders University Adelaide, 2018).

The evaluation also found, however that while the NDIS leaves a large minority (about a third) as well off as they were before the trial, it makes a small minority (between 10 and 20 per cent) feel worse off (those unable to effectively advocate for services on their own behalf, including some people with mental or psychosocial disability and/or those who struggled to manage complex NDIS processes) (National Institute of Labour Studies - Flinders University Adelaide, 2018). The evaluation also found that the speed of implementation was too fast and that more thought needs to go into the practical aspects of the NDIS rollout.

A Parliamentary Joint Standing Committee on the NDIS was also established to inquire into the Scheme's implementation and performance. In its inquiries, the Committee has found that the transition to a market-led service delivery model has raised challenges for both participants and service providers (Joint Standing Committee on the National Disability Insurance Scheme, 2019).

Difficulties in providing and accessing services in thin markets (e.g. rural and remote areas) have underscored the importance of appropriate market stewardship (Joint Standing Committee on the National Disability Insurance Scheme, 2018). Market stewardship comprises oversight actions to fully support the functioning of markets – such actions may include provision of information about providers to consumers, monitoring service quality, inequities and addressing any gaps, and steering markets towards innovation and encouraging the sharing of best practice (Carey, Dickinson, Malbon, & Reeder, 2017).

Formal childcare

Formal childcare services in Australia are subsidised by taxpayers and operate under a dual State or Territory and Australian Government regulatory system (Productivity Commission, 2014). Providers need state or territory approval to operate a childcare service in that jurisdiction. They also need to obtain approved provider status from the Australian Government in order for the Child Care Subsidy and Additional Child Care Subsidy to be claimable by families for care delivered at the provider's service (Australian Government Department of Education, 2019). Child care subsidies are paid to services as an offset to the fee otherwise payable by parents.

Centre-based day care, usually provided in purpose specific facilities (approved by the relevant state or territory authority), is the most common type of formal childcare service in Australia. Up until 2000, there was a cap on the amount of Long Day Care places (whole of day care to a group of children) and controls on the location of new Long Day Care centres. However, those caps and controls were removed in 2000 and since that time there have been no controls on the number of Long Day Care places or the location of new centres (Baxter, et al., 2019). This was intended to encourage market competition and to offer choice to families.

The changes resulted in a rapid increase in the proportion of Long Day Care centre places being provided by for-profit providers including the growth of large providers. One of the first was ABC Learning, which increased from 43 centres in 2001 to 1,037 in 2008 (Baxter, et al., 2019). At its peak ABC Learning provided around 25 per cent of the Long Day Care market, providing care to over 100,000 children (Baxter, et al., 2019). In November 2008 ABC Learning went into administration (Baxter, et al., 2019). The impact of this collapse was wide, with calls for more government monitoring of the child care sector. Following its collapse, the Government enacted requirements to monitor the financial viability of large long day care operators to smooth any transitional period once a supplier prepares to exit the market (Productivity Commission, 2014).

Despite the rapid market growth, the 2014 Productivity Commission Report on Child Care and Early Childhood Learning found that many parents were still reporting problems with affordability and issues finding a child care centre at a location, price, quality and hours that they want – coupled with extensive waitlists for places at centres (Productivity Commission, 2014). The underlying cost of provision of child care has grown much more rapidly than prices overall, reflecting many factors including increases in quality requirements (e.g. mandatory staffing ratios and qualifications) and the wage costs of staffing (Baxter, et al., 2019). It appears these increased operating costs had been passed onto parents through higher fees, which have posed a barrier to entry for parents and expansion for providers.

In response to the findings of the Productivity Commission, the Government introduced a 'Jobs for Families Child Care Package' which commenced in July 2018. It included targeted subsidy assistance to parents for the cost of childcare and targeted grant funding for services to reduce barriers to access (e.g. for disadvantaged, or vulnerable families and communities) and promote sustainability (e.g. to help new and existing services particularly in rural, regional or vulnerable communities) (Baxter, et al., 2019).

Consumer driven and market based residential aged care in other countries

Other developed countries are similarly contending with the needs of a rapidly increasing older population. New Zealand and the United Kingdom (noting that some commentary relates to England specifically) have been selected as case studies. Like Australia, the selected countries are liberal welfare states and are comparable at the macro, meso and micro levels (Jain, Cheong, Bugeja, & Ibrahim, 2019).

Japan, although very different from Australia, has also been selected as it is at the forefront of countries experiencing an ageing society (Akiyama, Shiroya, Fukuda, Murashima, & Hayashida, 2018). It provides a valuable case study in the design and implementation of a long-term social care insurance system²⁷ in the context of macro-level financial pressures.

Local contracting and regulation of providers

Similar to Australia, the United Kingdom, New Zealand, and Japan each have a form of quasi-market operating within a regulated framework for residential aged care, where a significant number of providers are not-for-profit and a large proportion of the consumers do not pay for services directly. In the United Kingdom and New Zealand, the state acts as a purchaser (and funder), by contracting with service providers on behalf of consumers. These local councils/authorities manage access and oversight of service provision in their respective catchments, rather than at a national level.

In the United Kingdom, local authorities predominantly procure care home places using spot purchasing (contracts used to place an individual) (Competition and Markets Authority, 2017). Spot purchasing involves the local authorities advertising prospective placements (i.e. approved consumers) and approved providers can bid to meet those needs in a reverse auction. The 'winner' is selected by the local authority based on the consumer's preferences, price and quality. Alternatively, block contracts (long term contracts which 'pre-book' a set number of placements at an agreed rate) are also used, commonly for securing beds for short-term placements, such as respite care. Care homes have to be registered with the local independent regulator, which is responsible for keeping a register of care providers and undertakes quality and safety inspections.

In the New Zealand system District Health Boards enter into contracts (annually negotiated) with rest homes once they are certified and comply with legislated standards (Office of the Auditor-General, 2009). Quality and safety is managed through contractual terms and provider performance management (Ministry of Health, 2019).

Fiscal controls through eligibility

In all the selected countries, care is rationed and costs are controlled through eligibility for care and for a government subsidy, rather than by fiscal caps on quantities of places. Eligibility is established through needs tests and means tests, such that it is only conferred to those with sufficient high care needs and only those with low financial resources are eligible for publicly funded services. Across all three countries, the assessment is undertaken by the local authority (UK), district health board (NZ) or local municipality (Japan) – who also manage the funding for their catchment.

In the United Kingdom, if a consumer is eligible for council support towards their care, they receive a personal budget – a choice of direct payment into their bank account, or a council-arranged payment for care on their behalf, or a mix of both (National Health Service, 2019). Consumer contributions may be

²⁷ The LTCL system was introduced in 2000 and is administered at municipality level and funded through a combination of social insurance contributions, general taxation and user contributions (known as co-payments). Every member of the population must pay into the system from the age of 40.

required. Consumers who are ineligible for council assistance with their care costs are required to self-fund their care.

In New Zealand, consumers with eligible care needs and whose means qualify them for subsidised care will have their subsidy follow them but it is paid to the provider. Again, consumer contributions may apply. For consumers who do not qualify for subsidy, they pay a capped contribution in line with the contract price paid by district health boards for the local region provided they receive care from a district health board contracted provider (Ministry of Health, 2012).

In Japan, the assessment is more complex and involves several check-points which start with a nationally standardised eligibility assessment system using a computerised algorithm to produce an assigned level of need. This assessment result is then submitted for a doctor's opinion and is finally submitted to the Long Term Care Insurance certification committee for review. The assigned level of need determines the notional budget (not cashed out) consumers have available to them and the services they can access. All older people who do not qualify for any subsidised care are able to access community support programs and long term care programs, which serve as cost containment mechanisms to reduce entries to the long term care system (Tamiya, Noguchi, Nishi, & Reich, 2011).

Consumer choice of aged care home

The consumers in the selected countries have considerable freedom of choice as to the provider from whom they will receive their care so long as their assessed needs can be suitably met.

In the United Kingdom, for people eligible for local authority funding, the authority is responsible for arranging a placement – the consumer has a right to choose any care home within their 'personal budget' (subject to certain conditions, they can pay a 'top up' fee to choose accommodation in excess of their budget). However, consumer research has found that choice can often be quite limited, either because there are few suitable homes or they did not have a current vacancy (Competition and Markets Authority, 2017).

Eligible consumers in New Zealand can choose any rest home with a district health board contract that can provide their assessed level of need. Similarly in Japan consumers can contract with any long-term care provider that can meet their assessed needs, but there are large numbers of people waiting for admission to facilities (particularly compounded by the government's focus on promoting the growth of the home care market) (Sugimoto, Kashiwagi, & Tamiya).

Consumer supports are also provided to assist in finding a provider. In England (North of England Commissioning Support Unit, n.d.) and New Zealand (Eldernet, n.d.), vacancies in aged care homes are published online on a 'service finder' website that show vacancies in real time. In Japan, all eligible consumers are assigned care managers to assist them in making informed choices about their care (Curry, Castle-Clarke, & Hemmings, 2018). In all countries, if the consumer's preferred home does not have a vacancy, they can be placed on the home's wait list (and take up care in another home in the interim).

Market incentives and tools

The selected countries also provide incentives and tools to encourage desired market behaviour.

In England, all care homes are given overall quality inspection ratings as well as individual ratings against core areas. These ratings must be displayed at the home and online (Care Quality Commission, n.d.). Most care homes are mostly rated 'good' but almost 30 per cent of care homes received a rating of 'requires improvement' or 'inadequate' (Competition and Markets Authority, 2017).

In Japan, financial incentives are offered to reward providers that exceed minimum quality requirements on certain criteria (e.g. improvements in physical function) (OECD European Union, 2013).

To assist New Zealand providers in their planning, detailed information about demographic trends and how many beds are being used in each local catchment is published annually (Technical Advisory Services, Health New Zealand, n.d.). This helps providers to determine where and when the largest growth in older people will occur, where the areas of high use and low growth are, and the mix of care required.

Local Authorities in the United Kingdom are encouraged to publish a Market Position Statement, to signal to the market the likely need to extend or expand services, encourage new entrants to the market in their area, or if appropriate, signal a likely decrease in needs (Competition and Markets Authority, 2017).

Market responsiveness

The markets in these countries has been responsive to the changing preferences of consumers to remain living in home-like environments. In the United Kingdom, rooms in new or redeveloped aged care homes are increasingly spacious, often coming with an ensuite (GrantThornton, 2018). Co-location or integration of care homes is also occurring across retirement living and aged care homes in both United Kingdom (Elderly Accommodation Counsel, n.d.) and New Zealand (Ansell Strategic, 2014). In New Zealand, retirement village operators have been the main investors in new capacity in recent years, providing a continuum of care on their village sites – which also spreads the construction costs of facilities across a wider cost base (Ernst & Young, 2019). Similarly, in Japan, the number of private nursing homes and senior housing units has also expanded greatly over the past decade (Savills, 2018).

Financial pressures

Across all three selected countries providers are facing viability pressures with thin profit margins, which can be linked to increases in operating and building costs exceeding levels of government funding for care. This has meant that supply has not been able to match demand, resulting in a shortage of vacant beds. Against the backdrop of increased financial pressures and competition, providers have been found to be pursuing cost efficiencies in Japan (Kubo, 2014). In New Zealand, providers are increasingly offering optional additional services to levy extra charges on those consumers who can afford to pay to cover costs and enable the development or maintenance of facilities (Ansell Strategic, 2014) (Ernst & Young, 2019). Similarly, in the United Kingdom, the market catering to the self-funded (non-supported) cohort of consumers has expanded. Creation of new stock has been more focused in areas that have high numbers of self-funded consumer populations (higher fees provide investors with stronger returns on capital) and some existing homes are re-positioning themselves to attract these consumers (GrantThornton, 2018).

There are mechanisms in place in New Zealand and England to support managed transition and continuity of care. New Zealand providers are contractually required to notify district health boards when there is an intention to close or downsize (Technical Advisory Services, Health New Zealand, n.d.). The independent regulator in England has a statutory responsibility – as part of a market oversight scheme – to assess the financial sustainability of providers who would be the most difficult to replace if they failed (Care Quality Commission, n.d.).

Conclusion

The experiences and insights from other consumer markets provide valuable input into understanding the possible benefits and complexities that may arise from developing more consumer driven market based models for the delivery of residential aged care.

The lessons arising from this research have been taken into account in the Impact Analysis.

Chapter 5: Assessment of the current ACAR and places management arrangements

This chapter assesses the current ACAR and places management model against each of the five principles set out in chapter 3.

Criterion 1. Provide greater consumer choice and control in a competitive residential aged care market

Choice of aged care home

Allocation of places to providers

Residential aged care places under ACAR are allocated to providers selected by the department according to a set of legislated criteria (discussed in chapter 2), but the allocations do not necessarily reflect consumer preferences.

COTA Australia argued that:

‘the current allocation model constrains choice for consumers and fosters a power imbalance between providers and consumers/residents.’ (sub. 34, Q. 7)

Carers NSW said the current system is:

‘leaving consumers minimal choice and control over services as they are limited to providers or facilities with available allocated places.’ (sub. 33, p. 4)

Leading Aged Services Australia (LASA) agreed that features of the current system:

‘impact competition and create mismatches that limit access to preferred service providers.’ (sub. 44, p. 3)

Some stakeholders have contended that consumers have choice now, as providers do not receive a subsidy until the allocated place is occupied by a consumer.

For example, an anonymous stakeholder suggested that:

‘Residents have a strong bargaining position as providers need residents to fill available places.’ (sub. 29, Q. 7)

In essence, the allocation of a set number of places to selected providers – regardless of whether or not they are preferred by consumers – means the locus of control is with those providers, not the consumers.

Capped number of places and the aged care provision ratio

The government controls the supply of residential aged care places by setting a cap on the number of places it subsidises (Tune, 2017), including the number of new places released through the ACAR as guided by the aged care provision ratio (see chapter 2). These regulatory constraints on supply are not conducive to a competitive environment, as preferred providers cannot easily expand their capacity or locations in response to demand. There are also inherent barriers to expansion within the sector given its capital- and resource-intensive nature (such as acquiring land, constructing buildings and employing staff). As such, the threat of competition is particularly constrained in residential aged care.

The aged care provision ratio, by its nature, could be seen as a blunt demographic tool – using as its denominator the populations of people aged 70 and over as a proxy for demand. As such, places may not always be allocated to providers in locations where consumers want to receive residential aged care (e.g. some people may move to become closer to family). Some flexibility in the approach is noted, however, as new places can be allocated to well-supplied locations in excess of the target ratio where providers can demonstrate additional need exists. For example, in the 2018-19 ACAR, 17 per cent of places were allocated to providers in locations considered to have low need against the ratio (see chapter 2).

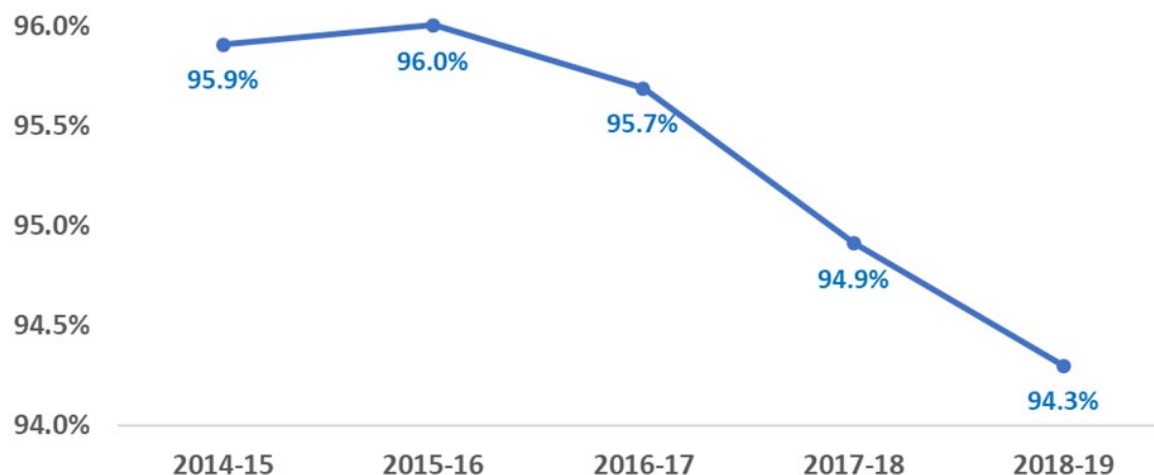
Nonetheless, the number and distribution of places are not directly in response to consumer actions and choices. This means that vacant places may not readily exist in aged care homes or locations that are actively

sought out by consumers, as evidenced by the variation in occupancy levels (discussed below). Nonetheless, with a cap on supply, even less preferred aged care homes can have high occupancy rates.

Occupancy levels of aged care homes

Median occupancy rates are a measure of the degree of choice of vacant places available to consumers and the extent to which providers need to compete for consumers. Overall, occupancy data shows a median level that is only slowly declining within a range of 94-96 per cent for the last five financial years (figure 5.1). This means that half of all aged care homes have low vacancies of around 5 per cent or less of their available places, and the remaining half of homes have vacancies greater than 5 per cent, some of which are ramping up occupancy after being first opened or after refurbishment.

Figure 5.1 Median occupancy rates in residential aged care, 2014-15 to 2018-19



Source: Analysis based on unpublished data from Department of Health

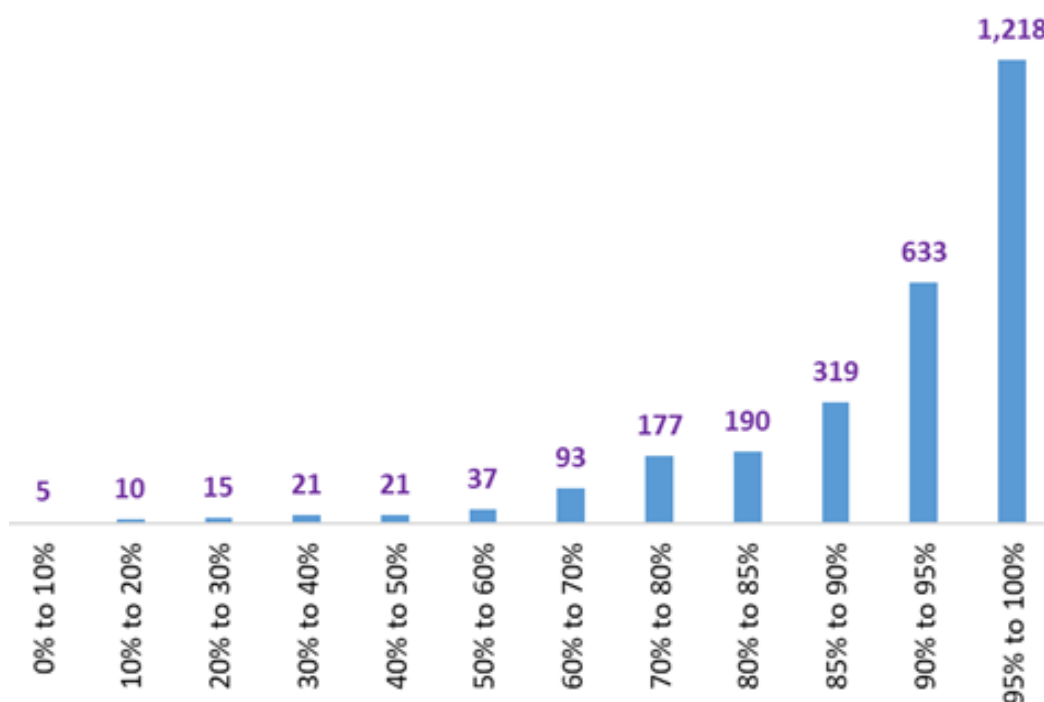
Figure 5.2 shows the distribution of aged care homes based on mean (average) occupancy for 2018-19. Most aged care homes have mean occupancy levels in the 90 per cent and over range, fewer than 20 per cent of aged care homes have occupancy levels lower than 85 per cent. High occupancy levels above 95 per cent may affect consumer choice. This can be due to the unavailability of a vacancy in a sought after aged care home, or to vacancies being in aged care homes which do not have accommodation or services (including food) which meet a consumer's needs or preferences or which do not have a good reputation for the quality and safety of their care. However, this is dependent upon the geographic location and the number and range of homes within that location or nearby locations.

The Royal Commission:

'heard many accounts of older people and their loved ones having to contact service after service to find out if there is a suitable place available.' (Royal Commission into Aged Care Quality and Safety, 2019) (p. 3)

In essence, there are providers or individual aged care homes that are not preferred by consumers, but which are able to retain reasonable occupancy within the current system.

Figure 5.2 Number of aged care homes in each mean occupancy bracket, 2018-19



Source: Analysis based on unpublished data from Department of Health

Occupancy levels across geographic areas

The limitations on consumer choice of aged care homes varies geographically. All states and territories have median occupancy levels between 92 and 97 per cent (table 5.1). The states of Western Australia and South Australia, as well as the Northern Territory, have median occupancy above the overall level of 94.3 per cent in 2018-19, suggesting that the choice of aged care homes with vacant places may be limited in some areas within these jurisdictions.

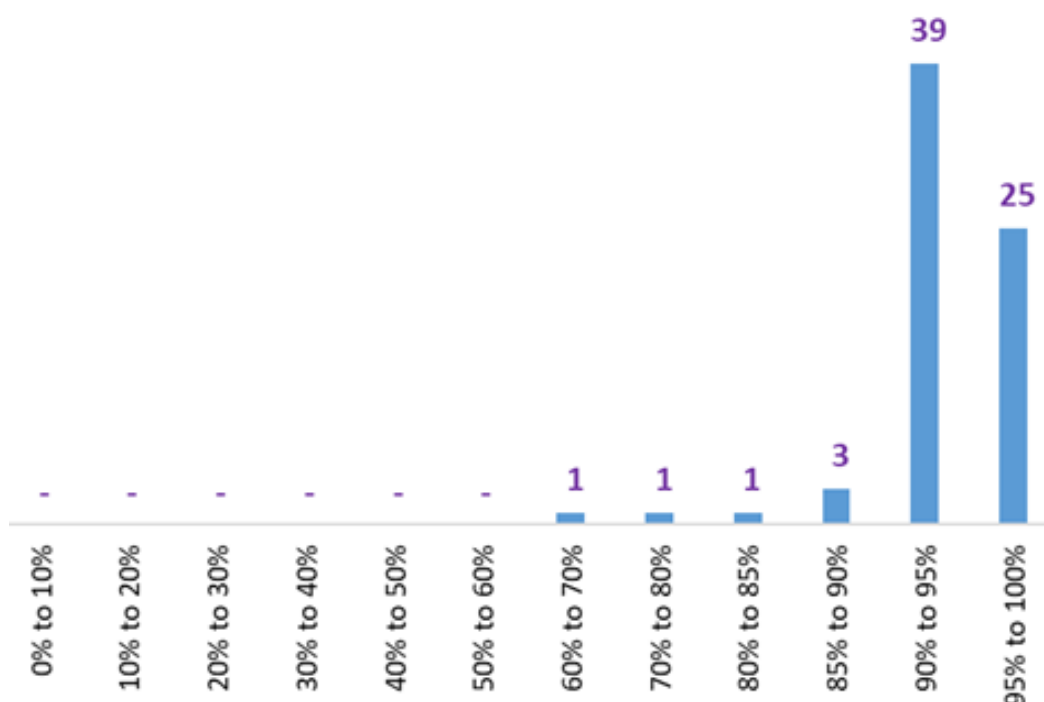
Table 5.1 Median occupancy rates in residential aged care, by states and territories, 2018-19

State/territory	Median Occupancy
New South Wales	93.4%
Victoria	93.7%
Queensland	93.6%
Western Australia	96.9%
South Australia	95.8%
Tasmania	93.4%
Australian Capital Territory	92.8%
Northern Territory	96.0%
Australia	94.3%

Source: Analysis based on unpublished data from Department of Health

At the more granular level, the great majority of aged care planning regions have a high median occupancy (figure 5.3). In 2018-19, over 90 per cent of regions had median occupancy levels greater than 90 per cent. More than a third of regions had median occupancy levels greater than 95 per cent. This suggests that choice of aged care homes with vacancies may be limited due to unavailability or to less preferred styles, quality or affordability of accommodation and additional services or to reputations for poor standards of care and basic services within certain areas of these regions.

Figure 5.3 Number of aged care planning regions in each median occupancy bracket, 2018-19



Note: Occupancy data was not available for two Northern Territory aged care planning regions: Barkly and East Arnhem

Source: Analysis based on unpublished data from Department of Health

Less than 10 per cent of regions (i.e. six regions) had median occupancy at 90 per cent or below in 2018-19 (table 5.2). These are largely in regional areas, with the exception of Western Sydney. The relationship between occupancy and choice in regional areas has a number of facets and low occupancy may be primarily due to changing population demographics and lower standards of accommodation. The latter can be the consequence of financial constraints as a result of the aged care homes incurring substantial and ongoing operational losses and having limited capital bases for major refurbishment. As a recent review of multi-purpose health and aged care services²⁸ made clear, there are many ‘legacy hostels’ still providing residential aged care in rural and remote towns and villages (Woods, Edwards, Nejad, Haywood, & Wise, 2019).

Table 5.2 Aged care planning regions with median occupancy rate below 90 per cent, 2018-19

Aged care planning region	Median occupancy
NSW-Western Sydney	88%
QLD-North West	76%
QLD-South West	90%
WA-Kimberley	66%
WA-Pilbara	84%
NT-Alice Springs	89%

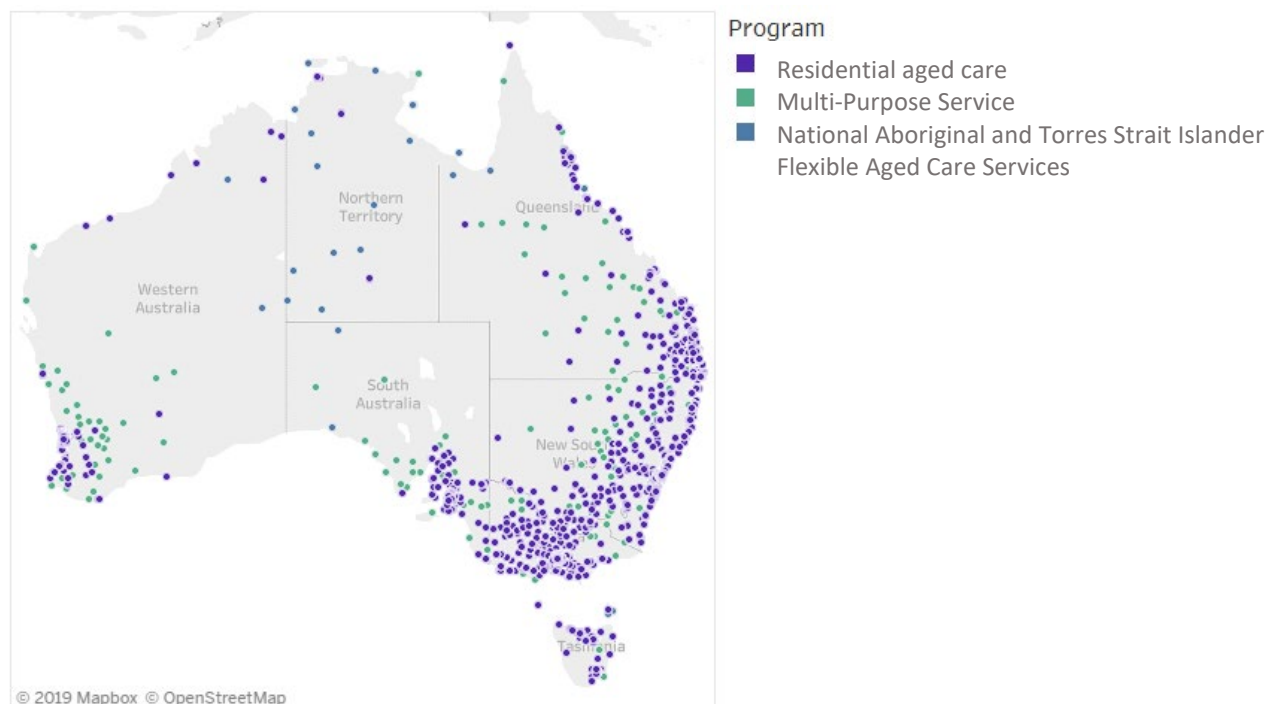
Source: Analysis based on unpublished data from Department of Health

However, even where there are lower occupancy rates it does not necessarily mean that there is a choice of aged care homes with vacancies for consumers within their immediate locality or that there is active competition between providers. This can be due to either the unequal distribution of aged care homes

²⁸ Multi-Purpose Services (MPS) is a flexible care program that provides integrated health and aged care services for small regional and remote communities that could not viably support stand-alone hospitals or aged care homes. This program primarily provides a residential aged care service. MPS is provided as a block funded subsidy to each MPS pooled fund and is based on the number of places allocated to each MPS (not based on occupancy of those places).

across non-metropolitan areas, or the long distances between homes in rural and remote areas. As shown in the map below (figure 5.4), aged care homes tend to be concentrated along the populated coastal areas and more sparsely distributed elsewhere. That is, greater choice of aged care homes (subject to finding a vacant place, noting high median occupancy rates in most regions) is likely to exist in the metropolitan coastal areas. The map also shows the flexible forms of aged care (Multi-Purpose Services and National Aboriginal and Torres Strait Islander Flexible Aged Care Program²⁹) that are available in non-metropolitan areas.

Figure 5.4 Distribution of aged care homes, Multi-Purpose Services and National Aboriginal and Torres Strait Islander Flexible Aged Care services, 30 June 2018



Source: Australian Institute of Health and Welfare, GEN Aged Care Data

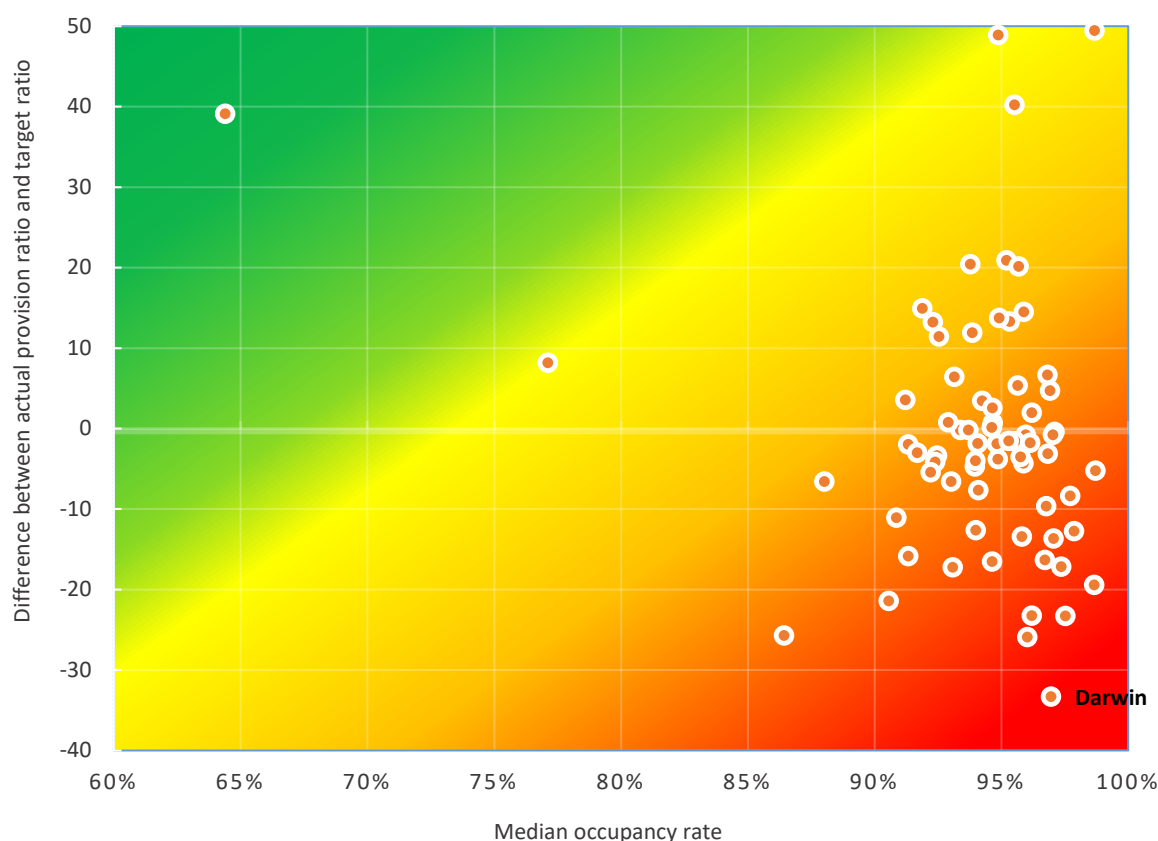
Occupancy and aged care provision ratio

Occupancy can also be assessed relative to potential demand, based on the gap between the levels of the actual service provision ratio and the target provision ratio. Figure 5.5 shows aged care planning regions charted by their median occupancy rates and by the differential between the actual and target ratios. A positive differential is where the actual provision is in excess of the target ratio whereas a negative differential is where the actual provision ratio is below the target ratio.

In general terms, planning regions located in green areas are those that would be considered to more likely have a choice of aged care homes, because of lower median occupancy and a generally positive differential between actual and target ratios. Conversely, planning regions in red areas are those that may have quite restricted choice, given higher median occupancy and generally negative differentials between actual and target ratios.

²⁹ The National Aboriginal and Torres Strait Islander Flexible Aged Care is a grant funded program that provides culturally safe aged care to older Aboriginal and Torres Strait Islander people close to home and community. Services are mainly located in rural and remote areas. This care can be residential and/or home care services in accordance with the needs of the community. Block funding is based on an agreed allocation of places (not on the occupancy of those places).

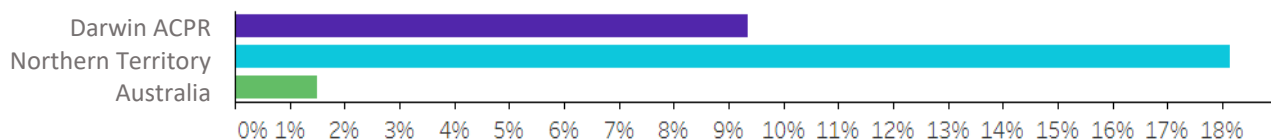
Figure 5.5 Aged care planning regions distributed by median occupancy rate and differential between provision and target ratios for residential aged care, 2017-18



Source: Analysis based on unpublished data from Department of Health

According to this mapping, most planning regions may have a quite limited choice of aged care homes with vacancies. Darwin in the Northern Territory, in particular, shows a significant 33-point deficit of actual operational places compared to the target ratio, together with high median occupancy across the aged care homes (of which there are five) in the region. While the Government has worked to increase the supply of places in the Northern Territory more broadly, by offering additional places through the ACAR, there has been a trend of undersubscription. This has been partly driven by an increased demand for places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, noting the relatively larger population of Aboriginal and Torres Strait Islander people in the territory (figure 5.6). It may also reflect the high cost of delivering services in areas such as this, compared to the income received through the government subsidies and consumer contributions.

Figure 5.6 Comparison of the proportion of Aboriginal and Torres Strait Islander people (age 50+) in Darwin aged care planning region, Northern Territory, and Australia, 30 June 2018



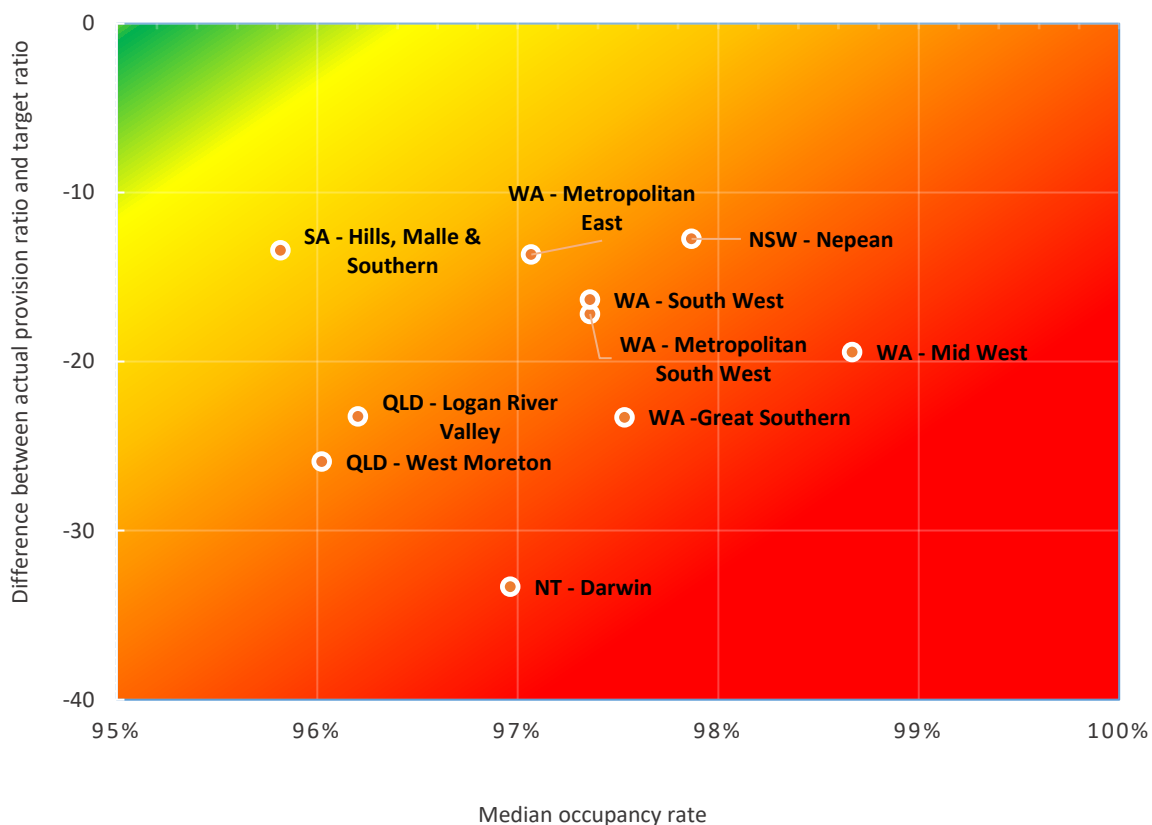
Source: Australian Institute of Health and Welfare, GEN Aged Care Data

There is also an over-representation of regions in Western Australia (WA) where the actual provision ratio is below the target ratio and the occupancy is high (specific regions are shown in figure 5.7). In WA, a key factor affecting supply has been the mining boom, which significantly increased the price of land and labour. This reduced the relative attractiveness of residential aged care from capital investment and workforce perspectives. Five successive ACARs between 2007 and 2012-13 in WA were undersubscribed. Of the 6,691 new residential aged care places made available for allocation in this period, only 2,721 (41 per cent) were allocated. This has contributed to under-provision in WA. However, demand for places in WA has since

increased significantly, with all subsequent ACARs being fully subscribed and the number of allocated places similarly increasing.

The examples of Darwin and WA demonstrate that in some locations, due to their unique local characteristics, residential aged care may be a less attractive sector in which to invest. Rural and remote issues more generally impact on the ability of providers to sustainably deliver viable residential aged care in these areas.

Figure 5.7 Aged care planning regions with a negative differential between provision and target ratios and median occupancy rate greater than overall median rate, 2017-18



Source: Analysis based on unpublished data from Department of Health

Summary of conclusions: criterion 1

The Impact Analysis concludes that the current model does not provide for a consumer-driven market that offers genuine choice. The allocation of a capped number of places to a selected group of providers gives them greater control and enables non-preferred homes to enjoy higher levels of occupancy than they may have in a more open market. Providers have less incentive to compete and the more successful providers have less flexibility to increase the scale of their operations or locate in other regions where there may be strong consumer demand for their accommodation and care services.

The ACAR process and regulatory controls on the quantity and location of supply also caps the number of vacant places for consumers to choose from in any one area. There is limited choice of vacant places in many aged care homes and regions. There is, however, even under existing arrangements, greater scope for choice and competition wherever there is a larger clustering of aged care homes, particularly in metropolitan and coastal retirement areas.

Criterion 2. Drive outcomes for quality and safety in residential aged care that meet or exceed approved standards

Gatekeeper role

Through the ACAR, the department has the opportunity to competitively assess the suitability of providers seeking to establish or expand aged care homes. Some stakeholders have suggested that this comparative suitability check affords a level of protection regarding who is able to operate.

As one anonymous service provider put it in their submission:

‘they have comfort knowing that the Government has issued the bed license to the provider after a comprehensive review of the providers ACAR application submission.’ (sub. 27, Q.7)

In terms of quality, the assessment is not comprehensive and it only occurs at one point in time – the time the application is assessed. The current ACAR carries out minimum quality checks such that providers with sanctions are excluded from being allocated new places and a provider’s non-compliance history is taken into consideration when assessing ACAR applications (although the latter does not preclude places from being allocated). As outlined in chapter 2, in the 2018-19 ACAR, the majority of residential aged care places (76 per cent) were allocated to providers who had no compliance issues or sanctions but a still sizable percentage of places (22 per cent) were allocated to providers with a history of non-compliance and/or active issues, suggesting ACAR’s quality gatekeeping role is minimal. No further quality or safety information is taken into account as part of the competitive assessment process.

Further, where an applicant is not or has not previously been an approved provider of aged care, there is no information available to be considered as part of the assessment to determine the applicant’s conduct record.

Ongoing quality assurance

Analysis of data on successful applicants over the last few ACARs has indicated only a limited number of occasions where places or capital grants were allocated to providers (not necessarily the specific aged care home awarded the places or grant) who subsequently received a notice of non-compliance within the next year of receiving those places or the grant. It is noted that the Aged Care Quality and Safety Commission has the ability to suspend or revoke places where a provider is found to be non-compliant, in order to limit the number of consumers receiving care under a provider who is not meeting their quality and safety standards.

Given the ACAR process can only consider compliance records at the time of assessment, it is not the appropriate mechanism for ensuring ongoing quality and safety compliance. The minimum quality check approach of the ACAR does not incentivise continual improvements in quality or safety as it only requires that providers be sanction-free at the time of application. Further, by restricting competition through the regulatory controls on supply (as discussed under criterion 1), some stakeholders have suggested the current model may be ‘propping up’ poorer quality providers (noting all providers are still required to meet Aged Care Quality Standards) who are not incentivised to exceed standards.

As COTA Australia put it, the existing system:

‘Restricts good providers from expanding in response to consumer preference and demand, in areas of known need, and to compete directly with poorer quality / out of date providers. Protects poorer quality providers and thus creates reputational damage for the whole sector.’ (sub. 34, Q. 8)

Dementia Australia similarly stated:

‘the current model does seem to enable poorer quality providers to operate and remain financially viable/operational – and market mechanisms are not strong enough to drive quality or genuine competition – especially as it relates to people with dementia. As demonstrated in the current Royal Commission into Aged Care Quality and Safety, as well as numerous Government inquiries into the aged care sector over recent years, poor quality dementia care can be delivered by approved providers who are able to operate, in part, as a result of their success in the ACAR funding rounds.’ (sub. 28, Q. 8)

Summary of conclusions: criterion 2

The Impact Analysis concludes that the current model is performing a limited suitability check and minimal quality check at one point in time. The check only applies to existing providers who are seeking to expand their number of places. Less verifiable information is available for checking new entrants who do not have an approved provider history. The 'minimum threshold' approach to gatekeeping quality, coupled with restricted competition, does not incentivise providers to improve quality and safety beyond the approved standards.

Criterion 3. Facilitate timely and equitable access to residential aged care and respite services for those in need

One of the most important characteristics of a sound place allocation process is that it facilitates consumer access to care and does so in a timely and equitable way. This includes attempting to ensure that a choice of places is available to vulnerable consumers, many with diverse needs: when they need a place; that is of an appropriate (and preferred) standard; and where they want it.

Timely access

Availability of places

Occupancy rates reflect the balance between the demand and supply of available places. In 2018-19, the mean (average) occupancy rate was 89.4 per cent (Australian Government Department of Health, 2019b), which indicates that there is potential spare capacity of 10 per cent of operational places. The mean occupancy rate has shown a slight downward trend over the last few years, with sizable variation by remoteness (see table 5.3). As noted in the discussion of criterion 1, decline is also evident in median occupancy but to a lesser extent.

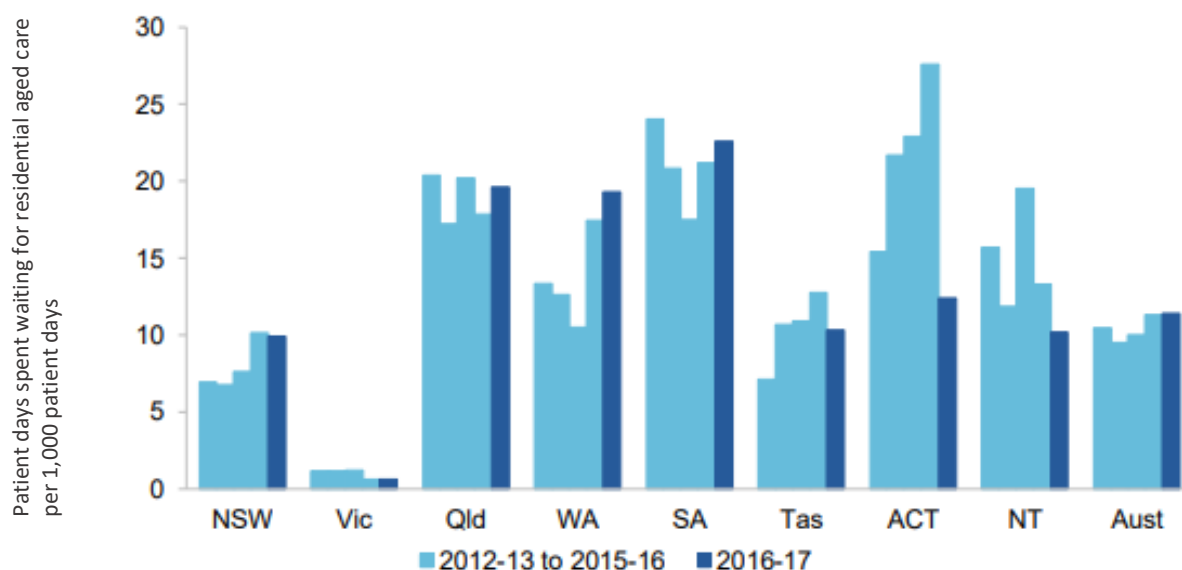
Table 5.3 Mean occupancy rate in residential aged care by remoteness, 2013-14 to 2017-18

Provider location	2013-14	2014-15	2015-16	2016-17	2017-18
Major cities	93.2%	92.6%	92.4%	91.4%	90.0%
Inner regional	92.9%	92.4%	92.5%	92.7%	91.4%
Outer regional	92.4%	92.1%	92.0%	92.2%	90.8%
Remote	88.6%	86.5%	89.7%	91.7%	88.4%
Very remote	84.4%	84.8%	80.0%	77.4%	77.1%
Australia	93.0%	92.5%	92.4%	91.8%	90.3%

Source: Aged Care Financing Authority, July 2019, Seventh report on the Funding and Financing of the Aged Care Industry

Thus while there is spare capacity in aggregate, such that available residential aged care places exist, particularly in remote or very remote areas, this may not result in availability in a consumer's preferred aged care home or locality. There are parts of the country where people are waiting to access residential aged care that is suitable for their needs or preferences. For example, nationally in 2016-17, the proportion of all hospital patient days used by patients waiting for residential aged care was 11.4 per 1000 patient days (figure 5.8).

Figure 5.8 Hospital patient days used by patients waiting for residential aged care in each state and territory, 2012-13 to 2016-17



Source: Productivity Commission, Report on Government Services 2019

Time taken to enter residential aged care

ACAT approvals data suggests consumers who are likely to be needing residential aged care are generally able to enter an aged care home within a reasonable period of time. This is consistent with there being spare capacity in residential aged care, as discussed above.

Elapsed time³⁰ between when a consumer is assessed as eligible for residential aged care and their entry to an aged care home provides only a limited proxy for how long it takes to access residential aged care. For instance, in 2017-18, the median elapsed time between a consumer's ACAT approval and entering an aged care home the same financial year was 121 days (Productivity Commission, 2019). 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. This is explained below.

Aged care legislation does not prevent a person from being approved for more than one type of care. Consumers, when assessed by an ACAT for care eligibility, can be given approval simultaneously for home care and residential aged care. In 2017-18, departmental records indicate that almost 70 per cent of approvals for permanent residential aged care also simultaneously included an approval for home care. Analysis of 2017-18 ACAT approvals data suggests that most consumers prefer to receive care in the home where possible. Approximately 72.5 per cent of consumers who received an approval for residential aged care in 2017-18 had not yet entered an aged care home by 30 June 2018. Most of these consumers (80.3 per cent) who had not yet entered were also approved for home care – the majority (81.7 per cent) of whom were in the home care prioritisation system, while close to 20 per cent were receiving a home care package. As such, this distorts the relevance of elapsed time analysis. Nonetheless, this dual approval gives families access to options for care and provides an assurance that should the person need this option quickly, the approval is already in place.

Greater insight is gained by examining the elapsed time to enter residential aged care among consumers who may be more likely to be actively seeking to enter an aged care home. That is, consumers who were assessed as only eligible for residential aged care and for whom the ACAT recommend residential aged care as the most appropriate long term living situation. In 2017-18, the mean period from approval to entry into residential aged care for these consumers was 37 days (median of 22 days). This suggests that when a

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.

consumer is eligible for residential aged care and they do not have the option of a subsidised home care package, they can typically enter an aged care home in around one month's time.

Equitable access

Some providers and other stakeholders expressed the view that the current targeting provided under ACAR, including by attaching conditions of allocation, works to support populations with specific needs and those in regional, remote and rural areas.

Special Needs Groups

The allocation of places in the ACAR may have specific conditions attached. Of the 13,500 residential aged care places allocated in the 2018-19 ACAR, 2,968 (22 per cent) specified priority of access to special needs groups and 4,849 (36 per cent) were allocated in respect of key issue groups, mainly with a focus on dementia care.

Approved providers without a priority of access condition attached to their allocation of places are still able to, and indeed do, deliver care to persons from special needs groups.

The Impact Analysis notes that conditions of allocation give priority to, but do not guarantee that a place will be used by, a consumer from a particular special needs group and further notes that the department does not currently assess and monitor whether the place is being used by a person from that special needs group.

As an anonymous service provider put it:

'the extent to which this objective is met in practice is questionable. The methodology for targeting special needs groups is inconsistent...and there is currently no audit process to measure how these places meet the needs of the identified groups once they are made operational or on an ongoing basis.' (sub. 46, p. 3-4)

COTA raised the same issue, saying that the condition of allocation:

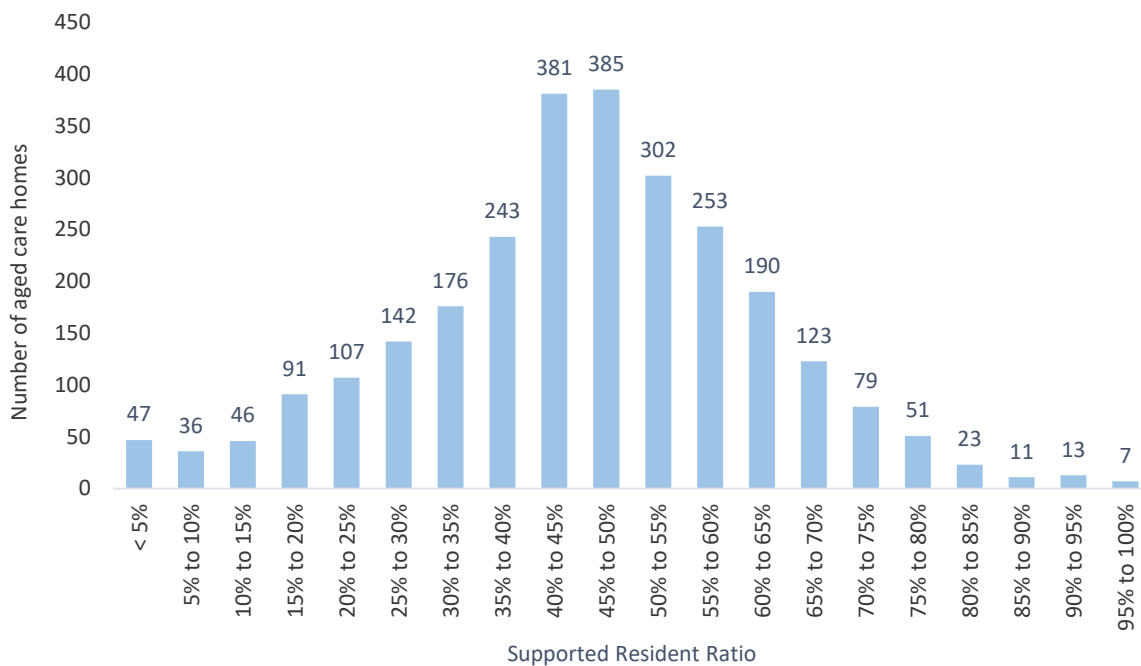
'often lasts one cycle of resident death or transfer (if that!) and subsequent consumers seeking placement are not necessarily of the same target population. While we understand the operational imperative to 'fill a bed', the lack of ongoing matching of places allocated based on special needs characteristics with resident profiles over time means that there is no reliable data about actual and current places filled for the initial allocated group/s.' (sub. 34, Q. 8)

Supported residents

To encourage service provision to economically disadvantaged consumers, an accommodation supplement is payable on behalf of consumers who do not have the capacity to pay for in full, or contribute in part to, the cost of their accommodation in an aged care home. The rate of accommodation supplement payable is reduced by 25 per cent whenever an aged care home does not have more than 40 per cent of consumers in their aged care home who are requiring assistance with their accommodation costs (i.e. supported residents).

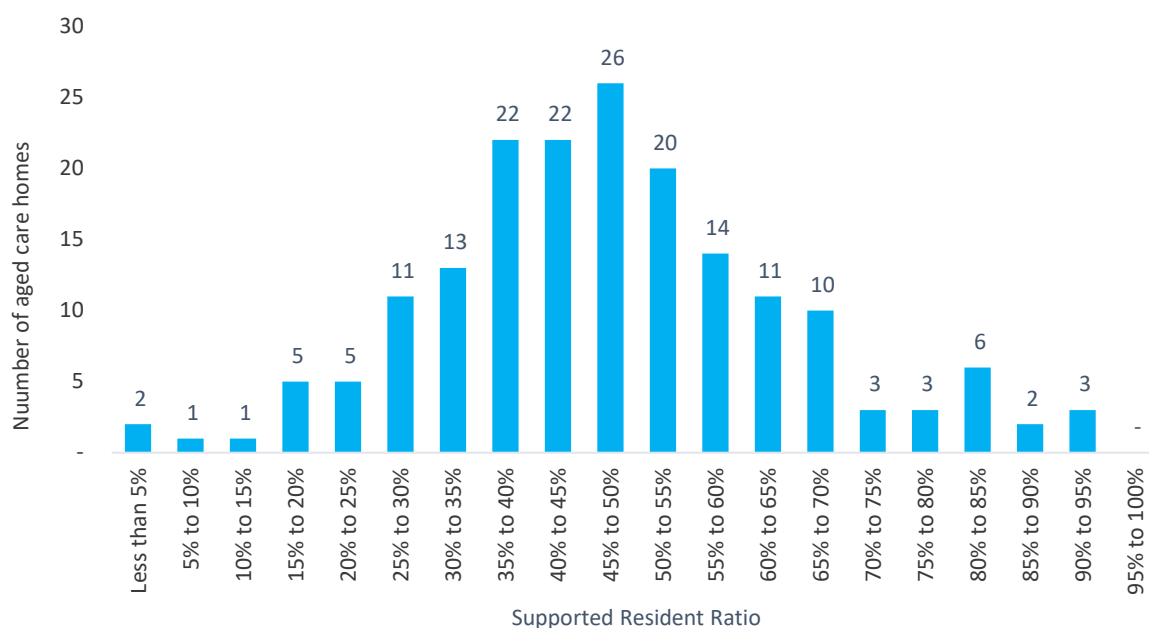
Given the incentive to achieve the 40 per cent threshold, it is not surprising that the peak numbers of aged care homes is in the 40 – 50 percent supported resident ratio band (figure 5.9). The distribution is similar among aged care homes that have conditions of allocation which require that they prioritise access for Financially and Socially Disadvantaged residents (one category of special needs groups) (figure 5.10). That is, aged care homes with this specific condition of allocation do not have a skewed supported resident ratio distribution towards higher levels, which suggests that the priority of access condition at the time of allocation may not necessarily be driving behaviour above and beyond the financial incentive of gaining the accommodation supplement at the 40 per cent threshold.

Figure 5.9 Number of aged care homes in each supported resident ratio bracket, 2017-18



Source: Analysis based on unpublished data from Department of Health

Figure 5.10 Number of aged care homes, with priority of access conditions of allocation for Financially and Socially Disadvantaged residents, in each supported resident ratio bracket, 2017-18



Source: Analysis based on unpublished data from Department of Health

There is evidence that the accommodation supplement is helping ensure positive financial results for providers, thus giving them an incentive to accommodate supported residents. As seen in figure 5.9 earlier, in 2017-18 a large proportion of aged care homes had supported resident ratios greater than the 40 per cent level required to be eligible for the full rate of accommodation supplement. An important point to note is in relation to the Higher Accommodation Supplement received as a result of approved significant

refurbishments or newly built aged care homes. For the 20 September 2019 to 19 March 2020 period³¹, the base accommodation supplement for homes with more than 40 per cent supported resident ratio was \$31.48 per day, however if there was a significant refurbishment, this increases to \$57.49 per day. Therefore, a supported resident in a significantly refurbished home attracts \$57.49 per day which is disclosed as revenue, whereas for a non-supported resident paying for their accommodation costs via a Refundable Accommodation Deposit, the interest earned on the lump sum (noting that it is not fully invested, likely to be only 25 per cent - 35 per cent actually invested) is not included as revenue in the aged care home in most cases (it is included as corporate revenue).

However, as indicated in Figure 5.11, aged care homes with supported resident ratios less than 40 per cent (e.g. around 30-35 per cent in 2018-19) can still have higher Aged Care Home Results³² than homes with 40 per cent supported resident ratio. This can be due to a number of reasons, including the operational efficiency of the home, additional services revenue, homes receiving higher accommodation pricing, and homes having a higher percentage of consumers paying a Daily Accommodation Payment rather than a Refundable Accommodation Deposit which attracts lower investment revenue. This suggests that providers have diverse business models based on the resident and geographic demography and their capital structure and mission.

Figure 5.11 Aged Care Home Results sorted by supported resident ratio, 2017-18 and 2018-19



Source: Analysis based on unpublished data from Department of Health

In short, service delivery to supported residents appears largely to be a strategic decision by a provider, driven by factors including their mission/operating purpose, business needs (e.g. sources of cash flow) and local demographics (e.g. in areas of higher socio-economic advantage it would be more difficult to achieve the 40 per cent ratio).

³¹ See Australian Government Department of Health, Schedule of Aged Care Subsidies and Supplements from 20 September 2019

³² Aged Care Home result is the Net Profit Before Tax based on the operating result. This result excludes non-recurrent revenue and expenses including fundraising, investments, bequests, fair value adjustments, impairments and sundry non-operating revenue/expenses

Locational targeting

The ACAR seeks to target the additional residential aged care places to areas in need. However, locational targeting has had mixed results – providers are not necessarily always interested in applying for places in targeted locations.

For example, in the 2018-19 ACAR, the department was unable to fill the number of places it sought to have built in the Northern Territory, the Australian Capital Territory and Tasmania, despite the ACAR as a whole being oversubscribed by 2.8 times. The department's published ACAR results summary states:

- Ninety-nine (99) places were not allocated in the Northern Territory (NT) from a total 149 available.
- One hundred and fifty eight (158) places were not allocated in the Australian Capital Territory (ACT) from a total 360 available.
- Fifty-one (51) places were not allocated in Tasmania from a total 212 available.

Due to insufficient suitable applications in NT, ACT and Tasmania, the 308 unallocated residential care places were re-allocated to New South Wales, Victoria and South Australia and successfully allocated as part of the 2018-19 ACAR.

The department will continue to encourage development of mainstream residential aged care services in the NT while ensuring aged care needs continue to be addressed through existing services offering care in residential, community and home based settings. (Australian Government Department of Health, 2019a)

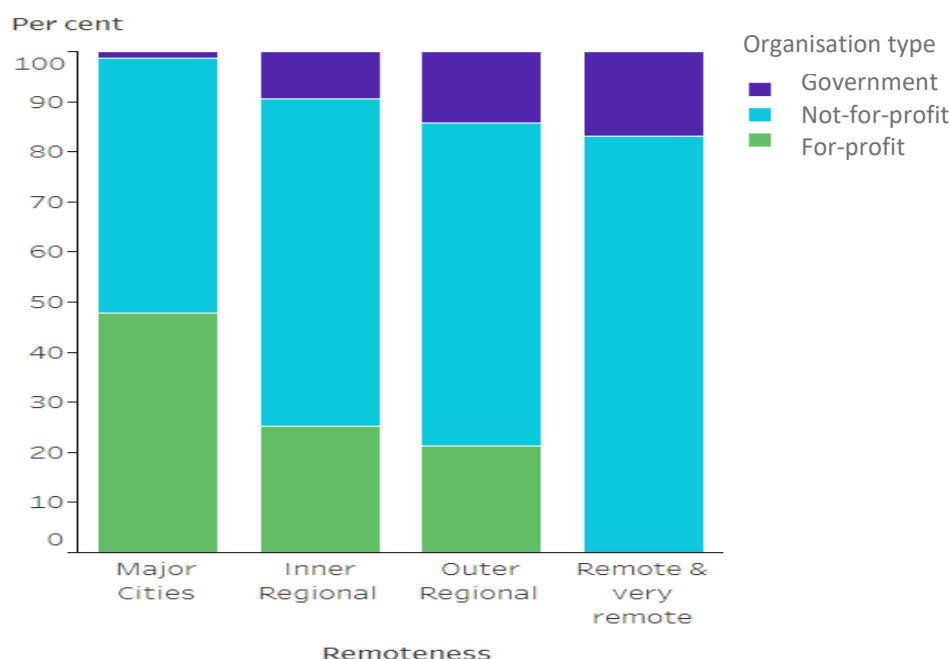
The prioritisation of regional, rural and remote areas in the 2018-19 ACAR appears to have had some success, although largely confined to regional areas and more significantly so in terms of influencing departmental allocations than in provider applications (see chapter 2). Compared to the 2016-17 ACAR, there was only a marginal increase in the relative number of places sought by providers in non-metropolitan areas but the number of places allocated to non-metropolitan areas almost doubled – however, for both places sought and allocated, they were almost exclusively in respect of regional areas.

While locational targeting may lead to a greater allocation of places in targeted areas, it does not guarantee that provision will eventuate. The ACAR's capacity to achieve this goal is limited by its reliance on providers being willing to follow through with investing in those locations and being confident of remaining viable over the longer term (including at times through internal organisational subsidisation).

Service delivery in regional, rural and remote areas

Almost all residential aged care places in rural, remote or very remote areas are not-for profit, with the remaining places in these areas being state or local government (figure 5.12). For-profit providers do not currently operate in remote or very remote areas primarily due to the lack of a sustainable financial return. This suggests the 'mission-based' approach of not-profit-profit providers and the 'provider of last resort' approach of state/local government (whose presence is linked to their community health responsibilities and the delivery of aged care through the Multi-Purpose Services Program) may be significant drivers of their willingness to operate in these areas. For example, in the 2018-19 ACAR, the majority of the places sought by state or local government providers were for the highest priority category of need (see chapter 2).

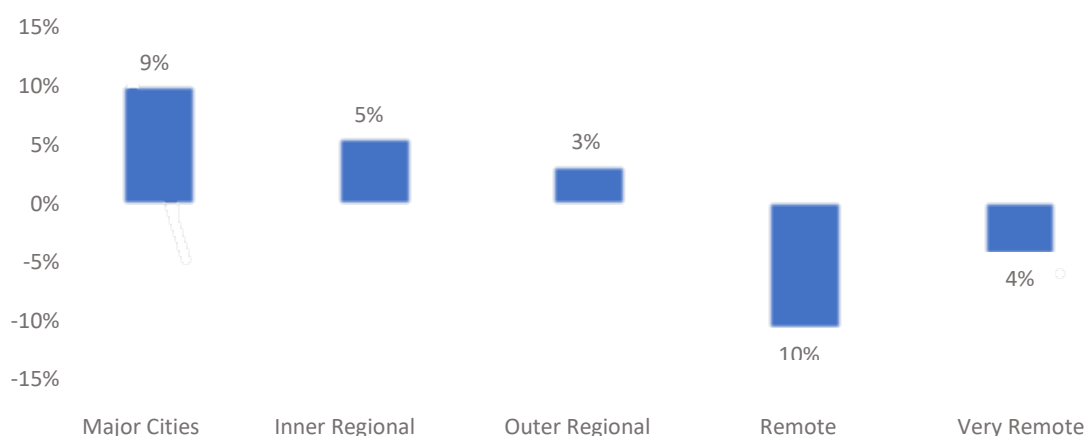
Figure 5.12 Proportion of residential aged care places by organisation type and remoteness, 30 June 2018



Source: Australian Institute of Health and Welfare, GEN Aged Care Data

However, over the last few years, despite continued allocations in the ACAR, there has been a contraction of service delivery in remote and very remote areas. Data (figure 5.13) shows the number of residential aged care places has declined in remote areas and increased in urban areas over the last four years. These reductions in places are likely influenced by the poor financial results being achieved in rural and remote areas relative to metropolitan regions (discussed further under criterion 4). This is despite governmental incentivising financial mechanisms in the form of capital grants and viability supplements. The latter is an additional amount paid to eligible providers in rural and remote areas to supplement the higher costs of delivering care in aged care homes in these areas. The issue of ensuring continued service delivery in rural and remote areas is broader than the places allocation model and centres on financial and workforce sustainability.

Figure 5.13 Percentage change in number of residential aged care places by remoteness, 2014-15 to 2017-18



Source: Analysis based on unpublished data from Department of Health

Unsurprisingly, the time taken to access an aged care home in remote and very remote areas³³ appears to take longer than the national average. According to departmental data, in 2017-18, consumers in remote areas (Modified Monash Model category 6) who received an ACAT approval as only eligible for residential aged care and for whom ACAT recommended residential aged care as the most appropriate long term living situation entered an aged care home within 58 days (median of 37 days) or 57 days (median of 14 days) in very remote areas (Modified Monash Model category 7). This suggests it may take almost two months on average for an eligible consumer in remote or very remote areas to enter an aged care home compared to the national average of around one month.

The Royal Commission also:

‘heard evidence that people in regional and remote areas have to wait longer for the services that they need...especially the case in residential aged care.’ (Royal Commission into Aged Care Quality and Safety, 2019) (Volume 1, p. 150)

Residential respite care

Residential respite is currently delivered through permanent residential aged care places, via a respite care allocation. It is a matter for providers as to what mix of respite and permanent residential aged care places they deliver in their aged care homes in any one financial year. Access to respite services will depend on an eligible consumer’s need/choice to access this type of care and on an approved provider’s willingness and ability to provide respite care.

In some instances, respite days are allocated through ACAR as a condition of allocation. Some providers specify that they will provide a certain number of respite days in their ACAR application (this may provide them with a competitive advantage, such as when respite is a key issue for that ACAR). Depending on the conditions of allocation, an approved provider may be allocated a maximum (pre 2013)³⁴ or minimum (from July 2013)³⁵ number of residential respite days per financial year. However, providers can write to the department to reduce or increase the number of respite days they are required to provide annually. Follow-through with delivering the number of respite days as per conditions of allocation is not currently consistently monitored and enforced. As noted in chapter 2, all residential aged care providers are able to provide respite regardless of whether or not it is a condition of allocation. However, an aged care home must have an allocation of respite care days recorded in the payment system in order to receive respite care subsidies and supplements.

Providers’ decisions to offer residential respite can be a business decision to manage occupancy in their aged care home. For example, the department’s state and territory offices have advised that newly built aged care homes will generally offer residential respite until their permanent resident occupancy increases, and services with lower occupancy also tend to deliver respite more often. This is corroborated by consultation submissions to the Aged Care Financing Authority’s (ACFA) review of existing respite care arrangements where providers stated that residential respite care is usually only offered to fill an empty bed between discharge and admission, while other providers stated they only offer planned residential respite care to guarantee income and enable the planning of occupancy (Aged Care Financing Authority, 2018).

ACFA’s Review of Respite also identified key issues around access, funding, consumer fees, administrative processes, and the availability of respite care. In particular, the most common issues relating to residential respite care that were raised during ACFA’s consultations were funding-related:

- residential respite funding does not meet the cost of providing care and services

³³ Based on Modified Monash Model (MMM), which defines whether a location is a city, rural, remote or very remote. The model measures remoteness and population size on a scale of MM category 1 to 7. MM 1 is a major city and MM 7 is very remote.

³⁴ Prior to July 2013, the allocation was for a maximum number of respite days in a year and providers would have to apply for a variation to the allocation to either increase or decrease the number of respite care days they could offer.

³⁵ Since July 2013 allocations have been for a minimum number of respite care days per year. This change reduced red tape as it enables providers to more easily increase their allocation through a request to the department’s state or territory office.

- respite care funding does not address accommodation costs
- there are additional costs in providing respite care for people with special needs, such as dementia and bariatric care and for Culturally and Linguistically Diverse (CALD) communities
- there is a proportionally higher cost of admission processes for short-term respite
- consumer fees for residential respite care are a barrier to access.

Notably, ACFA also found that:

- providers face financial risk if they provide respite care beyond their respite days allocation or if the respite place is not occupied, as relevant subsidies and supplements are not payable in those circumstances. The system is administratively complex for providers in managing their minimum or maximum respite allocation in order to be paid the appropriate level of respite subsidy, including the incentive supplement.
- there is evidence of respite places being used on a 'try before you buy' basis before a person enters permanent residential aged care.

As such, residential respite is in need of reform as discussed later in this report.

Summary of conclusions: criterion 3

The Impact Analysis concludes that under the current model, there is a sufficient number of residential aged care places available in aggregate (though not all aged care homes and places necessarily meet consumer preferences). It appears that consumers can generally access residential aged care within a reasonable timeframe, albeit longer timeframes are evident in remote and very remote areas.

It is unclear how effective the current model is in supporting the aim of equitable access. There was no evidence to determine whether priority of access conditions are effective in supporting access for special needs groups as it is not monitored. Access for supported residents appears to be driven by a financial incentive rather than by imposing conditions of priority access. Locational targeting such as to rural and remote areas appears to go some way in increasing allocations in these areas, but it does not guarantee service provision.

The residential respite care places allocation system, including the role played by ACAR, do not appear to be facilitating access to respite and there are broader administration and funding-related barriers to approved providers offering respite.

Government interventions in the market to achieve timely and equitable access should be designed with clearly specified rationales and should be the minimum necessary to achieve these outcomes. On this basis, ACAR should not attempt to deliver outcomes that are more efficiently, effectively and equitably achieved by more targeted forms of intervention (e.g. financial incentives/supplements) for these policy objectives.

Criterion 4. Facilitate a residential aged care sector that has continued growth and financial investment which responds to increasing consumer demand and changing preferences

Responsiveness to consumers

Movement of places

There are locational restrictions on the movement of places allocated under ACAR. While places cannot be moved outside of the state or territory to which they were originally allocated, there is some scope for providers to relocate them within the original jurisdiction. This can be in response to changes in the geographical distribution of consumer demand or perceived opportunities to expand the service footprint, though all movements are subject to departmental approval.

Providers do make use of the ability to vary conditions of allocation to change the location of their places within the relevant state or territory. For example, departmental data shows that during 2018-19, providers applied to vary the location of their allocation for around 4,100 residential aged care places (over 50 per cent were provisionally allocated, around 30 per cent were operational, and the remainder were offline),

representing around 2 per cent of total allocated places as at 30 June 2019. Providers were mostly seeking to move places (almost 3,000 places) within the same aged care planning region rather than into a different region (over 1,000 places). In almost all cases, the movements were allowed to proceed; the department advised that applications rarely reach the stage where the delegate needs to exercise any form of refusal as the departmental state offices work closely with the applicants in discussing issues and options.

The ability of providers to move places within a state or territory means that the current system does have some elements of market behaviour. Within a given region, incumbent providers need to anticipate and factor in any changes in the location and availability of places belonging to their competitors. However, between ACARs, the current system does afford providers certainty that the overall number of allocated places within their state or territory will not change.

Flexibility to expand

New places are hard to obtain under ACAR. The ACAR is both irregular and highly competitive because the places available in each round are limited in number, and obtaining an allocation (either via ACAR or transfer from another provider) is the only way by which approved providers can deliver subsidised residential aged care. Further, places are sought after because, while providers do not pay for places allocated under ACAR, the places are treated by some providers as having value as intangible assets (discussed further below), which may be sold in a secondary market (discussed further under criterion 5).

Providers who wish to expand their capacity between ACARs (or where they have been unsuccessful in the ACAR) are limited in their flexibility to do so. This was a commonly raised issue among stakeholders. In order to respond to increased demand at short notice, these providers would need to seek approval to move any surplus places they may have in another aged care home within that state/territory, or to transfer places from another provider (which may involve purchasing in the secondary market).

In terms of transfers, departmental data shows that in 2018-19, almost 11,000 residential aged care places (mostly operational places, 80 per cent) – representing around 4 per cent of allocated places – were transferred to another provider for expansions, new builds, consolidations or exits (including as a result of sanctions imposed on the transferor). Providers are restricted from expanding their service footprint interstate unless they obtain places for the relevant state or territory via the ACAR or seek a transfer from another provider in that jurisdiction.

Innovation

Stakeholders were concerned that the current ACAR application process focusses on questions based around current models of care. It reinforces the stereotype ‘nursing home’ accommodation and care perspective rather than actively encouraging providers to propose alternative ways in which consumer needs and preferences might be met, or to develop innovative service delivery or business models. For instance, Brisbane South Primary Health Network (sub 22, Q.8) raised questions about whether the ACAR model undermines the emergence of innovative care models and ways of organising different types of service. The Royal Commission similarly identified that the aged care system, including some providers, has not kept up with changing needs and community expectations, and that the system provides no incentive or encouragement to do so (Royal Commission into Aged Care Quality and Safety, 2019).

Growth of the sector

New entrants

Stakeholders have suggested that the ACAR can act as a barrier to entry for new entrants. It appears that applicants who have not previously been approved providers are less likely to be allocated places because their service proposal is – on average – assessed to be less competitive than those of existing providers. For example, in the 2018-19 ACAR (as discussed in chapter 2), for new entrants, 12 per cent of the places they sought were allocated to them compared to 37 per cent of places sought by existing approved providers. Overall, the majority of new residential aged care places were allocated to existing approved providers (98 per cent) compared with 2 per cent of places allocated to new entrants.

Non-operational places

The system also allows providers to hold non-operational places for extended periods of time, thus preventing alternative providers from being able to meet that local demand. At least 17 per cent of allocated places are not operational and therefore are unavailable to consumers as at 30 June 2019 (Australian Government Department of Health, 2019g). Most non-operational places are provisionally allocated (14 per cent), and in most cases are in the process of being planned or constructed following a successful allocation through an ACAR. However, nearly ten percent of provisional places have been held by providers for over six years without being operationalised (see chapter 2).

A small proportion of non-operational places are offline (at least 3 per cent). While offline places do not impact the number of places released via ACAR, the department does not currently have full visibility of all offline places³⁶. Providers are encouraged to report them to the department, but reporting is not mandatory – unlike for provisional places. As a result, some of these places appear to the department as operational places that are unoccupied, which can then reduce the number of places released in a subsequent ACAR.

Investment in the sector

Certainty and uncertainty for investment decisions

There are mixed views on the role of ACAR in facilitating investment. It is regarded by some providers as supporting investment decisions. This is primarily by providing a relatively stable investment environment through the allocation of a capped number of places to individual providers and the restriction of competition. Some providers at the forums argued that the ACAR is also useful as a market awareness and advisory mechanism that supports businesses to plan on where to invest and operate in future. Some providers stated that the outcomes of ACAR offer transparency of the market, including around future local competitors through visibility of where places are allocated, allowing current providers to adjust accordingly.

Representatives from the banking and financing sector at the forums advised that they do not consider allocated places per se when assessing applications for financing. They emphasised the importance of a provider's certainty of cash flow, business case, and governance. However, some noted that there are 'three pillars of comfort' for lenders: limits on the threat of new entrants, known competition, and a low threat of substitution – the ACAR supports particularly the first two of these pillars.

Because of the capped number of places together with median occupancy remaining at consistently high levels, there is some degree of certainty of return on investment under the current ACAR process. If median occupancy were lower, then ACAR would not be able to deliver the current level of provider confidence in rates or return. Conversely, other stakeholders have expressed concerns that the uncertainty surrounding the timeframes and outcomes of ACAR makes it difficult to undertake business planning and inhibits potential and timely investment.

Catholic Health Australia considered that:

'the current process is seen as "a lucky dip" (noting also that value for money, invariably a key criterion for tender processes, does not apply for the ACAR).' (sub. 25, Q .8)

Another service provider submission similarly wrote:

'The primary source of bed licences for residential aged care facilities is the periodic ACAR rounds where a limited number of licenses are allocated to providers. This introduces an unknown quotient that cannot be factored into our feasibility studies and a deterrent to invest due to the risk that we will build beds that do not receive licences to be occupied.' (sub. 42, p .4)

Value of places

Allocated residential aged care places are currently recorded on the balance sheets of some providers as 'intangible assets' (an asset that is not physical in nature). As at 30 June 2018, around 35 per cent of residential aged care providers held allocated places as intangible assets.

³⁶ A separate departmental Review of Offline Residential Care Places Management has been completed

- Not-for-profit providers have the option of recording allocated residential aged care places obtained via the ACAR as intangible assets at a “fair value” assessment. While the majority of not-for-profit providers have removed allocated places from being disclosed as intangible assets, some have not. Departmental data indicates that just under 30 per cent of not-for-profit providers included allocated places as intangible assets as at 30 June 2018.
- For-profit providers can only record allocated residential aged care places as intangible assets at cost or fair value via acquisition (that is, the places were not acquired by the provider through ACAR but by transfer at a cost from another provider). Departmental data indicates almost 60 per cent of for-profit providers recorded at least some of their allocated places as intangible assets as at 30 June 2018.

When disclosed as intangible assets, places are assessed as having an indefinite useful life as they are issued for an unlimited period. What this means is that the intangible assets are not amortised (unlike fixed assets such as buildings), so their value is maintained and only reduced if they are considered to be impaired (this requires a greater level of testing). Disclosing intangibles assets increases the net assets of an organisation, but outside of this there is minimal benefit. Representatives of the finance sector advised the Impact Analysis that they do not take any recorded value of places into account when assessing applications for finance.

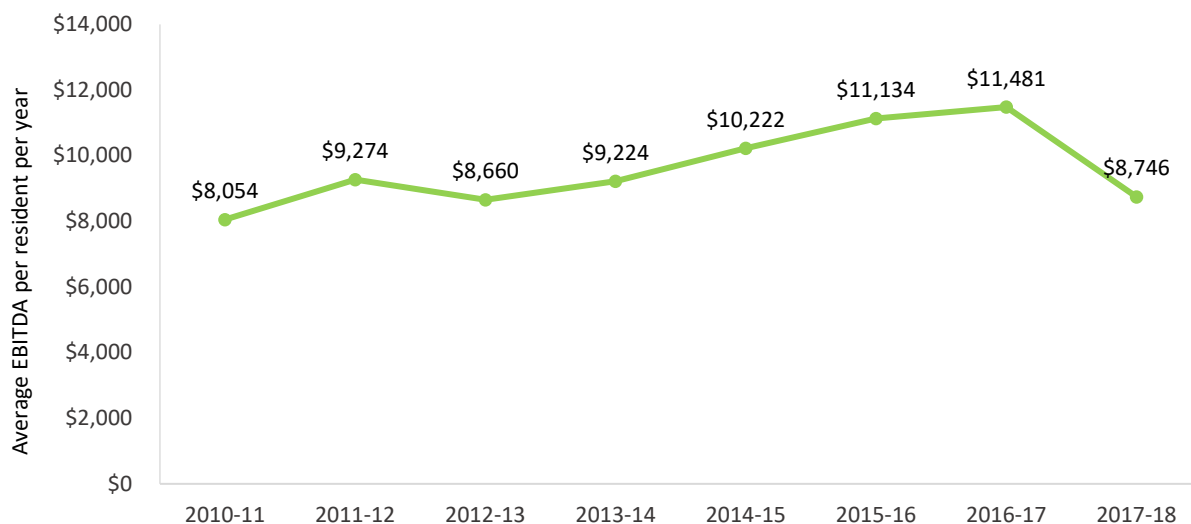
Financial pressures

Other factors which impact on the returns on investment include the viability of the individual providers and of the sector overall. At the time of this Impact Analysis the majority of providers in the sector are under high financial stress, as observed by the Aged Care Financing Authority and StewartBrown. As the following analyses demonstrates, this is not as a result of ACAR, but of declining returns as well as of policy and regulatory uncertainty.

In its 2019 Annual Report, ACFA reported that total profit in the residential aged care sector was \$435 million in 2017-18 (Aged Care Financing Authority, 2019). This was a significant reduction from \$1,006 million in 2016-17. A total of 44 per cent of residential aged care providers reported a loss. ACFA’s analysis shows that, while Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA)³⁷ per resident has remained within a band of between \$8,000 and \$12,000 per annum over the last eight years, there was a sharp decline in 2017-18, seeing that measure drop to its lowest level since 2012-13 (figure 5.14).

³⁷ Earnings Before Interest Depreciation Amortisation (EBITDA) is the Aged Care Home Result add/less interest expense/revenue (as these are solely relational to the approved provider); taxation (relative to for-profit entities only) and depreciation/amortisation as these are both non-cash and the amounts vary between providers based on their respective policies.

Figure 5.14 Residential aged care provider average EBITDA per resident per year, 2010-11 to 2017-18



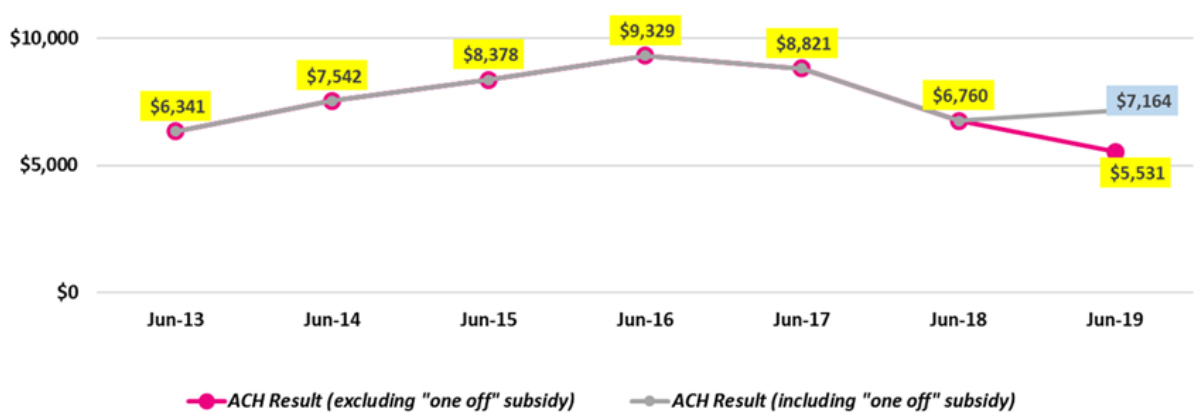
Source: Aged Care Financing Authority, July 2019, Seventh report on the Funding and Financing of the Aged Care Industry

Using a different measure, the StewartBrown 2018-19 Aged Care Financial Performance Survey report updated this deteriorating trend in providers' overall financial position up to 30 June 2019, using Aged Care Home Results (see figure 5.15). It is noted that, without a one-off government subsidy boost³⁸ which slightly improved results, the downward trend continues.

StewartBrown explained this decline was largely driven by expenses increasing at a greater rate than revenue:

'... the residential care sector has experienced a significant decline in the Aged Care Home Result [ACH]. This is mainly due to the continued trend of expenses increasing at a much higher rate (5.2% in FY19) than revenue excluding the one-off grant (3.2% in FY19).' (StewartBrown, 2019a) (p. 18)

Figure 5.15 Aged Care Home Result per resident per year, June 2013 to June 2019



Source: StewartBrown, Aged Care Financial Performance Survey - Aged Care Sector Report 2018-19

This deterioration has been particularly acute among aged care homes operating in regional, rural, and remote areas. StewartBrown report that in 2018-19, 74 per cent of surveyed aged care homes in rural and remote areas have a negative Aged Care Home result and 49 per cent have a negative earnings before interest including investment revenue, taxation, depreciation, amortisation and rent (EBITDAR) (StewartBrown, 2019a).

³⁸ Between March 2019 and June 2019, the Australian Government provided a one-off increase to the general residential aged care subsidy, paid as a 9.5 per cent increase in the subsidy for residents in mainstream residential aged care.

According to ACFA, an important influence on the decline in the performance of residential aged care providers was the changes to the Aged Care Funding Instrument (ACFI) that took effect in 2016 and 2017 and the pause in ACFI indexation in 2017-18 – coupled with costs, particularly staff costs, continuing to rise at a greater rate. Work is underway by the department to test a potential new funding model for residential aged care – the Australian National Aged Care Classification – to possibly replace the existing ACFI.

The poor financial performance of the sector has likely contributed to the slowing of investment intentions and building activity (see chapter 2), despite the encouragement for investment that some have claimed the ACAR provides.

Summary of conclusions: criterion 4

The Impact Analysis concludes that the ability of the sector to respond to increasing consumer demand and changing preferences, as well as to facilitate growth and investment, is constrained under the current model. Providers cannot easily relocate existing places or obtain new places in response to changes in consumer demand. The ACAR process itself does not encourage innovations in service and accommodation offerings that match evolving preferences, and the conditions of the ACAR process appear to be more difficult for new entrants to satisfy. Responsiveness and growth is also affected by the longstanding presence of a number of places allocated under ACAR which remain non-operational.

While some providers have suggested that having ACAR and allocated places affords a level of comfort for capital investment financing and strategic decisions, others have contended that the uncertainty of the process and outcomes poses challenges for business planning and investment. Further, growth and investment in the sector are also clearly impacted by financial performance pressures, separate to the current place allocation model.

Criterion 5. Have transparent and accountable processes

ACAR process

Several aspects of the ACAR process are seen to lack transparency and accountability. The timeframe of the ACAR process was a key criticism of stakeholders. In particular, the irregular occurrence of the ACAR and lack of advance notice to the sector, short response times for applications, and long delays before results are announced, were all commonly raised.

Some stakeholders also took issue with the planning process for the ACAR. Insufficient engagement with stakeholders in identifying local priorities and inadequate signalling of key priorities in the ACAR were often identified as issues.

An anonymous service provider explains:

‘The timing of approvals rounds is irregular, leaving providers with strategic development plans frustrated by the unpredictable release of places. Further, the Commonwealth does very little to foreshadow the priorities in upcoming rounds or make the evidence behind those priorities publicly available. When a new ACAR is announced, providers generally have only a six-week window to align their own market analysis and strategic plans with the government’s identified priorities for geographic areas, special needs groups and key issues. It is difficult to see how this approach is conducive to effective planning and the production of high-quality applications for new places. The lack of transparency around the ACAR is a problem that is felt uniformly around the country.’
(sub. 46, p .4)

It is noted that, prior to 2014, Aged Care Planning Advisory Committees (ACPACs) in each state and territory, comprising both government and non-government members with a range of expertise and experience in aged care, existed to provide advice to the department on the number of places that should be made available for allocation in each region, and local priority issues. The ACPACs were abolished as part of the

Smaller Government reforms of 2014 to reduce 'red tape' with the ongoing functions instead to be performed by the department³⁹.

Some stakeholders perceived the ACAR assessment process itself as lacking transparency and accountability. There were questions raised about the extent to which claims and information provided in applications are verified during the assessment process and whether allocation decisions reflected the stated priorities for the round and/or the needs of the local community.

Service provider, Advantaged Care, set out some concerns around how the current system operates:

'the process for assessing applications changes every year, the criteria for assessing applications is not transparent, is based on the answering of constant changing iterations of similar but different questions, and changing stated or unstated agendas, driven by politics of some form or another.'
(sub. 35, Q. 8)

There have also been suggestions from stakeholders that some applicants are applying for places with no immediate intention of operationalising them. For example, Advantaged Care suggested the system needed to change to:

'reduce the appetite to apply on a contingency basis and progress projects that are more seriously committed to and where resources have been expended and the likelihood of timely delivery is higher.' (sub. 35, Q.8)

³⁹ Social Services Legislation Amendment (No. 2) Bill 2015, Explanatory Memorandum

The Impact Analysis notes that improvements were introduced in the 2018-19 ACAR which placed a greater focus on verifying an applicant's readiness to commence their building project. The 2018-19 ACAR advised applicants that those with demonstrated evidence of their capacity to operationalise places quickly would be more competitive.

The existing system does provide some transparency. At the conclusion of the ACAR allocation process the department issues a public statement of: the location of newly allocated places; which providers have been successful with their application/s; and what special needs groups (if any) their approvals are targeted towards. However, based on stakeholders' comments in the forums and submissions, this does not appear to be widely seen by the sector as sufficient to understand why some applications are successful and others are not. Since the 2018-19 ACAR, individual feedback to applicants is no longer provided (Australian Government Department of Health, 2019a). Nonetheless, some providers consider the visibility of knowing who their future competitors will be in the local region is valuable input to their future planning and investment decisions (see criterion 4 discussion).

Places management

Several aspects of post-allocation management also lack transparency and accountability. Key to these is that conditions of allocation are not consistently monitored or enforced. This includes conditions relating to priority of access to special needs groups and delivery of residential respite care. Further, it is not mandatory for providers to report when their places are offline. As such, there is minimal accountability for providers to follow-through with the targeting specified in their ACAR applications, which undermines the purpose of priorities in the ACAR.

Outside of ACAR, providers can apply to vary the locations of places or transfer places to another provider within a state or territory (subject to departmental approval). Neither of these processes (conditions of variation or transfers) are transparent to other providers, as information on which providers have varied their conditions of allocation or transferred places is not published.

In relation to transfers, a secondary market exists where approved providers sell allocated places gained through previous ACAR/s to another approved provider. These sales are generally using brokers to enable a more competitive price. The department can veto any transfer of places to another provider if it is not satisfied that the transfer would suitably meet local needs, but does not have visibility of any sale price attached, as that is undertaken as a private business transaction between the providers. The sale of allocated places is somewhat contrary to the principles of ACAR in that it is not an open tender process – in most cases the broker (or approved provider) approaches a select number of potential acquirers. It should be noted that the sale of allocated places can be with or without inclusion of the aged care home (land and buildings) and the sale price is entirely dependent upon demand (e.g. many rural, regional or remote areas would not, and do not, attract any interest from potential purchasers).

At the time of finalising this report, the Minister announced that there would be several process changes to a 2020 ACAR. In the first instance, the existence of an ACAR in March 2020 was announced in December 2019. Second, a more extensive consultation process would be undertaken in the lead-up to the March release of the ACAR guidelines. Third, the Round would not close until May 2020, potentially therefore being open for longer than the previous 6-week period. These developments are discussed further in the assessment of Model 1.

Summary of conclusions: criterion 5

The Impact Analysis concludes there are aspects of both the ACAR and places management processes that lack transparency and accountability, which can undermine the intended purposes of those processes as well as public confidence.

Chapter 6: Model 1 assessment and refinement

Model 1 proposes retaining the ACAR and the places management arrangements but improving them in a number of ways. The core elements of Model 1 as set out in the Discussion Paper were as follows:

- reduce locational controls on the distribution of residential aged care places
- reduce the number of non-operational residential aged care places
- improve the administration of ACAR and allocated places management processes. During the consultations this was broadened to include giving greater predictability to the timing of, and targeted conditions set out in, ACAR.

This chapter considers the changes proposed in Model 1 against each of the five principles established in chapter 3. Based on data analysis as well as feedback from stakeholders, the chapter then sets out amendments to Model 1 that would further improve the functioning of ACAR and allocated places.

Overall stakeholder reaction to Model 1

There was a 'neutral to somewhat positive' reception from stakeholders for Model 1. It was seen to offer incremental improvements to operational flexibility and responsiveness to consumer demand while preserving a level of certainty and stability for providers. Some providers expressed the view that the ACAR is not fully broken and can be fixed through changes such as those proposed under this model.

Aged and Community Services Australia (ACSA) commented in their submission that:

'Model 1 would appear to address a number of the identified deficits of the current allocations process...and would likely be less disruptive than Model 2.' (sub. 52, p. 4)

Leading Age Services Australia (LASA) also noted in their submission that:

'given current instability in residential aged care and uncertainty about both the benefits and risks of change, LASA supports a measured and incremental approach to reform in line with model 1.' (sub. 44, p. 3)

However, given that Model 1 does not propose structural change, some stakeholders considered that it offered little by way of significant improvement for consumers.

For example, COTA Australia noted in its submission that Model 1:

'...does not fundamentally change the architecture and culture of aged care toward a more consumer choice and control approach.' (sub. 34, Q. 11)

Dementia Australia wrote that Model 1:

'...will go some way to stimulating the market and potentially give rise to greater consumer choice...it is also worth emphasising that a more flexible allocation process will not necessarily translate into increased choice for people impacted by dementia. For people living with dementia and their carers, there may be minimal impact of this model as the changes are largely administrative in nature.' (sub. 28, Q. 11)

Catholic Health Australia suggested that any modest benefits would likely only arise in metropolitan areas. It also noted the need for equity assurance measures:

'[Model 1] essentially preserves the main features of the existing process i.e. allocating a regulated supply of subsidised residential places to approved providers, its impact on improving consumer access, choice and control and stimulating innovation and higher quality services would be modest, and more likely confined to metropolitan areas.'

Without compensating measures, Model 1 would have negative consequences for the provision of services for certain special needs groups, areas with thin markets and lower socio-economic status areas.’ (sub. 25, Q. 16)

The following sections assess Model 1 against each of the criteria set out in chapter 3. The assessment draws on qualitative views from stakeholders.

Criterion 1. Provide greater consumer choice and control in a competitive residential aged care market

Choice of aged care home

Reduced locational control on allocated places

Some stakeholders considered that a reduction in locational controls over the movement of places (whether provisionally allocated, operational or offline) had the potential to increase the degree of consumer choice of aged care homes. This would be due to the redistribution of places in response to locational variations in demand.

However, others expressed concern that, given there are caps on the total number of allocated places, this must necessarily be a zero-sum game. Any increase in locational flexibility would only bring about greater choice for some consumers, such as in profitable metropolitan areas, at the expense of reduced choice for others, including consumers in the less profitable rural and remote areas and those with special needs.

Carers Australia considered:

‘Benefits would include greater flexibility in reallocating places to higher areas of demand.’ (sub. 23, Q. 15)

Lifecare suggested that choice would just continue to grow in well-served locations:

‘... the market will follow profit and with any reduction in locational specificity we could see the continuation of larger numbers of aged care in areas with good existing provision.’ (sub. 3, Q. 11)

Resthaven considered that the redistribution of places may detract from overall choice:

‘There is still a risk that APs will move places within the State to an area where there is greatest opportunity for financial gain (suburbs with higher socio economic status, or to increase size of facilities to utilise infrastructure in one place), reducing the number and locations of services.’ (sub. 51, Q. 15)

ACSA also cautioned that choice could be reduced in some areas or for some groups:

‘The proposed strategy in Model 1 to loosen ‘locational controls’ is likely to impact these identified areas and is a two-edged sword. Being able to move allocated places between geographical location could on the one hand increase choice and options for consumers but could also see places moved out of geographical areas or special needs provision which are less financially viable or appealing.’ (sub. 52, p. 8)

These concerns were also echoed in an anonymous state government submission:

‘Allowing additional locational flexibility while maintaining the limit on supply would mean that places would gravitate towards the most profitable/least risk areas, leaving areas of low population density or high concentrations of difficult to service clients (clinical complexity/diversity/low S.E.S.) poorly serviced. This outcome would stifle consumer choice and risk concentrating operating models by location.’ (sub. 53, p. 4)

Dementia Australia shared similar concerns:

‘The proposed improvements will go some way to stimulating the market and potentially give rise to greater consumer choice; however, the potential disruption to services – especially in regional or remote areas is of concern to Dementia Australia. It is also worth emphasising that a more flexible allocation process will not necessarily translate into increased choice for people impacted by dementia.’ (sub. 28, Q. 11)

In contrast, some providers suggested they would have greater scope to develop aged care homes in rural, regional or remote areas.

Menarock Aged Care Services explained the opportunity to enter regional areas:

‘Modification to the existing model will have a very positive impact on us as an operator as we will be able to commence construction in the regional areas which (to date) we have not been able to get bed allocations granted. In the absence of being issued with bed licences, we cannot obtain the requisite bank funding to commence construction.’ (sub. 11, Q. 15)

Similarly, an anonymous service provider also asserted:

‘As a provider focused on areas outside metro - this enables us to develop in RRR areas and support older people living in these areas.’ (sub. 27, Q. 15)

These latter two submissions indicate that there are providers with a mission or business model for rural, regional or remote service delivery who favour the relaxation of locational controls and would welcome the opportunity to increase their presence in these areas.

Some stakeholders suggested that targeted restrictions to the relaxation of locational controls could prevent the loss of places in unprofitable areas of need.

ACSA suggested:

‘If ‘locational controls’ are loosened consideration to ensuring supply will be required. This could be addressed by excluding some areas and groups from the supply changes or introducing mechanisms, overseen by the Department of Health, to ensure continued provision by:

- Controlling the geographical movement of allocated places if the above cohorts are being disadvantaged; and/or
- Providing additional out-of-round, or one-off allocation of places with special conditions attached, to address shortfalls in these cohort groups.’ (sub. 52, p. 8)

LASA similarly agreed:

‘... locational controls (including state based controls) for metropolitan bed licenses should be removed, while maintaining current restrictions on the allocation of bed licenses in regional, rural and remote areas.

This will allow lessons from a more market based approach to be learned in the locations where there is the least risk of market failures. This experience could then be used to inform decisions about whether to loosen restrictions in thinner markets.

Provided ACAR retains a focus on allocating places to address capacity constraints or access problems there will continue to be some implicit locational targeting in the initial allocation even in the absence of explicit constraints.’ (sub. 44, p. 9)

During the conduct of this Impact Analysis a legislative change to locational controls came into effect from September 2019⁴⁰ (see chapter 2). Under the changes, approved providers are able to apply to the department to vary a provisional allocation to enable them to operationalise the place and deliver aged care services to consumers in a different region to where the place was originally allocated. The approved provider is required to demonstrate that the movement is in the interests of aged care consumers, there is a clear need for places in the new region, and the movement is not detrimental to the region to which the provisionally allocated places are currently allocated. Places cannot be moved out of the initial state or territory. For the transfer of provisionally allocated places to another provider in a different state or territory, the department must also consider what exceptional circumstances will justify the transfer.

The legislative change addresses part of Model 1 by reducing locational controls on provisionally allocated places. However, notwithstanding the need for departmental approval on the basis of exceptional circumstances, the change enables places that were allocated to providers to become operational in

⁴⁰ Aged Care Amendment (Movement of Provisionally Allocated Places) Bill 2019

specified aged care homes to be moved or transferred elsewhere within the state or territory while still only provisional. This may have prevented another provider who intended to provide residential aged care in the initial region from obtaining places under ACAR. The Impact Analysis also considers that there is a potential impact in particularly thin markets and encourages the department to not approve the movement of allocated places (provisional, operational or offline) by a provider:

- from the location specified in the application if the places have conditions of allocation relating to priority access for a specific cohort of people – unless the department is satisfied that those conditions can be fully satisfied in the new location
- if the places have conditions of allocation that they are to be located in a remote, rural or regional area (e.g. with the condition specifying the relevant Monash Modified Model (MMM) zones such as 6 and 7) – unless the department is satisfied that the places will remain in the same zone/s.

One stakeholder suggested that the benefits of greater flexibility under Model 1 could be further enhanced if locational controls were reduced across state or territory boundaries.

Specifically, Catholic Health Australia suggested:

‘the benefits of flexibility would be greater if Australia was treated as ‘one region’, rather than settle for fewer regions based on administrative boundaries that have no relevance to a national program.’ (sub. 25, Q. 11)

A change such as this proves problematic within existing ACAR arrangements. Specifically, an increase in the number of places in one state or territory, within an unchanged total, must necessarily result in a reduction of places in one or more other states and/or territories. One variation would be for places to continue to be allocated at a state or territory level, but jurisdictional boundaries could be relaxed where it is determined by the department to be in the best interests of the local communities such as those near state/territory borders. This would allow, for example, for the movement of places between Albury and Wodonga, Canberra and Queanbeyan, or Coolangatta and Tweed Heads.

However, such a policy may produce little benefit but have the potential to subvert the competitive allocation process and the policy of expanding service capacity within each state and territory. On balance, this suggestion is not supported by the Impact Analysis.

Reduce non-operational places

Another proposed element of Model 1 is to increase the number of operational places within the funding envelope of total places allocated through ACAR by reducing the prevalence of non-operational places. Overall, more operational places would mean more choice for consumers.

During consultation there was support for this feature of the model.

One anonymous service provider said:

‘Reducing the numbers of non operational places is an integral change that is needed. It will save providers ‘banking’ places for extended periods of time while consumers struggle to find beds in their preferred area.’ (sub. 15, Q. 11)

LASA proposed strengthening monitoring and enforcement of timeframes relating to non-operational places:

‘Persistent non-operational places should be investigated more closely and stricter expiry dates should be considered taking into account factors outside of a provider’s control.’ (sub. 44, p. 3)

As mentioned in chapter 2, changes were introduced in 2016 to encourage providers to operationalise their provisional places in a timely manner (within four years). However, as at 30 June 2018 there were 5,623 provisionally allocated places (representing 18 per cent of total provisionally allocated places) which had been allocated for more than four years (see chapter 2). Some stakeholders suggested that providers should be held to greater account in meeting their plans to operationalise places, notwithstanding that providers are already required to provide updates to the department on milestone progress. Other stakeholders said that delays – such as those relating to planning and development approval and construction – were often outside of the provider’s control.

For example, Victorian Healthcare Association noted:

‘there are issues such as planning regulations, heritage listing and financing that may impact on the development of a facility.’ (sub. 48, p. 4)

Improvements were also made in the 2018-19 ACAR to encourage applicants to be in a position to commence their building project, including the following:

- Applicants seeking places that could be immediately operationalised, i.e. existing unfunded beds, were not required to provide any financial or milestone information, substantially reducing the administrative burden
- For the first time, applicants were advised applications would be more competitive if proof of land ownership, zoning and development approval were provided

On balance, in light of the recent improvements and feedback, this Impact Analysis considers that there is minimal scope at this stage to further improve the rate of operationalising provisionally allocated places other than to more rigorously scrutinise milestone progress reports and to take action as required.

In respect of offline places, however, the Impact Analysis concludes that there is scope to align their monitoring and management by the department with arrangements applying to provisionally allocated places.

An anonymous service provider explained some of the current issues with offline places:

‘Offline places are invisible, and can be held indefinitely, with little justification to Government, and it is only appropriate that they be monitored with a rigour similar to provisional allocations and revoked after a prescribed period.’ (sub. 39, Q. 11)

Another anonymous provider similarly suggested that timeframes to bring offline places back online should be consistent with that of provisionally allocated places:

‘Timeframes should be established under the legislation for operational places that are taken offline or unused. These timeframes should be consistent with provisional allocation timeframes, as places are usually taken offline pending the redevelopment or building of new facilities.’ (sub. 24, Q. 11)

However, Catholic Health Australia, as well as a state government submission, both noted the flexibility that offline places affords providers.

‘...offline places affords the system some flexibility, in an otherwise rigid place allocation system, to plan service development and refurbishment, including through access to a secondary market for subsidised places.’ (sub. 25, Q.11)

‘If non-operational or offline beds were reclaimed, the flexibility for providers to provide and flex between more than one aged care service depending on demand may be diminished.’ (sub. 55, p. 5)

Discouraging providers from taking places offline or revoking offline places may reduce providers’ flexibility to meet demand or have the capacity to undertake refurbishments or redevelopment, which could inadvertently decrease rather than increase the availability of places. Rather, improving the visibility of offline places, minimising instances where places are taken offline for strategic reasons unrelated to refurbishment/re-building, and minimising their duration may better serve the objective of increasing the availability of operational places.

Improving the visibility of offline places would enable the department to more closely monitor the rationale for providers taking places offline. It could also enable a more accurate departmental assessment of operational places when determining how many places to release in subsequent ACARs.

The Impact Analysis is aware that a ‘Review of Offline Residential Care Places Management’ has made a number of recommendations on the future monitoring and management of these places. The Impact Analysis concludes that, as a minimum, providers should be required to notify the department why, when and for how long all places are offline and update the department on when those places are brought back online.

Summary of conclusions: criterion 1

The Impact Analysis concludes that Model 1 can only marginally improve consumer choice:

- through increasing the number of operational places by requiring providers to notify the department why, when and for how long all places are offline and update the department on when those places are brought back online.

Greater locational flexibility of allocated places within the capped ACAR framework could negatively impact on choice in thin markets and the Impact Analysis proposes that there should be no movement of such places by a provider:

- from the location specified in the application if the places have conditions of allocation relating to priority access for a specific cohort of people unless the department is satisfied that those conditions can be fully satisfied in the new location
- if the places have conditions of allocation that they are to be located in a remote, rural or regional area (with the condition specifying the relevant Monash Modified Model locator (MMM) zones such as 6 and 7) unless the department is satisfied that the places will remain in the same zone/s.

Criterion 2. Drive outcomes for quality and safety in residential aged care that meet or exceed approved standards

The Impact Analysis received little evidence or feedback relating to quality effects of the changes proposed in Model 1. Only a small number of stakeholders suggested the changes may result in an incremental improvement in quality.

One anonymous employee from the sector submitted:

‘Although there is more benefit for the consumers in terms of availability of more beds on offer, I see a little benefit on the quality of beds provided.’ (sub. 7, Q. 11)

Brisbane South Primary Health Network offered some hope:

‘Incremental change hopefully leading to providers with higher quality services prevailing in areas of stronger market competition...With sufficient targeting, hopefully RRR communities and vulnerable groups would have high quality options (maybe slightly lesser choice).’ (sub. 22, Q. 16)

Model 1 is not expected to have the capacity to significantly increase competition – and therefore create incentives to improve quality and safety – given that competition is still capped under ACAR. Further, and equally relevant currently and under Model 2, in order to drive quality and safety, consumers need the ability to choose between aged care homes based on their performance. Such metrics are not currently available to consumers for easy comparison.

Some stakeholders have suggested there is scope to improve the role of the ACAR itself as it relates to quality.

Dementia Australia said that:

‘...receipt of ACAR funding should be tied to the provision of quality care that is publicly reported on so that consumers are able to easily compare approved providers to enable them to be more informed.’ (sub. 28, Q. 14)

Australian Projections similarly suggested:

‘Allocation of places should take into account objective quality measures...’ (sub. 31, Q. 14)

The department could improve the ACAR assessment process by considering the applicant’s performance in Consumer Experience Reports which capture the consumer’s experience of the quality of care and services in an aged care home. The Reports are compiled by Aged Care Quality and Safety Commission quality assessors through consumer interviews during a quality review or site audit (Aged Care Quality and Safety Commission, 2019). Where an approved provider can demonstrate high consumer satisfaction in other homes (all other application factors being equal), then their application could become more competitive.

However, Consumer Experience Reports would only be available for existing providers and so may perpetuate their advantage over new providers.

Summary of conclusions: criterion 2

The Impact Analysis concludes that Model 1 is unlikely to drive quality and safety improvements. However some limited improvement may arise, notwithstanding its bias in favour of existing providers:

- through recognising providers who are better satisfying consumers by departmental consideration of Consumer Experience Reports as part of the ACAR competitive assessment process.

Criterion 3. Facilitate timely and equitable access to residential aged care and respite services for those in need

Timely access

Timely access is determined to a significant extent by the supply of places available in areas where there is demand, because that affects whether people have to wait for a suitable place. As Model 1 may enable more of the operational places released in ACAR to be online and available, the Impact Analysis concludes that timeliness of access could be marginally improved for consumers in particular areas.

Equitable access

Model 1 would preserve the ability for the department to impose conditions of allocation on places to encourage priority of access for consumers from special needs groups and target particular geographical areas.

The retention of controls to encourage equitable access has been broadly advocated by stakeholders.

For example, Catholic Health Australia cautioned that Model 1 may not support the more equitable distribution of places without retaining some element of control on location:

‘in the absence of any location-specific incentives or controls, this approach would reduce the government’s ability to manage the distribution of subsidised places within each jurisdiction in order to achieve a more equitable distribution of rationed places ‘held’ by providers, and whose location is controlled by providers. As a result, while increased investment, competition and consumer choice of service may eventuate in more attractive regions, it would likely be at the expense of other locations, especially rural and remote locations and lower socio-economic status regions.’ (sub. 25, Q. 11)

As such, it has been proposed under criterion 1 that locational controls be retained where they will encourage equitable access in thin markets.

As noted in chapter 5, many stakeholders consider the system of setting conditions of allocation on places is an important mechanism by which diverse care needs can be supported. However, with no follow-up on those conditions, and no requirement that the places be used for those purposes, it is not clear what effect they are having, particularly for some of the smaller special needs groups. The government could consider administering a follow-up provision by requiring the Aged Care Quality and Safety Commission, as part of a site audit, review audit, quality review or assessment contact, to examine whether providers are supporting the diversity of consumers.

For this to occur in the existing framework, the regulator would need to be aware of the priority of access conditions of an aged care home’s places and assess compliance against the relevant Aged Care Quality Standard. Standard 8 Organisational Governance requires that *“the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery”* (Standard 8 (3)(b)). If there are conditions of allocation on places, then the aged care home should be able to demonstrate to the regulator how it is promoting the use of the places by people from those groups.

A second complementary option is to improve data collection on the special needs status of consumers. This would allow the department to monitor whether consumers with that status have occupied or are occupying places with priority of access conditions. If monitoring shows only limited compliance with the

conditions, the provider could be required to demonstrate what measures they have in place to ensure compliance. Revocation of non-complying places could be a regulatory option.

The Impact Analysis concludes that ensuring places allocated on condition of giving priority to special needs groups are actually available, the department could more rigorously follow-up on priority of access conditions and improve its data collection on the special needs status of consumers. The Aged Care Quality and Safety Commission could be required to examine whether providers are supporting the diversity of consumers.

Residential respite care

Stakeholders mostly considered that Model 1 would be unlikely to improve access to residential respite care.

As explained in chapter 5, an aged care home must have an allocation of respite days recorded in the payment system in order to receive respite care subsidies and supplements. The administrative process for managing the respite care allocations has been identified as a barrier to availability and access.

Some providers indicated that respite care allocations create an upper ceiling on respite care offerings.

For example, an anonymous service provider wrote:

‘A respite allocation tends to limit provision of respite to within that allocation. It also creates an unnecessary administrative workload for providers who need to monitor and extend their allocations, or incur a loss of funding, if they exceed their allocation.’ (sub. 24, Q. 12)

The Aged Care Financing Authority (ACFA) concluded in its Review of Respite that the administrative red tape surrounding respite needs to be removed and recommended removal of the minimum and maximum respite care allocation:

‘...the market should be primarily left to respond to consumer demand and determine the number of respite places particular providers offer ...

If neutrality in the funding of respite and permanent residential care is achieved, the Government should remove the minimum and maximum allocation rules for respite care and allow providers respond to consumer demand for respite...’ (Aged Care Financing Authority, 2018) (p. 4)

One consumer advocacy group, Quality Aged Care Action Group, considered that setting a number of dedicated places for residential respite would better facilitate its availability:

‘...the allocation of a set number of places specifically for transitional or respite care would guarantee service provision, and be better facilitated through option one. (sub. 43, p. 4)

The Impact Analysis considers that providers should be allowed to respond to demand for residential respite care within their total allocation of residential aged care places, noting that the consumer’s cap of respite days (currently 63 days per financial year) would remain. The Impact Analysis agrees with the ACFA recommendation that, in order to improve access to residential respite care, the minimum and maximum allocation rules should be removed. In this instance, an approved provider’s allocation of places that are available would set the theoretical limit on their delivery of respite care. While Model 1 may provide some improvements for access to residential respite by reducing the administrative burden for providers associated with respite care allocations, it may still not fully address the limitations of respite availability inherent in the allocation of places. Further, removing the respite care allocation would mean changes to the operation of the respite incentive supplement would be required – or removed completely if funding neutrality between permanent and respite care is achieved. In practice, until there is funding neutrality between permanent and respite care, respite is likely to remain a secondary consideration in providers’ business planning.

Summary of conclusions: criterion 3

The Impact Analysis concludes that Model 1 on its own, without funding reform, is unlikely to significantly improve timely and equitable access, but the following measures may make some improvements:

- increasing the number of operational places through the improved monitoring and reporting requirements for offline places (see criterion 2)

- ensuring places allocated on condition of giving priority to special needs groups are actually available. This would be by the department more rigorously following-up on priority of access conditions and improving its data collection on the special needs status of consumers. The Aged Care Quality and Safety Commission could be required to examine whether providers are supporting the diversity of consumers.
- through increasing the availability of residential respite care by removing the minimum and maximum allocation rules and allowing providers to respond to demand for respite within their total allocation of residential aged care places (though a consumer limit of 63 days per annum would remain, along with limitations of allocated places inherent under ACAR).

Criterion 4. Facilitate a residential aged care sector that has continued growth and financial investment which responds to increasing consumer demand and changing preferences

Responsiveness to consumers

There was no evidence available to the Impact Analysis that suggested any of the elements of Model 1 would lead to service or accommodation offerings becoming significantly more responsive to consumer preferences.

Ultimately Model 1, and ACAR itself, cannot significantly increase responsiveness to consumers at the aggregate level given that competition is limited to the pool of places allocated to approved providers. The issue is not one of system capacity - the Impact Analysis demonstrates elsewhere in this report that the overall quantum of subsidised places exceeds current demand and this outcome is likely to continue in the future. Rather, the issue is that existing and new innovative approved providers are unable to significantly expand and change their own operations as they see fit in response to consumer demand and preferences and poorer providers have limited pressure to leave the sector.

As such, the Impact Analysis concludes that any impact on responsiveness to consumer demand and preferences under Model 1 would be minimal.

Growth and investment

Model 1 would retain the level of comfort afforded to current approved providers (and their financiers/lenders) by them holding a capped allocation of places, which some stakeholders see as a key strength of the current system.

ACSA explains:

‘The allocation of provisional licenses to an approved provider provides a degree of income security when planning and financing aged care development/re-developments/expansions.’ (sub. 52, p. 5)

Stakeholders in general were receptive to the concept of ‘topping up’ places under Model 1 in limited circumstances. It would support the growth of some aged care homes and help ensure the financial sustainability of some providers through an incremental increase in places.

For example, Resthaven saw potential to support expansion of their service footprint:

‘Continuation of a process where there is an assessment by Government of the ability of an AP to provide aged care services (demonstrate that they understand the legislation, can implement high quality services, and can demonstrate impact on business and market). For us this means greater confidence to invest and grow, as we have in the past, when we are successful in gaining allocation of places. The ability to ‘top-up’ places on sites that have the potential to increase places, the reduction of locational controls would allow Resthaven to apply for places in the areas where we see demand and the ability to transfer places across Aged Care Planning Regions within the state.’ (sub. 51, Q. 15)

However, the Impact Analysis considers that, on balance, an ability to top up places would increase the discretionary powers of the department and pose issues relating to a lack of administrative clarity and transparency. The proposal is not pursued further.

Others were less confident about the potential of Model 1 to drive much change in growth and innovation given that the opportunities would still be limited to those providers who had allocated places.

Catholic Health Australia stated:

‘There may be some increased flexibility for providers to manage the distribution of their allocated places across a larger area, including when planning and negotiating acquisitions in the secondary market. However their capacity to expand and innovate would still be substantially subject to providers’ success in having been allocated places, rather than their success in attracting business through their reputation as a provider of quality aged care services and their capacity to access capital.’ (sub. 25, Q. 11)

An option to potentially improve responsiveness under Model 1 is to expand the focus placed on innovation in the ACAR application and assessment. Innovative models of service delivery and accommodation, including clusters of small aged care homes, residential aged care in assisted living environments and other residential aged care which may be preferred by consumers could gain a higher ranking in the assessment process. This could also improve the opportunities for new entrants to enter the sector.

Financial performance

There are, however, more significant forces at play that are limiting the potential for growth and investment in residential aged care. In particular, stakeholders agreed that the current viability issues are a greater priority.

Lifecare stated:

‘The biggest concern in the sector is the seriously constrained profitability. If the current terms of trade continue, how the places are allocated is irrelevant as there will be many more viability issues, currently the number of facilities up for sale is high and growing. Rural remote Cald are highly overrepresented in the group with compliance issues and market reforms or greater flexibility in setting the location will not change this.’ (sub. 3, Q. 16)

A regional health professional, the Forrest Centre, made a similar observation:

‘Operating Profits of providers are essential if we are to maintain or attract investment in the residential aged care sector... In this respect the decision whether to maintain, modify or replace the ACAR model is not as important as the real and pressing priority of ensuring operational funding to ensure providers don't close their doors.’ (sub. 10, Q. 43)

An anonymous service provider stated:

‘Serious problems regarding both the quantum and allocation of existing funding structures make it problematic to proceed with reforms to encourage greater competition given that competition would be occurring on the basis of funding mechanisms that have been identified as in need of reform.’ (sub. 27, p. 7)

One anonymous state government submission cautioned that Model 1 could possibly lead to a higher operating cost for providers if it increases variability in occupancy:

‘Increasing numbers of places available in lower risk areas could lead to higher vacancy rates (choice) but higher cost associated with reserve capacity.’ (sub. 53, p. 5).

The Impact Analysis concludes that given the current viability pressures of the sector, the reform of the funding model for residential aged care is a very high priority.

Greater certainty of the timing and size of ACAR

A common complaint raised by providers at the consultation forums was the uncertainty of when ACAR were to be announced, the number of new places to be allocated, the special conditions to be targeted and the short time-frame in submitting applications (see chapter 5). This issue is explored in greater depth under criterion 5.

Providing greater certainty regarding the ACAR would enable current and potential providers to factor the ACAR into their strategic thinking and business planning. This small move to greater certainty (of process, but not of place allocation outcomes) would improve the business environment and support sector growth and investment.

Summary of conclusions: criterion 4

The Impact Analysis concludes that Model 1 can result in modest improvements in responsiveness to consumer preferences and in increased growth and investment:

- through a greater diversity of providers competing in the market, by increasing the focus placed on innovation in the ACAR application and assessment. Service proposals that have innovative models could be considered as more competitive even if the applicant is not an existing residential aged care provider.
- through greater certainty regarding the administration of ACAR to enable improved business planning.

However, any improvements in responsiveness to consumers would be minimal given that competition would remain limited to the capped pool of places allocated to approved providers. The Impact Analysis also concludes that viability will be a key determinant of future growth and investment, irrespective of changes proposed under Model 1.

Criterion 5. Have transparent and accountable processes

There is potential within the improvements proposed under Model 1 to increase the transparency and accountability of the ACAR and associated processes and outcomes.

Movement and transfer of places

The Impact Analysis considers that locational controls on the movement of allocated places should be accompanied by publicly communicated, clear and consistent rules. The communication should include criteria relating to place relocations and to the exercise of control by the department in circumstances such as thin markets.

During consultations, there were some calls to restrain the secondary market for the transfer of places between providers.

For example, Lifecare was an advocate for restricting this practice:

‘Limit the secondary market in places if an approved provider wins the places and doesn't need or want them any more they should go back to a central pool and be reallocated according to the existing area of highest need not sold for profit.’ (sub. 3, Q. 14)

Allowing some providers to bypass the competitive process of ACAR by dealing through the secondary market undermines the effectiveness of the allocation process and reduces transparency and accountability. As outlined in chapter 2, in 2018-19, nearly 11,000 allocated residential aged care places were transferred to another provider, representing around 4 per cent of total allocated places as at 30 June 2019. However, due to financial viability issues in recent years, the secondary market for acquisitions has slowed but is likely to increase due to expected exits by unviable providers.

The Impact Analysis concludes that if the integrity of ACAR is to be retained:

1. transfers of places between providers should be limited to certain unavoidable circumstances, including:
 - the sale is of an aged care home or organisation to another provider (permanent transfer)
 - sanctions have been imposed on a provider (temporary transfer to another provider)
 - the provider is in administration or liquidation (permanent or temporary transfer to another provider)
2. transfer should only be approved on the following conditions:
 - the acquiring provider has a building which is established or is being acquired as part of the transfer, or is in a position to commence the building project
 - the acquiring provider has been satisfactorily assessed for quality of care, prudential standards and governance by the department
 - all conditions attached to the allocated places are to be retained and adhered to.

ACAR administration

There was widespread support from providers for the ACAR process overall to be more transparent. Key reoccurring suggestions were that the ACAR should be conducted according to a regular published schedule and there should be longer timeframes for the preparation of the applications.

Catholic Health Australia explained the broad rationale for the proposal:

‘conducting ACARs to a firm timetable, rather than the current seemingly ad hoc approach which keeps the sector guessing, would help with certainty and service planning.’ (sub. 25, Q. 14)

Eldercare outlined the benefits of this approach for providers:

‘Introduction of longer announcement periods for allocation rounds would be helpful particularly for smaller providers to prepare adequate evidence and effectively resource the application process while managing business as usual. ACAR being held at the same time period every year so that providers can better plan for the process.’ (sub. 20, Q. 18)

In a similar vein, there were suggestions for a more detailed and longer engagement with stakeholders as part of the ACAR planning phase to identify unmet needs and priorities in local communities. This would not only assist in ensuring appropriate local targeting, but it also would make the process appear less opaque by having greater involvement of stakeholders from the outset.

Model 1 may also achieve greater transparency if the reasons for successful ACAR allocations were clearly communicated. For example, suggestions along these lines from several providers included:

‘We don’t see transparency as a major problem. In any case, this can be overcome by publishing the strong “elements” that led to the successful bids in each respective area. Eg. Strong focus on ethno specific in a particular location due to the demographic with specific cultural services delivered on site. This informs future ACAR bids. By making this information public it will lift the standard of bids overall.’ (Anonymous service provider, sub. 37, Q.11).

‘We welcome greater transparency in the ACAR process however the determinants for allocation need to be explicitly defined to enable clarity of understanding regarding the overall success factors contributing to successfully being allocated places.’ (Eldercare, sub. 20, p. 2)

‘The drivers of place allocations through ACAR need to be reviewed and more clearly disclosed.’ (LASA, sub. 44, p. 8)

Corroborating the claims that providers made in ACAR applications with information or data from other systems (such as on performance) was also suggested, alongside publishing the scoring.

For example, Advantaged Care wrote:

‘Scoring should be transparent and publicly available on record, and should focus on providers track record (with evidence from cross system reference on performance) and commitment to demonstrating capacity and commitment to delivering said project.’ (sub. 35, Q. 11)

While there may be practical and privacy reasons why publishing individual application scores may not be feasible, several of the suggestions for pre (criteria) and post (basis of decisions) allocation transparency have considerable merit.

As outlined in chapter 5, during the finalisation of this report, the Minister announced that there would be several process changes to a 2020 ACAR. These included providing greater advance notice to the sector about the opening of the ACAR, extended timeframes for consultation and the application process.

While supporting these recent initiatives, the Impact Analysis concludes that ACAR should occur at regular and known intervals and that the criteria for selecting applications and the decisions which led to the allocations should be more transparent. Monitoring the fulfilment of priority of access conditions and reporting of offline places, as discussed earlier, would also assist in enhancing accountability.

Market information

From both the consumer and provider perspectives, there have been suggestions that the government should ensure the provision of more relevant and timely information to support respective decision-making processes.

For consumers, Dementia Australia suggested:

‘Greater transparency is needed to facilitate a more consumer driven and competitive residential aged care sector ... clearly articulated information on providers, including performance indicators, policies with regards to restraints and medications, staff training and skills mix should be made available to consumers.

Without this information there is no meaningful way to distinguish between providers and ultimately make an informed choice about residential aged care.’ (sub. 28, Q. 14)

For providers, an anonymous submission made the case that:

‘to encourage the building of places in areas of greatest need, the Department should provide current, needs-based planning data at the local government, SA2 and SA3 levels, that providers can readily access and easily extract from its website.

The data should include population demographics (70 years and above) and the number of allocated, operational, unused and provisionally allocated places at the sub-regional level (this is available in the annual Stocktake but only at the State and regional levels).’ (sub. 24, Q. 12)

There may also be merit in publishing the intra-provider movement and inter-provider transfer of places to enable transparent market monitoring.

The Impact Analysis concludes that there is considerable scope for more relevant and timely information to be available that would assist both consumers and providers.

Summary of conclusions: criterion 5

The Impact Analysis concludes that Model 1 can increase transparency and accountability:

- through restrictions on the transfer of places on the secondary market which could otherwise bypass the ACAR competitive process, by limiting transfers of places between providers to certain unavoidable circumstances as set out in this chapter and by only approving the transfers on the conditions as also set out above.
- through administrative reforms by undertaking ACAR at regular and known intervals and by being more transparent about the criteria for selecting applications and the decisions which led to the allocations.

Transparency and accountability could also be increased by publishing clear criteria for the movement and transfer of places, as well as places movement and transfer activity as part of open market monitoring, and by monitoring priority of access conditions and reporting all offline places.

Revised Model 1

Following analysis of the available evidence, consideration of consultation feedback and assessment against the five criteria, refinements have been made to Model 1. The Impact Analysis concludes that Model 1 should provide for the following:

Amend locational controls on the distribution of residential aged care places

Recognising that greater locational flexibility of allocated places within the capped ACAR framework could negatively impact on thin markets, the department should not approve the movement of such places by a provider:

- from the location specified in the application if the places have conditions of allocation relating to priority access for a specific cohort of people unless the department is satisfied that those conditions can be fully satisfied in the new location
- if the places have conditions of allocation that they are to be located in a remote, rural or regional area (with the condition specifying the relevant Monash Modified Model (MMM) zones such as 6 and 7) unless the department is satisfied that the places will remain in the same zone/s.

To retain the integrity of ACAR, the secondary market on the transfer of places between providers should be controlled in the following manner:

1. transfers of places between providers should be limited to certain unavoidable circumstances, including:
 - the sale is of an aged care home or organisation to another provider (permanent transfer)
 - sanctions have been imposed on a provider (temporary transfer to another provider)
 - the provider is in administration or liquidation (permanent or temporary transfer to another provider)
2. transfer should only be approved on the following conditions:
 - the acquiring provider has a building which is established or is being acquired as part of the transfer, or is in a position to commence the building project
 - the acquiring provider has been satisfactorily assessed for quality of care, prudential standards and governance by the department
 - any conditions attached to the allocated places are not contravened.

Reduce the number of non-operational residential aged care places

Providers should be required to notify the department why, when and for how long all places are offline and update the department on when those places are brought back online.

Improve the administration of the ACAR

The ACAR should be undertaken on a regular set schedule, with published dates for opening, closing, and the announcement of results. Applicants should also be provided with longer timeframes to prepare an application.

In the context of the recent changes to the ACAR process for the 2020 Round, consultation with stakeholders to determine unmet needs and priorities should be detailed and undertaken across a sufficient period of time to enable all interested stakeholders time to provide considered and informed contributions.

The application form should include scope for applicants to specifically detail innovative models of care or accommodation as it relates to their service proposal. Innovation should be considered as part of the competitive assessment and enable applicants who are not existing residential aged care providers to be competitive.

An applicant's Consumer Experience Report performance in respect of their aged care home/s should be considered as part of the competitive assessment, where the applicant is an existing residential aged care provider.

Other improvements to increase the transparency of the ACAR allocations process should be explored, including by being more transparent about the criteria for selecting applications and the decisions which led to the allocations, and by publishing clear criteria and activity regarding the movement and transfer of places.

[Improve the allocated places management processes](#)

The availability of residential respite care should be increased by removing the minimum and maximum allocation rules and allowing providers to respond to demand for respite care within their total allocation of residential aged care places (noting the limitations of the consumer annual cap on respite days and on a provider's allocated places remain). Further, until there is funding neutrality between permanent and respite care, respite is likely to remain a secondary consideration in providers' business planning.

Priority of access conditions should be followed-up more rigorously by the department and an improved data collection on special needs status should be developed to support departmental monitoring. The Aged Care Quality and Safety Commission, during its various site visits and other performance assessments, should be required to examine whether providers are supporting the diversity of consumers. Providers who show only limited compliance with the allocation conditions could be required to demonstrate what measures they have in place to ensure compliance. Revocation of non-complying places could be a regulatory option.

[Operation of the amended Model 1 from consumer and provider perspectives](#)

[From the consumers' perspective](#)

The steps for a consumer to receive subsidised residential aged care or residential respite care under this model would be unchanged from current arrangements, though a greater number of currently allocated places may be available to be occupied.

There would be greater focus on ensuring that places allocated for special needs groups and in rural and remote areas would be retained for those purposes, but allocation does not necessarily result in supply as issues of viability dictate whether providers take up those allocations.

As currently occurs, those consumers actively seeking care may need to wait until a vacancy arises at one of their preferred aged care homes or accept a vacancy with a less preferred provider and/or location.

[From the providers' perspective](#)

Generally speaking, the steps for a provider to be able to deliver subsidised residential aged care and receive a subsidy under this model would be unchanged from current arrangements.

However, providers would have greater flexibility in offering residential respite care, within the limits of their allocated residential aged care places.

Providers would be able to better undertake business planning as ACARs would be held on a regular set schedule with advanced notice, with enhanced consultations and longer timeframes to prepare applications.

ACAR applicants (including new entrants) would be more competitive if they have innovative service delivery models and styles of accommodation, as would existing providers with good track records of consumer satisfaction.

Impact analysis: alternative models for allocating residential aged care places

Providers would be required to report any offline places and provide updates on bringing them back online. Providers holding places with priority of access conditions would be held accountable and must have mechanisms in place to support priority of access to the targeted consumers.

There would only be limited circumstances under which places could be transferred between providers.

Chapter 7: Model 2 assessment and refinement

This chapter directly addresses the Australian Government's in-principle support for the transition of residential places to consumers, itself responding to a recommendation in the Legislated Review of Aged Care to discontinue the ACAR for residential aged care and instead assign places directly to consumers. Under this Model 2 there would be no ACAR or provider-held allocated places. Consumers would be directly assigned places and would be able to receive subsidised residential aged care from any approved provider who has an available bed and is able to deliver the required care and services.

This chapter assesses Model 2 against each of the five principles established in chapter 3. Based on data analysis as well as feedback from stakeholders, the chapter then sets out amendments to Model 2.

Overall stakeholder reaction to Model 2

Model 2 was the more polarising of the two models set out in the Discussion Paper among stakeholders, due in part to it being the more significant reform.

Some stakeholders who were strongly supportive cited the potential opportunities for consumers and providers afforded by discontinuing the ACAR, but emphasised the need for appropriate sequencing with complementary reforms as well as safeguards for vulnerable consumer groups and thin markets.

COTA Australia, a long-term advocate for assigning residential aged care places to consumers, argued that Model 2 will afford:

‘a true market operating with consumers able to choose their provider, but with adequate safety nets and solutions to ensure consumers from special needs and vulnerable groups and communities are not disadvantaged.’ (sub. 34, Q. 8)

Catholic Health Australia also supported Model 2, given its:

‘potential to support innovation and to reward providers delivering quality services that are responsive to consumer preferences...After a period of transition, and if implemented in parallel with complementary reforms, [Model 2] would result in a more competitive and flexible service environment that is more responsive to meeting consumer preferences.’ (sub. 25, Q. 7)

Estia Health viewed Model 2 as representing:

‘[an] opportunity to move from a centrally-planned and controlled market which is leading to inefficiencies, protected providers, and sustenance of poor-quality service to a consumer driven market offering choice and flexibility to residents and a more efficient allocation and use of resources.’ (sub. 21, p. 4)

Carers Australia considered:

‘that assigning places on the basis of specific consumer assessed need is an incentive for providers to meet the real demands of the neediest consumers. As such it is likely to be more responsive to demand than the current system of broad-based ageing population estimates of needs. However, we are unsure of how such a system would work out with respect to ensuring adequate access to residential care in less populous areas and for special needs groups.’ (sub. 23, Q. 19)

While Dementia Australia supported consumer-directed approaches, it was concerned about whether the benefits of a market model will be realised in practice – especially for consumers with dementia:

‘there are number of issues inherent in Model 2, which raise concerns for people with dementia, their families and carers...underpinning ideal of a consumer-focused and market-driven approach to service quality and innovation within aged care... predicated on the idea that consumers who have the tools and comparable information to make informed choices will ‘vote with their feet’ ...In the case of dementia care, these mechanisms are flawed and/or underdeveloped.’ (sub. 28, Q. 8)

Aged and Community Services Australia (ACSA) offered in-principle support for Model 2 but also noted that:

‘there appears to be an assumption that innovation will automatically follow the introduction of Model 2. This assumption needs to be further tested, as there are likely a range of factors that drive innovation, including adequate funding to the sector.’ (sub. 52, p. 4)

Other stakeholders were less convinced that the potential opportunities of Model 2 would outweigh the potential disruption. The most contentious aspect of Model 2 was a concern that, like the home care reforms, a possible prioritisation arrangement that may be required if demand for residential aged care exceeds the number of funded assignable places. This chapter directly addresses this concern and concludes that a prioritisation arrangement would not be required.

An anonymous service provider stated:

‘Introducing Model 2 will continue to lose community confidence in a system that is already under immense scrutiny. Additional processes in accessing and allocating a person’s eligibility and prioritisation into RAC will take more time and energy for family members, social workers or community based workers to navigate the system on behalf of the elderly.’ (sub. 37, Q. 36)

Another anonymous provider expressed concern that providers would lose decision-making control under a more market-based model:

‘Deregulation will jeopardise access and choice for vulnerable groups and in non-metropolitan locations, as larger providers are less likely to invest in low means markets, and smaller providers will struggle to weather the heightened volatility and insecurity.

The creation of a national queue strips providers of the decision-making control they require to ensure organisational viability in a constrained funding environment...Providers will simply not be prepared to invest in a climate of such uncertainty, nor will be able to manage the likely increased turnover, vacancies and liquidity impacts.’ (sub. 39, Q. 19)

Wintringham spoke on behalf of homeless consumers:

‘Based on our extensive home care experience, Model 2 will severely disadvantage homeless consumers.

The reality currently faced by this cohort is one of exclusion by mainstream providers. The case for change is relevant, but not the consumer driven change envisaged in the Discussion Paper.’ (sub. 56, p. 9)

Leading Age Services Australia (LASA) was one of several stakeholders who expressed reservations about the evidence base underpinning the benefits of a market model:

‘limited evidence on both problems with ACAR and the risks of a more market driven approach make it difficult to determine the nature, scale and urgency of reform that is required.’ (sub. 44, p. 3)

The following sections assess Model 2 against each of the criteria set out in chapter 3. The assessment draws on data analysis as well as the qualitative views of stakeholders.

Criterion 1. Provide greater consumer choice and control in a competitive residential aged care market

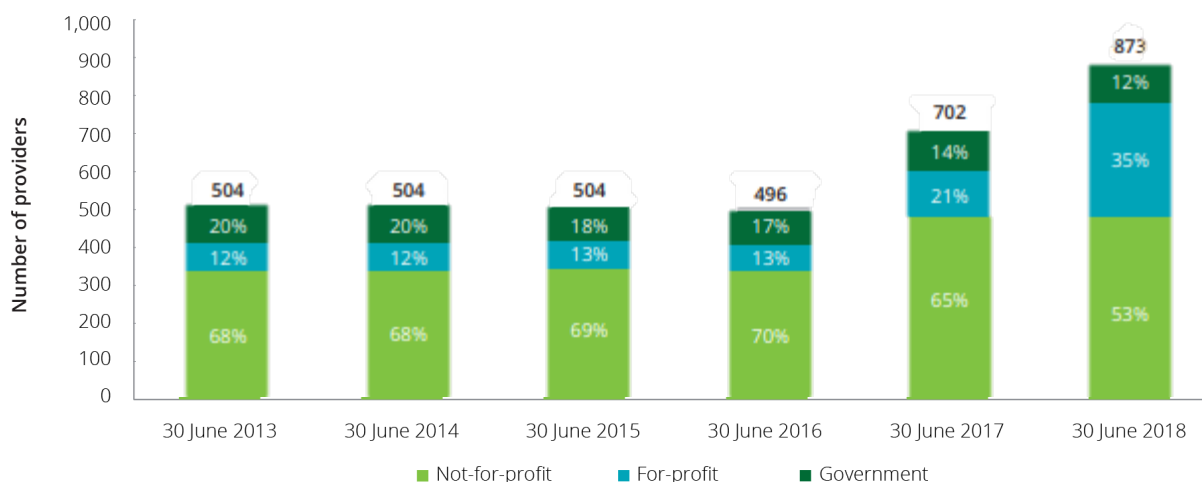
Choice of aged care home

By removing the ACAR as one of the barriers to entry into the subsidised residential aged care market, consumers’ choices of providers and aged care homes may grow, and better performing providers may prosper at the expense of those that offer lower quality services, are less efficient and less responsive to consumer preferences. The trend of oversubscription in ACARs (see chapter 2) suggests appetite exists among some providers to enter or expand in the residential aged care market. It should be noted, however, that the number of applications submitted is likely to be greater than overall provider-assessed demand given that the total number to be allocated is fixed and applicants do not expect to have 100 percent success.

While lessons from changes made to the allocation of home care packages in February 2017 are not fully relevant to residential aged care, it is noted that the changes led to a significant increase in approved home care providers, from around 500 up to June 2016 (Australian Government Department of Health, 2017b) to

over 900 in June 2019 (Australian Government Department of Health, 2019e). The new entrants have primarily been from the for-profit segment, increasing its representation from a stable 12-13 per cent in the several years preceding the home care reforms to 35 per cent as at 30 June 2018 (figure 7.1).

Figure 7.1 Number of home care providers by proportion of organisation type, 30 June 2013 to 30 June 2018



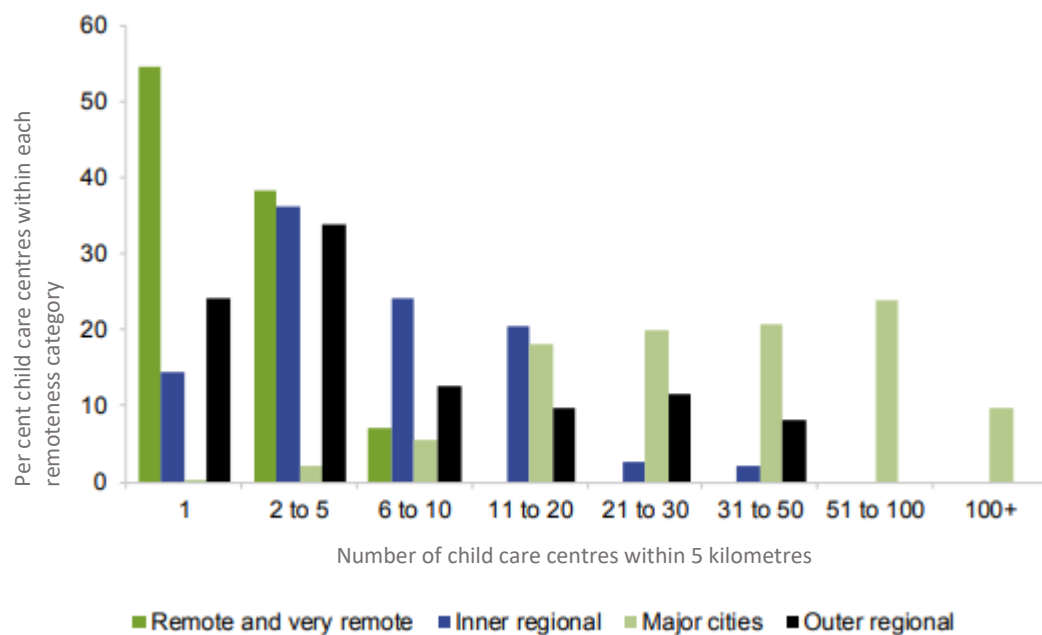
Source: Aged Care Financing Authority, July 2019, Seventh report on the Funding and Financing of the Aged Care Industry

Since 2017, the largest growth in the number of home care providers has occurred in, but has not been confined to, major cities. The home care sector has grown across all remoteness categories. While not every aged care planning region saw an increase in providers, none have decreased.

It appears the home care reforms have supported greater choice of home care providers for consumers. Consumer research has indicated that among home care consumers who were surveyed, 66 per cent reported having entered a home care agreement with their preferred provider and there were positive attitudes around personal control and choice, including in relation to the selection of a provider in their area (AMR, 2019).

Similarly, in the childcare market, following the uncapping of long day care places and deregulation of the location of centre-based childcare services, there was also growth in the number of providers. The number of centre-based services increased by 50 per cent over the decade to 2012-13, with the market share of not-for-profit and government providers declining (Productivity Commission, 2014). In its inquiry report into the childcare market, the Productivity Commission was advised that for-profit providers are better able to source the required capital to establish new services or expand existing services in response to changes in demand. The Productivity Commission found that in the vast majority of local centre-based markets, parents had a range of centres available to choose between within a five kilometre distance of one another. The potential for competition and choice was higher in major cities compared to regional and remote areas (figure 7.2).

Figure 7.2 Per cent of child care centres by number of centres within a 5 kilometre distance of one another, 2011-12



Source: Productivity Commission, 2014, Childcare and Early Childhood Learning, Inquiry Report No. 73, Canberra

Drawing on the home care and childcare market growth experiences, to the extent they are relevant, it is likely that there will be greater increases of choice of aged care home in major cities, as compared to rural, regional and remote areas. This is also currently the case with ACAR application trends, where the 2018-19 ACAR saw almost 70 per cent of places being sought in metropolitan areas.

However, a range of factors intrinsic to residential aged care will influence the extent and pace to which increased choice of aged care home is realised under Model 2, recognising that these forces also currently apply under ACAR. These factors include:

- residential aged care providers have capital requirements which can pose barriers to entry for new aged care homes; for example, identifying (and purchasing where necessary) a suitable site, building and fitting the home. Departmental data shows that, currently under ACAR, it takes providers on average 4.3 years from being allocated places to bringing them online, inclusive of the time it takes to achieve planning permission.
- expansion of existing aged care homes needs to be of sufficient scale to be economic, which means that growth of existing homes is often 'lumpy'. To avoid low occupancy and low profitability, providers can delay investment until supply shortfalls are more acute and demand is more certain. Currently, some places allocated under ACAR have not been made operational for six or more years.
- residential aged care is experiencing less growth in demand, compared to home care.

The Impact Analysis concludes that under Model 2 there will be an increase in the availability of choice of, and competition between, aged care homes, though it will be greater in areas of higher demand and is likely to be gradual over the medium term, rather than result in a rapid upsurge of either homes or providers.

Capacity of consumers to exercise choice

Some stakeholders, particularly providers, expressed concern about the capacity of consumers requiring residential aged care to exercise choice. Common issues raised were:

- the majority of consumers requiring residential aged care are too frail and vulnerable to exercise choice solely by themselves
- entry to residential aged care is generally a decision made in a situation of crisis or urgency that does not lend itself to lengthy or deeply informed decision-making processes

Notwithstanding, an increased opportunity to choose between providers should be made available to all consumers, irrespective of the degree to which they rely on the support of families, advocacy services, system navigators and improved information.

Choice, and the availability of information and support, may be most important to consumers and their carers at the point of entry to an aged care home given the evidence that the rate of switching between homes once admitted is low. Further, the proportion of consumers changing providers has decreased over the decade (see chapter 2). It may be that higher acuity and shorter stays are factors that mean the capacity, inclination or opportunity to change providers has fallen.

Nonetheless, assigning the place to the consumer will be giving them the power to exercise choice provided there are appropriate supports in place to assist their decision-making. Providers would then need to, and have greater flexibility to, compete for these consumers.

Summary of conclusions: criterion 1

The Impact Analysis concludes that Model 2 will increase the availability of choice of, and competition between, aged care homes through:

- an increase in the necessity for approved providers to compete for consumers, by assigning the places to consumers and removing the supply-side restrictions imposed by ACAR, thereby giving the providers the flexibility to make decisions about the form, scale and location of their aged care homes
- empowering consumers and their carers and giving them greater control over the choice of their preferred aged care home by assigning the places to them and improving advocacy services, system navigators and consumer-oriented information.

The opportunity to exercise choice is likely to be greater in areas of higher demand and this increase is likely be gradual over the medium term, rather than result in a rapid upsurge of either new homes or providers.

Criterion 2. Drive outcomes for quality and safety in residential aged care that meet or exceed approved standards

Gatekeeping

If ACAR is removed, departmental scrutiny of an approved providers' service proposal and consideration of their sanction and compliance history would no longer occur. However, the impact of this change is limited given that the assessment during ACAR is at a single point in time and performs more of a minimum quality gatekeeping role rather than quality assurance (see chapter 5).

Since the home care reforms commenced, the department has received a significant increase in the number of applications for approved home care provider status but rejection rates have also increased compared to rates before the reforms (table 7.1).

Table 7.1 Approved provider applications for home care by assessment outcome, 2015-16 to 2017-18

Home care approved provider applications	2015-16	2016-17	2017-18
Approved	129 (82.1%)	340 (84.6%)	167 (45.8%)
Not approved	7 (4.5%)	16 (4%)	171 (46.8%)
Withdrawn	21 (13.4%)	46 (11.4%)	27 (7.4%)
Total number of applications assessed	157	402	365

Source: Compiled based on information from the Department of Health's 2015-16, 2016-17 and 2017-18 Report on the Operation of the Aged Care Act 1997

The current home care market is immature, but there is not yet sufficiently reliable data available – coupled with other confounding factors such as the new quality standards – to glean clear trends in compliance and non-compliance following the home care reforms.

In the absence of ACAR, there would need to be a greater focus on processes relating to the approved provider status of residential aged care providers – coupled with existing quality and safety compliance regulatory processes. The importance of these regulatory processes under Model 2 is discussed in more detail in chapter 9.

Markets and quality

A significant issue is whether deregulation of the places allocation model and consequent increase in market competition could have indirect effects on quality through the changes it may trigger in efficiency and scale. Given that quality reviews have not been undertaken on all home care services on a regular annual basis and new aged care quality standards have been introduced only recently, comparable data was not available to this Impact Analysis to reliably determine what impact the home care reforms have had on quality of service delivery.

In a more market-based system, the relationship between efficiency and strong financial performance, alongside business acumen, becomes increasingly critical. Data from the StewartBrown annual sector survey offers insights into this relationship. It shows that the aged care homes which are in the top 25 per cent financial operating results are delivering 20 percent fewer aggregate care staffing hours per resident, despite having a slightly higher level of average consumer need, as determined by the Aged Care Funding Instrument (StewartBrown, 2019a). These top financial performers also tend to have newer buildings where staff movement within the home can be substantially reduced through efficient building design and technology. Under Model 2, it will be important to ensure greater efficiencies are achieved alongside greater quality and safety outcomes.

Model 2 provides opportunities for aged care home providers to determine their optimum scale of operations, raising the question of quality as it relates to the size of aged care homes or portfolios. Analysis of Consumer Experience Reports on Australian aged care homes, which is collected through consumer interview questions during quality reviews or site audits of homes (table 7.2), show that consumers from small homes were more likely to respond positively to all questions (figure 7.3). The responses to the first three questions (dealing with respect, safety and meeting healthcare needs) were all highly positive (in contrast to the impression presented in the Royal Commission Interim Report) and this applied across all home care sizes. Responses for all groups were not as overwhelmingly positive for questions relating to food and availability of staff to talk to when feeling a bit sad or worried, though small homes performed better than larger homes (Wells & Solly, 2018).

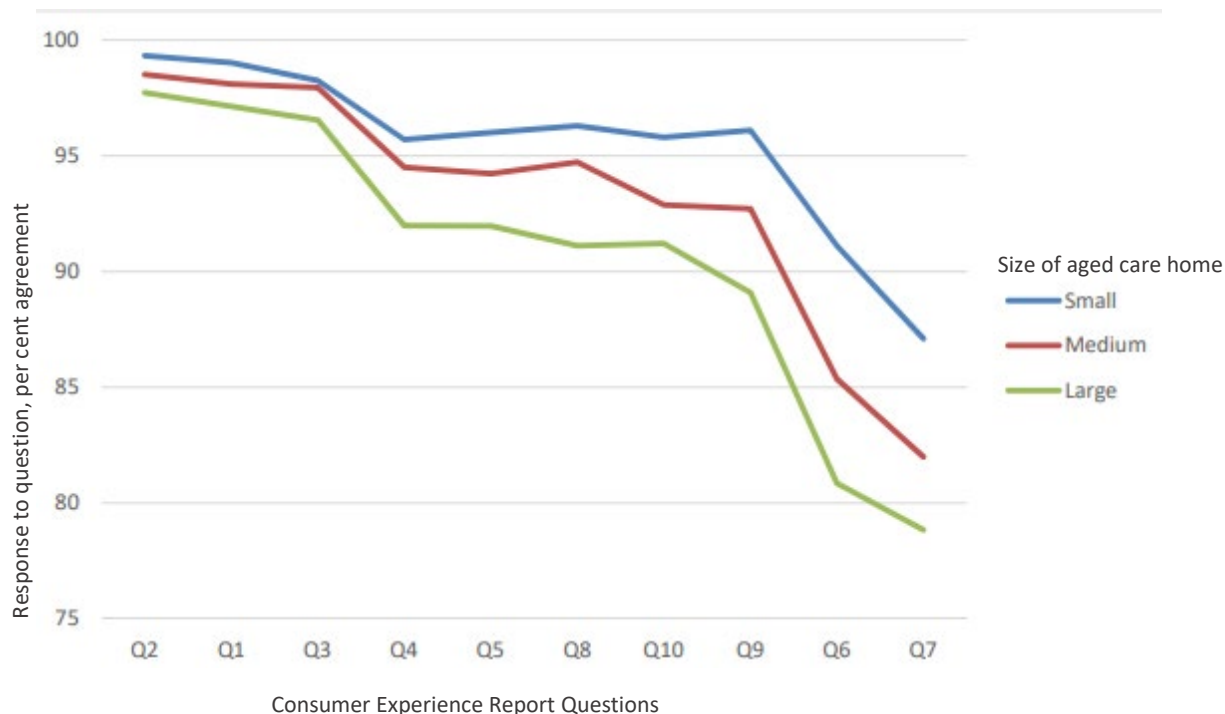
In England, care homes with greater bed capacity and providers with larger portfolios have also been slightly more likely than average to achieve the middle bands of quality inspection ratings compared to smaller homes and providers with smaller portfolios. Providers with smaller portfolios and homes were found to be most polarised in their quality inspection ratings, exhibiting a much higher likelihood of receiving either the top rating or bottom rating (GrantThornton, 2018). As aged care homes and providers expand their scale, they are less likely to perform poorly, but equally, they – along with smaller providers and homes – need robust operational governance and management processes to ensure close oversight of the quality of their care and services, and consumer satisfaction.

Table 7.2 Consumer Experience Report questions and response options

Question
1. Do staff treat you with respect? (<i>Never – Always</i>)
2. Do you feel safe here? (<i>Never – Always</i>)
3. Do staff meet your healthcare needs? (<i>Never – Always</i>)
4. Do staff follow up when you raise things with them? (<i>Never – Always</i>)
5. Do staff explain things to you? (<i>Never – Always</i>)
6. Do you like the food here? (<i>Never – Always</i>)
7. If I'm feeling a bit sad or worried, there are staff here who I can talk to. (<i>Strongly disagree – Strongly agree</i>)
8. The staff know what they are doing. (<i>Strongly disagree – Strongly agree</i>)
9. This place is well run. (<i>Strongly disagree – Strongly agree</i>)
10. I am encouraged to do as much as possible for myself. (<i>Strongly disagree – Strongly agree</i>)
11. What would you say was the best thing about this home? (Open-ended)
12. What is one thing you would suggest as an improvement at this home? (Open-ended)

Source: Wells and Solly, 2018, Analysis of consumer experience report data: Final report to the Australian Aged Care Quality Agency

Figure 7.3 Variation in agreement to Consumer Experience Report questions by size of aged care home



Notes: The data set provided included ratings from interviews held between 9 May 2017 and 4 July 2018. This data set included data from: 1,159 homes.

Source: Wells and Solly, 2018, Analysis of consumer experience report data: Final report to the Australian Aged Care Quality Agency

The role of competition in driving quality is enhanced if consumers are able to differentiate between quality homes and are making choices based on this quality differentiation. However, this can be challenging given the typical personal and family circumstances surrounding entry to an aged care home. For example, in England, it has been found that consumers were often willing to accept the first care home that was ‘good enough’ – often not considering quality ratings of the homes in their final decision because of low expectations and pressure to make decisions quickly under distressing circumstances (Competition and Markets Authority, 2017). As noted earlier, it is important to have appropriate advocacy and support networks for consumers to support them and their carers with these urgent decisions and for all of them to have good access to relevant and clear information.

The regulatory regime also plays an essential role in ensuring quality and safety, including through the ongoing approval of providers and the Aged Care Quality Standards. This is discussed in chapter 9. Attempting to place weight on quality assurance through a places allocation process that is designed for other purposes, as currently occurs under ACAR, is likely to make the regulatory environment more complex for both providers and government.

Summary of conclusions: criterion 2

The Impact Analysis concludes that under Model 2:

- there will likely be increased numbers of new entrant providers, as well as greater efficiencies of scale, both of which will require robust governance and oversight of quality and safety. The regulatory regime plays an essential role in ensuring quality and safety, including through the approved provider process and assessment against the Aged Care Quality Standards.
- more competition should drive improvements in quality and safety – on condition that the regulatory oversight of quality and safety is maintained and consumers have sufficient information and support to be able to differentiate between aged care homes based on their quality and safety performance.

Criterion 3. Facilitate timely and equitable access to residential aged care and respite services for those in need

Timely access

A key issue in assessing Model 2 is whether the assignment of places to consumers, rather than their allocation to providers, will change the waiting time for people to receive care relative to current waiting times. Such concerns need to be considered in the context of the current ACAR system where there is a lack of consolidated information on unmet need, including the number of consumers actively seeking residential aged care.

One of the most significant concerns raised by stakeholders was the possible introduction of a prioritisation arrangement to manage access to a residential aged care place, in order to retain fiscal control on the supply of places.

Advantaged Care expressed its concerns as follows:

‘It is clear from the home care experience that the national prioritisation queue is problematic, given that it is not working well for home care why would you look at implementing it in residential care at this point in time when there are so many other present pressure points in the industry. It seems that for the consumer it is less efficient than the old system of an ACAT approval to allocated places for home care, as it has added another level of approval that does not seem to be efficient for the delivery of required services.’ (sub. 35, Q. 19)

A service provider who wished to remain anonymous was concerned that a prioritisation system would exacerbate an already complex and stressful time for consumers and their families:

‘Model 2 will have a negative impact on new consumers as many come into residential age care from hospital (close to 90%) following a medical crisis. A queuing and ticketing system will further

amplify the crisis being experienced as it is already compounded by administrative complexities, legal, financial and family dynamic complexities. Currently, our organisation is able to escort a consumer through the process and admit them within a week. This will be increased substantially under Model 2 as there will be further delays and frustrations to consumers caused by the queuing and ticketing system.’ (sub. 37, Q. 19)

Some stakeholders called for more sophisticated mechanisms to control expenditure, such as eligibility assessment, rather than some form of prioritisation.

Estia Health explains:

‘In principle, we do not believe that the operation of a queue is viable in relation to residential aged care. Many admissions to residential are event driven, whether by fall, injury, acute illness, or for example rapid onset dementia. In these circumstances almost immediate admission to a home is necessary to avoid serious health risk, or would result in an extended stay in hospital at a greater cost. The operation of a “queue” would have to be able to take account of the need for immediate admission regardless of “length of time in the queue.”

We believe that the Department has adequate means to control expenditure by more sophisticated management based on assessed need. We do not believe that current supply constraints control or limit expenditure, nor would their removal result in burgeoning demand.’ (sub. 21, p.3)

The Impact Analysis has closely assessed this issue. The following evidence is pertinent:

- Chapter 2 outlines available evidence that home care is substituting for residential aged care, which has been reducing the demand for the latter. ACAT approvals data, presented in chapter 5, suggests that most consumers prefer to remain living at home rather than enter an aged care home.
- Departmental data indicates that in 2017-18, of the over 119,000 people approved for residential aged care, 86,450 (72.5 per cent) had not entered an aged care home by the end of that financial year. Of this group, 17,030 held an approval only for residential aged care. Consumers who are eligible only for residential aged care and did not have the option of home care - and have entered an aged care home - generally enter residential aged care around one month of ACAT approval (see chapter 5). This indicates a reasonable balance between demand and supply for subsidised residential aged care.
- As discussed in chapters 2 and 5, occupancy rates have been on a slight decline so there is around 5-10 per cent vacant capacity in the residential aged care sector in aggregate. In terms of a conservative estimate, this suggests vacancy in the order of 10,000 beds in 2017-18⁴¹.
- Based on the Aged Care Financial Authority’s (ACFA) projections of future demand, discussed in chapter 2, it is estimated that the sector’s bed capacity – if it grows in line with the planning ratio – will exceed demand for the next two decades (until the late 2030s).

Taken together, the evidence indicates that, in aggregate, supply is meeting demand and will continue to do so over the next two decades at least. As such, a prioritisation system under Model 2 is unlikely to be required as there would be no effective benefit in capping the supply of subsidised residential aged care places. Removal of the supply-side constraints on capacity is likely to increase the availability of beds without impacting on the demand for subsidised places.

Nonetheless, recognising that there is always a degree of uncertainty in projections, the Impact Analysis also concludes that the uncapping of supply under Model 2 should be implemented following an assessment of the impact of related reforms which have been identified in chapter 9.

Having reached the conclusion that demand is unlikely to exceed supply based on current policy settings, a subsequent consideration is whether there would be a need for a two-stage assessment (as originally proposed under Model 2) prior to entry to residential aged care.

⁴¹ This is estimated based on a 5 per cent vacancy rate, which computes as 10,357 vacant operational places using the number of operational places as at 30 June 2018

A possible model was to retain, as a first stage, the current assessment of eligibility by an ACAT and then to introduce, as a second stage, the assignment of a subsidised place by an ACAT when an eligible consumer is actively seeking entry to an aged care home. Given that supply is now proposed to be uncapped, the Impact Analysis concludes that the introduction of a second stage to the assessment is unwarranted. It would subject consumers and their carers to unnecessary bureaucracy at a time of great stress and would represent an inefficient divergence of valuable assessment resources.

However, as shown in the evidence presented above, there were over 119,000 consumers who were assessed as eligible for residential aged care in 2017-18 and the vast majority (over 70 per cent) did not enter residential aged care that same financial year. As such, this data on the numbers of consumers eligible for residential aged care, and its trends over time, is of little value to planning and investment by the government or providers. The Impact Analysis considers that the eligibility assessment process must more accurately assess consumers' current and foreseeable needs for residential aged care and must become more responsive to assessing the changing needs of eligible consumers.

The Impact Analysis concludes that under Model 2 the overall time taken to access residential aged care and the timeliness of access is likely to improve in the aggregate given the increased availability of bed capacity due to the liberalisation of supply.

Equitable access

Aligning overall supply with consumer need for subsidised residential aged care is a key step in facilitating access, but it is also important that there is equitable availability of appropriate services for consumers regardless of their race, culture, language, gender, economic circumstance or location.

Some stakeholders have expressed two main concerns with discontinuing the allocation of residential aged care places to providers as it relates to equity of access for all consumers:

1. as conditions of allocation for priority of access to special needs consumers would no longer exist, these consumers may be neglected by providers in favour of consumers whose needs can be more easily met with a standard service offering and/or with greater ability to pay for premium offerings
2. without targeting or locational controls on the distribution of service delivery, it could facilitate investment in metropolitan markets to the detriment of rural, regional and remote areas.

These two concerns are analysed in the following sub-sections

Diverse needs and vulnerable cohorts

Removal of the ACAR targeting and priority of access conditions under Model 2 is not expected to detract from current levels of equity of access for vulnerable consumers or those with diverse needs. As noted in chapter 5, the current targeting and priority of access conditions for some allocated places do not guarantee equitable access among consumers from special needs groups.

Some stakeholders at the consultation forums considered there were potentially greater opportunities for specialisation (e.g. cultural food and language) under Model 2, with some noting that even large providers could deliver niche, specialist services in parallel with other non-specialised service offerings.

An anonymous service provider explained the opportunity for greater service differentiation:

'The residential aged care services that will flourish in the market facilitated by Model 2 will include those that develop a specific focus to meet particular needs. Local providers in regional areas may focus on knowing their area better than anyone else, while other providers may develop services particularly for people from certain culturally and linguistically diverse (CALD) or Aboriginal and Torres Strait Islander backgrounds.

A single aged care home could also have multiple specialties within different wings or household units. Encouraging providers to adopt a differentiated focus will not only assist them to stand out in a crowded marketplace, it should also increase service quality. Rather than expecting the government to facilitate differentiation in the aged care markets, providers should see the proposed reform as an opportunity to embrace greater focus and specialisation in their services in response to identified consumer needs.

It must be acknowledged that not all special needs groups will have a large enough market share in each location to warrant specialised services, so all providers will need to develop a basic understanding of the specific needs of various consumer cohorts.’ (sub. 46, p. 8)

The Impact Analysis concludes that under Model 2, some specialist providers, such as those addressing needs of consumers from a Culturally and Linguistically Diverse (CALD) or Aboriginal and Torres Strait Islander background, would have the freedom to locate in areas of high concentration of consumers from such a background.

However, markets on their own may not necessarily achieve equitable outcomes in all instances, particularly for consumers with complex care needs, and therefore other supporting policy mechanisms will be required. For example, the Joint Standing Committee on the National Disability Insurance Scheme (NDIS) has heard that, in some instances, the unsustainable NDIS pricing has led to service providers discontinuing services to participants with high and complex needs and ‘cherry picking’ clients (Joint Standing Committee on the National Disability Insurance Scheme, 2018). This underscores the importance of ensuring there are viable levels of funding for residential aged care.

Further, NDIS was found to work best for participants and families who were able to strongly advocate for themselves but poorer outcomes were reported for NDIS participants with intellectual disability, psychosocial disability and complex needs or with older carers facing their own health issues. NDIS participants who were from CALD backgrounds and living outside urban areas were also considered to be similarly disadvantaged (National Institute of Labour Studies - Flinders University Adelaide, 2018). Differential access to the NDIS has also been found to occur along the lines of education, socio-economic status and disability type (Malbon, Carey, & Meltzer, 2019).

Some consumers on their own will not be able to navigate the system and exercise choice and control to access care. As quoted earlier in this chapter, Dementia Australia cautioned on the impact of confusion and stress on consumers.

Wintringham cautioned that for the smaller number of consumers who were homeless, access and provision of care needed to be tailored to their very specific needs:

‘The case is a lot more simple, as choice is rarely an option for a homeless client, they just seek access full stop. Furthermore, they seek access to services provided by specialist organisations that understand their background and can respond to their particular care needs in a non-judgemental and supporting manner. When considering reform, the particular needs of homeless clients is at risk of being collateral damage when identifying models that work for the 99% majority.’ (sub. 56, p. 6)

The Impact Analysis considers that two issues critical to facilitating equity of access are ensuring that funding levels recognise the higher costs of specialised or complex care to support viable service provision, and ensuring the availability of tailored information and supports to equip all consumers with the ability to exercise informed choice and access care. Supporting equitable access is discussed further in chapter 9.

Service delivery in regional, rural and remote areas

Key factors impacting access to aged care in remote and very remote communities are the low density and dispersed consumer population, the challenges of attracting and retaining a suitable aged care workforce, and higher costs of service delivery (Royal Commission into Aged Care Quality and Safety, 2019). These were factors often cited by stakeholders who were concerned about a potential shift of service provision out of rural, regional and remote areas into metropolitan cities where returns are generally higher.

Under the current ACAR system there are very different levels of availability of operational residential aged care places outside of the metropolitan areas. Nationally, at 30 June 2018, the number of residential aged care places overall was 75.9 per 1000 people in the aged care planning population (i.e. aged 70 years or over) (Productivity Commission, 2019). The actual rate is significantly higher in major cities (79.4) compared to regional areas (66.7) and is almost twice the rate of availability in remote/very remote areas (43) (Productivity Commission, 2019). The home care trends, coupled with the greater interest among ACAR applicants in seeking metropolitan places (see chapter 2), suggest that changing the allocation of places to consumers rather than providers, in itself, is unlikely to trigger significant changes in availability of residential aged care in rural, regional or remote areas.

The availability of residential aged care in regional, rural and remote Australia, as shown in chapter 5, is largely dependent on the presence of not-for-profit providers given their mission-based approach to delivering care, as well as government providers. However, the key factor is not the availability of places through ACAR but the sustainable viability of providing care in these areas including the availability of a suitable workforce. The Multi-Purpose Services and National Aboriginal and Torres Strait Islander Flexible Aged Care Programs will also continue to play an important role in supporting flexible service delivery in rural, regional and remote areas.

As stated earlier, the home care market experience has demonstrated that changing the allocation model has not triggered mass movement of providers out of rural, regional and remote areas and into major cities. There has been growth in home care providers across all remoteness categories, although it has been at a lower rate in rural, regional and remote areas compared to major cities.

The NDIS transition to a market-based system has brought challenges for delivering services in areas of thin markets, including rural and remote areas. The fee for service pricing, which according to some accounts has not adequately recognised the costs of doing business in a rural or remote area, has posed complex challenges for providers in these areas to achieve sustainability and viability (Joint Standing Committee on the National Disability Insurance Scheme, 2019). As a result, some service providers were considering or had already opted out of delivering services under the NDIS. The Department of Social Services and the National Disability Insurance Agency have commissioned the NDIS Thin Markets Project to develop strategies to address supply gaps in these areas. The public consultation currently underway as part of the Thin Markets Project will assist in developing a framework for addressing the issue and a “roadmap” to guide pilot projects that will test solutions (Australian Government Department of Social Services, 2019a).

The Impact Analysis concludes that while allocating residential aged care places to consumers may not necessarily redress all existing inequities in the system, it would provide greater opportunities for providers to respond to the preferences of cohorts of consumers who have specific needs or live outside major markets. Changes in other policies, not the least being ensuring the viable delivery of services to these communities, are required to more significantly address the equitable delivery of services.

Chapter 9 canvasses a range of government interventions that will be required to address thin market issues. These policy settings, not ACAR, will remain the main vehicles for ensuring the delivery of care to special needs groups and to consumers in rural and remote regions.

Residential respite care

There was overall support from stakeholders that residential respite places should be assigned to consumers based on an eligibility assessment, with consumers being able to choose between available providers. When combined with funding reform for respite (see chapter 9) this would also enable providers to have greater flexibility in offering residential respite according to their mission and business strategy.

Eldercare explained:

‘In the model where a consumer has choice and the funds follow the consumer it is consistent to then allow the consumer to choose their type of service including respite. If places could be used for long-term or respite care, providers would have additional options for reducing bed vacancies.

Increased respite opportunities for consumers is likely to be favourably received by consumers, however to ensure viability for providers demand will need to be sufficient to keep the bed occupied or alternatively be lucrative enough to manage any dip in supply.’ (sub. 20, Q. 38)

Model 2 proposes that residential respite care places be assigned to eligible consumers, separate from the assignment of permanent residential aged care places. The uncapping of supply is likely to increase the availability of residential respite as, in a more competitive market, providers may be more inclined to offer respite to reduce their vacancies and also to attract prospective permanent residents. To continue incentivising providers to deliver high level respite, the Impact Analysis notes that removing the concept of the respite care allocation, and instead assigning respite places directly to consumers, would require changes to the operation of the respite incentive supplement – or that it be removed completely if funding neutrality between permanent and respite care is achieved.

ACFA's Review of Respite found there has been a steady increase in the proportion of people who enter permanent residential aged care immediately after a period of residential respite care (Aged Care Financing Authority, 2018). In 2013-14, around 25 per cent of the people admitted to permanent residential aged care had just ended a period of respite care, which increased to 44 per cent in 2017-18. ACFA notes that during 2015-16, 2016-17 and 2017-18, more than a third of all residential respite care recipients converted to permanent residential aged care at the end of their respite care stay. More recently, of the consumers who received residential respite during 2018-19, 34,984 (approximately 53 per cent) were later admitted to permanent care (Australian Government Department of Health, 2019b).

ACFA suggested that this trend may indicate that the increasing use of residential respite care is not primarily for the intended purpose of providing a period of respite, but could be due to other reasons, including people wanting to try out an aged care home. It would also allow the provider to ascertain the consumer's fit for permanent care in that home. This may enhance consumer choice when seeking an appropriate aged care home for permanent care, while also reducing financial risk for the provider.

Ryman Healthcare suggests:

'As new facilities open, they have scope to offer higher levels of respite care in early stages. With no cap on the number of bed days providers could offer, it would be easier to provide respite care to a larger group of consumers.

Respite is seen as a 'try before you buy' options, as evidenced in research that suggests it is the primary funding used before entry into permanent residential care. This is encouraging for providers, so it is unlikely there will be any reluctance to accommodate respite care consumers.

Respite care funding could be reviewed to reflect the intensive investment in time to induct a new consumer, with little return for this investment if the consumer only stays for a short period.' (sub. 36, Q. 38)

In its review, ACFA considered 'try before you buy' as an appropriate market response, but emphasised that it needs to be balanced against ensuring that the availability of short-term respite to support those wishing to remain living at home for as long as possible (and their carers) is not compromised.

To that end, a cap on an eligible consumer's respite usage (currently 63 days per financial year) could continue to apply – coupled with increased accountability and monitoring of the assessment workforce in their granting of an extension to the cap in specified circumstances. Ensuring that eligibility assessments are accurate and approvals reflect current or foreseeable need for residential respite care should also assist in ensuring the availability of short-term respite to those who wish to remain living in the community (as well as affording a level of fiscal control over expenditure).

A more detailed discussion of residential respite care, including the importance of achieving funding neutrality between permanent and respite residential aged care, together with the associated conclusions of the Impact Analysis, is provided in chapter 9.

Summary of conclusions: criterion 3

The Impact Analysis concludes that Model 2 will improve timely access to subsidised residential aged care:

- through an increase in the number and diversity of aged care homes by removing supply-side constraints – noting that the Impact Analysis also concludes that uncapping supply:
 - is unlikely to negatively affect the budget outlays on residential aged care over the next two decades at least, based on current policy settings (the target provision ratio)
 - would best be implemented in conjunction with other reforms, some of which are either in progress or have been announced (see chapter 9).
- through a more accurate eligibility assessment of consumers' need for residential aged care and greater responsiveness to assessing the changing needs of eligible consumers.

Regarding equity of access, the Impact Analysis concludes that Model 2 will:

- enable specialist providers and those wishing to enter or expand in non-metropolitan areas to have greater flexibility in meeting the needs of their consumer bases by no longer depending on being allocated places under ACAR
- require changes in other policies to more significantly address inequitable availability of services. There needs to be a change in funding to ensure the sustainable viability of providers in their delivery of services to consumers who have special needs or who live in rural and remote areas, as well as more tailored information and supports for consumers with diverse needs.

Criterion 4. Facilitate a residential aged care sector that has continued growth and financial investment which responds to increasing consumer demand and changing preferences

Responsiveness to consumers

Stakeholder support for Model 2 was often based on its ability to shift the mindset of the sector and incentivise providers to compete for consumers who are assigned a subsidised residential aged care place.

COTA Australia was strongly of the view that assigning places to consumers would require providers to either respond to consumers, or exit the sector, which it argued was good for increasing responsiveness to consumers:

‘COTA believes providers will make this call [of altering the business, service or workforce models] depending on how successful they think they will be. Some providers won't need to change anything because they are in demand and are waiting for the ACAR to be removed so they can expand; while others will need to become market responsive for the first time; some will learn some won't and they will eventually disappear, which is good.’ (sub. 34, Q.27)

Evidence from the NDIS Final Evaluation Report indicates that the shift from funding providers to funding consumers has increasingly empowered participants to take greater control over the supports they receive:

‘The evaluation found that the NDIS is leading to improved satisfaction with choice and control - both over what supports are received and where these are obtained - for the majority of participants. Furthermore, these improvements with choice and control became stronger with longer time in the NDIS, and with increased familiarity with the NDIS. As a consequence, NDIS participants were increasingly requesting different types of supports and flexibility of service provision. Change of service providers was also more commonly seen as the evaluation progressed.’ (National Institute of Labour Studies - Flinders University Adelaide, 2018) (p. xvi)

In terms of the home care reforms, early indications are that consumers feel they have greater control of their package. The majority (66 per cent) of surveyed home care consumers who were aware of their package funding distribution were satisfied with the proportion of funding that their provider allocated to directly fund their home care services (AMR, 2019).

Some stakeholders suggested during the consultations that greater competition brought about by assigning places to consumers could also drive improvement in aged care home buildings. Such building stock improvements have been observed in the residential aged care market in the United Kingdom, where rooms in new or redeveloped aged care homes are increasingly spacious, often including ensuites (GrantThornton, 2018).

There were also suggestions from stakeholders that, with fewer supply restrictions, there would be more opportunities for some providers to specialise in meeting particular consumer needs that may be prevalent in a local community (see discussion for criterion 3).

The Impact Analysis concludes that assigning the place to the consumer and uncapping supply would increase supply-side competition and would increase provider responsiveness of care and accommodation to better reflect their preferences.

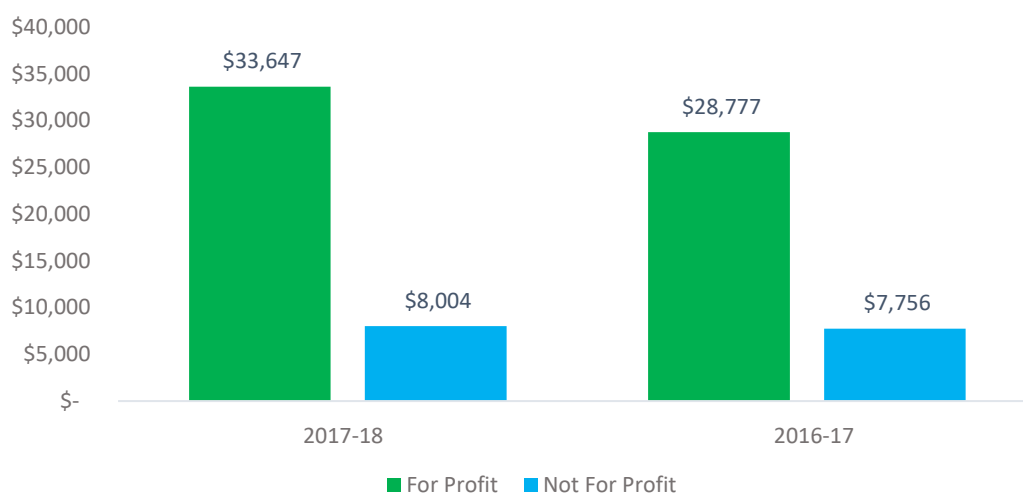
Maintaining and stimulating investment

Value of allocated places

Under the ACAR, places are allocated by the government at no charge to successful provider applicants. However, because of the policy induced scarcity of places, providers may offer some of these places for a value, on the secondary market. This increases the cost of providing residential aged care for those providers who have purchased these places (bed licences).

In 2017-18, the average value of an allocated residential aged care bed licence for for-profit providers was over \$30,000, compared to \$8,000 for not-for-profit providers (figure 7.4). Not-for-profit providers tend to acquire (or value) licences at a lower amount (often acquired from other not-for-profit providers).

Figure 7.4 Average financial value of residential aged care place for not-for-profit and for-profit providers, 2017-18 and 2016-17

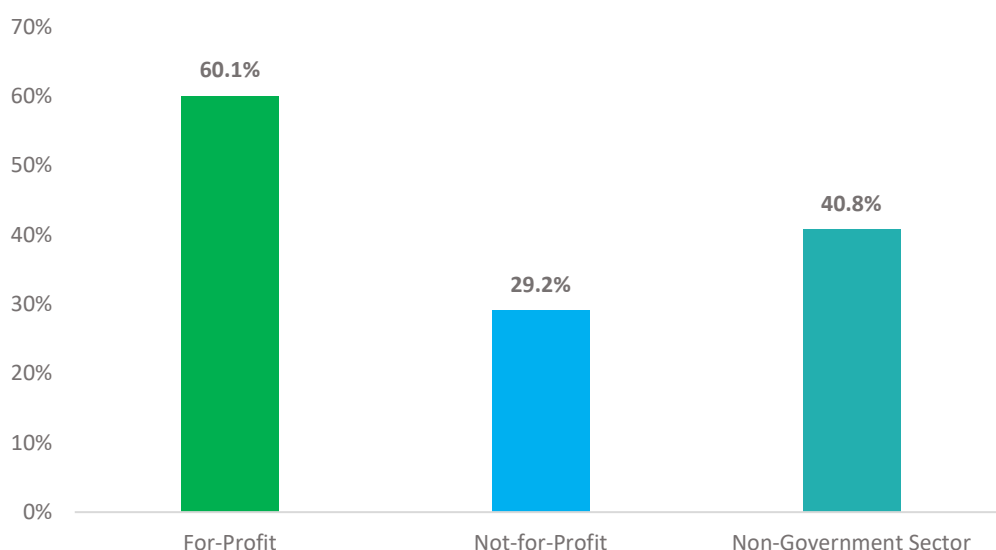


Source: Analysis based on unpublished data from Department of Health

An analysis of the information provided in the department's Aged Care Financial Report for 2017-18 shows that 40.8 per cent of non-government aged care providers include a value for bed licences in their financial statements (figure 7.5), particularly for-profit providers (60 per cent of for-profit providers attribute a value to bed licences).

These values are not necessarily indicative of secondary market values as it depends on the area and existing competition (and strategic value). By way of example from market intelligence, a secondary market in the Ryde region of Sydney has seen bed licences sold for over \$55,000 and yet others have not been able to be sold.

Figure 7.5 Residential aged care providers by organisation type reporting residential aged care places as intangible assets, 2017-18



Note: The data above is for all providers excluding the Government Sector

Source: Analysis based on unpublished data from Department of Health

Under Model 2 the disclosure of bed licences as an intangible asset will require specific assessment. In relation to not-for-profit providers who have valued licences gained from ACAR or through other government allocation it is likely that these will be required to be written back. In the case of providers (for-profit and not-for-profit) who acquired licences through an arms-length transaction with a cost or fair value attributed to them, these are currently disclosed as having an indefinite useful life and accordingly are not amortised. This disclosure treatment will likely require the licences to be impaired (based on the assessment of the ongoing value), written-off or the licence value will need to be amalgamated within goodwill or buildings (if they were acquired as part of the aged care home acquisition).

All assets, intangible and tangible, require regular assessment as to whether the carrying value is fairly stated based on financial performance, and this will also determine the future value of bed licences. The intrinsic value of bed licences is where they are attached to an accredited aged care home, which is the rationale for valuing bed licences under Model 2 as being “value in use” or as part of the aged care home.

Removing the places as an intangible asset would decrease the net assets of the provider in their financial statements. In 2017-18, there were 70 approved providers that were already in a position of negative equity (table 7.3). This would increase to 144 providers with negative equity if bed licences were to be fully impaired and removed as an intangible asset. However, in practice, negative equity would have little implication from an operational perspective although there may be some indirect borrowing implications for some providers as a result of the financial statements showing the entity to have a lower net asset backing.

Table 7.3 Residential aged care places as intangible assets and negative equity position before and after impairment, 2017-18

Organisation type	No. providers reporting places as intangible assets	Value of residential aged care places	No. providers in negative equity	No. providers in negative equity after impairment
For-Profit	140	\$970,801,007	62	132
Not-For-Profit	173	\$2,311,810,292	8	12
Total	313	\$3,282,611,299	70	144

Source: Analysis based on unpublished data from Department of Health

From a borrowing perspective, financiers/banks have advised the Impact Analysis that they generally discount or eliminate the value of allocated places as an asset. Nonetheless, it may require the security covenants in relation to secured borrowings to be reviewed. Such covenants may include maintaining a certain net asset position, being restricted in the volume of debt etc. Generally, financial institutions will not include intangible assets when determining the value of net assets required to be maintained in a covenant.

Estia outlines why they do not view removal of licences from financial statements as a concern:

‘Depending on the implementation time-frame, providers would be likely have to write off the millions of dollars ascribed to licences currently on their balance sheets which value was assigned to them at the time of business acquisition in accordance with accounting standards. This should not be of concern because it would be a non-cash, accounting adjustment and the potential impact is known and understood by investors and lenders without concern.’ (sub. 21, p. 2)

Future revenue streams and the roles of transparency and certainty

Some stakeholders consider that allocated places provide a level of certainty, to an extent, of future revenue streams. Eldercare contends:

‘There will be a reduction in availability of capital financing from financial institutions if a provider does not have assured income from an aged care facility. Currently a bed place translates to assured future funding.’ (sub. 20, Q. 31)

Australian and New Zealand Banking Group (ANZ) explains how the transparency afforded by ACAR and allocated places interacts with lending appetite:

‘ANZ currently assesses funding for aged care developments with the benefit of the relative certainty around the short to medium term supply of aged care beds. This certainty stems from the known quantum of existing licenses and Provisionally Allocated Places in any locality. Reform that reduced such certainty may affect lending appetite for development funding.’ (sub. 45, p. 1)

Some providers advised that investment decisions will become harder, as providers will no longer be able to assume very high occupancy unless they are offering a service that is responding to consumer preferences.

LASA considered:

‘Increased risk will raise the cost of capital, and in some cases the higher level of risk may actually lead to less investment than would have been the case under the current model of place allocation.’ (sub. 44, p. 6)

An anonymous service provider said increased investment risk could mean greater returns on capital would be sought, which is challenging in the current environment of poor financial performance:

‘Strong occupancy is the most important marker of financial performance and in our view, there is an undeniable nexus between industry licencing and strong occupancy...’ (sub. 50, p. 2)

The Impact Analysis considers that it is this certainty, the assured higher occupancy, which is one of the core concerns with the ACAR. Poorer performing providers are beneficiaries of this certainty and higher occupancy and have little incentive to improve their quality or respond to consumer preferences. Conversely, the more innovative, efficient and responsive performers have little flexibility under ACAR to take advantage of the consumer support they would receive in a more open and competitive market.

Several finance sector representatives have advised this Impact Analysis that it is the reliability of cash flow (not the allocated places per se) that is important when considering applications for financing. An allocated place currently serves as a proxy indicator of future cash flow sources. At the consultation forums, they suggested that if allocated places ceased (and therefore could not be used to indicate future cash flow streams), lending would focus more directly on the providers’ brand (reputation) and proposition to consumers and the market (the quality of their performance and business case), coupled with sound financial equity and organisational governance. There were suggestions from some stakeholders that larger portfolios would offer greater comfort to lenders/financiers in this respect.

Estia Health explains that removing the constraint of ACAR on investment could lead to more efficient use of capital:

‘The current system of ACAR means that approved providers such as Estia which have access to capital and proven management capability are not able to contribute to meeting the demand simply because the Department has allocated places to others or in fact, not allocated places in locations with demand. Conceptually, the ACAR system creates a non-competitive environment because the Department of Health determines which providers can expand their offering.

Maintaining the current model does not lead to efficient and effective use of scarce resources, nor lead to innovation and other consumer benefits of increased competition.’ (sub. 21, p. 2)

Other providers have similarly highlighted that investor sentiment is influenced by factors which are separate to having allocated places, including financial viability and reform certainty.

Catholic Health Australia noted other ways to secure investor confidence:

‘As well as achieving returns commensurate with the risk profile of the aged care sector, greater clarity and certainty about future reform directions and sequencing is important to secure investor confidence in the sector.’ (sub. 25, Q. 32)

Ryman Healthcare underscored the role of ensuring appropriate funding levels:

‘Investment is driven by a return on investment and certainty of long term viability. With the current poor return on investment, which is primarily driven by under funding of residential aged care, the sector is less appealing. Lenders will expect an increase in compliance costs mandated by the outcome of the Royal Commission, which will worsen returns.’ (sub. 42, Q. 32)

As discussed in chapter 5, the assurances provided by allocated places arise from the capped supply (supported by the publication of ACAR allocation results) rather than the allocated place itself. If the supply of places is uncapped, then the predictability is reduced.

Regarding transparency of the market, the Impact Analysis concludes that information relating to the factors affecting demand, together with the quantum and characteristics of supply, could still be gathered and provided without an ACAR, though it should only supplement the normal market intelligence that providers should be responsible for as part of their business planning.

Availability of financing

Some stakeholders suggested that a reduction of loan amounts relative to assets was another possible outcome of increased investment risk (perceived or otherwise). They referred specifically to reduced loan-to-value ratios (LVRs). The LVR is the amount of external (secured) borrowings expressed as a percentage of the security held, the majority being property and all undertakings (other assets) of the provider organisation.

Table 7.4 below shows on all three datasets ranging from listed entities, StewartBrown and ACFA, the average LVR is below 13 percent, though the greater leverage of the for-profit sector is evident. Given the already low average LVR (which may not change significantly under Model 2), whether there will be a significant or material effect on future secured borrowings based on LVR is open to question.

Table 7.4 Loan-to-value ratios in residential aged care, 2017-18 and 2018-19

Listed entities, 2018-19	\$'000	ESTIA	JAPARA	REGIS	Average
	Gross assets (Y)	1,894,789	1,378,635	1,792,898	1,688,774
	Refundable loans	806,337	554,649	1,126,920	829,302
	External Borrowings (X)	125,000	210,500	303,080	212,860
	LVR % (X/Y)	7%	15%	17%	13%

StewartBrown, 2018-19	\$'000	Not For Profit (67 Organisations)	For Profit (3 Organisations)	Total Average (73 Organisations)
	Gross assets (Y)	296,353	261,267	293,469
	Refundable loans	159,888	184,762	161,932
	External Borrowings (X)	13,476	47,796	16,297
	LVR % (X/Y)	5%	18%	6%

Aged Care Financing Authority, 2017-18	\$'000	Not For Profit (203 Organisations)	For Profit (242 Organisations)	Total Average (445 Organisations)
	Gross assets (Y)	157,046	80,628	115,488
	Refundable loans	74,240	48,664	60,331
	External Borrowings (X)	8,262	15,817	12,371
	LVR % (X/Y)	5%	20%	11%

Note: Gross assets include bed licences, and only providers with external borrowings were considered for this analysis

Source: Analysis based on data from StewartBrown and Aged Care Financing Authority

If the investment environment becomes less predictable, investors will seek higher rates of return, or be more reluctant to commit capital.

ACFA explained:

‘Investment activity requires equity investor and debt provider confidence in the capacity of providers to deliver sustainable returns on capital and of the sector overall. The amount of (and change in) invested capital is one key metric of sustainability.

In order to attract future investment the industry needs to generate consistent rates of return on capital that are appropriate for the risk involved and are competitive with returns in other sectors that have similar attributes.’ (Aged Care Financing Authority, 2019) (p. 137)

To attract investment in a post ACAR environment, providers will have to demonstrate that they have an efficient, competitive and quality service that is attractive to consumers, and those that do not meet consumer expectations will need to improve or leave the sector. This is a positive for both the consumers and the better performing providers.

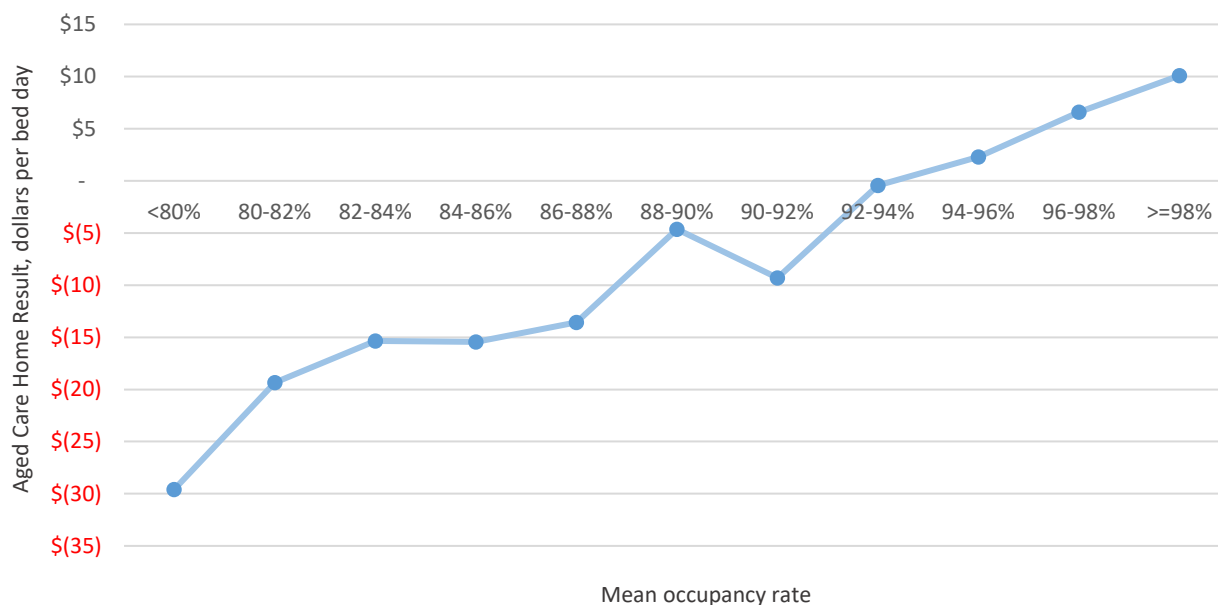
In relation to subsidised residential aged care, a level of funding (from the government and consumers combined) that supports a viable sector, together with reform certainty, is critical. This is discussed further in chapter 9.

Financial performance

As seen in chapter 5, current building activity and planned investment in constructing new aged care homes and refurbishing or expanding existing homes have slowed as the sector as a whole is facing viability concerns. A key concern of some stakeholders is that the removal of allocated places may put some aged care homes under even greater financial pressure, driven by reductions to occupancy as a result of increased competition. To a lesser extent this circumstance already exists under the current ACAR arrangements. A new aged care home built in the local region may increase competition and if it is efficiently run and better meets consumer preferences, it may be very viable. Accordingly, the viability of the sector in aggregate may not be affected. Further, as addressed in chapter 9, the impact of greater competition on current providers will not be felt to any material degree before the mid-2020s.

Occupancy is highly correlated with an aged care home’s financial performance (figure 7.6). As the occupancy levels in individual aged care homes increase, the average Aged Care Home Result also increases.

Figure 7.6 Aged Care Home Result sorted on mean occupancy rate, 2017-18

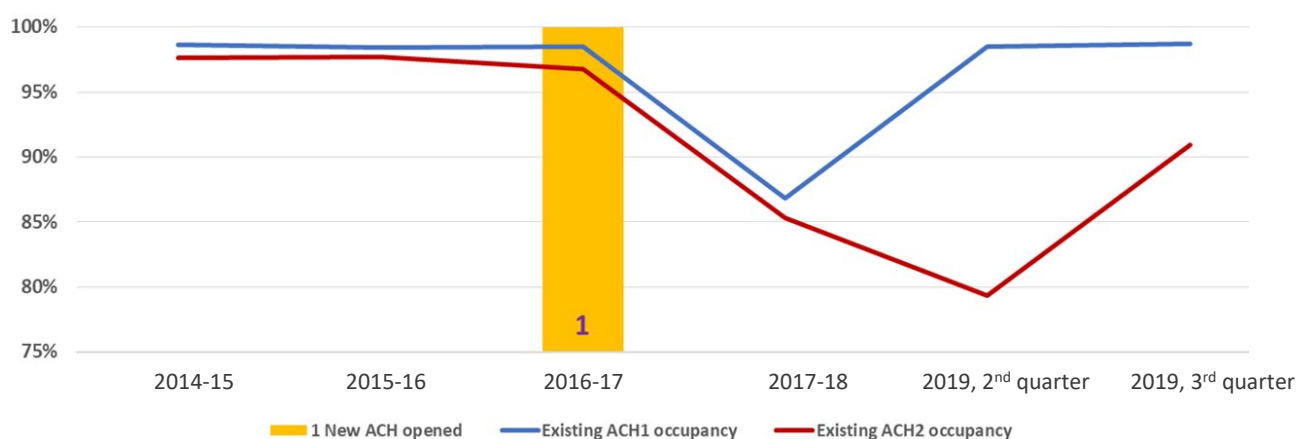


Source: Analysis based on StewartBrown data

To assess the possible impact of increased competition on occupancy, analysis was undertaken which tracked the occupancy trend of several aged care homes where a new aged care home commenced operations in the same postcode: one in inner regional Queensland (figure 7.7) and one in urban Victoria (figure 7.8). There was a general trend for the occupancy of existing aged care homes in the postcode to initially decline and then gradually bounce back over a couple of years.

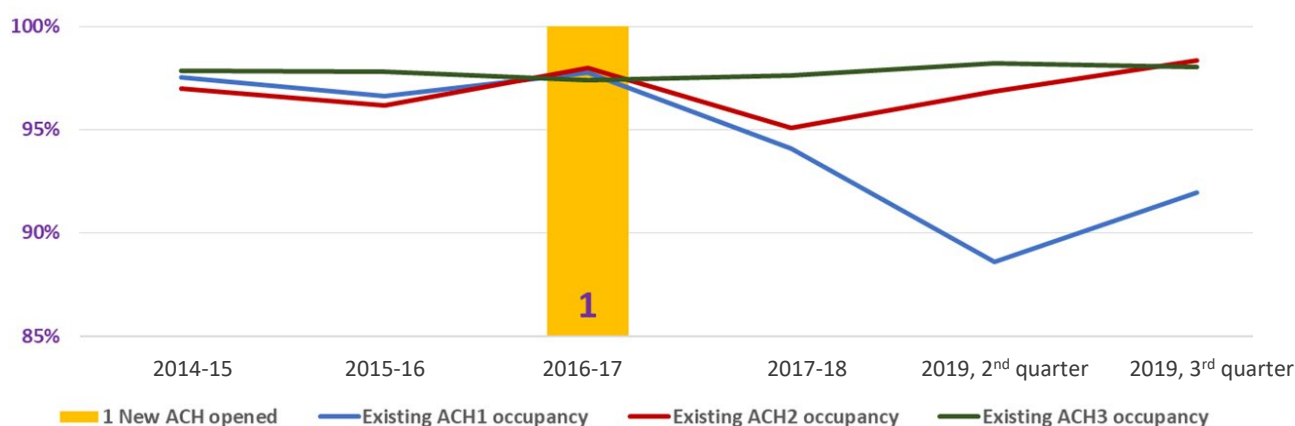
While in some cases the occupancy does not return fully to original levels, in others the occupancy was only marginally affected. When the occupancy declines in each case, the profitability of the aged care home also declined, however the later increase in occupancy addressed this decline in profitability.

Figure 7.7 Occupancy impact on two existing aged care homes from opening of new aged care home – inner regional Queensland, June 2015 to June 2018



Source: Analysis based on unpublished data from Department of Health

Figure 7.8 Occupancy impact on three existing aged care homes from opening of new aged care home – urban Victoria, June 2015 to June 2018



Source: Analysis based on unpublished data from Department of Health

Resthaven expressed their concern that a more market based system will reduce occupancy while not having the flexibility to adjust staffing:

‘It remains in residential care that occupancy is a key viability factor and such a new market may cause critical occupancy impact ...

With the current Modern Award system, there is limited ability to flex staff models to respond to outcomes. Potential new minimum staff regulations will also assume consistency in occupancy, and impact on viability in a less certain future.’ (sub. 51, p. 17)

Separate case study analysis was undertaken of the impact of declining occupancy on workforce levels and composition in an aged care home. It was found that there was generally little change to staffing as a result of changes in occupancy rates. The Aged Care Home Result also tended to decline with occupancy in these case studies. This suggests that staffing costs are generally stable. Given limited short-term flexibility in adjusting fixed overheads, any reduction in occupancy levels would tend to lead to a reduced financial result. Financial performance of some existing aged care homes may further decline, at least in the short-term, due to increased local competition reducing occupancy levels. However the possible impact will only occur some years after the introduction of Model 2 and for those homes that have current viability issues this will need be addressed in any case before that time.

While the home care reform experience included a downward impact on prices for consumers (in particular, exit fees – see chapter 4) and reduced provider profitability, the effect on prices in the residential aged care environment would be less significant given that the care subsidy and basic daily fee are both regulated. Pricing for additional services and accommodation may be subject to competition pressures as is already the case under the current ACAR regime.

Some stakeholders such as LASA have raised concerns about the risks of growth and disruption associated with a more market based system and cited the childcare experience, in particular ABC Learning (see chapter 4). However, the issue is not so much the closure of non-viable services, but the need for market oversight and managed transition to ensure the continuity of care for consumers. For example, following the collapse of the ABC Learning child care provider, the Government enacted requirements to monitor the financial viability of large long day care operators to smooth any transitional period once a supplier prepares to exit the market (Productivity Commission, 2014). Similarly, in the English care home system following some major provider collapses, as part of a market oversight scheme, the independent regulator assesses the financial viability of providers who would be difficult to replace if they collapsed, to ensure continuity of care arrangements (Care Quality Commission, n.d.).

In like manner, the strengthening of approved provider administration and financial monitoring is considered by this Impact Analysis to be an important condition if Model 2 is adopted. The Government will need a line of sight to market conditions and the capacity to intervene when necessary – including in instances of aggressive and risky growth. Proactive identification of providers at risk of financial collapse will be key,

alongside strengthened prudential standards that are already underway to reduce the risk of calls on the Accommodation Payment Guarantee Scheme.

Supporting innovation

Model 2 supports greater innovation. By removing the need for providers to apply for places via the ACAR, some providers will develop new, innovative approaches to the delivery of care that are more attractive to consumers and increase operational efficiency.

In New Zealand, contemporary integration models across retirement living, home care and aged residential care have become a common feature (Ansell Strategic, 2014) (Ernst & Young, 2019). Retirement village operators have increased their presence in the sector, providing a continuum of care on their village sites for residents. They have been the main investors in New Zealand's new bed capacity in recent years. As a result of escalating operating and construction costs and low economic returns on invested capital, almost all homes built in New Zealand over the past decade have been a part of co-located villages to spread the facility construction costs across a wider cost base. Many providers of these modern aged care homes have used extra/additional resident charges or accommodation deposits to cover increasing costs and enable the development and maintenance of homes (Ansell Strategic, 2014) (Ernst & Young, 2019).

Similarly, in the United Kingdom, there have been increasing numbers of developments where older people can buy or lease a house or flat in the grounds of a care home, known as 'close care' (Elderly Accommodation Counsel, n.d.). This allows them to move into the main care home if required at a later time.

There is evidence that there may already be a level of consumer demand for similar integrated care models in Australia.

For example, a relatively new provider in Australia operating co-located retirement villages and aged care homes on the same site, advised in their submission that they are in high demand for their continuum of care service offering:

'Although ACFA reports a drop in overall occupancy in residential aged care, this has not been our experience. We remain predominantly full, with extensive waitlists and are under constant pressure to provide sufficient places for our retirement living residents, as they transition to residential aged care.' (sub. 42, p. 7)

The Impact Analysis is also aware of at least one provider in Australia delivering subsidised residential aged care within independent living units. This provider is able to offer their integrated care model because the accommodation is a Class 9c building, under the National Construction Code (NCC)⁴² – which is an aged care building⁴³ under the building code (Australian Building Codes Board, n.d.). The provider is holding a surplus of unoccupied subsidised residential aged care places and this enables people in independent living units to take up one of the places when they transition into residential aged care while remaining in their same room. The person exits the retirement village agreement and enters into a residential aged care agreement for that room. The provider also delivers home care packages to people in independent living units.

Discontinuing the need for allocated places in order to deliver residential aged care can further facilitate models of care which support integrated ageing in place. For example, seniors housing operators who meet the necessary standards could apply to become approved providers and – provided the buildings comply with the appropriate building classification and accreditation for aged care homes – could offer 'full-time professional aged care' to independent living unit residents as soon as it is required. This could mean a shift away from institutional-style residential aged care that has been typically offered to-date. It would also allow

⁴² The National Construction Code (NCC) provides the minimum necessary requirements for safety and health; amenity and accessibility, and sustainability in the design, construction, performance and liveability of new buildings (and new building work in existing buildings) throughout Australia.

⁴³ Defined as residential accommodation for elderly people who, due to varying degrees of incapacity associated with the ageing process, are provided with personal care services and 24 hour staff assistance to evacuate the building in an emergency (under the NCC)

them to make plans and decisions regarding innovative models based on a known number of beds – that is, the number of beds they wish to offer rather than what they might be successfully allocated. This change will also require eligibility for full-time professional care to be prudently and precisely assessed so that funding for subsidised care is directed only to those in need of the various forms of care.

Ryman Healthcare explains:

‘Under the current ACAR model we have no certainty that we will be able to provide the beds we wish to build to offer the continuum of care intrinsic in our model and that consumers desire. We have had limited success in ACAR rounds, where we have sought bed licences for our new developments and have built beds that we are not licensed to occupy. This creates uncertainty that we will be allocated enough beds licences to build to a financially viable scale, and to service our resident population of the Retirement Village.

Due to the extended time frame between ACAR rounds and the prospect we will not receive the desired allocation, we are forced to buy licences on market, which are trading for \$80,000 - \$90,000 per licence. ..This poses a significant upfront cost that is a deterrent when considering whether to invest in a market already showing a poor return on investment.’ (sub. 36, Q. 19)

The Impact Analysis concludes that the places allocation model is limiting the ability or willingness of some providers to innovate and dampening the incentives arising from greater competition. The Impact Analysis has also identified several changes to the regulatory framework that would enhance the benefits arising from Model 2. They include:

- reviewing relevant building regulations – including state or territory regulations relating to fire and work, health and safety and retirement villages
- revising the legislated definition of residential aged care which currently precludes such care from being provided in person’s private home (which can include seniors housing)
- clarifying the scope of additional services so that providers clearly understand where they can differentiate their service offerings beyond specified care and services and boost their income streams to fund innovation.

Any changes to some parts of the regulatory regime would need to be balanced with strengthened regulatory controls in other parts, such approved provider status, prudential risk and the regulation of quality and safety.

Capital grants

Capital grants are currently made available by the government to fund essential capital works (the construction or upgrades of aged care homes) where geographical constraints, significantly higher costs and/or reduced capacity to generate revenue impede the ability of providers to otherwise make such investments (see chapter 2).

Without the ACAR to target the availability of places to particular areas or groups, there is a heightened role for capital grants in supporting equitable access to care. The distribution of capital grants, through a competitive process (as is the case now), would remain a significant policy lever (supported by relevant viability and other supplements) to encourage service delivery to areas or groups that would otherwise be unviable for providers.

As Catholic Health Australia affirms:

‘As is currently the case, the availability of residential aged care services in rural and remote areas and other thin markets and for special needs groups can only be assured through the use of targeted incentives such as viability supplements and capital grants that support investment and ongoing viability.’ (sub. 25, Q. 33)

Under Model 2, capital grants would no longer be tied to providers in defined categories of need who have an allocation of places. Given this, the Impact Analysis concludes that grants should only be allocated to providers who meet the eligibility criteria and can clearly demonstrate their readiness to build or upgrade and provide assurances that they can deliver residential aged care over the long term in accordance with the specifications of the grant agreement once the works have been completed.

Summary of conclusions: criterion 4

The Impact Analysis concludes that Model 2 can result in improvements in responsiveness to consumer preferences:

- through increased competition between providers by removing supply-side constraints and by giving consumers control of the places that are assigned to them

It is also concluded that Model 2 can materially increase growth and investment:

- through new approved providers entering the market and existing providers expanding their service footprint based on their business acumen and access to capital. Given that bed licence values play little part in investment analysis currently, financial institutions will focus financing/lending decisions more directly on the providers' brand, service proposition, equity structure and organisational governance
- through greater provider willingness and ability to innovate by removing the implicit aged care home model that is embedded in the assessment of applications under the current ACAR process, and by opening the market to all providers who can meet approved provider status and operate accredited aged care homes that meet building regulations
- through allocating capital support to providers in defined categories of need who can clearly demonstrate their readiness to build or upgrade, by no longer tying capital grants to those who have an allocation of places and by requiring providers to demonstrate that they can deliver residential aged care as per the specifications of the grant agreement once the works have been completed
- through supplementing the normal market intelligence that providers should be responsible for as part of their business planning by the government being more transparent with its own market-relevant information.

The Impact Analysis also concludes there may be greater scrutiny of investment decisions due to revenue becoming less predictable but notes that the growth of individual providers and financial investment in their businesses will very much depend on the returns and viability of the sector overall, as well as their individual management and ability to present service and accommodation offerings which meet consumer preferences. While the better performing providers will compete successfully, some existing aged care homes that survive under the ACAR arrangements may experience poorer financial performance, either over the medium term or to the level where they exit the sector.

Criterion 5. Transparent and accountable processes

This criterion is assessed from the perspectives of consumers, providers and the government.

Consumers

The assignment of residential aged care places to consumers would be based on a more precise eligibility assessment than currently occurs. The assignment of places to eligible consumers would be transparent and accountable insofar as the needs assessment process provides. Improvements to the assessment process are canvassed in chapter 9.

Transparency and comparability of information about aged care homes, including their vacancies, will be particularly important for Model 2 to work effectively. The publication of real-time information on vacancies as well as detailed information on quality and safety, in easily understood and comparable formats, will be important to support consumer choice and control in finding a suitable aged care home with a vacant bed. 'Service finders' in England (North of England Commissioning Support Unit, n.d.) and New Zealand (Eldernet, n.d.), enable consumers to search for real time vacancies to reduce the time spent contacting homes directly.

Providers

Providers' ability to expand their capacity and enter the market will be based on their business acumen and ability to access capital, and no longer on their success in the ACAR as determined by the department. This aligns with the transparency of other markets.

Estia Health notes that the market analysis should become more sophisticated than the current target ratio approach:

'Model 2 creates a system where providers will identify emerging demand and build in those locales. That notion of demand is not based simply on the number of people over 70 years but rather on an analysis by individual providers of need and preparedness to participate in residential care based on customer research as we would see in other service sectors. We believe the variation in regional health status, family support and the availability of substitute services influences real demand.' (sub. 21, p. 1)

However, not all current providers consider that they have the resources or capability to undertake sophisticated market analysis.

One anonymous service provider observed:

'In a typical competitive market, market intelligence and insight into competitor activity would be expected from participants. However, the low profit margins in the sector and the prevalence of not-for-profit participants means that the capacity to invest in ascertaining the market and competitive position is limited. In this context, the industry requires Government to provide a level playing field with consistent and reliable policy and regulation, so that all participants are equally informed and critical investment decisions can be made with confidence.' (sub. 24, Q. 8)

Without the ACAR process serving as a planning mechanism and providing visibility of the current and future market, providers would need to make investment and growth decisions based on their assessment of consumer needs and market conditions. As noted next, the government also has a role to play.

Government

To support both consumers and providers in making informed decisions in the residential aged care market, the government should have an oversight role. Such a role could include promoting transparency through:

- providing consumers with platforms for information about aged care homes to assist them in finding, comparing and selecting a home that is suitable for their needs and preferences
- monitoring markets for inequities
- targeting capital grants and actively encouraging diffusion of best practice and innovation
- making market-relevant administrative data publicly available to assist providers in identifying areas of greatest need

Summary of conclusions: criterion 5

The Impact Analysis concludes that Model 2 will provide greater transparency and accountability:

- through aligning transparency and accountability with that of a regular market, based on consumers' demands and preferences and providers' ability (e.g. business acumen, capital) and willingness to respond to that demand, by removing the opaque ACAR and places management processes
- through the government facilitating transparency of the market to both consumers and providers in order to support their respective decision making and supporting the effective functioning of the market overall, by playing an active role as market steward.

Revised Model 2

Following analysis of the available evidence, consideration of consultation feedback and assessment against the five criteria, refinements were made to Model 2.

The three significant changes were:

- assigning residential respite places to consumers, separate from permanent residential aged care places (see chapter 9).
- removing the prioritisation requirement for consumers to be allocated places. This entails uncapping the funded number of subsidised residential aged care and respite places.
- combining eligibility approval and assignment of a place, for residential aged care or residential respite care, as a single step

Operation of the amended Model 2 from consumer and provider perspectives

An overview of how the final Model 2 would function from the consumer and provider perspectives is outlined below.

From the consumers' perspective

The eligibility assessment for a consumer to receive subsidised residential aged care or residential respite care under this model would be based on current and foreseeable need, though any consumer who has a change of circumstances would be receive a targeted and limited reassessment of those changes as a matter of urgency.

Once deemed eligible for residential aged care or residential respite care, the consumer would be concurrently and automatically assigned a residential aged care place or a residential respite place.

The consumer can then identify an approved provider who has a vacancy in the consumer's preferred aged care home and be offered that vacancy.

Access to residential aged care or respite care is likely to improve overall given the increased availability of beds (and greater alignment of those places with the preferences of consumers) due to the liberalisation of supply.

From the providers' perspective

In order to deliver and be paid for delivering subsidised residential aged care or residential respite under this model, an organisation must be an approved provider of residential aged care, have an accredited aged care home (as per current arrangements), and have accepted a consumer who has an assigned residential aged care place or residential respite place (as applicable for the care being delivered).

Capital grants would continue to be made available on a competitive basis based on targeted needs but would no longer require the applicant provider to hold allocated residential aged care places.

Chapter 8: Comparative evaluation of the alternative models

This chapter compares the current arrangements for allocating and managing residential aged care places with Model 1 and Model 2. Comparative assessment and scoring was used to determine which model would best meet the key principles outlined in chapter 3. The models are also assessed in terms of whether or not they are complementary to the broad direction of aged care reform.

Any potential reform model must provide material net benefits over and above the current model. If there are risks and complexities, strategies must be put in place to minimise or mitigate their impact and their residual impacts must be at acceptable levels.

Comparison of current arrangements, Model 1 and Model 2

A comparison of the key points of similarities and differences between the current arrangements and two alternative models is presented in table 8.1.

Table 8.1 Comparison of current residential aged care place allocation model and alternative allocation models

	Current model	Model 1	Model 2
Eligibility assessment	Comprehensive assessment by ACAT to determine a person's eligibility for subsidised residential aged care or residential respite care		As per current model – but must ensure assessment is more reflective of current and foreseeable needs and be more responsive to assessing the changing needs of consumers
Allocation of place	<ul style="list-style-type: none"> Places are allocated to providers, either through a successful ACAR application or transfer/acquisition from another provider outside of the ACAR Conditions of allocation exist for some allocated places to target specific need, including residential respite care Residential respite care is delivered via respite care allocation (linked to residential aged care places) Allocated places can be moved or transferred within the state or territory, subject to 	<ul style="list-style-type: none"> Places are allocated to providers, through a successful ACAR application Outside of the ACAR, places can only be transferred to another provider under certain unavoidable circumstances Conditions of allocation exist for some allocated places to target specific need Providers can offer residential respite care within their residential aged care place allocations Allocated places can be moved within the state or territory, subject to 	<ul style="list-style-type: none"> Places are assigned to consumers once assessed as eligible An allocation of residential aged care places is no longer required for approved providers to deliver subsidised residential aged care or residential respite care

	Current model	Model 1	Model 2
	departmental discretion	departmental discretion, with an emphasis on protecting thin markets	
Consumer choice of aged care home	Eligible consumer can choose and apply for entry to any approved provider's aged care home that has an available allocated place		Consumer with an assigned place can choose and apply for entry to any approved provider's aged care home with a vacancy
Funding	<ul style="list-style-type: none"> Subsidies and supplements paid to providers Capped number of funded places 		<ul style="list-style-type: none"> Subsidies and supplements paid to providers Uncapped number of funded places

Comparative assessment against key principles

A comparative assessment of the status quo and final form of the alternative models against each of the following key principles is presented at table 8.2.

1. Choice and competition

The extent to which the model would provide greater consumer choice and control over their residential aged care in a more market-based and competitive, though regulated, environment

2. Quality and safety

The extent to which the model would drive outcomes for quality and safety in residential aged care that meet or exceed approved standards

3. Timely and equitable access

The extent to which the model would facilitate timely and equitable access to subsidised residential aged care and respite services for those in need, including in instances of thin markets

4. Growth and investment

The extent to which the model would facilitate a residential aged care sector that has continued growth and financial investment which responds to consumer demand and changing preferences

5. Transparency and accountability

The extent to which the model would have transparent and accountable processes

Table 8.2 Summary scoring of the alternative models against the key principles relative to status quo

Key principle	Status quo	Relative performance and scoring of models
1. Consumer choice and competition	a) Allocation of places to providers means control is not held by consumers	<u>Model 1 (+)</u> a) No change b) No change c) Possible small increase in number of operational places, through management initiatives to reduce the number of offline places and increase visibility of remaining offline places which in turn may lead to more places released in ACAR
	b) ACAR does not necessarily allocate places to providers or locations preferred by consumers c) Cap on places sustains high occupancy levels for many providers across majority of regions irrespective of their performance. Capped supply reduces choice of, and competition between, aged care homes	<u>Model 2 (++)</u> a) Control held by consumers b) Numbers and locations of beds and diversity of supply will be determined by the market in response to consumer demand and preferences c) Uncapped supply should increase choice of, and competition between, aged care homes over the medium term
2. Quality and safety	a) Suitability of the provider applicant, including their service proposal, is competitively assessed	<u>Model 1 (+)</u> a) No change b) Includes consideration of consumer satisfaction indicators (bias to existing providers) c) May incentivise providers to improve consumer satisfaction, noting this may not always equate to quality and safety improvements
	b) Minimum quality check (must not have active sanctions, and non-compliance issues are also considered) as part of competitive assessment c) Minimum quality requirement to qualify for places, coupled with restricted competition, does not incentivise providers to improve quality and safety beyond approved standards.	<u>Model 2 (+)</u> a) Suitability check is removed and service proposals are subject to competitive scrutiny by consumers b) Minimum quality check is removed but approved provider status check is strengthened c) Increased competition should drive improvements in quality and safety, provided that regulatory oversight is maintained and consumers can differentiate and choose aged care homes based on quality and safety performance.
3. Timely and equitable access	a) Eligible consumers can enter an aged care home (not necessarily preferred home) within a reasonable timeframe	<u>Model 1 (+)</u> a) Modest improvements to timely access, via possible small increase in number of operational places through offline places management initiatives

Key principle	Status quo	Relative performance and scoring of models
	<p>(longer in remote and very remote areas)</p> <p>b) Encourages but does not guarantee equitable service provision in thin markets</p> <p>c) Availability of residential respite is determined by provider's business model, and restricted by respite days allocation</p>	<p>b) Improvement to equity of access for special needs groups, via following-up on priority of access conditions, and tighter controls on movement of places in thin markets</p> <p>Important that funding levels recognise higher costs of service delivery in thin markets</p> <p>c) Improvement to respite access, via removing current minimum and maximum allocation conditions</p> <p><u>Model 2 (++)</u></p> <p>a) Eligible consumers can more readily enter a preferred aged care home within a reasonable timeframe as supply-side controls are removed</p> <p>b) Specialist aged care homes can expand their capacity without need to acquire places, which may improve equity of access. Less significant changes in access in outer areas likely.</p> <p>Important that funding levels recognise higher costs of service delivery in thin markets</p> <p>c) Improvement to residential respite access, as providers can deliver respite to any eligible consumer</p>
4. Growth and investment	<p>a) Providers cannot easily re-locate existing places or obtain new places (capped supply) in response to changes in consumer demand.</p> <p>b) Responsiveness and growth is also limited by inappropriately high numbers of non-operational places, including some longstanding and some not visible</p> <p>c) The ACAR process itself does not encourage innovation, and appears to be more difficult for new entrants to satisfy.</p> <p>d) Mixed views on whether or not ACAR creates certainty and therefore supports investment environment</p>	<p><u>Model 1 (+)</u></p> <p>a) No change</p> <p>b) Offline places management initiatives may lead to increased number of operational places</p> <p>c) Expanded focus on innovation in ACAR, which may support some new entrants</p> <p>d) Modest improvement in providing certainty of investment decisions, due to published ACAR schedule</p> <p><u>Model 2 (++)</u></p> <p>a) Wider range of approved providers can flexibly expand and respond to consumer demand and preferences, as not restricted by allocated places</p> <p>b) Non-operational allocated places no longer exist, as concept of allocated places ceases</p> <p>c) Increased competition and incentives for efficiencies may encourage innovation</p> <p>d) Investment and financing decisions will be made on the same basis as other markets. Reducing supply-side controls, including uncapping places,</p>

Key principle	Status quo	Relative performance and scoring of models
		may reduce the predictability of revenue, which may lead to increased scrutiny of investment and financing decisions and reduce financial results of poorly performing aged care homes
5. Transparency and accountability	<ul style="list-style-type: none"> a) Irregular timeframes of ACAR, not communicated in advance prior to 2020 ACAR, and short application period b) Limited consultations to inform ACAR, including priorities and places – though improved for 2020 ACAR c) Movement of places and basis for ACAR allocations not publicly communicated d) Secondary market for places that can bypass intent of ACAR e) Limited accountability relating to conditions of allocation f) Limited visibility of offline places 	<p><u>Model 1 (+)</u></p> <ul style="list-style-type: none"> a) ACAR held at regular and known intervals b) More extensive consultation during ACAR planning phase c) Publication of criteria and activity relating to movements and transfers of places. More transparency about the basis for successful allocations in ACAR d) Restrictions on the secondary market for transfer of places. e) More active monitoring and requirement to fulfil priority of access conditions f) Increased monitoring and reporting of offline places <p><u>Model 2 (++)</u></p> <ul style="list-style-type: none"> a) No longer an issue, as no ACAR b) Role of government as market steward in providing market information to support decision making of consumers and providers c) Approved providers' ability to offer subsidised residential care would be more dependent on their business acumen and access to capital (itself dependent on proven capacity to deliver services and accommodation which met consumer demand and preferences) d) No longer an issue, as no ACAR e) No longer an issue, as no ACAR f) No longer an issue, as no ACAR

Legend

+ represents that this model would improve in this principle relative to the status quo

++ represents that this model would improve this principle relative to the other model

Complement reforms to residential aged care and aged care more broadly

Chapter 3 explains the aged care reform pathway, commencing with the Productivity Commission 2011 Report *Caring for Older Australians*. The chapter notes that the Aged Care Sector Committee, comprising the sector's key leaders, published its 2016 *Aged Care Roadmap* which:

'sets out the path to a system where people are valued and respected, including their rights to choice, dignity, safety...and quality of life... have access to competent, affordable and timely care and support services through a consumer driven, market based, sustainable aged care system.' (Aged Care Sector Committee, 2016) (p. 3)

Model 1

The changes to ACAR proposed under Model 1 do little to progress the overall reform of aged care services. The administration of the residential aged care sector would still place the focus on providers who were successful in being allocated places through ACAR. Providers would be seen as continuing to have control over places.

Providers who were not preferred by consumers, but who had places within the supply-constrained system, would likely continue to enjoy high occupancy and therefore have little incentive to respond to consumer demands and preferences or increase standards of quality and safety above the regulated minimum.

Model 2

The structural reform proposed under Model 2, centred on ceasing ACAR for subsidised residential aged care, is consistent with the pathway set out in independent reviews and policy reform guidance over the past decade. It represents an important move towards a more consumer driven, market based arrangement which remains underpinned by a strong and proportionate regulatory foundation.

In the Productivity Commission's 2011 Inquiry Report, Recommendation 7.1 was that:

'The Australian Government should remove regulatory restrictions on the number of community care packages and residential bed licenses...' (Productivity Commission, 2011) (Volume 1, p. LXIV)

The Aged Care Roadmap 2016 put forward an overarching destination of:

'a consumer driven, market based, sustainable aged care system.' (Aged Care Sector Committee, 2016) (p. 2)

This was similarly echoed in the Aged Care Legislated Review which outlined a desired future of an uncapped, consumer demand-driven system:

'in which the quantity and types of consumer demands for care drive the size and shape of the aged care system'. (Tune, 2017) (p. 34)

The Legislated Review recommended the discontinuation of the ACAR for residential aged care and the assignment of places directly to consumers within the cap (recommendation 3).

Summary and recommended alternative model

Opportunities

It is evident from the comparative evaluation that Model 1 offers incremental improvements to the status quo, but ultimately retains supply-side controls and a government-managed market. Model 2 removes supply-side controls, which would shift residential aged care to a more market-based system that is centred on consumer choice and control while retaining a strong and proportionate regulatory underpinning – consistent with broad reform directions put forward to-date. Accordingly, Model 2 offers greater opportunities for improvements across the key principles relative to both the status quo and Model 1.

Complexities and risks

Greater opportunities do, however, entail more complexity and risk.

- The greatest risk of Model 1 is that it may achieve only minimal improvements over the status quo and yet be represented by some providers as demonstration that they have accepted the challenge

of being more responsive to consumer demands and preferences. This would be a misleading claim and may result in reform complacency.

- Model 2 presents greater complexities that are inherent with more significant structural change. Importantly, these changes cannot, alone, drive the necessary improvements in consumer choice of provider, equity of access, quality and safety, growth and investment, and transparency and accountability without improvements in other supporting mechanisms. Necessary sequencing with other requisite reforms and complementary regulatory mechanisms is discussed in detail in chapter 9.
- The specific risk to the fiscal sustainability of residential aged care has been closely assessed by this Impact Analysis. As set out in chapters 2 and 7 in detail, the Impact Analysis concludes that uncapping supply is unlikely to negatively affect the Budget's outlays on residential aged care over the next two decades at least, based on current policy settings (the target provision ratio).

The Impact Analysis, based on this comparative assessment, concludes that Model 2 offers the best alternative to the existing places allocation model. This includes its ability to achieve the key principles at a level which is above and beyond the status quo and Model 1, and the risks arising from its associated complexities being able to be mitigated with appropriate sequencing.

Chapter 9: Transition to a more consumer-led residential aged care sector

The Impact Analysis has concluded that a more consumer-led residential aged care sector (Model 2) has the greater benefits relative to either Model 1 or the status quo, as well as manageable risks (chapter 8). This chapter follows by considering the sequencing of reforms required to transition to the new arrangements.

The chapter outlines why, how and when several of the related changes to the aged care arrangements should occur before, or concurrent with, the transition from ACAR to the assignment of subsidised residential aged care places to eligible consumers. Importantly, many of these reforms will, of themselves, lead to significant improvements in the delivery of aged care services. They focus on better care for consumers, on allowing consumers to make meaningful decisions about their care journey, and on ensuring a sustainable sector.

In considering the evidence available, and the submissions from stakeholders, the Impact Analysis has concluded that there are six significant initiatives that need to be considered in the transition phase:

1. Strengthening the approved provider assessment, including introducing reassessment requirements
2. Developing the reforms to residential aged care funding to replace the Aged Care Funding Instrument (ACFI)
3. Reforming the assessment of consumer eligibility to better reflect current and foreseeable needs and be more responsive to assessing the changing needs of consumers
4. Clarifying the scope of additional services
5. Improving information and support available to consumers and information available to providers and government
6. Developing a residential respite care program which is attractive to both consumers and providers (as a business model in its own right).

The Impact Analysis also notes several other considerations that should be undertaken in order to maximise the potential opportunities under Model 2.

1. Approved Provider status

Under the current ACAR arrangements there are four key layers of oversight regarding the suitability of aged care homes and their operators (approved providers) and the extent of the government's fiscal exposure to subsidised residential aged care:

1. allocation of a capped number of subsidised places
2. granting of approved provider status to providers who seek allocated places
3. accreditation of aged care homes
4. assessment of consumers of aged care services as being eligible for subsidised residential aged care.

The replacement of ACAR with the assignment of uncapped subsidised places to eligible consumers removes the first of these layers. In so doing it could allow the expansion of full-time care in a range of accommodation settings while being cognisant of the potential to expose the government to a measure of fiscal risk. As such, this change elevates the importance of the approved provider regulatory mechanism, alongside other mechanisms including the monitoring of the financial viability of providers and their prudential compliance, the accreditation/re-accreditation of aged care homes, and the assessment of consumers as being eligible for subsidised permanent and respite residential aged care.

To provide government-subsidised aged care under the current arrangements, an organisation must first become an approved provider (see chapter 2). Approved providers are required to continue to meet the suitability criteria in order to maintain their approved provider status (Australian Government Department of Health, 2019d). However, this status is not, at present, subject to ongoing scrutiny as there is no scheduled formal departmental review once the status has been attained. Whilst *the Aged Care Act 1997* requires an approved provider to notify the department (since 1 January 2020, the Aged Care Quality and Safety Commission) of a material change that affects its suitability within 28 days of the change occurring, there is a reliance on the approved provider to self-report.

Accordingly, before changing the allocation model, the Impact Analysis considers that changes are required to enable the approved provider status to be closely monitored and regularly reviewed.

As Eldercare put it:

‘Ensure that the approval process for gaining “approved provider status” is rigorous from a financial viability point as well as the provider being able to demonstrate that they can meet consumer needs and expectations. It should not be a “given” that a provider is able to obtain approved provider status. This status should then be regularly reviewed using transparent assessment criteria (different from accreditation).’ (sub. 20, Q. 14)

As a trigger for the regulator to reassess an organisation’s approved provider status (in concert with other existing regulatory oversight mechanisms), the Impact Analysis considers that providers be required to notify the regulator when planning to:

- operate new aged care homes (whether it be through construction, merger or acquisition), or
- expand an existing aged care home by a material proportion (such as an increase in capacity by one third or more).

The review of approved provider status should be complemented by the following existing regulatory mechanisms:

- assessing the quality of new services (accreditation) and existing services (re-accreditation).
 - The Aged Care Quality and Safety Commission accredits residential aged care services to assess the quality of care and services delivered by approved providers against the Aged Care Quality Standards. This process includes accreditation of commencing services and the re-accreditation of accredited or previously accredited services via the conduct of site audits.
 - Accreditation is supported by monitoring the quality of care and services provided by accredited aged care homes through assessment contacts and review audits.
 - If a provider is not meeting its legislative obligations, the department may take regulatory action, including imposing sanctions⁴⁴.
- assessing the financial viability of the organisation.
 - Approved providers are responsible for exercising sound financial management.
 - In cases of serious financial mismanagement, the department can take action to revoke an approved provider’s status to provide aged care.
 - Oversight and proactive identification of providers who have severe financial viability concerns will also be key to ensuring managed transition and continuity of care arrangements. This also needs to be paired with initiatives to strengthen prudential standards that are underway to reduce the risk of calls on the Accommodation Payment Guarantee Scheme.

⁴⁴ A range of sanctions can be imposed on an approved provider including revoking or suspending approval as a provider of aged care services and restricting approval to provide aged care services.

Implementation sequencing and timeframes

From 1 January 2020, the responsibility for determining whether to approve an applicant to become an approved provider, and to receive notification of a material change, transitioned to the Aged Care Quality and Safety Commission. This provides an opportunity for the independent regulator to ensure the regulatory mechanisms are robust, coordinated and complementary prior to moving to Model 2.

The department has advised that initiatives to strengthen prudential standards and more closely monitor financial management and governance are also under development.

A period of two years should be sufficient for these matters to be concluded and operational.

2. Reform of the residential aged care funding model

To support the ability of Model 2 to drive improvements in consumer access to care and sector growth, income streams (from subsidies and consumer contributions) will need to adequately reflect the costs of service delivery, including in thin markets. While replacement of the current ACFI is necessary regardless of reform to the places allocation model, funding reform would enhance provider acceptance of the greater opportunities under Model 2 to expand their operations to respond to the diversity of consumer demands, preferences and locations.

In recognition of the need to replace ACFI, a Resource Utilisation and Classification Study (RUCS) was completed in December 2018 (Australian Government Department of Health, 2019f).

The shortcomings in the existing ACFI model were described as follows:

‘There have been substantial changes in the profile of people entering residential care, partly due to the success of programs to enable them to stay at home as long as possible. Residents are older (half are aged 85 and over on entry) and frailer, with an annual mortality rate of around 32%. Reflecting this profile, half of those entering residential care will be there for two years or less.

The Department and providers have both experienced issues of funding uncertainty, instability and inequity in recent years... as a result of the changing profile of residents, the ACFI no longer satisfactorily discriminates between residents in terms of what drives the costs of delivering care.’ (Eagar, et al., 2019) (p. 2-3)

Stakeholder responses to the Impact Analysis Discussion Paper argued that funding levels needed to recognise the differential costs of, and provides incentives for, service delivery in particular locations or to particular consumers.

Estia Health supported Model 2 and said discontinuing the ACAR should be accompanied by:

- a) strong incentives to maintain specified levels of supported residents across the approved providers portfolio, which when balanced with higher means and capital contributing residents would still deliver a sustainable financial outcome for providers;
- b) an appropriate differential pricing regime for remote and regional areas would result in providers giving equal assessment to the provision of services and homes in such locations and remove the necessity to cross subsidise these areas. (sub. 21, p. 3)

Leading Age Services Australia (LASA) also contended:

‘A market based approach may actually be more responsive to some niche markets than administrative allocations, but there is a real risk that, over time, commercial realities may result in the needs of some older Australians not being met.

Other mechanisms also act to support supply to vulnerable groups, but relying solely on these mechanisms would be risky, particularly in the absence of a rigorous approach to measuring vulnerability and unmet need.

Serious problems regarding both the quantum and allocation of existing funding structures make it problematic to proceed with reforms to encourage greater competition given that competition

would be occurring on the basis of funding mechanisms that have been identified as in need of reform.’ (sub. 44, p. 5-8)

Eldercare set out their views on the importance of a sound funding model in supporting equity of access:

‘Equitable access is best supported via the funding model to ensure that the consumer is able to purchase the care they need. Providers are in a commercial, highly regulated environment where business decisions regarding resident mix must be considered to ensure that the facility is able to provide appropriate levels of care for the cohort of residents within the facility. The risk of getting this wrong does result in serious financial consequences for providers, for example accreditation issues which may result in financial and long-term reputational risk... The only way to encourage support to improve equity in the current system is to provide financial incentives.’ (sub. 20, Q. 26)

This Impact Analysis noted earlier that the current ACAR has sought to play a role in meeting the diverse needs of consumers and those living in non-metropolitan locations. As indicated in chapter 5, however, the ACAR is not necessarily the most effective means of achieving these objectives:

- In relation to consumers with special needs, there has historically been no follow up audit of whether places allocated to providers with priority of access conditions for special needs consumers are being used for these purposes. However, it is noted that the department has recently committed to monitoring the conditions of allocation for special needs groups.
- In relation to the location of residential aged care, the decisions of providers as to whether they operate in rural, remote and other challenging areas is much more dependent on whether they would be financially viable on a sustainable basis, rather than whether they were allocated places. Mandating that places be allocated to, and remain in, a location – irrespective of remoteness – does not ensure their construction and operation.

As now, the funding model will need to reflect costs of care for different groups and different locations, to encourage providers to establish services which meet their needs. It is expected that these requirements will be, in part, met in the new funding model – the Australian National Aged Care Classification (AN-ACC) that is now being trialled (Australian Government Department of Health, 2019f).

The RUCS, which informed the development of the AN-ACC, made a number of recommendations that are important in ensuring that the allocation of places to consumers supports the equitable delivery of care to all consumers. These include setting the reference price for subsidies each year at a level that reflects costs:

‘Under the proposed new funding model, the government makes an annual determination about the funding (price) of NWAU [National Weighted Activity Unit] of 1.00. This price is standard across both the fixed and individualised components. All prices in the funding model are then set relative to this annually determined NWAU price. In the national hospital funding model, this price is termed the National Efficient Price (NEP). Following the precedent already established in the national hospital funding model, there needs to be an explicit relationship between cost and price [in aged care].’ (Eagar, et al., 2019) (p. 20)

The AN-ACC model includes a base care tariff that varies according to several proven key drivers of the cost of shared care for everyone using the service: location; the size of facilities where they are in remote locations; specialised Indigenous services where they are in remote locations; and specialised homelessness services. However, the higher hotel costs⁴⁵ of aged care homes in remote and regional areas were outside of the scope of the AN-ACC model (as the costs were not care-related) so are not reflected in the base care tariff. Further, the AN-ACC currently proposes that in respect of remote aged care homes (i.e. Modified Monash Model MMM 6 and 7), the base care tariff should be payable on operational places (regardless of whether occupied or not).

If the concept of operational places ceases, as proposed under Model 2, there would need to be a process to determine the funded operational bed capacity of these homes. The department already undertakes a

⁴⁵ Non-care related costs of providing accommodation within an aged care home, including catering, cleaning, laundry, maintenance and utilities.

related process when determining its funding of aged care in Multi-Purpose Services. It is noted that the department also commissioned a further study on the fixed costs of providing care in residential aged care in regional and rural Australia and accepted the final report in October 2019. As such, the Impact Analysis considers that these remaining issues in respect of non-metropolitan aged care homes should be resolved as part of the funding model reform.

The AN-ACC model also includes an individualised care tariff that responds to a number of the proven variables affecting the cost of delivering care to different people. The range of variables includes palliative care needs, cognitive ability, vulnerability to pressure sores and mobility. However, it is possible that the AN-ACC does not currently fully reflect all costs relating to the provision of residential aged care to consumers with particular characteristics (McNamee, et al., 2019). Currently, there are supplements payable in respect of consumers who are veterans or require administration of oxygen or enteral feeding, but for these items there were insufficient consumers in the RUCS sample to fully understand the costs and therefore recommend a funding approach under the AN-ACC model. Similarly, residential respite care was not in scope for the RUCS, so the true costs of residential respite care are also not fully understood. It is noted that the RUCS suggested that supplementary studies on these elements be undertaken (Eagar, et al., 2019).

The funding model and reference price to be applied under the AN-ACC model will be critical to the sector achieving both adequate subsidies for the care of all eligible consumers whatever their needs, as well as a distribution of funds that reflects the costs of care whatever the location. However, as previously covered, there are still several factors that may be contributing to higher costs of residential aged care in certain areas or to certain types of consumers that were not examined in the original RUCS and therefore are not fully addressed in the AN-ACC model. The Impact Analysis considers it important that these costs are addressed, in order to ensure the new funding model is comprehensive in reflecting the true cost of residential aged care in all locations and for all consumers.

[Implementation sequencing and timeframes](#)

The Impact Analysis considers that transition to the Model 2 places assignment system needs to be cognisant of progress on the development of the new funding model in order to maximise opportunities for improving consumer access and sector growth. By better reflecting the true differential costs of residential aged care, this should support provider willingness to offer services across the range of consumers and locations.

The department advises that there are substantial lead-times associated with the introduction of a new funding model. Changes would be required to legislation, IT systems (both government and provider) would need to be updated, an external assessment workforce procured and trained, and aged care providers would need time to consider and prepare for the impacts of the changes on their business. These considerations suggest that the implementation of a new funding model could occur between 18 months and two years after a decision is made by Government.

The Impact Analysis considers that Model 2 can come into effect once the parameters of the new funding model are more reliably known. The trial of the AN-ACC model underway is expected to complete in June 2020, which then should enable sufficient understanding of those parameters. If the government announced the replacement of ACAR with the assignment of subsidised residential aged care places to eligible consumers in 2020, and gave two year's notice for the arrangements to come in to effect, that would suggest a date of 2022. Given the long lead times to establish new residential aged care capacity (e.g. construction of new, or expansion of existing, aged care homes), there will be little practical market impact of the changes in the first four years until new capacity comes on stream. This should allow for a new funding model to be in place before the practical market impacts of Model 2 become evident from 2026 onwards.

It is acknowledged that the sector's viability issues – particularly in thin markets – would not be addressed by a new funding model at the time Model 2 commences. This may reduce the immediate ability of the sector to take-up the expansion and construction opportunities afforded by Model 2. A targeted funding boost could be made available at the same time as the commencement of Model 2 in order to support and

incentivise construction of new capacity in thin markets where the effects of removing supply-control will be slower to emerge. For example, this could include the awarding of capital grants (without the need for an allocation of places, see chapter 7) to approved providers that best demonstrate their ability to viably deliver appropriate residential aged care in regional, rural and remote areas or to consumers with specialised needs for the grant period (up to 20 years).

3. Assessment of consumer eligibility for a subsidised residential aged care place

The effective and equitable assignment of subsidised residential aged care places requires an accurate eligibility assessment process that focuses on a consumer's current and foreseeable care needs, supported by timely reassessments when there are material changes to those needs. The robustness of process, and its consistency and integrity over time and across the nation is necessary to deliver optimal and equitable care to individual consumers, to ensure that eligibility for full-time professional care is prudently and precisely assessed so that funding for subsidised care is directed only to those in need of the various forms of care, and to ensure the efficient planning, funding (including government budgeting) and delivery of each subsidised care type on a local and national scale in response to anticipated demand.

Currently many consumers are assessed by ACATs as being simultaneously eligible for both home care and residential aged care. Around 70 per cent of people assessed as eligible for residential aged care in 2017-18 were also assessed as eligible for home care at the same time. Similarly, as at 30 June 2019, almost 70 per cent of people who were awaiting a home care package at their approved level were also assessed as eligible to access residential aged care (Australian Government Department of Health, 2019e).

Dual approvals have a role to play. They can ensure that people whose care needs increase while waiting for a package can go straight to residential aged care if that becomes necessary, without being reassessed, and it can also provide choice of care types for the consumer. However, the high level of dual approvals under current arrangements provides little understanding of the likely demand for residential aged care, either in aggregate or in local areas.

Importantly, if the caps on the number of subsidised permanent residential aged care places and residential respite places are removed under Model 2, the assessment must play an even greater role in ensuring that only those who are eligible are assigned a subsidised place and that budget expenditures can be accurately forecast. To that end, a more accurate assessment of care need (differentiating between whether or not full-time professional aged care is required either at the time or in the foreseeable future) and responsive reassessment to changes in need will be critical. The Impact Analysis considers that this approach should be integrated into the new aged care assessment arrangements to be undertaken by a new single assessment workforce.

It is noted that greater precision in, and frequency of, assessments may increase overall costs, but not to the extent some stakeholders have predicted. The initial assessment of a consumer's needs should be a full assessment. Where a person is assessed as requiring home care, the report could also record that this is conditional on the availability of significant support that was making home care possible. Any loss of this support, or significant deterioration of the eligible person's own condition, would trigger a supplementary short-form reassessment, including the need for either a higher level package or full-time care. As such, the reassessment need not be as resource intensive as the initial assessment or overly burdensome for the consumer.

Implementation, sequencing and timeframes

The Impact Analysis considers that sufficient changes need to be made to the assessment process when introducing Model 2 such that there is a reasonable level of confidence in estimating the number of eligible consumers requiring residential aged care at any one time and, in turn, enabling the planning, funding and delivery of residential aged care to be managed appropriately.

The department has advised that new aged care assessment arrangements will commence from April 2021. A single assessment workforce and network of assessment organisations will be created which can undertake all aged care assessments. The new arrangements are intended to reduce duplication and inefficiency and help people connect to the care they need in a timelier manner. An assessment workforce

will be selected through a national tender process which will commence from April 2020. Existing assessment arrangements and the delivery of aged care assessments by the existing assessment workforces will continue until the commencement of the new arrangements in April 2021.

Verifiable Key Performance Indicators will need to be built into the new contracts to ensure that the new workforce is held accountable for undertaking accurate assessments based on current and foreseeable need and that the contractual arrangements allow for timely and responsive short-form reassessments. It is noted that further changes will be required with the introduction of the AN-ACC funding model.

4. Additional services

Currently, providers may charge additional fees for 'other care or services' that are beyond the minimum care and service requirements where the consumer receives a direct benefit or has the capacity to take up or make use of the services. The charging of fees for additional services to those consumers who wish to receive them had been progressively superseding the older less flexible model of 'extra service' (see chapter 2). However, due to the current uncertainty among stakeholders around what services are 'additional', including the scope for charging additional fees (such as whether additional fees can be mandatory at the discretion of the provider), there have been suggestions that the relevance of extra service status (ESS) remains in limbo.

As Catholic Health Australia noted:

'The expectation was that the other incentive for having extra service status, fees for extra services, would be accommodated within existing arrangements allowing providers to charge fees for services that are additional to those described in the Schedule of Specified Care and Services. However, the latter has proved problematic because the regulations governing the latter are uncertain at best, and are also more restrictive than those that apply for additional services in facilities with extra service status.

So the relevant question in this context is not so much how to manage extra service status under Model 2, but how to clarify and improve the regulations currently governing the charging of fees for additional services in non-extra service facilities so that they allow providers flexibility to be more responsive to consumer expectations.

The future value of extra service status will therefore be determined by policies on fees for additional services. If the latter is appropriately addressed, the earlier trend for providers to phase out extra service status services is likely to resume.' (sub. 25, Q. 39)

One of the reasons for giving greater certainty to the scope and charging of additional services is that in an environment where consumers are assigned places, providers will be wishing to compete for consumers by, in part, offering different types and levels of additional services.

For example, an anonymous service provider wrote:

'There is significant regulatory uncertainty regarding the use of additional services fees that discourage many providers from differentiating their offerings.' (sub. 27, p. 7)

The current lack of clarity around additional services regulation was raised at the consultation forums. Stakeholders argued that greater clarification was needed, possibly through guidelines, and/or through deregulation including of fees. The key objective is to allow providers to respond to the more market-like conditions, and to differentiate their offerings. Many stakeholders suggested the replacement of extra service with the more flexible additional services model, once the latter model has been clarified. The department has advised that it continues to work closely with providers and consumer groups to improve understanding and transparency around additional services and their fees.

Implementation sequencing and timeframes

The Impact Analysis considers that greater regulatory clarity around additional services and the removal of ESS is desirably implemented at least at the same time as removing ACAR. This would provide a consistent basis on which providers can differentiate their additional service offerings, from which consumers can choose, and providers can better position their business models in a more competitive market. However, it

may be sufficient if there was evident progress in clarifying the regulation of additional services and phasing out ESS, and confidence that it would be finalised in a timely manner.

5. Consumer and provider information

For consumers

For consumer choice to be effective in any market-based environment, consumers must have available to them meaningful and timely information that allows them to discriminate between alternative products or services and to reliably select the service that best meets their needs and preferences. A lack of such information not only adversely affects the consumer, it also deprives providers and other parts of the market of the signals that help guide service offerings and investments overall.

The ability to exercise choice is particularly challenging in aged care. The circumstances of entry to an aged care home is that it often occurs at a point of crisis, either through a person's adverse health event or a change in their care environment. Timeframes can be short, the administrative and financial arrangements are complex and most intending consumers and their families or carers know little about the quality and cost of services and accommodation offered by providers. This is a new purchase experience and is unlikely to be repeated by that resident (noting that only 10 percent of residents currently change aged care homes – see chapter 2). Accordingly, the incentives on providers are to attract that initial consumer choice, but equally there may be less incentive than in many markets to retain the consumer's loyalty. It is noted that opportunity for choice and competition may bring inherent risk of anti-competitive behaviour among some providers, including exploiting potentially vulnerable consumers or their families at a time of crisis. It will be important to reduce information asymmetry by equipping consumers and their families with appropriate information, educational material and support to exercise informed choice of aged care home, in a format that can be easily understood, including in crisis situations.

Addressing information asymmetry and ensuring appropriate navigational and decision-making supports for consumers, including for those who are vulnerable or with diverse needs, will be paramount for an effective market experience. Information, even if available, can have a limited impact depending on the circumstances of the consumer. The United Kingdom (UK) Competition and Markets Authority (CMA) examined residential aged care across the UK and found that:

'low expectations and pressure to make decisions quickly meant that people were often willing to accept the first home that was 'good enough'. We consider that this behaviour, combined with a lack of transparency on fee rates, has the effect of dampening competition on price and quality.' (Competition and Markets Authority, 2017) (p. 38)

The CMA's research showed that people found the UK system complex, difficult to understand, and they were often unaware of sources of information that were available (Competition and Markets Authority, 2017).

In Australia, departmental evaluation of My Aged Care has indicated that, overall, consumers had a positive view with the way My Aged Care allows older Australians to access quality aged care services. Almost three in four (72 per cent) indicated some degree of satisfaction and only 14 per cent were dissatisfied with My Aged Care (AMR, 2019). The Royal Commission has called a number of consumer witnesses who were dissatisfied, leading the Commission to note in its interim report that:

'...My Aged Care is still no substitute for local knowledge and face-to-face interactions...Seven years after its introduction, My Aged Care is not delivering the vision ... of seamlessly allowing people to navigate the aged care system. The Royal Commission will give further detailed consideration to the future of My Aged Care, including the need for appropriate local infrastructure and comprehensive information, in the next phase of its work.' (Royal Commission into Aged Care Quality and Safety, 2019) (p. 130)

For residential aged care there is a range of information that should be central to consumer decisions. The 'Find a provider' tool on the My Aged Care website allows people to search and compare residential aged care providers, including information on location, quality (sanctions and non-compliance), specialisations, room details and costs. However, stakeholders have noted scope for improvement.

COTA Australia stressed that the reform of the available information was necessary to support consumer choices:

‘COTA Australia strongly believes in the need for the compulsory provision of information in a much more comprehensive, comparable and transparent way than is currently done by most providers; and a staged timetable for implementation of this (some things can be done immediately, others will need development). This is an essential step in equipping consumers and their families or other informal carers with information sufficient for them to narrow down choices for service provision on a more level playing field.’ (sub. 34, Q. 25)

Providers raised some of the same issues as consumers about information.

Leading Age Services Australia (LASA) said:

‘While work to develop stronger support for ‘care navigation’ is underway there is still significant work to do. Similarly, performance indicators that consumers could use to compare providers are not available – and the narrow set of non-risk adjusted clinical indicators that have recently been made mandatory are unlikely to be particularly useful for this purpose.’ (sub, 44, p. 8)

Many other reports have drawn similar conclusions, including those by the Productivity Commission (Productivity Commission, 2011), the Aged Care Sector Committee (Aged Care Sector Committee, 2016) and the more recent Review of National Aged Care Quality Regulatory Processes (Carnell & Paterson, 2017). However, further improvements are in prospect. As noted in chapter 2, from July 2020, aged care homes will have their differentiated performance ratings, as assessed against the Aged Care Quality Standards, published on My Aged Care. It will include an overall service compliance rating; performance metrics against each of the Aged Care Quality Standards; easy to read audit reports, and the outcomes of consumer satisfaction interviews (Consumer Experience Reports). Further, service ratings will be able to be compared to other services on a regional basis.

A significant exception is information on vacancies, which is not collected by the department. Given allocated places would no longer exist, the collection of real-time information on vacancies will be important to support consumer choice and control in finding a suitable provider with a vacant place to reduce the time spent contacting homes directly.

Another initiative to assist consumers is the aged care system navigator trials, which are testing different ways to help people understand and engage with the aged care system. The trials are intended to help people who have difficulty engaging through the existing channels and who need additional support to understand, choose and access aged care services. There is a focus on people from special needs groups, people living with dementia and those who may lack trust in the system or face specific barriers in accessing services or effectively exercising individual choice. The trials are scheduled to conclude in June 2020 and are being evaluated to inform decisions about how to best support people to navigate aged care.

The Government has also announced a further \$10 million for Culturally and Linguistically Diverse consumer-specific navigator services (The Hon Ken Wyatt AM MP, Former Minister for Senior Australians and Aged Care, 2019) - design is underway for this additional service.

Another source of information is the National Aged Care Mandatory Quality Indicator Program, which is supporting the use of three clinical indicators. However, reporting of these to government only became mandatory in July 2019. The program’s first objective is that providers have robust, valid data to measure and monitor their performance and support continuous quality improvements. However, it is not yet developed to the extent that the data for individual providers is available to consumers. Accordingly, its second objective of giving consumers transparent, comparable information about quality in aged care to aid in decision-making has not yet been met. The department has not published a timeline for when this will be available to consumers, nor a plan to extend the system beyond those indicators to include quality of life measures, although it is understood that the department considers the program will develop over time.

For providers

Government (in partnership with peak bodies) as a market steward, should collect and disseminate timely information to be able to signal to the market the state of the sector, including the likely need to extend or expand services in some areas, the decrease in need in others, and changing consumer preferences. There is

already a range of published data about demand and service delivery at the Aged Care Planning Region level. The Impact Analysis considers that more detailed local information should be made available to the sector in addition to that already provided by Australian Institute of Health and Welfare GEN Aged Care Data. This could include:

- the number of consumers approved for care in a geographic region. An estimation of the regional distribution of need would further assist in informing the market and the strategic planning of providers, workforces, financiers and others.
- administrative data which could indicate newly proposed services (based on the approved provider notification process proposed earlier)
- bed occupancy/vacancy information in each local area (excluding occupancy data in areas with only a small number of possibly identifiable aged care homes)
- diffusion of best practice and innovation, e.g. sharing case studies of innovative care, services or accommodation and the delivery of best practice residential aged care in a competitive market.

For government

The government will need a deeper understanding of the supply and demand for care, and in particular will need visibility of whether all vulnerable and special needs groups are able to access care equitably. Currently, the department only has data about some special needs groups, such as Culturally and Linguistically Diverse consumers, older people who are financially disadvantaged and Aboriginal and Torres Strait Islander peoples. The extent and distribution of care delivered to other groups, such as care leavers and lesbian, gay, bisexual, transgender and intersex consumers, is poorly understood and further work needs to be undertaken to improve the monitoring of their patterns of access.

Under Model 2, visibility becomes more important, to allow the government to perform an active role as market steward and to consider possible interventions (such as greater viability support for thin markets) where the information shows market or policy failure. The Government has committed to steps to improved data in relation to special needs groups under its *Australian Government Diversity Action Plan* which was launched in February 2019 (Australian Government Department of Health, 2019c). This work remains in its scoping phase and will need to be further progressed to support a market under Model 2.

Implementation sequencing and timeframes

The Impact Analysis considers that improvements in the availability of appropriate information and supports is required to occur in a timely manner to assist consumers, providers and government. While there are certain improvements underway, and commitments to additional reform, further improvement should be promoted and closely monitored by key stakeholders.

6. Delivery of residential respite care

The availability of respite care will become increasingly important in an environment where more care is delivered at home. Improving its availability will support more meaningful consumer outcomes across the aged care system.

Residential respite care is currently delivered using a mechanism (respite care allocation) that relies on the concept of allocated residential aged care places. Therefore the administration of the residential respite program would need to change with the uncapping of the supply of respite care places and their assignment to eligible consumers under Model 2, separate from the assignment of permanent residential aged care places.

Separate to these reforms, the Impact Analysis notes that appropriate financial incentives for providers to offer respite as a viable alternative to permanent residential aged care were considered by stakeholders to be the key prerequisite for improving access to respite.

Carers Australia stated:

‘These changes to the model are unlikely to introduce much improvement in access to respite without addressing other matters which make offering of respite places unattractive to providers.’ (sub. 23, Q. 12)

Dementia Australia advised that consumer groups with complex care needs, including those with dementia, face challenges accessing residential respite care and considered that lack of dedicated funding for respite (alongside other system support) may be the cause:

‘Eligibility for respite does not necessarily translate into access to respite, let alone access to quality dementia-specific respite.

In order to address some of these challenges, Dementia Australia has previously recommended...a distinct funding envelope for residential respite care places, with a dementia supplement.’ (sub. 28, Q. 12)

As discussed in previous chapters, respite care was recently examined by the Aged Care Financing Authority (ACFA). Its October 2018 report made 19 recommendations, including five of relevance to the sequencing of reform and the relationship between respite and the residential places allocation system:

3) Establishing funding arrangements that are neutral between respite residents and permanent residents, and not act as a disincentive to respite care.

...

5) Recognising that consumers should make an appropriate contribution towards the cost of their respite care and accommodation where they can afford to do so, with appropriate support from the Government where consumers are not able to contribute.

6) Ensuring consistency with other potential reforms, including that consumer fees for respite care be considered in conjunction with wider changes to consumer care fees, such as better integration of fees more broadly in the residential, home care and CHSP sectors as recommended by the Legislated Review.

11) Allowing the market to respond to consumer demand and in turn the numbers of respite places that providers offer based on funding arrangements that do not act as a disincentive or incentive to the provision of respite care. Given that respite care is central to the aged care system, there should be an expectation that all providers be prepared to offer respite care.

14) Reviewing the respite incentive supplement in the context of the outcomes of the University of Wollongong work on broader residential care funding reform. If the relative rates of funding between respite residents and permanent residents are set appropriately, there may not be a need for a separate incentive supplement with all the associated administrative red tape that it brings. (*Aged Care Financing Authority, 2018*) (p. 4-5)

ACFA reasoned that neutrality in the funding of, and consumer contributions to, respite and permanent residential aged care would provide less incentive for providers to favour ‘try before you buy’ options over short-term respite. In the absence of such neutrality, ACFA contended there would be a risk of removing the cap on respite entitlement per eligible person each financial year (currently 63 days), which may encourage more use of respite as a ‘try before you buy’ arrangement at the expense of genuine respite care. On balance, ACFA recommended keeping a cap on an individual consumer’s yearly entitlement to respite care but suggested consideration should be given as to whether it should be less than 63 days.

ACFA’s recommendations demonstrate that the design of the respite care program requires overhaul. Model 2 presents an opportunity to discontinue the respite care allocation concept at the same time that allocated subsidised residential aged care places cease.

Catholic Health Australia observed:

‘Subject to reforms to achieve funding neutrality between residential respite and permanent residents (as previously argued by CHA and proposed by the Aged Care Financing Authority), residential respite should be allowed the flexibility to become a viable business model in its own

right to support the growing proportion of consumers (and their carers) accessing home-based aged care services.’ (sub. 25, Q. 11)

Implementation sequencing and timeframes

Once Model 2 is introduced, residential respite places would be allocated to eligible consumers and be fiscally uncapped as per residential aged care places. In order to retain a level of fiscal control over residential respite expenditure, a cap on an eligible consumer’s respite usage (currently 63 days per financial year) could continue to apply. This could be coupled with increased accountability and monitoring of the assessment workforce in their granting of an extension to the cap in specified circumstances.

Ensuring that eligibility assessments are accurate and approvals reflect current or foreseeable need for residential respite care should also assist in controlling expenditure. However, recognising that dual approvals for residential aged care and home care will likely decrease once the earlier discussed improvements to assessment are in place, there may be merit in considering whether an approval for residential respite care is automatically given alongside an approval for a higher level home care package. This could further improve timely access to respite care, particularly in an emergency event (e.g. sudden unavailability of a carer).

The Impact Analysis supports ACFA’s approach to reforming respite care set out above. The changes would complement the benefits to be derived from the abolition of ACAR as proposed under Model 2, in terms of being more responsive to demand and market forces.

Given that the Impact Analysis considers that Model 2 can come into effect once the parameters of the new funding model are more reliably known, interim alignment between the funding of residential respite and permanent residential aged care using the existing funding model would be required. This would then also remove the need for the respite incentive supplement (currently calculated on the basis of each provider’s respite care allocation) in order to incentivise the offering of high level residential respite care.

Once a new funding model is introduced, then residential respite funding would need to be re-aligned to the new funding parameters. The Impact Analysis also notes suggestions that a supplementary resource utilisation study is needed to be undertaken for residential respite care (Eagar, et al., 2019).

Further considerations

Increasing home care packages to reduce avoidable entry to residential aged care

In an uncapped residential aged care system it will be important to better understand true demand for residential aged care. It is possible that, currently, demand for residential aged care may in part be reflecting the level of unmet demand for home care.

Over the last five years the government has been announcing increases in the availability of home care. Throughout the transition to a new system for allocating residential aged care places to the consumer, the home care package program is scheduled to continue expanding. By 2022-23, around 158,000 total home care packages will be available (including around 77,000 high level packages) (The Hon Scott Morrison MP, Prime Minister of Australia, 2019).

This will help overcome the situation where some consumers enter residential aged care despite their preference for, and ability to benefit from, care at home. It is recognised, however, that there will always be circumstances where the complexity and hours of care a person needs is best delivered in a residential environment, or that carer support which would enable them to remain at home is not sufficient. The limitations of home care packages, as currently constructed, cannot replace the full-time wrap around professional support services of residential aged care.

COTA Australia has proposed that there should be an increase in the number of packages such that the wait for home care has been reduced to less than 3 months (COTA Australia, 2019). Any additional increase in home care beyond that already announced is subject to Government decision making.

As home care availability increases, the extent of over and/or under-supply of residential aged care, in aggregate and locally, will be able to be estimated with greater certainty, and the level to which residential aged care supply exceeds demand may well be more than the estimates arrived at in chapter 2.

There are several other supporting changes to programs that may enhance the benefits to be gained from Model 2.

[Rethinking accommodation settings for full-time aged care](#)

The Impact Analysis argues that consideration should be given to revising the legislated definition of residential aged care which currently precludes such care from being provided in a person's private home. This would support opening up the accommodation settings in which full-time professional care could be delivered.

Specifically, it is suggested that consideration be given to enabling providers to offer residential aged care in seniors housing, including assisted/independent living and retirement villages, provided the residential aged care building code and accreditation requirements are met. This may start to shift current negative perceptions of residential aged care accommodation. While increasing the appeal of residential aged care is desirable in providing greater quality and choice for consumers, it is also acknowledged that this may result in a marginal increase in the fiscal risk for Government.

Opening up the scope for more innovative full-time care delivery and accommodation offerings would need to be balanced with regulatory controls in other aspects of the system, such as approved provider status and the regulation of quality and safety. There may also be merit in a complementary review of relevant building regulations – including state or territory regulations relating to fire and work, health and safety and retirement villages.

Detailed work to estimate future demand for residential aged care would also be valuable and consumer means testing settings should be regularly reviewed to retain equity and fiscal sustainability over the longer term.

[Aligning the Specialist Dementia Care Program](#)

The Specialist Dementia Care Program is a new grant-funded initiative that has yet to formally commence (the first phase is expected to commence from April 2020). The program will provide intensive, specialised care in a dementia friendly environment, generally in a dedicated unit within an aged care home. Under the current program framework, providers of this new initiative must be an approved residential aged care provider, hold an allocation of residential aged care places through which to deliver the program, and have been selected via a grant opportunity process (Australian Government Department of Health, 2018f).

The Specialist Dementia Care Units are expected to be fully rolled out in 2022-23, with at least one unit in each Primary Health Network. It is understood that additional 'top up' funding is planned to be provided through a grant to the provider – calculated on the basis of number of places, not based on occupancy.

If Model 2 is implemented, both the requirement for specialist dementia care unit providers to hold allocated places and the top up funding would need to be based on the approved operational capacity for the program, rather than places.

[Integrating short-term restorative care into models of aged care](#)

Short-term restorative care places, while also distributed via the ACAR, are out of scope for the Impact Analysis. However, the Impact Analysis considers that restorative and reablement approaches should be an integral part of all aged care service delivery, for both home care and residential aged care, rather than a separate program and places for a limited number of people. This integrated approach could facilitate a more fluid aged care system. The funding model should also incentivise providers to undertake reablement and restorative approaches, for example by rewarding improvements in consumer functioning or by not withdrawing care funding when improvements occur as a consequence of provider investment in reablement or restorative care.

Supporting the aged care workforce

A growing and evolving residential aged care sector, as facilitated by the changes of Model 2, will need to be supported by a suitably sized and qualified workforce. The Impact Analysis notes the progress and actions underway in this area to grow and shape the aged care workforce of the future, including:

- The sector-led Aged Care Workforce Strategy, which sets out 14 strategic actions for the sector to shift attitudes to caring, to attract and retain a skilled workforce, to boost workforce capability, and to improve the quality of life for senior Australians.
- An Aged Services Industry Reference Committee will review and develop national competency standards for aged care vocational training.
- A sector Accord on the Remote Aged Care Workforce will provide a unified voice on remote aged care issues.
- A new Aged Services Workforce Industry Council will steward the Strategy and develop an implementation plan.

In addition to the broader work underway to grow and shape the aged care workforce, the transition to Model 2 may also require aged care industrial relation agreements and enterprise awards to be renegotiated and adjusted to better operate in a more competitive and potentially flexible market.

Adjusting the disclosure of bed licences

As noted in chapter 7, under Model 2 the disclosure of residential aged care places as an intangible asset will require specific assessment. Removing the places as intangible assets would decrease the net assets of those providers who record them in their financial statements. From a borrowing perspective, financiers/banks have advised that they already generally discount or eliminate the value of allocated places as an asset. While the change may require the security covenants in relation to secured borrowings to be reviewed, generally financial institutions do not include intangible assets when determining the value of net assets required to be maintained in a covenant.

Impact Analysis Proposals

In terms of timing for the implementation of Model 2, COTA Australia suggested ACAR be replaced after 2 years, as did the Legislated Review. Another factor is the Royal Commission's Final Report, which will not be available until 12 November 2020 and the government's development of an appropriate response to its recommendations.

The proposed staging of reforms is consistent with the advice of the 2011 Productivity Commission inquiry that it would be:

'disruptive to remove the supply restrictions in residential settings immediately... [and] it would be preferable to liberalise supply gradually, allowing time for providers to assess emerging market opportunities and to build their capacity to provide additional services.' (Productivity Commission, 2011) (Volume 2, p. 504)

Proposed timeframe for assigning residential aged care places to eligible consumers

The Impact Analysis recommends the following as an appropriate timeframe to best support the successful replacement of ACAR and allocated places:

1. 2020. Government announcement of a decision to transition residential aged care places to consumers, with two years' notice to all stakeholders in the interests of policy certainty. This will enable the education of consumers, business planning by providers, workforce and financiers, and the undertaking of related reforms by government.
2. 1 July 2022. Commencement of the assignment of residential aged care places to consumers.

Proposed sequencing of related reforms

The Impact Analysis recommends that there should be an appropriate sequencing of related reforms. One reform (the regulatory administration of approved provider status) should be a pre-requisite to the commencement of assigning places to consumers, while all other related reforms should be undertaken in conjunction with these changes.

1. Strengthening the approved provider assessment, including introducing reassessment requirements

This should be a pre-requisite reform, given the significance of opening up supply-side innovation.

Responsibility for determining whether to approve an applicant to become an approved provider transitioned to the Aged Care Quality and Safety Commission from 1 January 2020. This will mean that the approved provider process and assessment against the Aged Care Quality Standards will be both undertaken by the regulator. The process needs to be robust, coordinated and complementary and reassessments need to be undertaken on a regular basis.

The Impact Analysis considers that an organisation's approved provider status should be reassessed (in concert with other existing regulatory oversight mechanisms), when the organisation is planning to:

- operate new aged care homes (whether it be through construction, merger or acquisition), or
- expand existing aged care home by a material proportion (such as an increase in capacity by one third or more).

The department's related strengthening of financial management and prudential standards for approved providers needs to be completed within two years of the government's announcement.

2. Introducing the reforms to residential aged care funding to replace ACFI

The trial of the new AN-ACC funding model has commenced and is due to be completed in June 2020. If the Government announced a decision on the new model in 2021 the new funding may well be operational from July 2023.

Given the long lead times to establish new residential aged care capacity under Model 2, with a commencement date of 1 July 2022, there would be little 'on the ground' change in the first four years. On this basis, it is anticipated that a new funding model would be in place before the practical market impacts of Model 2 become evident from 2026 onwards.

A targeted funding boost could be made available at the same time as the commencement of Model 2 in order to support and incentivise construction of new capacity in thin markets where the effects of removing supply-control will be slower to emerge.

3. Reforming the assessment of consumer eligibility to better reflect current and foreseeable needs and to be more responsive to assessing the changing needs of consumers

The new aged care assessment arrangements which aim to provide streamlined consumer assessment for access to aged care services are to commence from April 2021. Associated changes required to better reflect current and foreseeable needs, be more responsive to assessing the changing needs of consumers, and be appropriately prudent and precise in assessing eligibility for subsidised care in its various forms could be in place by that time.

4. Clarifying the scope of additional services

It is understood that the department is working closely with the sector (providers and consumer groups) to improve understanding and transparency around additional service fees. The Impact Analysis considers that, given the importance of this issue with or without a reform of ACAR, the department should aim to resolve the ambiguities in a timely manner, preferably by 2022 to support the development of a more competitive market.

5. Improving information and support available to consumers and information available to providers and government

The Impact Analysis considers that improvements in the availability of appropriate information and supports is required to occur in a timely manner to assist consumers, providers and government. From July 2020, aged care homes will have their differentiated performance ratings against the Aged Care Quality Standards published on My Aged Care. The Impact Analysis considers there is also merit in publishing real-time vacancies. The system navigator trials are scheduled to conclude in June 2020 and are being evaluated to inform decisions about how to best support people, including those with diverse needs, to navigate aged care.

6. Developing a respite care program which is attractive to both consumers and providers (as a business model in its own right)

Once Model 2 is introduced, residential respite places would be allocated to eligible consumers and be fiscally uncapped as per residential aged care places. In order to retain a level of fiscal control over residential respite expenditure, a cap on an eligible consumer's respite usage (currently 63 days per financial year) could continue to apply. As Model 2 can be implemented prior to a new funding model, interim alignment between the funding for residential respite and permanent residential aged care using the existing funding model would be required to achieve neutrality. The funding would need to be re-aligned with new funding parameters once a reformed funding model is implemented.

Residential aged care under Model 2: a view of the future

Under Model 2, over time, it is expected that eligible consumers will be more likely to access professional care on a full-time basis when they need it, in a form they need and prefer, and where they want it. Most consumers will be able to exercise choice and make decisions according to their needs and preferences. They may prioritise providers who deliver higher standards of care or who offer accommodation (ranging from a traditional aged care home through to independent living units and retirement villages) and additional services that they can afford and wish to pay for. Published information on each aged care home's performance against the standards and real-time vacancies and other information will enable consumers to differentiate aged care homes based on their quality and offerings, and identify vacancies to facilitate timely access.

Diversity of choice, including for some consumers with specialised needs, will be particularly enhanced in metropolitan areas, but is more likely elsewhere as well. Advocacy and support services would be needed to assist consumers who require help to request an assessment and to conclude an arrangement with a preferred provider.

Providers will compete for consumers on the basis of their additional services and accommodation offerings but all aged care homes would, as a minimum, be required to meet standards of care as set out in the Aged Care Quality Standards. Some providers may decide to exceed these care standards.

New and existing providers offering services or accommodation in line with consumers' preferences will flourish and be able to expand their footprint. Poorly performing providers will need to improve or leave the sector. Their business decisions will be based on their own market research, market information made available by the department, and their ability to access capital. The sector – provided it is supported by a viable public and consumer funding model – will generate rates of return on investment that are competitive with that of other similar sectors, thus attracting investment to continue to build, refurbish and operate high quality full-time professional care that consumers need and prefer.

References

- AMR. (2019). *My Aged Care Evaluation - Wave 3, Summary Report. March to late May 2019*. Currently unpublished.
- Aged Care Financing Authority. (2018). *Report on respite for aged care recipients*. Australian Government.
- Aged Care Financing Authority. (2019). *Seventh report on the Funding and Financing of the Aged Care Industry*. Australian Government.
- Aged Care Quality and Safety Commission. (2019). *Consumer Experience Reports*. Retrieved 2019, from Aged Care Quality: <https://www.agedcarequality.gov.au/consumers/consumer-experience-reports>
- Aged Care Sector Committee. (2016). *Aged Care Roadmap*.
- Akiyama, N., Shiroya, T., Fukuda, T., Murashima, S., & Hayashida, K. (2018). Healthcare costs for the elderly in Japan: Analysis of medical care and long-term care claim records. *13*(5).
- Ansell Strategic. (2014). *Aged Residential Care Service Review II - Costing Summary Report*.
- Australian Building Codes Board. (n.d.). *Understanding the NCC*. Retrieved 2019, from Building Classifications: <https://www.abcb.gov.au/Resources/Publications/Education-Training/Building-classifications>
- Australian Government Department of Education. (2019, August). *Child Care Provider Handbook, Version 2*. Retrieved 2019, from Child Care Provider Handbook: <https://www.education.gov.au/child-care-provider-handbook>
- Australian Government Department of Health. (2016a). *2015-16 Report on the Operation of the Aged Care Act 1997*. Commonwealth of Australia.
- Australian Government Department of Health. (2016b). *Red Tape Reduction in Aged Care Places Management Guide - Guidance Material for Approved Providers*.
- Australian Government Department of Health. (2017a). *2016-17 Report on the Operation of the Aged Care Act 1997*. Commonwealth of Australia.
- Australian Government Department of Health. (2017b). *Home Care Packages Program: Data Report 27 February - 30 June 2017*.
- Australian Government Department of Health. (2017-18). Total average completed length of stay in permanent residential aged care, by diagnosis of dementia. *Aged Care Data Warehouse*. Unpublished data.
- Australian Government Department of Health. (2018a). *2017-18 Report on the Operation of the Aged Care Act 1997*. Commonwealth of Australia.
- Australian Government Department of Health. (2018b). *2018-19 Aged Care Approvals Round - Essential Guide*.
- Australian Government Department of Health. (2018c, May). *2018-19 Budget Fact Sheet: Better Access to Care - Impact analysis of allocating residential aged care places to consumers instead of providers*. Retrieved 2019, from 2018-19 Budget Fact Sheets: webarchive.nla.gov.au/wayback/20190404140226/http://www.health.gov.au/internet/budget/publications/Content/budget2018-factsheet78.htm
- Australian Government Department of Health. (2018d, December). *Extra service status (ESS) service list: 30 June 2018*. (Australian Institute of Health and Welfare) Retrieved 2019, from GEN Aged Care Data: [gen-agedcaredata.gov.au/Resources/Access-data/2018/December/Extra-service-status-\(ESS\)-service-list-30-June-2](http://gen-agedcaredata.gov.au/Resources/Access-data/2018/December/Extra-service-status-(ESS)-service-list-30-June-2)
- Australian Government Department of Health. (2018e). Portfolio Budget Statement, Budget Related Paper No. 1.9 - Health Portfolio. *Budget 2018-19*. Commonwealth of Australia.

- Australian Government Department of Health. (2018f, December 3). *Specialist Dementia Care Program framework*. Retrieved 2019, from Ageing and Aged Care: agedcare.health.gov.au/sites/default/files/documents/12_2018/specialist_dementia_care_program_framework_general_release_v1_0.pdf
- Australian Government Department of Health. (2019a, March 05). *2018-19 Aged Care Approvals Round Results*. Retrieved 2019, from Ageing and Aged Care: agedcare.health.gov.au/funding/aged-care-approvals-round-acar/2018-19-aged-care-approvals-round/results
- Australian Government Department of Health. (2019b). *2018-19 Report on the Operation of the Aged Care Act 1997*. Commonwealth of Australia.
- Australian Government Department of Health. (2019c). *Aged Care Diversity Framework action plans*. Retrieved 2019, from Ageing and Aged Care: agedcare.health.gov.au/support-services/people-from-diverse-backgrounds/aged-care-diversity-framework-action-plans
- Australian Government Department of Health. (2019d). *Becoming an Approved Provider*. Retrieved 2019, from Ageing and Aged Care: agedcare.health.gov.au/funding/becoming-an-approved-provider#1.0
- Australian Government Department of Health. (2019e). *Home Care Packages Program - Data Report 4th Quarter 2018-19, 1 April - 30 June 2019*.
- Australian Government Department of Health. (2019f). *Resource Utilisation and Classification Study - RUCS Overview and Reports*. Retrieved 2019, from Ageing and Aged Care: agedcare.health.gov.au/reform/resource-utilisation-and-classification-study-rucs-overview-and-reports
- Australian Government Department of Health. (2019g, August). *Stocktake of Australian Government Subsidised Aged Care Places, 30 June 2019*. Retrieved from GEN Aged Care Data: agedcaredata.gov.au/Resources/Access-data/2019/August/Stocktake-data-30-June-2019
- Australian Government Department of Social Services. (2019a). *NDIS Thin Markets Project*. Retrieved 2019, from Engage: <https://engage.dss.gov.au/ndis-thin-markets-project/>
- Australian Government Department of Social Services. (2019b, March 22). *Younger People in Residential Aged Care - Action Plan*. Retrieved 2019, from Disability and Carers: dss.gov.au/disability-and-carers-programs-services-for-people-with-disability-younger-people-with-disability-in-residential-aged-care-initiative/younger-people-in-residential-aged-care-action-plan
- Australian Institute of Health and Welfare. (2017). *Glossary*. Retrieved 2019, from GEN Aged Care Data: agedcaredata.gov.au/Resources/Glossary
- Australian Institute of Health and Welfare. (2017-18). *Explore people leaving aged care*. Retrieved 2019, from GEN Aged Care Data: agedcaredata.gov.au/Topics/People-leaving-aged-care/Explore-people-leaving-aged-care
- Baxter, J., Bray, J., Carroll, M., Hand, K., Gray, M., Katz, I., . . . Blaxland, M. (2019). *Child Care Package Evaluation: Early monitoring report (Research Report)*. Melbourne: Australian Institute of Family Studies.
- Beauchamp, G. A. (2019, February 4). Witness Statement - Royal Commission into Aged Care Quality and Safety. *Exhibit 1-23 - WIT.0022.0001.0001*. Adelaide Hearing 1.
- Care Quality Commission. (n.d.). *Care Quality Commission: Independent regulator of health and social care in England*. Retrieved 2019, from <https://www.cqc.org.uk/>
- Carey, G., Dickinson, H., Malbon, E., & Reeders, D. (2017). The Vexed Question of Market Stewardship in the Public Sector: Examining Equity and the Social Contract through the Australian National Disability Insurance Scheme. 52(1).
- Carnell, K., & Paterson, R. (2017). *Review of national aged care quality regulatory processes*.
- Commonwealth of Australia. (2018). Budget Measures - Budget Paper No. 2, 2018-19. *Budget 2018-19*.

- Competition and Markets Authority. (2017). *Care homes market study: Final report*. United Kingdom: GOV.UK.
- COTA Australia. (2019). *Pre-Budget Position Statement - Federal Budget 2019-20*. Retrieved from cota.org.au/wp-content/uploads/2019/02/Federal-Budget-2019-COTA-Position-Statement-FINAL.pdf
- Coulter, A., & Ellins, J. (2007). Effectiveness of strategies for informing, educating and involving patients. 335(24).
- Curry, N., Castle-Clarke, S., & Hemmings, N. (2018). *What can England learn from the long-term care system in Japan? Research Report*. Nuffield Trust.
- Department of the Prime Minister and Cabinet. (2014). *The Australian Government Guide to Regulation*. Commonwealth of Australia.
- Eagar, K., McNamee, J., Gordon, R., Snoek, M., Duncan, C., Samsa, P., & Loggie, C. (2019). *The Australian National Aged Care Classification (AN-ACC). The Resource Utilisation and Classification Study: Report 1*. Australian Health Services Research Institute, University of Wollongong.
- Eagar, K., McNamee, J., Gordon, R., Snoek, M., Kobel, C., Westera, A., . . . Quinsey, K. (2019). *A national classification and funding model for residential aged care: Synthesis and consolidated recommendations. The Resource Utilisation and Classification Study: Report 6*. Australian Health Services Research Institute, University of Wollongong.
- Elderly Accommodation Counsel. (n.d.). *First Stop: Advice for older people*. Retrieved 2019, from Housing Care: <http://www.housingcare.org/guides/item-close-care-housing.aspx>
- Eldernet. (n.d.). *Residential care*. Retrieved 2019, from Eldernet: Rest Homes, Retirement Villages and Home Services in New Zealand: <https://www.eldernet.co.nz/Residential%20Care>
- Ernst & Young. (2019). *Aged Residential Care Funding Model Review*.
- GrantThornton. (2018). *Care homes for the elderly: Where are we now?*
- Jain, B., Cheong, E., Bugeja, L., & Ibrahim, J. (2019). International transferability of research evidence in residential long-term care: A comparative analysis of aged care systems in 7 nations. 20(12).
- Joint Standing Committee on the National Disability Insurance Scheme. (2018). *Market readiness for provision of services under the NDIS*. Canberra: Commonwealth of Australia.
- Joint Standing Committee on the National Disability Insurance Scheme. (2019). *Progress Report*. Canberra: Commonwealth of Australia.
- Kubo, M. (2014). Long-term care insurance and market for aged care in Japan: focusing on the status of care service providers by locality and organisational nature based on survey results. 33(3).
- Le Grand, J. (2007). *The other invisible hand: Delivering public services through choice and competition*. Princeton University Press.
- Malbon, E., Carey, G., & Meltzer, A. (2019). Personalisation schemes in social care: Are they growing social and health inequities? 19(805).
- McNamee, J., Snoek, M., Kobel, C., Loggie, C., Rankin, R., & Eagar, K. (2019). *A funding model for the residential aged care sector. The Resource Utilisation and Classification Study: Report 5*. Australian Health Services Research Institute, University of Wollongong.
- Ministry of Health. (2012). *Long-term Residential Care for Older People: What you need to know* (revised 2019). Wellington.
- Ministry of Health. (2019, June). *Residential care questions and answers*. Retrieved 2019, from Long-term residential care: <https://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/residential-care-questions-and-answers>

- National Health Service. (2019). *Care homes*. Retrieved from NHS - Social care and support guide: www.nhs.uk/conditions/social-care-and-support-guide/care-services-equipment-and-care-homes/care-homes/
- National Institute of Labour Studies - Flinders University Adelaide. (2018). *Evaluation of the NDIS - Final Report*.
- Newman, J., & Tonkens, E. (2011). *Participation, responsibility and choice: summoning the active citizen in Western European welfare states*. Amsterdam: Amsterdam University Press.
- North of England Commissioning Support Unit. (n.d.). *Capacity Tracker*. Retrieved 2019, from NECS: necsu.nhs.uk/services/system-wide-transformation/capacity-tracker/
- OECD European Union. (2013). *A Good Life in Old Age?: Monitoring and Improving Quality in Long-term Care, OECD Health Policy Studies*. Paris: OECD Publishing.
- Office of the Auditor-General. (2009). *Part 2: How rest homes are certified and monitored*. Retrieved from Effectiveness of arrangements to check the standards of services provided by rest homes: <https://www.oag.govt.nz/2009/rest-homes/part2.htm>
- Productivity Commission. (2011). *Caring for Older Australians, Report No. 53, Final Inquiry Report*. Canberra: Commonwealth of Australia.
- Productivity Commission. (2014). *Childcare and Early Childhood Learning, Inquiry Report No. 73*. Canberra: Commonwealth of Australia.
- Productivity Commission. (2017a). *Introducing competition and informed user choice into human services: Reforms to Human Services, Report No. 85*. Canberra: Commonwealth of Australia.
- Productivity Commission. (2017b). *National Disability Insurance Scheme (NDIS) Costs, Study Report*. Canberra: Commonwealth of Australia.
- Productivity Commission. (2019). *Report on Government Services, Part F, Chapter 14 Aged care services*.
- Royal Commission into Aged Care Quality and Safety. (2019). *Interim Report: Neglect - Volume 1*. Commonwealth of Australia.
- Savills. (2018). *Spotlight - Japan Healthcare: New opportunities in an ageing society*.
- Senator the Hon Richard Colbeck, Minister for Aged Care and Senior Australians. (2019, December 18). *Meeting future demand for residential aged care places [media release]*. Retrieved from health.gov.au/ministers/senator-the-hon-richard-colbeck/media/meeting-future-demand-for-residential-aged-care-places
- Smith, J. A. (2019a, May 10). Witness Statement - Royal Commission into Aged Care Quality and Safety. *Exhibit 4-17, WIT.0128.0001.0001*. Broome Hearing.
- Smith, J. A. (2019b, October 9). Royal Commission into Aged Care Quality and Safety. *Melbourne Hearing 2: Diversity in aged care [transcript of proceedings, p. 5519 - 5521]*. Melbourne.
- StewartBrown. (2019a). *Aged Care Financial Performance Survey - Aged Care Sector Report 2018-19*.
- StewartBrown. (2019b). *Aged Care Financial Performance Survey - Quarter 1 2019-20 Survey Results Summary*.
- Sugimoto, K., Kashiwagi, M., & Tamiya, N. (n.d.). Predictors of preferred location of care in middle-aged individuals of a municipality in Japan: a cross-sectional survey. 17(1).
- Tamiya, N., Noguchi, H., Nishi, A., & Reich, M. R. (2011). Population ageing and wellbeing: lessons from Japan's long-term care insurance policy. *Lancet*, 378(9797).
- Technical Advisory Services, Health New Zealand. (n.d.). *Aged Residential Care*. Retrieved 2019, from Health of Older People Programme: health.nz/dhb-programmes-and-contracts/health-of-older-people-programme/aged-residential-care/

- The Hon Ken Wyatt AM MP, Former Minister for Senior Australians and Aged Care. (2019, May 8). *\$10 million to navigate more choice in multicultural aged care [media release]*. Retrieved from kenwyatt.com.au/ministerial-news/2019/5/12/10-million-to-navigate-more-choice-in-multicultural-aged-care
- The Hon Scott Morrison MP, Prime Minister of Australia. (2019, November). *Response to Aged Care Royal Commission Interim Report [media release]*. Retrieved from pm.gov.au/media/response-aged-care-royal-commission-interim-report
- Tune, D. (2017). *Legislated Review of Aged Care*. Commonwealth of Australia, as represented by the Department of Health.
- Wells, Y., & Solly, K. (2018). *Analysis of consumer experience report data: Final report to the Australian Aged Care Quality Agency*. Melbourne: Australian Institute for Primary Care & Ageing, La Trobe University.
- Woods, M., Edwards, K., Nejad, M. N., Haywood, P., & Wise, S. (2019). *Final Report - Aged care in MPS: Response to the Australian Government Terms of Reference*. Royal Commission into Aged Care Quality and Safety - Mudgee Hearing, Exhibit 12-1 General tender bundle - Tab 13 CTH.1000.0003.8206.

Index of figures

Figure 2.1 Map of 2018-19 ACAR Categories of Priority across Australia	26
Figure 2.2 Distribution of provisionally allocated residential aged care places by years since allocation, proportion and number, 30 June 2018	30
Figure 2.3 Share of total allocated residential aged care places by organisation type, last five ACARs	33
Figure 2.4 Frequency of length of residential respite care stay, 2017-18	37
Figure 2.5 Age-specific usage rates of residential aged care, 30 June 2019	39
Figure 2.6 Care need ratings for activities of daily living of people in residential aged care, 30 June 2009 to 30 June 2018	41
Figure 2.7 Exits from residential aged care by discharge reasons, 2008-09 to 2017-18	41
Figure 2.8 Age-specific utilisation of residential aged care and home care, 2000 to 2018	42
Figure 2.9 Utilisation of residential aged care and home care for 85-89 year olds, 2000 to 2018	43
Figure 2.10 Aged care homes by organisation type and remoteness, 30 June 2018	44
Figure 2.11 Size of aged care home by organisation type, 30 June 2018	45
Figure 2.12 Projected demand for and supply of residential aged care and respite places, 2018 to 2039	46
Figure 2.13 Proportion of aged care homes planning to either upgrade or rebuild, 2013-14 to 2017-18	47
Figure 2.14 Rate of year-on-year growth in residential aged care building activity, 2012-13 to 2017-18	47
Figure 2.15 Residential aged care building work undertaken by activity, 2011-12 to 2017-18	48
Figure 2.16 Distribution of new residential aged care buildings by organisation type, 2017-18	49
Figure 2.17 Distribution of new residential aged care buildings by remoteness, 2017-18	49
Figure 2.18 Proportion of aged care homes with approval for higher accommodation supplement, 2014 to 2019	50
Figure 2.19 Number of aged care homes and operational residential aged care places, 2014 to 2019	50
Figure 5.1 Median occupancy rates in residential aged care, 2014-15 to 2018-19	68
Figure 5.2 Number of aged care homes in each mean occupancy bracket, 2018-19	69
Figure 5.3 Number of aged care planning regions in each median occupancy bracket, 2018-19	70
Figure 5.4 Distribution of aged care homes, Multi-Purpose Services and National Aboriginal and Torres Strait Islander Flexible Aged Care services, 30 June 2018	71
Figure 5.5 Aged care planning regions distributed by median occupancy rate and differential between provision and target ratios for residential aged care, 2017-18	72
Figure 5.6 Comparison of the proportion of Aboriginal and Torres Strait Islander people (age 50+) in Darwin aged care planning region, Northern Territory, and Australia, 30 June 2018	72
Figure 5.7 Aged care planning regions with a negative differential between provision and target ratios and median occupancy rate greater than overall median rate, 2017-18	73
Figure 5.8 Hospital patient days used by patients waiting for residential aged care in each state and territory, 2012-13 to 2016-17	76
Figure 5.9 Number of aged care homes in each supported resident ratio bracket, 2017-18	78
Figure 5.10 Number of aged care homes, with priority of access conditions of allocation for Financially and Socially Disadvantaged residents, in each supported resident ratio bracket, 2017-18	78
Figure 5.11 Aged Care Home Results sorted by supported resident ratio, 2017-18 and 2018-19	79
Figure 5.12 Proportion of residential aged care places by organisation type and remoteness, 30 June 2018	81
Figure 5.13 Percentage change in number of residential aged care places by remoteness, 2014-15 to 2017-18	81
Figure 5.14 Residential aged care provider average EBITDA per resident per year, 2010-11 to 2017-18	87
Figure 5.15 Aged Care Home Result per resident per year, June 2013 to June 2019	87
Figure 7.1 Number of home care providers by proportion of organisation type, 30 June 2013 to 30 June 2018	109
Figure 7.2 Per cent of child care centres by number of centres within a 5 kilometre distance of one another, 2011-12	110
Figure 7.3 Variation in agreement to Consumer Experience Report questions by size of aged care home	113
Figure 7.4 Average financial value of residential aged care place for not-for-profit and for-profit providers, 2017-18 and 2016-17	121

Figure 7.5 Residential aged care providers by organisation type reporting residential aged care places as intangible assets, 2017-18.....	122
Figure 7.6 Aged Care Home Result sorted on mean occupancy rate, 2017-18.....	126
Figure 7.7 Occupancy impact on two existing aged care homes from opening of new aged care home – inner regional Queensland, June 2015 to June 2018.....	126
Figure 7.8 Occupancy impact on three existing aged care homes from opening of new aged care home – urban Victoria, June 2015 to June 2018.....	127

Index of tables

Table 2.1 Opening, closing and results announcement dates of last five ACARs	32
Table 2.2 Residential aged care places and capital grants available, sought and allocated in last five ACARs	32
Table 2.3 2018-19 ACAR applications and residential aged care places sought and allocated by priority category	35
Table 2.4 2018-19 ACAR capital grants applications, amounts sought and allocated, by priority category....	38
Table 2.5 Age-specific usage rates of residential aged care per 1,000 people, 30 June 2015 to 30 June 2018	40
Table 2.6 Number of providers, aged care homes, and places in residential aged care, by organisation type, location and portfolio scale, 2018-19.....	44
Table 5.1 Median occupancy rates in residential aged care, by states and territories, 2018-19	69
Table 5.2 Aged care planning regions with median occupancy rate below 90 per cent, 2018-19	70
Table 5.3 Mean occupancy rate in residential aged care by remoteness, 2013-14 to 2017-18	75
Table 7.1 Approved provider applications for home care by assessment outcome, 2015-16 to 2017-18	111
Table 7.2 Consumer Experience Report questions and response options.....	113
Table 7.3 Residential aged care places as intangible assets and negative equity position before and after impairment, 2017-18.....	122
Table 7.4 Loan-to-value ratios in residential aged care, 2017-18 and 2018-19	125
Table 8.1 Comparison of current residential aged care place allocation model and alternative allocation models	133
Table 8.2 Summary scoring of the alternative models against the key principles relative to status quo	135